THE SCOTTISH OFFICE

National Health Service in Scotland
Management Executive

10912

NHS
MEL(1995)78

St. Andrew's House
Edinburgh EH1 3DG

22 November 1995

Dear Colleague

IN-YEAR CONTRACT PERFORMANCE MONITORING 1996/97

Summary

1. The template introduced in January 1995 (NHS MEL(1994)119) for reporting contract activity and expenditure in 1995/96 has been revised to take account of comments from Health Boards and GP fundholding practices. A copy of the amended template for use in 1996/97 is attached at Annex C.

Action

2. The contracting template plays an important role in the management of contracted activity and expenditure at Health Board level. I therefore attach particular importance to its timely and accurate completion. Health Boards should work with providers, with whom they have contracts, and GP fundholders to ensure the information needed is submitted timeously, and that considered returns are forwarded to me according to the timetable set out in Annex A. The developments to the 1996/97 template outlined in Annex B, should provide more robust and meaningful data on which to monitor the efficiency and effectiveness of Health Boards' contracted activity and expenditure in 1996/97.

3. Can Health Boards please ensure that this circular is copied to GP fundholders in their area, for their information.

Yours sincerely

KEVIN J WOODS
Director of Purchasing

Addressees

For action:
General Managers,
Health Boards

For information:
General Manager,
Common Services Agency

General Manager,
Health Education Board for Scotland

General Manager,
State Hospitals Board for Scotland

Executive Director,
SCPMDE

Chief Executives,
NHS Trusts

Enquiries to:

Mr A Inglis
Purchasing Strategy Division
Management Executive
Room 275
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 2625
Fax: 0131-244 2051

(Technical)

Mr Peter Knight
Information and Statistics
Division
Trinity Park House
South Trinity Road
EDINBURGH
EH5 3SQ

Tel: 0131 551 8739
Fax: 0131 551 1392

ANNEX A

Timetable for Submission of Returns

1. Contract template returns and an accompanying commentary should be formally signed off by Health Board General Managers and submitted to the Chief Executive, by:

1995/96 Returns (based on MEL(1994)119)	**1996/97 Returns (based on this MEL)**
30 November 1995 (2nd quarter figures)	1 February 1996 (initial plan for 1996/97 + forecast outturn 1995/96)
	28 June 1996 (final plan for 1996/97)
29 February 1996 (3rd quarter figures)	30 August 1996 (actual 1st quarter figures)
31 May 1996 (final outturn 1995/96)	29 November 1996 (2nd quarter figures)
	28 February 1997 (3rd quarter figures)
	31 May 1997 (final outturn)

ANNEX B

DETAILS OF THE MAIN CHANGES TO IN-YEAR CONTRACT PERFORMANCE MONITORING FOR 1996/97

1. The main changes to the contracting template for 1996/97 are:

1.1 additional columns have been added to the template to provide a more complete picture of in-year contracting performance;

1.2 the present division between in-patient discharges and occupied bed days for mental health, and learning difficulties, has been removed and reporting arrangements standardised on occupied beds;

1.3 a new separate category for psychogeriatric long-stay has been introduced.

1.4 integration and reconciliation of the contracting template with Income and Expenditure financial returns (for this purpose form CT1 and accompanying instructions on completion, will be issued in due course under separate cover but, nonetheless, should be considered as an integral part of the contracting template returns); and

1.5 the provision of more extensive notes on how the contracting template should be completed.

2. The Shortlife Working Group which reviewed the 1995/96 template agreed, as part of the new arrangements for providing a more complete picture of in-year contracting performance, the introduction of measures of efficiency changes. Estimates of year-on-year changes in efficiency should therefore be calculated for each of the following service groups:

2.1 acute, maternity and geriatric assessment;

2.2 geriatric long-stay (including the young chronic sick;

2.3 mental health;

2.4 learning difficulties; and

2.5 community services.

The calculation of in-year quarterly estimates, based on comparison between planned (or forecast outturn) activity and expenditure in 1996/97 and actual activity and expenditure in 1995/96, should be regarded as an integral part of the contracting template returns. (The methodology for deriving these measures of efficiency and the returns for completion can be found at Annex D.)

