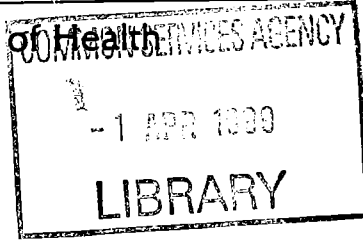




THE SCOTTISH OFFICE

Department of Health



NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG
31st March 1999
Telephone 0131-244
Fax 0131-244

Dear Colleague

**IN YEAR PERFORMANCE MONITORING TEMPLATE
1999/2000**

1. The 1998/99 template for reporting activity and expenditure was revised by a Working Group comprising representatives of Health Boards and GP practices. There is very little change to the template for 1999/2000 and a copy of the amended template for use in 1999/2000 is attached at Annex B. The slightly revised guidelines for its completion are at Annex C. Health Boards should ensure that all of their data suppliers receive a copy of this MEL for information.

2. The performance monitoring template plays an important role in the monitoring of HCH activity and expenditure at Health Board level. It is essential that the returns are submitted timeously, and that these are signed off by the Health Board General Manager to confirm that they provide an accurate reflection of the Board's latest position. The timetable for completion of the returns is set out in Annex A. You will note from MEL(1999)15 '1999/2000 Corporate Contract' that the template now forms part of the corporate contract, and initial plans for 1999/2000 should be submitted by 31 March 1999.

3. The changes to the guidance notes this year are intended to provide more robust and meaningful data - especially in relation to inter-Board comparisons. Any suggestions for improvements to the guidance notes should be made directly to Mrs Wilson, who will ensure that these are considered in the course of this year.

4. The calculation of in-year quarterly estimates of efficiency changes are still an integral part of the monitoring process. Please ensure the efficiency calculations are also completed each quarter.

Yours sincerely,

Thea S. Teale

JK

KEVIN J WOODS
Director of Strategy and Performance Management

March 1999

Addressees

For action:

General Managers, Health Boards

For information:

General Manager, Common Services Agency
Chief Executive, Health Education Board For Scotland
General Manager, State Hospital
Executive Director, SCPMDE
Chief Executives, NHS Trusts

Enquiries to:

Mrs Julie Wilson
Senior Statistician
NHS Management Executive
Economics and Information Division
Room 349
St Andrew's House
EDINBURGH

Tel: 0131-244 2368
Fax: 0131-244 2074

SCOTTISH HEALTH SERVICES COMMON SERVICES AGENCY TRINITY PARK HOUSE, 100, N. BRIDGE
CLASS Ref.
ACC. 1P-115: 105251
Date / /

TIMETABLE FOR SUBMISSION OF RETURNS

Performance monitoring template returns and an accompanying commentary should be formally signed off by Health Board General Managers and submitted to the Chief Executive with a copy to Mrs Julie Wilson, by:

1998/1999 Returns (based on MEL(1998)45)

- **28 May 1999**
Final outturn 1998/99

1999/2000 Returns (based on this MEL)

- **31 March 1999**
Initial plan for 1999/2000
- **28 May 1999**
Final plan for 1999/2000)
- **27 August 1999**
1st quarter figures and forecast outturn for 1999/2000
- **26 November 1999**
2nd quarter figures and forecast outturn for 1999/2000
- **25 February 2000**
3rd quarter figures and forecast outturn for 1999/2000
- **26 May 2000**
Final outturn 1999/2000

