Health Department

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Dear Colleague

IN-YEAR PERFORMANCE MONITORING TEMPLATES 2000/2001

1. In year performance monitoring templates for 2000-2001 will cover both Hospital and Community Services (HCH) and Family Health Services (FHS) activity and expenditure. The templates were set up by a Steering Group comprising representatives of Health Boards, Trusts and the Information Statistics Division (ISD) Scotland. This is the first year FHS information will be collected in addition to HCH information.

2. The template for reporting HCH activity and expenditure was recently revised by the Steering Group. There are a number of changes to the template for 2000-2001 and a copy of the amended template for use in 2000-2001 is attached at Annex B. The slightly revised guidelines for its completion are at Annex D. Health Boards should ensure that all of their data suppliers receive a copy of this MEL for information.

3. The template for reporting FHS activity and expenditure (as agreed by the Steering Group) is similar in format to the existing HCH template and a copy of the new template for use in 2000-2001 is attached at Annex C. The guidelines for its completion are at Annex E. There will be an ongoing review of the FHS template throughout 2000-2001 by the Steering Group.

4. The performance monitoring templates play an important role in the monitoring of HCH and FHS activity and expenditure at Health Board level. It is essential that both 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 both returns is set out in Annex A. You will note from MEL(1999)89 '2000-2001 Corporate Contract' that the template forms part of the corporate contract. Following circulation of MEL (1999)89, the date for submission of initial plans for 2000-2001 has now been extended to 28 April 2000.

March 2000

Addressees

For action:

General Managers, Health Boards

For information:

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

Enquiries to:

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5. The changes to the HCH 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 HCH or FHS guidance notes should be made directly to Helen Mansbridge, who will ensure that these are considered during the course of 2000-2001.

6. The calculation of in-year quarterly estimates of HCH efficiency changes (Annex F) are still an integral part of the monitoring process. Please ensure your plans for 2000-2001 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

AGNES ROBSON
Director of Primary Care

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ANNEX A

TIMETABLE FOR SUBMISSION OF HCH AND FHS 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 Helen Mansbridge, by:

1999/2000 Returns
(based on MEL(1999)32)

- **26 May 2000**
  Final outturn 1999/00

2000/2001 Returns
(based on this MEL)

- **28 April 2000**
  Initial plan for 2000/2001
- **26 May 2000**
  Final plan for 2000/2001
- **25 August 2000**
  1st quarter figures and forecast outturn for 2000/2001
- **24 November 2000**
  2nd quarter figures and forecast outturn for 2000/2001
- **23 February 2001**
  3rd quarter figures and forecast outturn for 2000/2001
- **25 May 2001**
  Final outturn 2000/2001

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ANNEX B

HCH IN-YEAR PERFORMANCE MONITORING RETURN : Forecast Outturn

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	1999-2000 Outturn		2000-2001 Plan		Forecast Outturn 2000-2001		% 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 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)								
38 HEALTH PROMOTION								
39 OTHER HCH EXPENDITURE								
40 TOTAL HCH EXPENDITURE								
41 TOTAL VALUE OF ALL UNPACs								

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ANNEX B

HCH IN-YEAR PERFORMANCE MONITORING RETURN : Year to Date

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	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 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)						
38 HEALTH PROMOTION						
39 OTHER HCH EXPENDITURE						
40 TOTAL HCH EXPENDITURE						
41 TOTAL VALUE OF ALL UNPACs						