IN YEAR CONTRACT PERFORMANCE MONITORING:

FORECAST OUTTURN

	1995-96 Outturn		1996-97 Plan		Forecast Outturn (1996/97)		% Variances	
	Actual Activity	Actual Expenditure	Contracted Value	Contracted 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 New Out-Patients Attendances								
06 A&E New Out-Patient Attendances (HBT)								
MATERNITY								
07 In-Patient Discharges (incl SCBU patients)								
08 Births								
09 Day Cases								
10 New Out-Patient Attendances								
11 Total Community Midwife Visits (HBT)								
MENTAL HEALTH								
12 Occupied Bed Days - Adult & Child								
Occupied Bed Days - Psychogeriatric								
14 New Out-Patient Attendances								
15 Attendances by Mental Health Patients at Day Hospitals (HBT)								
16 Community Psychiatric Team Contacts/Visits								
LEARNING DIFFICULTIES								
17 Occupied Bed Days								
18 New Out-Patient Attendances								
19 Attendances by Learning Difficulties Patients at Day Hospitals (HBT)								
20 Community Mental Handicap Team Contacts/ Visits								
GERIATRIC ASSESSMENT								
21 In-Patient Discharges								
22 New Out-Patient Attendances								
23 Attendances at Geriatric Day Hospitals								
GERIATRIC LONG STAY								
24 Occupied Bed Days								
YOUNG CHRONIC SICK								
Occupied Bed Days								
COMMUNITY								
26 Community Nurses or Health Visitors Contacts (HBT)								
27 Community PAM's Contacts								
28 Community Dental Services - Courses of Treatment								
DIRECT ACCESS								
29 Laboratories and X-Ray								
30 PAM's and other Technical Departments								
RESOURCE TRANSFER ETC								
31 Resource Transfer								
32 Funding of Other Non-NHS Community Care Projects								
AMBULANCES								
33 Emergency Ambulance Services (Patient Journeys)								
34 OTHER CONTRACTED VALUE								
35 TOTAL CONTRACTED VALUE								
36 TOTAL VALUE OF ALL ECRs								

IN YEAR CONTRACT PERFORMANCE MONITORING:

YEAR TO DATE

	Year to Date		Year to Date		% Variances	
	Contracted Activity	Contracted 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 New Out-Patients Attendances						
06 A&E New Out-Patient Attendances (HBT)						
MATERNITY						
07 In-Patient Discharges (incl SCBU patients)						
08 Births						
09 Day Cases						
10 New Out-Patient Attendances						
11 Total Community Midwife Visits (HBT)						
MENTAL HEALTH						
12 Occupied Bed Days - Adult & Child						
13 Occupied Bed Days - Psychogeriatric						
14 New Out-Patient Attendances						
15 Attendances by Mental Health Patients at Day Hospitals (HBT)						
16 Community Psychiatric Team Contacts/Visits						
LEARNING DIFFICULTIES						
17 Occupied Bed Days						
18 New Out-Patient Attendances						
19 Attendances by Learning Difficulties Patients at Day Hospitals (HBT)						
20 Community Mental Handicap Team Contacts/Visits						
GERIATRIC ASSESSMENT						
21 In-Patient Discharges						
22 New Out-Patient Attendances						
23 Attendances at Geriatric Day Hospitals						
GERIATRIC LONG STAY						
24 Occupied Bed Days						
YOUNG CHRONIC SICK						
25 Occupied Bed Days						
COMMUNITY						
26 Community Nurses or Health Visitors Contacts (HBT)						
27 Community PAM's Contacts						
28 Community Dental Services - Courses of Treatment						
DIRECT ACCESS						
29 Laboratories and X-Ray						
30 PAM's and other Technical Departments						
RESOURCE TRANSFER ETC						
31 Resource Transfer						
32 Funding of Other Non-NHS Community Care Projects						
AMBULANCES						
33 Emergency Ambulance Services (Patient Journeys)						
34 OTHER CONTRACTED VALUE						
35 TOTAL CONTRACTED VALUE						
36 TOTAL VALUE OF ALL ECRs						