IN YEAR PERFORMANCE MONITORING RETURN : Forecast Outturn

	1998-99 Outturn		1999-2000 Plan		Forecast Outturn 1999-2000		% Variances	
	Actual Activity	Actual Expenditure	Planned Activity	Planned Value	Actual Activity	Actual Expenditure	Activity	Expenditure
ACUTE								
01 Elective In-Patient Discharges								
02 Emergency In-Patient Discharges (inc Transfers)								
03 Total In-Patient Discharges (01+02)								
04 Day Cases								
05 Day Patient Attendances								
06 New Out-Patients Attendances								
07 A&E New Out-Patient Attendances (HBT)								
MATERNITY								
08 In-Patient Discharges (inc. SCBU patients)								
09 Births								
10 Day Cases								
11 New Out-Patient Attendances								
12 Total Community Midwife Visits(HBT)								
MENTAL HEALTH								
13 Occupied Bed days - Adult & Child								
14 Occupied Bed days - Psychogeriatric								
15 New Out-Patient Attendances								
16 Attendances By Mental Health Patients At Day Hospitals (HBT)								
17 Community Psychiatric Team Contacts/Visits								
LEARNING DISABILITY								
18 Occupied Bed Days								
19 New Out-Patient Attendances								
20 Attendances By Learning Disability Patients At Day Hospitals (HBT)								
21 Community Learning Disability Team Contacts/Visits								
GERIATRIC ASSESSMENT								
22 In-Patient Discharges								
23 New Out-Patient Attendances								
24 Attendances At Geriatric Day Hospitals								
GERIATRIC LONG STAY								
25 Occupied Bed Days								
YOUNG PHYSICALLY DISABLED								
26 Occupied Bed Days								
COMMUNITY								
27 Community Nurses Or Health Visitors Contacts (HBT)								
28 Community PAMs Contacts								
29 Community Dental Services - Courses Of Treatment								
HOSPITAL DIRECT ACCESS								
30 Laboratories & X-Ray								
31 PAMs & Other Technical Departments								
RESOURCE TRANSFER ETC								
32 Resource Transfer (total of lines 33 to 36)								
33 Mental Health								
34 Learning Disability								
35 Geriatric Long Stay								
36 Young Physically Disabled								
37 Funding Of Other Non-NHS Services (including Community Care)								
AMBULANCES								
38 Emergency Ambulance Services (Patient Journeys)								
39 HEALTH PROMOTION								
40 OTHER HCH EXPENDITURE								
41 TOTAL HCH EXPENDITURE								
42 TOTAL VALUE OF ALL UNPACs								

IN YEAR PERFORMANCE MONITORING RETURN : Year to Date

	Year To Date		Year To Date		% Variances	
	Planned Activity	Planned Value	Actual Activity	Actual Expenditure	Activity	Expenditure
ACUTE						
01 Elective In-Patient Discharges						
02 Emergency In-Patient Discharges (inc Transfers)						
03 Total In-Patient Discharges (01+02)						
04 Day Cases						
05 Day Patient Attendances						
06 New Out-Patients Attendances						
07 A&E New Out-Patient Attendances (HBT)						
MATERNITY						
08 In-Patient Discharges (inc. SCBU patients)						
09 Births						
10 Day Cases						
11 New Out-Patient Attendances						
12 Total Community Midwife Visits(HBT)						
MENTAL HEALTH						
13 Occupied Bed days - Adult & Child						
14 Occupied Bed days - Psychogeriatric						
15 New Out-Patient Attendances						
16 Attendances By Mental Health Patients At Day Hospitals (HBT)						
17 Community Psychiatric Team Contacts/Visits						
LEARNING DISABILITY						
18 Occupied Bed Days						
19 New Out-Patient Attendances						
20 Attendances By Learning Disability Patients At Day Hospitals (HBT)						
21 Community Learning Disability Team Contacts/Visits						
GERIATRIC ASSESSMENT						
22 In-Patient Discharges						
23 New Out-Patient Attendances						
24 Attendances At Geriatric Day Hospitals						
GERIATRIC LONG STAY						
25 Occupied Bed Days						
YOUNG PHYSICALLY DISABLED						
26 Occupied Bed Days						
COMMUNITY						
27 Community Nurses Or Health Visitors Contacts (HBT)						
28 Community PAMs Contacts						
29 Community Dental Services - Courses Of Treatment						
HOSPITAL DIRECT ACCESS						
30 Laboratories & X-Ray						
31 PAMs & Other Technical Departments						
RESOURCE TRANSFER ETC						
32 Resource Transfer (total of lines 33 to 36)						
33 Mental Health						
34 Learning Disability						
35 Geriatric Long Stay						
36 Young Physically Disabled						
37 Funding Of Other Non-NHS Services (including Community Care)						
AMBULANCES						
38 Emergency Ambulance Services (Patient Journeys)						
39 HEALTH PROMOTION						
40 OTHER HCH EXPENDITURE						
41 TOTAL HCH EXPENDITURE						
42 TOTAL VALUE OF ALL UNPACs						

GUIDELINES FOR COMPLETION OF IN-YEAR PERFORMANCE MONITORING TEMPLATE 1999-2000

GENERAL NOTES

Forecast Outturn

The **final plan for 1999-2000** is required by **28 May 1999** and should reflect the latest available estimates of planned activity and expenditure following the successful agreement on the content of HIPs and TIPs and any other relevant agreements. These plans should also reflect the planned increases in expenditure and activity as a result of the £45m recurring money issued under the Waiting List Initiative. At the end of the first quarter and subsequent quarters, only the 1999-2000 plan and forecast outturn (1999-2000) columns require to be completed in respect of the Forecast Outturn sheet.