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ANNEX C

FHS IN-YEAR PERFORMANCE MONITORING RETURN : Forecast Outturn

	1999-2000 Outturn		2000-2001 Plan		Forecast Outturn 2000-2001	
	Actual Activity/ Number	Actual Expenditure £,000	Planned Activity/ Number	Planned Value £,000	Forecast Activity/ Number	Forecast Value £,000
GENERAL MEDICAL SERVICES (Non Cash-Limited)						
01 GPs Per 100,000 Population						
02 % Practices Claiming Sustained Quality Payment						
03 % Practices Achieving Higher Level Cervical Cytology Rate						
04 GP Local Development Schemes						
GENERAL MEDICAL SERVICES (Cash-Limited)						
05 Practice Staff - Nurses						
06 Practice Staff - Admin/Others						
07 Premises - Cost Rent Schemes						
08 Premises - Improvement Grants						
09 Computer Reimbursement Scheme						
10 Out-of-Hours						
11 Total						
PRESCRIBING						
12 Total FHS Prescribing Costs						
13 % Generic Of The Total No. Of Prescriptions Written						
GENERAL DENTAL SERVICES						
14 GDPs Per 100,000 Population						
15 Registrations 0-5 Year Olds						
16 Registrations 6-17 Year Olds						
17 Registrations Adults						
GENERAL OPHTHALMIC SERVICES						
18 Optometrists/OMPs Per 100,000 Population						
19 Number Of Sight Tests - Children						
20 Number Of sight Tests - 60+						
PHARMACEUTICAL SERVICES						
21 Community Pharmacies Per 100,000						
22 Number Of Prescription Items Dispensed						
23 Income From Prescription Charges						
24 Locally Negotiated Payments To Pharmacists						

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ANNEX C

FHS IN-YEAR PERFORMANCE MONITORING RETURN : Year to Date

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	Year To Date		Year To Date	
	Planned Activity/ Number	Planned Value £,000	Actual Activity/ Number	Actual Expenditure £,000
GENERAL MEDICAL SERVICES (Non Cash-Limited)				
01 GPs Per 100,000 Population				
02 % Practices Claiming Sustained Quality Payment				
03 % Practices Achieving Higher Level Cervical Cytology Rate				
04 GP Local Development Schemes				
GENERAL MEDICAL SERVICES (Cash-Limited)				
05 Practice Staff - Nurses				
06 Practice Staff - Admin/Others				
07 Premises - Cost Rent Schemes				
08 Premises - Improvement Grants				
09 Computer Reimbursement Scheme				
10 Out-of-Hours				
11 Total				
PRESCRIBING				
12 Total FHS Prescribing Costs				
13 % Generic Of The Total No. Of Prescriptions Written				
GENERAL DENTAL SERVICES				
14 GDPs Per 100,000 Population				
15 Registrations 0-5 Year Olds				
16 Registrations 6-17 Year Olds				
17 Registrations Adults				
GENERAL OPHTHALMIC SERVICES				
18 Optometrists/OMPs Per 100,000 Population				
19 Number Of Sight Tests - Children				
20 Number Of sight Tests - 60+				
PHARMACEUTICAL SERVICES				
21 Community Pharmacies Per 100,000				
22 Number Of Prescription Items Dispensed				
23 Income From Prescription Charges				
24 Locally Negotiated Payments To Pharmacists				

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ANNEX D

GUIDELINES FOR COMPLETION OF THE HCH IN-YEAR PERFORMANCE MONITORING TEMPLATE 2000-2001

GENERAL NOTES

Ambulance Service

HCH activity and expenditure relating to ambulance services will now be the responsibility of the Scottish Ambulance Service (SAS) Health Board. The 2000-2001 HCH template, will no longer contain a separate line for recording activity and expenditure for ambulance services. Instead the SAS Health Board will be required to submit activity and expenditure figures for ambulance services in accordance with the timetable set out in Annex A.

Forecast Outturn

The **final plan for 2000-2001** is required by **26 May 2000** 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. At the end of the first quarter and subsequent quarters, only the 2000-2001 plan and forecast outturn (2000-2001) 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.**

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

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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.

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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"

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

The information provided in the template should identify as far as possible the total expenditure on a service and the activity associated with that expenditure. Where it is not possible to identify activity - for example, funding for Post Basic Nurse Training - then the expenditure should be included in line 39, `Other HCH Expenditure'. There appear to be significant differences between Health Boards in the share of total expenditure accounted for by `Other HCH Expenditure', and this will obviously affect the allocation of expenditure to other lines in the template. This largely reflects differences in the interpretation placed on this category of expenditure. If the data provided in the template are to be comparable between Health Boards it is important that there is consistency in the way that expenditure is allocated between the different lines. To help achieve greater consistency, Health Boards should identify in their performance template plans for 2000-2001 the items that they are including in `Other HCH Expenditure' in line 39

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

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Anticipated changes over the year should be indicated in the completed template returns which are submitted on 28 April 2000. These 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.