GUIDELINES FOR COMPLETION OF IN-YEAR CONTRACT MONITORING TEMPLATE 1996-97

GENERAL NOTES

Forecast Outturn

The forecast annual plan for 1996-97 and forecast outturn figures for 1995-96 are required by 1 February 1996. Boards should complete the plan and 1995-96 outturn based on their best estimate of expected activity and expenditure at that time. At the end of the first quarter and subsequent quarters only the 1996-97 plan and forecast outturn (1996-97) columns require to be completed in respect of the Forecast Outturn sheet.

In-Year Changes to Plan

At the end of the first quarter, Boards should review annual plan figures and amend plan as necessary, explaining in a commentary what has required the change. (The first quarter's return might, for example, show a change of plan arising from final contract negotiation.) Unless changes to the forward plan are a direct result of a Management Executive initiative and specific notification is given to change "The Plan" in year, plan figures should only be changed at the end of the first quarter (ie the annual plan is finalised at the end of the first quarter). Any later initiatives should be reflected in the forecast outturn (1996-97) column and explained in the commentary.

GP Fundholder Purchased Activity

As in previous years, the template should cover **total care purchased** for residents in the Health Board area. It should therefore be an aggregation of care purchased by the Health Board and by GP Fundholders.

Cost Per Case Contracts

Where cost per case contracts have been negotiated without agreed activity levels, a forecast for the year of likely activity under the relevant heading(s) should be included on the annual plan, and actual activity and values reported on the quarterly returns. **Irrespective of actual "currencies" used in contracting locally the contracting template headings are mandatory for reporting contracted activity and expenditure (except as specified below).**

Financial Reporting and Reconciliation

Expenditure reported in the template should relate to the activity reported and should be reconciled with the monthly income and expenditure monitoring forms. Expenditure should therefore be recorded on an "accruals" basis.

Non-Activity Generating Expenditure

Expenditure on ACT and other "off the tops" such as dental hospitals should be excluded from expenditure reported in the template. Expenditure incurred under contract on Health Promotion, Colleges of Nursing and other non-activity generating expenditure should be included in line 34. (As a rule of thumb all expenditure by Health Boards and GP fundholders on purchasing 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.)

Health Board of Residence

The template is a purchaser return and 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 contract negotiated, and if data on activity for health board of residence are available, these should be included in a footnote.

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). Purchasers are required to identify emergency and elective activity separately.

01(04) Elective in-patient (day case) discharges includes patients admitted from true, deferred and repeat waiting lists. It does not include transfers.

02 This should include both emergency admissions and transfers.

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

06 Includes all new A&E attendances in period; activity data is routinely collected only on area of treatment.

MATERNITY including SCBU

07 Maternity and SCBU discharges

08 Births (live & still)

} Contracts for maternity care tend to use either discharges or births as the contracting currency. Purchasers should report activity under both headings but contract value on the line appropriate to the currency used.

09 Maternity Day Cases.

10 New out-patient attendances should include specialist obstetrics and GP obstetrics specialties.

11 Activity and values of visits made by community midwifes.

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

- Work is currently underway to identify the specific specialty for each patient resident in psychiatric hospitals and units, and this should enable health boards to report separately on the template the bed use of psychiatric patients, by April 1996.

- In previous templates a choice of reporting activity as discharges or occupied bed days was possible. This reflected the practice in some Boards of contracting for "acute" mental illness in terms of discharges, and "continuing" mental illness in occupied bed days. Once a workable national definition of the 2 separate classifications is available the template will require reporting under those headings. In the meantime for the purpose of standardisation all activity should be reported as "occupied bed days".

12 Occupied bed days from the specialties mental illness, child and adolescent psychiatry.

13 Occupied bed days from the specialty psychogeriatrics.

14 New out-patient attendances in all the above specified specialties.

15 Total attendances made by patients to day hospitals in all the above specified specialties; activity data is routinely collected only on area of treatment.