In-Year Changes to Plan

Service developments and planned changes in in-year activity levels, which it is known will get underway in the course of the year, should be included in the figures within the template submitted for the forthcoming year.

Where developments and other such changes are agreed for implementation in-year after the template has been submitted, the subsequent quarterly monitoring report should be amended to reflect these agreed changes: both the 'planned' and 'actual' activity and expenditure values should be adjusted, with the changes explained fully in the narrative which accompanies the Board's quarterly return. **The provision of a clear explanation of changes is essential.**

Residual GP Fundholder Commissioned Activity

As in previous years, the template should cover **total care commissioned** for residents in the Health Board area. It should therefore be an aggregation of care commissioned by the Health Board and by residual GP fundholders (see MEL(1999)3).

Cost Per Case Contracts

The White Paper "Designed To Care - Renewing The NHS in Scotland", published on Tuesday 9 December 1997, set out the Government's plans to replace the internal market. The number of cost per case contracts should have reduced substantially in 1998/99 and subsequent years, with more use being made of block contracts, thus reducing unnecessary bureaucracy. Cost Per Case contracts should be used only in a few exceptional instances.

Financial Reporting and Reconciliation

It is **essential** that expenditure reported in the template should **relate to the activity reported** and should be **reconciled with the monthly income and expenditure monitoring returns** as specified below. Expenditure should therefore be recorded on an **accruals** basis. It is recognized that the difference in the timetable for submitting these two returns will lead to differences in the expenditure reported. However, differences between the appropriate monthly financial returns and the template **must** be explained in the accompanying narrative.

ACT and "Off The Tops"

Expenditure on ACT and other "off the tops" such as dental hospitals should be **excluded** from expenditure reported in the template. As a rule of thumb all expenditure by Health Boards and residual GP fundholders on commissioning health services should be included in the appropriate line of the template; HQ expenditure, Reserves, activity purchased by the Management Executive on behalf of Health Boards and "off the tops" should be excluded.

There may be various cases where the Health Board has commissioned non-activity generating developments - such as quality improvements which do not correspond directly to patient numbers. Such expenditure should be allocated out to service lines where possible, with any amounts which cannot be allocated included within line 40. (Thus only genuinely exceptional issues, such as the small residual elements of funding for Post Basic Nursing Training which Boards receive, and other ad hoc items will be included in line 40.) Health Boards are encouraged to comment on the magnitude of such expenditure in the narrative - so that this can be taken into account when commenting on any assessment of efficiency.

Health Board of Residence

The template should be completed on a Health Board of Residence basis wherever possible. In some areas information on Health Board of Residence is not routinely available. In these areas the template asks for activity to be reported in terms of Health Board of Treatment (HBT). Expenditure should relate, however, to the actual agreement, and if data on activity for Health Board of Residence are available, these should be included in a footnote.

Occupied Bed Days : Mental Health, Learning Disabilities, Geriatric Long Stay and Young Physically Disabled

Anticipated changes over the year should be indicated in the completed template returns which are submitted on 31 March 1999. This data should cover NHS, Joint User and Contractual beds. Subsequent in-year changes to plan should be reported in the template and **must** be explained in the accompanying narrative.

DETAILED COMPLETION NOTES

The sections and numbering below relate to the relevant sections and rows on the template.

ACUTE

"Acute" is defined as all acute (including GP acute), supra-area, accident and emergency (A&E) and other special categories (excluding SCBU). Commissioners are required to identify emergency and elective activity separately.

01(04) Elective in-patient (day case) discharges include patients admitted from true, deferred and repeat waiting lists. It does not include transfers as these are included with emergency admissions.

02 This should include both emergency admissions and transfers.

04 A day case is a patient who makes a planned attendance to a specialty for clinical care, sees a doctor or dentist and requires the use of a bed or use trolley in lieu of a bed. The patient is not expected to, and **does not**, remain in over night. For more details see the ISD Definitions Manual.

05 A day patient attendance is the occasion of a day patient attending a day hospital, or an inpatient ward for day patient care, for one day or part of a day. The attendance usually lasts half a day. Not all Health Boards separately identify this activity in their planning of provision (and some have previously included it elsewhere in the template - either in line 04 or line 40). In order to prevent under reporting of activity or the distortion of the day case rate, day patient attendances should be separately identified where possible. Examples of the acute specialties to include here are paediatric medicine, stroke rehabilitation and haemodialysis; for the purpose of this return, hematology should be excluded from line 05 and shown in line 04 instead. For more details see the ISD Definitions Manual.