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DETAILED COMPLETION NOTES FOR THE HCH TEMPLATE

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 overnight. 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 in-patient 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 and haemodialysis; for the purpose of this return, haematology 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 are routinely collected only on area of treatment.

MATERNITY (including specialist obstetrics, GP obstetrics and SCBU)

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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 these 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 General Psychiatry (Mental Illness), Psychiatry of Old Age, Child Psychiatry, Adolescent Psychiatry and Forensic Psychiatry)

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 are routinely collected only on area of treatment.

17 Activity data should relate to all contacts/visits to registered patients, carers or relatives by community psychiatric team members, and should cover **all follow up contacts/visits irrespective of discipline** (this excludes telephone contacts). 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.

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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 are 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 MEDICINE: GERIATRIC ASSESSMENT

These notes have been updated to take account of the move to COPPISH, under which the facilities of geriatric assessment and geriatric long stay have migrated to the specialty of 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 for elderly patients from specialty of geriatric medicine, from the significant facilities of Geriatric Assessment Unit and Rehabilitation Unit (i.e. excluding discharges from a Long Stay Unit for Care of the Elderly). This **should** include rehabilitation, short-term convalescence and assessment of elderly patients in the above facilities. Younger physically disabled in-patient discharges should not be included (see line 26).

23 New out-patient attendances in the specialty of Geriatric Medicine, for the purposes of assessment, rehabilitation and convalescence.

24 Total attendances made by elderly patients and younger physically disabled patients to day hospitals within the specialty of Geriatric Medicine. GP Acute day patient activity should be recorded in line 39 of the template and detailed in the commentary. Activity data are routinely collected only on area of treatment.

GERIATRIC MEDICINE: GERIATRIC LONG STAY

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25 Occupied bed days for elderly patients undergoing long term continuing care in the speciality of Geriatric Medicine in significant facility of Long Stay Unit for Care of the Elderly. It does not include:

- patients undergoing rehabilitation, short-term convalescence or assessment in the specialty of Geriatric Medicine; these should be included within line 22
- younger physically disabled patients undergoing long term continuing care: these should be included within line 26

For year on year comparisons it is **essential** that this is handled consistently in both years' data. For consistency with ISD returns "elderly" is taken to cover patients aged 65 and over and "younger physically disabled" is taken to cover patients under 65 with a chronic physical disablement. Activity should be reported on a Health Board of Residence basis (i.e. using SMR50). Patients undergoing long term care in a Long Stay Unit for Care of the Elderly in specialties **other** than Geriatric Medicine should **not** be included in this section.

YOUNG PHYSICALLY DISABLED

26 Occupied bed days for younger physically disabled patients in any specialty in any significant facility. For consistency with ISD returns "elderly" 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 SMR01 and SMR50).

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COMMUNITY

27 The activity column should include all community nurse face-to-face contacts with patients and all health visitor face-to-face contacts with patients, relatives and carers (including child health). Activity data are routinely collected only on area of treatment.

28 The activity column should include face-to-face contacts with patients only, 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 are 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 be included as part of line 6.2 on the monthly financial monitoring form 5.

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.

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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 6.6 on the monthly financial monitoring form 5.

HEALTH PROMOTION

38 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

39 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.

The expenditure included in this line should be restricted to those items which cannot be associated with the activity shown in other lines of the template. (As noted in the General Notes, there are significant differences between Health Boards in the proportion of expenditure allocated to this line, and the content of this line will be monitored carefully to achieve greater consistency in the interpretation of `Other HCH Expenditure').

TOTAL HCH EXPENDITURE

40 Total HCH expenditure in the period commissioned for health services for residents by Health Board. The total should reconcile with line 6.7 (minus line 6.2) on the monthly financial monitoring form 5.