16 Activity data should relate to all contacts/visits by community psychiatric team members. (The intention is to replace this subhead with EPPIC care descriptions in 1997-98 once EPPIC is implemented across Scotland.)

LEARNING DIFFICULTIES

17 Occupied bed days in the period should include patients still resident at end of the period.

18 New out-patient attendances in the specialty of mental handicap.

19 Total attendances made by patients with learning difficulties at day hospitals; activity data is routinely collected only on area of treatment.

20 Activity data should relate to all contacts/visits by community mental handicap team members. (To be replaced in 1997-98 by EPPIC care descriptions.)

GERIATRIC ASSESSMENT

21 In-patient Discharges from speciality of geriatric assessment.

22 New out-patient attendances in the specialty of geriatric assessment.

23 Total attendances made by geriatric patients to day hospitals within the specialty of Geriatric Assessment (GP Acute day patient activity should be recorded in line 34 of the template and detailed in the commentary); activity data is routinely collected only on area of treatment.

GERIATRIC LONG STAY

24 Occupied bed days in specialty of geriatric long stay. Unlike in previous years activity should be reported on a Health Board of Residence basis (ie using SMR50).

YOUNG CHRONIC SICK

25 Occupied bed days in specialty of young chronic sick. Unlike previous years return should be based on Health Board of Residence data (ie younger physically disabled quarterly census/SMR50).

As SMR50 will not come into operation until April 1996 it is appreciated that it will not be possible to complete lines 24 and 25 of the February returns.

COMMUNITY

26 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.

27 The activity column should include face to face patient contacts by professions allied to medicine (which are covered by community based contracts); activity data is routinely collected only on area of treatment.

28 The <u>total</u> contract value for the community dental service should be shown; together with the number of courses of treatment purchased.

DIRECT ACCESS

29 This should include contract 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.

30 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

31 The value of resource transfer funds in the period should be shown.

32 The value of any funding of other non-NHS community care projects in the period should be shown.

The totals of 31 and 32 should reconcile with the sum of lines 6.1 and 6.2 plus 6.3 on the monthly monitoring form 2.1.

AMBULANCE

33 The number of patient journeys by the emergency ambulance service, and the associated value, should be shown.

OTHER CONTRACTED VALUE

34 The value in the period of other HCH expenditure on health services for the resident population (excluding ECRs), not reported elsewhere on the template, should be shown. A breakdown into the main expenditure headings covered (including values) should be included in the commentary.

TOTAL CONTRACTED VALUE

35 Total HCH expenditure in the period on contracts for health services for residents by health board and GP fundholders should be shown. This total should reconcile with the sum of lines 1-5 of the monthly monitoring form 2.2 plus the sum of lines 3.1 to 3.5 of the monthly monitoring form 3.1, plus lines 6.1-6.3 of the monthly monitoring form 2.1, plus line 4 of the monthly monitoring form 3.1.

ECRs

36 The total value in the period of all ECRs should be shown. This should reconcile with line 5, monthly monitoring form 2.1.

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 the young chronic sick);

(c) mental health;

(d) learning difficulties;

(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 forecast plan for 1996/97 by 1 February 1996. The planned efficiency changes will be based on a comparison between planned activity and expenditure for 1996/97 and forecast outturn activity and expenditure for 1995/96. Table 1 shows the form in which this information should be submitted. The planned estimates of efficiency changes submitted by 1 February may need to be revised as planned levels of activity and expenditure are revised following the completion of contract negotiations.

3. At the end of the first quarter and subsequent quarters of 1996/97 Boards should also provide a return with the contracting template return showing the forecast outturn efficiency changes for 1996/97 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 1996/97 and actual activity and expenditure for 1995/96. Table 2 shows the form in which this information should be provided with the quarterly returns of the contracting template. This form should show planned estimates of changes in activity, expenditure and efficiency alongside the forecast outturn estimates. The commentary which accompanies the contracting template should explain the reasons for differences between planned and forecast outturn figures.