06 New out-patient attendances in all acute specialties except A&E. Where agreements for out-patient care are for new and return out-patients, new attendances only should be included.

07 Includes all new A&E attendances in period. Activity data is routinely collected only on area of treatment.

MATERNITY (including specialist obstetrics, GP obstetrics and SCBU)

08 Maternity discharges

09 Births (live & still)

Health Boards should report activity under both discharges and births headings and the value of this activity on the appropriate line. It is recognised that there may be difficulties in providing accurate figures for births in-year; however, it should be possible for this data to be provided at the end of the year.

- 10 Maternity Day Cases.
- 11 New out-patient attendances.
- 12 Activity and values of visits made by community midwives.

MENTAL HEALTH (Comprises specialties mental illness, psychogeriatrics, child psychiatry, adolescent psychiatry reported on SMR4 returns)

- 13 Occupied bed days from the specialties mental illness, child and adolescent psychiatry.
- 14 Occupied bed days from the specialty psychogeriatrics.
- 15 New out-patient attendances in all the above specified specialties. This should cover **all new** out-patient attendances - as reported on SMR00.
- 16 Attendances by mental health day patients. Activity data is routinely collected only on area of treatment.
- 17 Activity data should relate to all contacts/visits by community psychiatric team members, and should cover **all follow up contacts/visits irrespective of discipline**. This should equate with all team contacts other than the first medical team contacts generating an SMR00 and recorded in line 15.

LEARNING DISABILITIES

- 18 Occupied bed days for the specialty of learning disability.
- 19 New out-patient attendances in the specialty of learning disability. This should cover **all new** out-patient attendances - as reported on SMR00.
- 20 Attendances by learning disability day patients. Activity data is routinely collected only on area of treatment.
- 21 Activity data should relate to all contacts/visits by community learning disability team members, and should cover **all follow up contacts/visits irrespective of discipline**. This should equate with all team contacts other than the first medical team contacts generating an SMR00 and recorded in line 19.

GERIATRIC ASSESSMENT/GERIATRIC MEDICINE

These notes have been updated to take account of the move to COPPISH, under which the specialties of geriatric assessment and geriatric long stay have migrated to geriatric medicine.

Lines 22 to 25 of this return are still intended to only cover what was geriatric assessment activity; geriatric long stay is recorded in line 25.

- 22 In-patient discharges from specialty of geriatric medicine, from the geriatric assessment facility (i.e. excluding geriatric long stay). This **should** include rehabilitation of geriatric and younger physically disabled patients.
- 23 New out-patient attendances in the specialty of geriatric medicine, from the geriatric assessment facility.
- 24 Total attendances made by geriatric patients and young physically disabled patients to day hospitals within the specialty of geriatric medicine, from a geriatric assessment facility (GP Acute day patient activity should be recorded in line 40 of the template and detailed in the commentary). Activity data is routinely collected only on area of treatment.

GERIATRIC LONG STAY/GERIATRIC MEDICINE

- 25 Occupied bed days for geriatric long stay patients. This should not include rehabilitation (which should be included within line 22). For year on year comparisons it is **essential** that this is handled consistently in both years' data. For consistency with ISD returns "geriatric long stay" is taken to cover patients aged 65 and over and "younger physically disabled" is taken to cover patients under 65. Activity should be reported on a Health Board of Residence basis (i.e. using SMR50).

YOUNG PHYSICALLY DISABLED

- 26 Occupied bed days in specialty of young physically disabled. For consistency with ISD returns "geriatric long stay" is taken to cover patients aged 65 and over and "younger physically disabled" is taken to cover patients under 65. Activity should be reported on a Health Board of Residence basis (i.e. younger physically disabled from SMR50).

COMMUNITY

- 27 The activity column should include community nurse and health visitor face-to-face contacts (including child health). Activity data is routinely collected only on area of treatment.
- 28 The activity column should include face-to-face patient contacts by professions allied to medicine (which are covered by community-based agreements). Community based direct access should also be included in this line. Activity data is routinely collected only on area of treatment.

- 29 The **total** value for the community dental service should be shown, together with the number of courses of treatment commissioned.

The total expenditure in lines 27 to 29 should reconcile with line 4 on the appropriate monthly monitoring form 3.1.

