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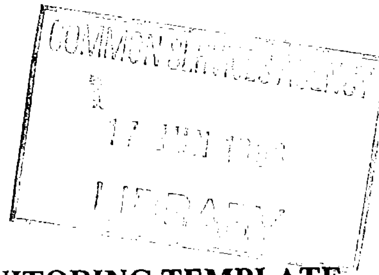

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NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

16th June 1998

Dear Colleague

IN YEAR PERFORMANCE MONITORING TEMPLATE 1998/99

1. The template for reporting activity and expenditure has been revised by a Working Group comprising representatives of Health Boards and GP practices. A copy of the amended template for use in 1998/99 is attached at Annex B, and the 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.

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, and particular attention will be paid to Health Board level acute efficiency this year as part of the monitoring for the Waiting List Initiative. Please ensure your plans for 1998/99 reflect the plan changes in activity needed to deliver your contribution to this initiative.

Yours sincerely,

KEVIN J WOODS
Director of Strategy and Performance Management

Addressees

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ANNEX A

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:

1997/1998 Returns (based on MEL(1997)5)	**1998/1999 Returns (based on this MEL)**
29 May 1998 (final outturn)	26 June 1998 (final plan for 1998/1999)
	28 August 1998 (actual 1st quarter figures and forecast outturn for 1998/99)
	27 November 1998 (2nd quarter figures and forecast outturn for 1998/99)
	26 February 1999 (3rd quarter figures and forecast outturn for 1998/99)
	28 May 1999 (final outturn)

IN YEAR PERFORMANCE MONITORING RETURN : Forecast Outturn

ANNEX B

	1997-98 Outturn		1998-99 Plan		Forecast Outturn 1998-99		% 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 DIFFICULTIES								
18 Occupied Bed Days								
19 New Out-Patient Attendances								
20 Attendances By Learning Difficulties Patients At Day Hospitals (HBT)								
21 Community Mental Handicap 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 ECRs								

IN YEAR PERFORMANCE MONITORING RETURN : Year to Date

ANNEX B

	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 DIFFICULTIES						
18 Occupied Bed Days						
19 New Out-Patient Attendances						
20 Attendances By Learning Difficulties Patients At Day Hospitals (HBT)						
21 Community Mental Handicap 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 ECRs						

ANNEX C

GUIDELINES FOR COMPLETION OF IN-YEAR PERFORMANCE MONITORING TEMPLATE 1998-1999

GENERAL NOTES

Forecast Outturn

The **final plan for 1998-1999** is required by **26 June 1998** 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 £20m issued under the Waiting List Initiative. At the end of the first quarter and subsequent quarters, only the 1998-1999 plan and forecast outturn (1998-1999) columns require to be completed in respect of the Forecast Outturn sheet. This information will require to be updated during the year as the remaining Waiting List Initiative money is allocated.

In-Year Changes to Plan

Service developments, planned changes in-year in activity levels and waiting list initiatives, 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.**

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 GP Fundholders.

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 be 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 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 Difficulties, Geriatric Long Stay and Young Physically Disabled

Anticipated changes over the year should be indicated in the completed template returns which are submitted on 9 April 1998. 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 <u>new</u> 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 } Health Boards should report activity under both
} discharges and births headings and value on the
09 Births (live & still) } appropriate line. It is recognized 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 DIFFICULTIES

18 Occupied bed days for the specialty of learning difficulties.

19 New out-patient attendances in the specialty of mental handicap. This should cover **all new** out-patient attendances - as reported on SMR00.

20 Attendances by learning difficulty day patients. Activity data is routinely collected only on area of treatment.

21 Activity data should relate to all contacts/visits by community mental handicap 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 total of lines 32 and 37 should reconcile with the sum of lines 6.1, 6.2 and 6.3 on the appropriate monthly financial monitoring form 2.1

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 ECRs), 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 recognized 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 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. Any differences between the two amounts (usually due to timing of submission of the returns) should be explained and quantified in the narrative to this return.

ECRs

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

The White Paper "Designed To Care - Renewing The NHS in Scotland", published on 9 December 1997, set out the Government's plans to replace the internal market. In 1998/99, 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 in Health Improvement Programmes and Trust Implementation Plans.

ANNEX D

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 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 final plan for 1998/1999 by 26 June 1998. The planned efficiency changes will be based on a comparison between planned activity and expenditure for 1998/1999 and the outturn activity and expenditure for 1997/1998. Table 1 shows the form in which this information should be submitted. The planned estimates of efficiency changes submitted by 26 June may need to be revised as planned levels of activity and expenditure are revised following the issuing of the remaining Waiting List Initiative money.

3. At the end of the first quarter and subsequent quarters of 1998/1999 Boards should also provide a return with the template return showing the forecast outturn efficiency changes for 1998/1999 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 1998/1999 and outturn activity and expenditure for 1997/1998. 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 : 1998-99

	1998/1999 Plan Against 1997/1998 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 : 1998-99

	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 1998-1999. These estimates are based on a comparison between planned (or forecast outturn) activity and expenditure in 1998-1999 and actual activity and expenditure in 1997-1998. 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 difficulties;

(c) community services.

Tables A1 - E1 show the information required to estimate planned changes in efficiency for these service groups for 1998-1999. Tables A2 - E2 show the information required to provide forecast outturn estimates of efficiency changes on a quarterly basis during 1998-1999.

Planned Efficiency Changes in 1998-1999

Table A1: Acute, Maternity and Geriatric Assessment

Column (a) shows the outturn estimates of activity and expenditure in 1997/1998.

Column (b) shows the planned levels of activity and expenditure in 1998-1999.

Column (c) shows the ratio of the planned levels of activity and expenditure in 1998/1999 to the outturn levels in 1997-1998. 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 1997-1998.

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 1997-1998 and 1998-1999. 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 1997-1998, the planned expenditure in 1998-1999 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 1998-1999.

Row 14 shows the 'real' change in expenditure between 1997-1998 and 1998-1999 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 1997-1998 and 1998-1999 (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 1997-1998 and 1998-1999.

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 1997-1998 and 1998-1999.

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 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 Dl shows the weighted change in activity for this service group between 1997-1998 and 1998-1999.

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 El: 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 mental handicap 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 El shows the weighted change in activity for this service group between 1997-1998 and 1998-1999.

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 Al, 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 1998-1999

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 1998-1999 are based on a comparison between forecast outturn activity and expenditure for 1998-1999 and the outturn activity and expenditure in 1997-1998.

Column (a) in Tables A2 - E2 shows the actual activity and expenditure in 1997-1998.

Column (b) shows the forecast outturn activity and expenditure for 1998-1999. These figures will be revised and updated on a quarterly basis during 1998-1999.

Column (c) shows the ratio of the forecast outturn levels of activity and expenditure in 1998-1999 to the actual levels in 1997-1998. 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 1997/1998.

TABLE A1 : ACUTE, MATERNITY & GERIATRIC ASSESSMENT

	(a) 1997-98 Outturn	(b) 1998-99 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) 1997-98 Outturn	(b) 1998-99 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) 1997-98 Outturn	(b) 1998-99 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) 1997-98 Outturn	(b) 1998-99 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) 1997-98 Outturn	(b) 1998-99 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) 1997-98 Actual	(b) 1998-99 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) 1997-98 Actual	(b) 1998-99 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) 1997-98 Actual	(b) 1998-99 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) 1997-98 Actual	(b) 1998-99 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) 1997-98 Actual	(b) 1998-99 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				