TABLE 1 - PLANNED EFFICIENCY CHANGES: 1996-97

	1996-97 Plan Against 1995-96 Forecast Outturn		
	Activity %	Expenditure %	Efficiency %
(a) Acute, maternity and geriatric assessment			
(b) Geriatric long stay			
(c) Mental health			
(d) Learning difficulties			
(e) Community services			

The planned changes in expenditure on each service group should be estimated after allowing for expected inflation.

TABLE 2 - FORECAST OUTTURN EFFICIENCY CHANGES: 1996-97

	Planned and Forecast Outturn Changes in Efficiency					
	Activity		Expenditure		Efficiency	
	Plan %	Forecast Outturn %	Plan %	Forecast Outturn %	Plan %	Forecast Outturn %
(a) Acute, maternity and geriatric assessment						
(b) Geriatric long stay						
(c) Mental health						
(d) Learning difficulties						
(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 1996-97. These estimates are based on a comparison between planned (or forecast outturn) activity and expenditure in 1996-97 and actual activity and expenditure in 1995-96. The estimates cover the following service groups:

(a) acute, maternity and geriatric assessment;
(b) geriatric long stay (including young chronic sick);
(c) mental health;
(d) learning difficulties;
(e) community services.

Tables A1 - E1 show the information required to estimate planned changes in efficiency for these service groups for 1996-97. Tables A2 - E2 show the information required to provide forecast outturn estimates of efficiency changes on a quarterly basis during 1996-97.

Planned Efficiency Changes in 1996-97

Table A1: Acute, Maternity and Geriatric Assessment

Column (a) shows the forecast outturn estimates of activity and expenditure in 1995-96.

Column (b) shows the planned levels of activity and expenditure in 1996-97.

Column (c) shows the ratio of the planned levels of activity and expenditure in 1996-97 to the forecast outturn levels in 1995-96. 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 forecast outturn expenditure data for 1995-96.

The measures of patient activity used in Table A1 are derived from the information provided in the contracting 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)
new outpatient attendances (row 5)
A&E new outpatient attendances (row 6)

Maternity
inpatient discharges (row 7)
day cases (row 9)
new outpatient attendances (row 10)

Geriatric Assessment
inpatient discharges (row 21)
new outpatient attendances (row 22)
attendances at geriatric day hospitals (row 23)

Row 10 of Table A1 shows the weighted change in activity between 1995-96 and 1996-97. 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 11 of Table A1 shows the forecast outturn expenditure on acute, maternity and geriatric assessment services in 1995-96, the planned expenditure in 1996-97 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 12 shows in ratio form the expected increase in pay and prices in 1996-97.

Row 13 shows the 'real' change in expenditure between 1995-96 and 1996-97. This is simply the ratio of the change in cash expenditure (row 11) divided by the inflation ratio (row 12).

The planned change in efficiency between 1995-96 and 1996-97 (row 14) is obtained by dividing the weighted activity ratio in row 10 by the real expenditure change in row 13.

Table B1: Geriatric Long Stay

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

geriatric long stay occupied bed days (row 24)
young chronic sick occupied bed days (row 25)

Row 3 of Table B1 shows the weighted change in activity for this service group between 1995-96 and 1996-97.

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

occupied bed days (sum of rows 12 and 13)
new outpatient attendances (row 14)
attendances at day hospitals (row 15)

Row 4 of Table C1 shows the weighted change in activity for this service group between 1995-96 and 1996-97.

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 Difficulties

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

occupied bed days (row 17)
new outpatient attendances (row 18)
attendances at day hospitals (row 19)

Row 4 of Table D1 shows the weighted change in activity for this service group between 1995-96 and 1996-97.

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

community midwife visits (row 11)
community psychiatric team contacts/visits (row 16)
community mental handicap team contacts/visits (row 20)
community nurses or health visitors contacts (row 26)
community PAMs contacts (row 27)
community dental services - courses of treatment (row 28)

Row 7 of Table E1 shows the weighted change in activity for this service group between 1995-96 and 1996-97.