HOSPITAL DIRECT ACCESS

- 30 This should include values for work carried out by laboratories or diagnostic radiology departments (X-ray) on a direct access basis. It is not necessary to record activity figures.
- 31 Values should be recorded, in aggregate, for all direct access work carried out by the various professions allied to medicine and other hospital departments (except laboratories and X-ray) offering a direct access service.

RESOURCE TRANSFER ETC.

Payments to Local Authorities/Others for Community Care.

- 32 The **total value** of resource transfer funds in the period should be shown. This amount should cover the expenditure based on agreements negotiated with Local Authorities as responsibility for long stay patients, and the associated care costs are transferred to the Authorities' Social Work Departments. It should also include payments to Local Authorities for "one off" or start up costs associated with the contraction of the NHS long stay sector.
- 33-36 The value of resource transfer funds in the period for these categories should be shown. The sum of these amounts should equal line 32, with any differences explained in the narrative.
- 37 The value of any funding of other non-NHS services, including community care, should be shown. This will include payments to voluntary bodies and other agencies (for example for hospices). Bridging finance should be shown here as should expenditure in respect of support finance. The sum of lines 33-37 should reconcile with line 6.7 on the monthly financial monitoring form 5.

AMBULANCES

- 38 The number of patient journeys by the emergency ambulance service, and the associated value, should be shown. Air ambulance expenditure should be included.

HEALTH PROMOTION

- 39 The cost of health promotion activities in the period should be shown. Only the costs appropriate to the activities of Health Promotion Teams and Divisions should be included. It is **not** necessary to apportion out the element of health promotion from any other areas of expenditure.

OTHER HCH EXPENDITURE

- 40 The aim of this section is to report on the value of other HCH expenditure on health services for the resident population (excluding UNPACs (see paragraph 41)), not reported elsewhere on the template. "Off The Tops" such as ACT should **not** be included as this type of expenditure is not covered by this return.

Where possible any expenditure on developments such as quality improvements, which do not have activity associated with them, should be **allocated out to the appropriate service lines**. It is recognised that this may affect any estimate of efficiency derived using the data in the return, so it is important to comment on any significant non-activity generating expenditure in the narrative to the return. A breakdown of any remaining expenditure recorded in this line (including values) should be included in the commentary - giving a reasonable amount of detail to assist with further improvements to the guidance notes.

TOTAL HCH EXPENDITURE

- 41 Total HCH expenditure in the period commissioned for health services for residents by Health Board and residual GP fundholders should be shown. The total should reconcile with line 6.8 on the monthly financial monitoring form 5.

ECRs / UNPLANNED ACTIVITY (UNPACs)

- 42 The White Paper "Designed To Care - Renewing The NHS in Scotland", published on 9 December 1997, set out the Government's plans to abolish the 'internal market' and with it the process of extra contractual referrals (ECRs). In 1999/2000, the number of ECRs should be reduced substantially, since the anticipated numbers of referrals outwith the Health Board area should, as far as possible, be covered by Service Agreements in Health Improvement Programmes and Trust Implementation Plans. The treatment of patients who present at Trusts where no Health Board/Trust SA exists will be classed as unplanned activity (UNPAC) and subject to a charge as outlined in MEL(1999)4: Funding Arrangements for Cross-Boundary and Cross-Border Patient Activity.

Therefore line 42 referring to ECR value on the Performance Template will now read 'Total Value of all UNPACs'. The total value in the period of all UNPACs should be shown. This should reconcile with line 6.6, monthly monitoring form 5.

EFFICIENCY CHANGES

1. Estimates of year-on-year changes in efficiency should be calculated for each of the following service groups:

- (a) acute, maternity and geriatric assessment;
- (b) geriatric long stay (including young physically disabled);
- (c) mental health;
- (d) learning disabilities
- (e) community services.

The definition of these service groups and the methods to be used in estimating efficiency changes are explained in the accompanying notes. These notes also include worksheets which can be used in estimating efficiency changes.

2. Boards should provide estimates of planned efficiency changes to accompany the submission of the final plan for 1999/2000 by 28 May 1999. The planned efficiency changes will be based on a comparison between planned activity and expenditure for 1999/2000 and the outturn activity and expenditure for 1998/1999. Table 1 shows the form in which this information should be submitted.