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ECRs/UNPLANNED ACTIVITY (UNPACs)

41 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 2000-2001, 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-Boundry and Cross-Border Patient Activity.

Therefore line 41 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 6.5, monthly financial monitoring form 5.

ANNEX E

GUIDELINES FOR COMPLETION OF THE FHS IN-YEAR PERFORMANCE MONITORING TEMPLATE 2000-2001

GENERAL NOTES

Forecast Outturn

Activity and expenditure data for **1999-2000** outturn should be reported according to their availability. It is recognised that some of these figures may not be available as this is the first time that data for Family Health Services has been collected in this format.

The **final plan for 2000-2001** is required by **26 May 2000** 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. At the end of the first quarter and subsequent quarters, only the 2000-2001 plan and forecast outturn (2000-2001) columns require to be completed in respect of the Forecast Outturn sheet.

In-Year Changes to Plan

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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.**

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DETAILED COMPLETION NOTES

General Medical Services (Non Cash Limited)

01 General Practitioners (GPs) per 100,000 population: number of Whole Time Equivalent (WTE) GPs per 100,000 population. In the`Expenditure/Value' columns, total expenditure on General Medical Services (GMS) Non Cost-Limited (NCL).

Source: local/ ISD (GPs number), Practioner Services Division (PSD) (Expenditure)

02 % practices claiming sustained quality payment: percentage of practices in an area qualifying under the sustained quality scheme (see NHS Circular MEL (1999)41) and associated payments.

Source: local/PSD

03 % practices achieving higher level cervical cytology rate: percentage of practices achieving 80% or more coverage of target population and associated payments.

Source: local/PSD

04 GP local development schemes: expenditure on schemes as defined in NHS Circulars MEL (1998)50 and (1999)41.

Source: local

General Medical Services (Cash Limited)

05 Practice Staff-Nurses: the number of WTE nursing staff in practices funded through the practice staff scheme (para 52 of the Statement of Fees and Allowances (SFA)) and associated payments.

Source: local

06 Practice Staff-Admin/Others: the number of WTE administrative and other non-nursing staff in practices funded through the practice staff scheme (para 52 of the SFA) and associated payments.

Source: local/PSD (payments only)

07 Premises – Cost Rent Schemes: the number of premises schemes being funded under the cost rent scheme (existing and new) and associated payments (para 51 of the SFA).

Source: local/PSD (payments only)

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08 Premises – Improvement Grants: the number of premises schemes being supported through improvements grants and associated payments (para 51 of the SFA).
Source: local/PSD (payments only)

09 Computer Reimbursement Schemes: expenditure under para 58 of the SFA.
Source: local/PSD

10 Out-of-Hours: expenditure from the out-of-hours development fund including any additional funding from HCHS.
Source: local/PSD

11 Total: total of lines 5 to 10 for expenditure only.

Prescribing

12 Total FHS prescribing costs: the total amount allocated by Health Board for FHS prescribing costs.
Source: local

13 % generic prescriptions: percentage of prescriptions written generically (whether or not dispensed generically).
Source: ISD

General Dental Services

14 General Dental Practitioners (GDPs) per 100,000 population: number of WTE GDPs (including salaried GDPs) per 100,000 population. In 'Expenditure/Value' columns, total expenditure on General Dental Services (GDS).
Source: local/ISD

15 Registrations 0-5 year olds: the number of 0-5 year olds registered with GDPs and associated payments (capitation fees).
Source: ISD

16 Registrations 6-17 year olds: the number of 6-17 year olds registered with GDPs and associated payments (capitation fees).
Source: ISD

17 Registrations adults: the number of 18+ year olds registered with GDPs and associated payments (continuing care payments)
Source: ISD

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General Ophthalmic Services

18 Optometrists/Ophthalmic Medical Practitioners (OMPs) per 100,000 population: number of WTE Optometrists/OMPs per 100,000 population. In 'Expenditure/Values' columns, total expenditure on General Ophthalmic Services (GOS).