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 1996-97

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 1996-97 are based on a comparison between forecast outturn activity and expenditure for 1996-97 and actual activity and expenditure in 1995-96.

Column (a) in Tables A2 - E2 shows the actual activity and expenditure in 1995-96.

Column (b) shows the forecast outturn activity and expenditure for 1996-97. These figures will be revised and updated on a quarterly basis during 1996-97.

Column (c) shows the ratio of the forecast outturn levels of activity and expenditure in 1996-97 to the actual levels in 1995-96. 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 1995-96.

Table A1 : ACUTE, MATERNITY & GERIATRIC ASSESSMENT

	(a) 1995-96 Forecast Outturn	(b) 1996-97 Plan	(c) Ratio (b)/(a)	(d) Expenditure Weights
Acute				
1. Inpatient & Day Cases				
2. New Outpatient attendances				
3. A & E New Attendances				
Maternity				
4. Inpatient Discharges				
5. Day Cases				
6. New Outpatient Attendances				
Geriatric Assessment				
7. Inpatient Discharges				
8. New Outpatient Attendances				
9. Attendances at Day Hospitals				
Total Activity				
10. Weighted Activity				
Expenditure				
11. Expenditure (Cash)				
12. Inflation				
13. Expenditure (Real)				
Efficiency				
14. Efficiency				

Table B1 : GERIATRIC LONG STAY

	(a) 1995-96 Forecast Outturn	(b) 1996-97 Plan	(c) Ratio (b)/(a)	(d) Expenditure Weights
Occupied Bed Days				
1. Geriatric Long Stay				
2. Young Chronic Sick				
3. Weighted Activity				
Expenditure				
4. Expenditure (Cash)				
5. Inflation				
6. Expenditure (Real)				
Efficiency				
7. Efficiency				

Table C1 : MENTAL HEALTH

	(a) 1995-96 Forecast Outturn	(b) 1996-97 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 DIFFICULTIES

	(a) 1995-96 Forecast Outturn	(b) 1996-97 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) 1995-96 Forecast Outturn	(b) 1996-97 Plan	(c) Ratio (b)/(a)	(d) Expenditure Weights
Community Activity				
1. Midwife Visits				
2. Psychiatric Team Contacts				
3. Mental Handicap 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) 1995-96 Actual	(b) 1996-97 Forecast Outturn	(c) Ratio (b)/(a)	(d) Expenditure Weights
Acute				
1. Inpatient & Day Cases				
2. New Outpatient attendances				
3. A & E New Attendances				
Maternity				
4. Inpatient Discharges				
5. Day Cases				
6. New Outpatient Attendances				
Geriatric Assessment				
7. Inpatient Discharges				
8. New Outpatient Attendances				
9. Attendances at Day Hospitals				
Total Activity				
10. Weighted Activity				
Expenditure				
11. Expenditure (Cash)				
12. Inflation				
13. Expenditure (Real)				
Efficiency				
14. Efficiency				

Table B2 : GERIATRIC LONG STAY

	(a) 1995-96 Actual	(b) 1996-97 Forecast Outturn	(c) Ratio (b)/(a)	(d) Expenditure Weights
Occupied Bed Days				
1. Geriatric Long Stay				
2. Young Chronic Sick				
3. Weighted Activity				
Expenditure				
4. Expenditure (Cash)				
5. Inflation				
6. Expenditure (Real)				
Efficiency				
7. Efficiency				

Table C2 : MENTAL HEALTH

	(a) 1995-96 Actual	(b) 1996-97 Forecast Outturn	(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 D2 : LEARNING DIFFICULTIES

	(a) 1995-96 Actual	(b) 1996-97 Forecast Outturn	(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 E2 : COMMUNITY SERVICES

	(a) 1995-96 Actual	(b) 1996-97 Forecast Outturn	(c) Ratio (b)/(a)	(d) Expenditure Weights
Community Activity				
1. Midwife Visits				
2. Psychiatric Team Contacts				
3. Mental Handicap 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				