3. At the end of the first quarter and subsequent quarters of 1999/2000 Boards should also provide a return with the template return showing the forecast outturn efficiency changes for 1999/2000 and the planned efficiency changes. The forecast outturn estimates of efficiency changes will be based on a comparison between forecast outturn activity and expenditure for 1999/2000 and outturn activity and expenditure for 1998/1999. Table 2 shows the form in which this information should be provided with the quarterly returns of the template. This form should show planned estimates of changes in activity, expenditure and efficiency alongside the forecast outturn estimates. The commentary which accompanies the template should explain the reasons for differences between planned and forecast outturn figures.

TABLE 1 – PLANNED EFFICIENCY CHANGES :1999-2000

	1999/2000 Plan Against 1998/1999 Outturn		
	Activity %	Expenditure %	Efficiency %
(a) Acute, maternity and geriatric assessment			
(b) Geriatric long stay			
(c) Mental Health			
(d) Learning Disability			
(e) Community Services			

TABLE 2 - FORECAST OUTTURN EFFICIENCY CHANGES : 1999 2000

	Planned And Forecast Outturn Changes In Efficiency					
	Activity		Expenditure		Efficiency	
	Plan %	Forecast %	Plan %	Forecast %	Plan %	Forecast %
(a) Acute, maternity and geriatric assessment						
(b) Geriatric long stay						
(c) Mental Health						
(d) Learning Disability						
(e) Community Services						

THE MEASUREMENT OF EFFICIENCY CHANGES

This note explains the methods which should be used to estimate planned and forecast outturn changes in efficiency for 1999-2000. These estimates are based on a comparison between planned (or forecast outturn) activity and expenditure in 1999-2000 and actual activity and expenditure in 1998-1999. The estimates cover the following service groups:

- (a) acute, maternity and geriatric assessment;
- (b) geriatric long stay (including young physically disabled);
- (c) mental health;
- (d) learning disabilities;
- (e) community services.

Tables A1 - E1 show the information required to estimate planned changes in efficiency for these service groups for 1999-2000. Tables A2 - E2 show the information required to provide forecast outturn estimates of efficiency changes on a quarterly basis during 1999-2000.

Planned Efficiency Changes in 1999-2000

Table A1: Acute, Maternity and Geriatric Assessment

Column (a) shows the outturn estimates of activity and expenditure in 1998/1999.

Column (b) shows the planned levels of activity and expenditure in 1999-2000.

Column (c) shows the ratio of the planned levels of activity and expenditure in 1999/2000 to the outturn levels in 1998-1999. This ratio is obtained by dividing the figures in Column (b) by the figures in Column (a).

Column (d) shows the expenditure weights which should be used to estimate the overall change in activity. The expenditure weights are the shares of expenditure on this service group accounted for by the different activities. These expenditure weights should be based on the outturn expenditure data for 1998-1999.

The measures of patient activity used in Table A1 are derived from the information provided in the template. The rows in the template from which the figures in Table A1 are derived are as follows:

Acute

inpatient and day cases (the sum of rows 3 and 4)
day patient attendances (row 5)
new outpatient attendances (row 6)
A&E new outpatient attendances (row 7)

Maternity

inpatient discharges (row 8)
day cases (row 10)
new outpatient attendances (row 11)

Geriatric Medicine : Geriatric Assessment

inpatient discharges (row 22)
new outpatient attendances (row 23)
attendances at geriatric day hospitals (row 24)

Row 11 of Table A1 shows the weighted change in activity between 1998-1999 and 1999-2000. This is found by multiplying the activity ratios in Column (c) by the corresponding expenditure weights in Column (d) and taking the sum of these figures.

Row 12 of Table A1 shows the outturn expenditure on acute, maternity and geriatric assessment services in 1998-1999, the planned expenditure in 1999-2000 and the ratio of planned to forecast outturn expenditure.

To estimate planned changes in efficiency, the planned change in cash expenditure on this group of services has to be adjusted for inflation. Row 13 shows in ratio form the expected increase in pay and prices in 1999-2000.

Row 14 shows the 'real' change in expenditure between 1998-1999 and 1999-2000. This is simply the ratio of the change in cash expenditure (row 12) divided by the inflation ratio (row 13).

The planned change in efficiency between 1998-1999 and 1999-2000 (row 15) is obtained by dividing the weighted activity ratio in row 11 by the real expenditure change in row 14.

Table B1: Geriatric Long Stay

The rows in the template from which the patient activity measures in this table are derived are as follows:

geriatric long stay occupied bed days (row 25)
young physically disabled occupied bed days (row 26)

Row 3 of Table B1 shows the weighted change in activity for this service group between 1998-1999 and 1999-2000.