Source: local/PSD

19 Number of sight tests – children: number of NHS sight tests for children and associated payments.

Source: PSD

20 Number of sight tests – 60+: number of NHS sight tests for 60+ year olds and associated payments.

Source: PSD

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Pharmaceutical Services

21 Community pharmacies per 100,000 population: number of community pharmacies (including part-time) per 100,000 population. In 'Expenditure/Values' columns, total gross cost on community pharmacies.

Source: local/ISD

22 Number of prescription items dispensed: number of prescription items dispensed and associated total gross cost on community pharmacies dispensing doctors and appliance suppliers.

Source: ISD

For lines 21 and 22, total gross cost relates to net ingredient cost, dispensing fees, professional allowance and oncosts (these include various allowances and the reimbursement of certain costs e.g. VAT and containers).

23 Income from prescription charges: amount received from prescription charges by patients (excluding pre-payment certificates).

Source: local/ISD

24 Locally negotiated payments to pharmacies: total amount paid to community pharmacies for dispensing of methadone, needle exchange services, disposal of unwanted medicines, domiciliary oxygen services, services to nursing/residential homes, rota services, collection and delivery services.

Source: local

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ANNEX F

HCH 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 2000-2001 by 26 May 2000 The planned efficiency changes will be based on a comparison between planned activity and expenditure for 2000-2001 and the outturn activity and expenditure for 1999-2000. Table 1 shows the form in which this information should be submitted.

3. At the end of the first quarter and subsequent quarters of 2000-2001 Boards should also provide a return with the template return showing the forecast outturn efficiency changes for 2000-2001 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 2000-2001 and outturn activity and expenditure for 1999-2000. 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 :2000-2001

	2000-2001 Plan Against 1999-2000 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 : 2000-2001

	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 2000-2001. These estimates are based on a comparison between planned (or forecast outturn) activity and expenditure in 2000-2001 and actual activity and expenditure in 1999-2000. 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;

(c) community services.

Tables A1 - E1 show the information required to estimate planned changes in efficiency for these service groups for 2000-2001. 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 2000-2001

Table A1: Acute, Maternity and Geriatric Assessment

Column (a) shows the outturn estimates of activity and expenditure in 1999-2000.

Column (b) shows the planned levels of activity and expenditure in 2000-2001.

Column (c) shows the ratio of the planned levels of activity and expenditure in 2000-2001 to the outturn levels in 1999-2000. 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 1999-2000.

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 1999-2000 and 2000-2001. 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 1999-2000, the planned expenditure in 2000-2001 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 2000-2001.

Row 14 shows the 'real' change in expenditure between 1999-2000 and 2000-2001. 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 1999-2000 and 2000-2001 (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 1999-2000 and 2000-2001.

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 1999-2000 and 2000-2001.

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 1999-2000 and 2000-2001.

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 1999-2000 and 2000-2001.

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 2000-2001

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 2000-2001 are based on a comparison between forecast outturn activity and expenditure for 2000-2001 and the outturn activity and expenditure in 1999-2000.

Column (a) in Tables A2 - E2 shows the actual activity and expenditure in 1999-2000.

Column (b) shows the forecast outturn activity and expenditure for 2000-2001. These figures will be revised and updated on a quarterly basis during 2000-2001.

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Column (c) shows the ratio of the forecast outturn levels of activity and expenditure in 2000-2001 to the actual levels in 1999-2000. 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 1999-2000.

TABLE A1 : ACUTE, MATERNITY & GERIATRIC ASSESSMENT

	(a) 1999-2000 Outturn	(b) 2000-2001 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) 1999-2000 Outturn	(b) 2000-2001 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) 1999-2000 Outturn	(b) 2000-2001 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) 1999-2000 Outturn	(b) 2000-2001 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) 1999-2000 Outturn	(b) 2000-2001 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) 1999-2000 Actual	(b) 2000-2001 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) 1999-2000 Actual	(b) 2000-2001 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) 1999-2000 Actual	(b) 2000-2001 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) 1999-2000 Actual	(b) 2000-2001 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) 1999-2000 Actual	(b) 2000-2001 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				