Rows 4 - 6 show the planned change in cash expenditure, the expected inflation increase and the planned change in real expenditure.

Row 7 shows the planned change in efficiency. As in Table A1, this efficiency measure is derived as the ratio of the planned change in (weighted) activity to the planned change in real expenditure.

Table C1: Mental Health

The rows in the template from which the patient activity measures in this table are derived are as follows:

occupied bed days (sum of rows 13 and 14)
new outpatient attendances (row 15)
attendances at day hospitals (row 16)

Row 4 of Table C1 shows the weighted change in activity for this service group between 1998-1999 and 1999-2000.

Rows 5 - 7 show the planned change in cash expenditure, the expected inflation increase and the planned change in real expenditure.

Row 8 shows the planned change in efficiency. As in Table A1, this efficiency measure is derived as the ratio of the planned change in (weighted) activity to the planned change in real expenditure.

Table D1: Learning Disabilities

The rows in the template from which the patient activity measures in this table are derived are as follows:

occupied bed days (row 18)
new outpatient attendances (row 19)
attendances at day hospitals (row 20)

Row 4 of Table D1 shows the weighted change in activity for this service group between 1998-1999 and 1999-2000.

Rows 5 - 7 show the planned change in cash expenditure, the expected inflation increase and the planned change in real expenditure.

Row 8 shows the planned change in efficiency. As in Table A1, this efficiency measure is derived as the ratio of the planned change in (weighted) activity to the planned change in real expenditure.

Table E1: Community Services

The rows in the template from which the patient activity measures in this table are derived are as follows:

- community midwife visits (row 12)
- community psychiatric team contacts/visits (row 17)
- community learning disability team contacts/visits (row 21)
- community nurses or health visitors contacts (row 27)
- community PAMs contacts (row 28)
- community dental services - courses of treatment (row 29)

Row 7 of Table E1 shows the weighted change in activity for this service group between 1998-1999 and 1999-2000.

Rows 8 - 10 show the planned change in cash expenditure, the expected inflation increase and the planned change in real expenditure.

Row 11 shows the planned change in efficiency. As in Table A1, this efficiency measure is derived as the ratio of the planned change in (weighted) activity to the planned change in real expenditure.

Forecast Outturn Efficiency Changes in 1999-2000

The structure of Tables A2 - E2 is similar to Tables A1 - E1 and the method of estimating changes in efficiency is essentially the same. The column headings are slightly different since the estimates of efficiency changes which will be produced on a quarterly basis during 1999-2000 are based on a comparison between forecast outturn activity and expenditure for 1999-2000 and the outturn activity and expenditure in 1998-1999.

Column (a) in Tables A2 - E2 shows the actual activity and expenditure in 1998-1999.

Column (b) shows the forecast outturn activity and expenditure for 1999-2000. These figures will be revised and updated on a quarterly basis during 1999-2000

Column (c) shows the ratio of the forecast outturn levels of activity and expenditure in 1999-2000 to the actual levels in 1998-1999. This ratio is obtained by dividing the figures in Column (b) by the figures in Column (a).

Column (d) shows the expenditure weights. These expenditure weights should be based on the actual expenditure figures for 1998/1999.

TABLE A1 : ACUTE, MATERNITY & GERIATRIC ASSESSMENT

	(a) 1998-99 Outturn	(b) 1999-2000 Plan	(c) Ratio (b)/(a)	(d) Expenditure Weights
Acute				
1. Inpatient & Day Cases				
2. Day Patient Attendances				
3. New Outpatient Attendances				
4. A&E New Attendances				
Maternity				
5. Inpatient Discharges				
6. Day Cases				
7. New Outpatient Attendances				
Geriatric Assessment				
8. Inpatient Discharges				
9. New Outpatient Attendances				
10. Attendances At Day Hospitals				
Total Activity				
11. Weighted Activity				
Expenditure				
12. Expenditure (Cash)				
13. Inflation				
14. Expenditure (Real)				
Efficiency				
15. Efficiency				

TABLE B1 : GERIATRIC LONG STAY

	(a) 1998-99 Outturn	(b) 1999-2000 Plan	(c) Ratio (b)/(a)	(d) Expenditure Weights
Occupied Bed Days				
1. Geriatric Long Stay				
2. Young Physically Disabled				
3. Weighted Activity				
Expenditure				
4. Expenditure (Cash)				
5. Inflation				
6. Expenditure (Real)				
Efficiency				
7. Efficiency				

TABLE C1 : MENTAL HEALTH

	(a) 1998-99 Outturn	(b) 1999-2000 Plan	(c) Ratio (b)/(a)	(d) Expenditure Weights
Activity				
1. Occupied Bed Days				
2. New Outpatient Attendances				
3. Attendances At Day Hospitals				
4. Weighted Activity				
Expenditure				
5. Expenditure (Cash)				
6. Inflation				
7. Expenditure (Real)				
Efficiency				
8. Efficiency				

TABLE D1 : LEARNING DISABILITY

	(a) 1998-99 Outturn	(b) 1999-2000 Plan	(c) Ratio (b)/(a)	(d) Expenditure Weights
Activity				
1. Occupied Bed Days				
2. New Outpatient Attendances				
3. Attendances At Day Hospitals				
4. Weighted Activity				
Expenditure				
5. Expenditure (Cash)				
6. Inflation				
7. Expenditure (Real)				
Efficiency				
8. Efficiency				

TABLE E1 : COMMUNITY SERVICES

	(a) 1998-99 Outturn	(b) 1999-2000 Plan	(c) Ratio (b)/(a)	(d) Expenditure Weights
Community Activity				
1. Midwife Visits				
2. Psychiatric Team Contacts				
3. Learning Disability Team Contacts				
4. Nurse/Health Visitors				
5. PAMs				
6. Dental Services				
7. Weighted Activity				
Expenditure				
8. Expenditure (Cash)				
9. Inflation				
10. Expenditure (Real)				
Efficiency				
11. Efficiency				

TABLE A2 : ACUTE, MATERNITY & GERIATRIC ASSESSMENT

	(a) 1998-99 Actual	(b) 1999-2000 Forecast Outturn	(c) Ratio (b)/(a)	(d) Expenditure Weights
Acute				
1. Inpatient & Day Cases				
2. Day Patient Attendances				
3. New Outpatient Attendances				
4. A&E New Attendances				
Maternity				
5. Inpatient Discharges				
6. Day Cases				
7. New Outpatient Attendances				
Geriatric Assessment				
8. Inpatient Discharges				
9. New Outpatient Attendances				
10. Attendances At Day Hospitals				
Total Activity				
11. Weighted Activity				
Expenditure				
12. Expenditure (Cash)				
13. Inflation				
14. Expenditure (Real)				
Efficiency				
15. Efficiency				

TABLE B2 : GERIATRIC LONG STAY

	(a) 1998-99 Actual	(b) 1999-2000 Forecast Outturn	(c) Ratio (b)/(a)	(d) Expenditure Weights
Occupied Bed Days				
1. Geriatric Long Stay				
2. Young Physically Disabled				
3. Weighted Activity				
Expenditure				
4. Expenditure (Cash)				
5. Inflation				
6. Expenditure (Real)				
Efficiency				
7. Efficiency				

TABLE C2 : MENTAL HEALTH

	(a)	(b)	(c)	(d)
	1998-99 Actual	1999-2000 Forecast Outturn	Ratio (b)/(a)	Expenditure Weights
Activity				
1. Occupied Bed Days				
2. New Outpatient Attendances				
3. Attendances At Day Hospitals				
4. Weighted Activity				
Expenditure				
5. Expenditure (Cash)				
6. Inflation				
7. Expenditure (Real)				
Efficiency				
8. Efficiency				

TABLE D2 : LEARNING DISABILITY

	(a)	(b)	(c)	(d)
	1998-99 Actual	1999-2000 Forecast Outturn	Ratio (b)/(a)	Expenditure Weights
Activity				
1. Occupied Bed Days				
2. New Outpatient Attendances				
3. Attendances At Day Hospitals				
4. Weighted Activity				
Expenditure				
5. Expenditure (Cash)				
6. Inflation				
7. Expenditure (Real)				
Efficiency				
8. Efficiency				

TABLE E2 : COMMUNITY SERVICES

	(a)	(b)	(c)	(d)
	1998-99 Actual	1999-2000 Forecast Outturn	Ratio (b)/(a)	Expenditure Weights
Community Activity				
1. Midwife Visits				
2. Psychiatric Team Contacts				
3. Learning Disability Team Contacts				
4. Nurse/Health Visitors				
5. PAMs				
6. Dental Services				
7. Weighted Activity				
Expenditure				
8. Expenditure (Cash)				
9. Inflation				
10. Expenditure (Real)				
Efficiency				
11. Efficiency				