THE SCOTTISH OFFICE

National Health Service in Scotland
Management Executive

St. Andrew's House
Edinburgh EH1 3DG

NHS
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Dear Colleague

GUIDANCE ON SETTING GP FUNDHOLDER ALLOTTED SUMS FOR 1995/96

18 October 1994

Addressees

For action:
General Managers,
Health Boards
GP Fundholders

For information:
Chief Executives,
NHS Trusts

Enquiries from Boards to:

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Enquiries from GP Fundholders should be to the appropriate Board.

Summary

1. This guidance is principally directed at Health Boards and sets the framework within which GP fundholders allotted sums should be set for 1995/96 only. The setting of these allotted sums should take place on the basis of information shared between Boards, NHS Trusts and GP fundholders with the continuing aim of establishing fair budgets.

Action

2. General Managers are asked to ensure that copies of this guidance are distributed to Directors of Finance and GP Fundholding Liaison Officers and that copies are issued to all existing and prospective GP fundholders in their Board area.

3. Health Board staff should use this guidance as the framework within which to set GP Fundholder allotted sums for 1995/96.

DAVID KERR
Directorate of Primary Care

GUIDANCE ON SETTING GP FUNDHOLDER ALLOTTED SUMS FOR 1995/96

Introduction

1. Health Boards are reminded that they are required by statute (the National Health Service and Community Care Act 1990 which amends the National Health Service (Scotland) Act 1978) to make arrangements for the setting of allotted sums for GP fundholders determined in such manner and by reference to such factors as the Secretary of State may direct. Boards are therefore requested to apply consistently the principles set out in this note.

2. The possibility of making significant changes to the overall scope of the GP Fundholding Scheme is currently under active consideration. It is expected that Ministers will wish to make a formal announcement shortly on the timescale and nature of the changes to the scope of the fundholding scheme which are to be introduced. It is therefore prudent to avoid significant upheaval in the process of budget setting for 1995/96, which might be counter-productive to Boards, fundholders and other interested parties and might not fit the longer term direction set by Ministers. In consequence the guidance set out in this note proposes that there should be no significant changes in budget-setting processes for 1995/96 to those which previously applied. Once the new developments have been announced and set in place further guidance will be considered with a view to increasing the accuracy of fundsetting arrangements between Boards and fundholders for subsequent years.

A. SUMMARY OF MAIN ELEMENTS

3. The significant changes from the previous guidance of 15 December 1993 are summarised below. Further work will be undertaken during 1995/96 with a view to testing the possibility of extending the use of weighted capitation benchmarks into the area of outpatient services.

Staff Element

4. The methodology for setting the staff element of the allotted sum remains unchanged from 1994/95. (See paragraph 7.4 of the GPFH Manual).

HCHS Element (Annex A)

5. For 1995/96 Boards are asked to follow Annex A to produce capitation benchmarks for inpatient and day cases as in 1994/95. The capitation benchmarks for inpatient and day cases will be built up by ISD using a formula based on Health Board utilisation rates. Boards may, if they wish, use more accurate local data or add further elements of Capitation **provided that they have the unreserved agreement of each GP fundholder in their area to this course of action.**

6. The methodology for setting the fund for community nursing services remains broadly unchanged a described in paragraph 4.3 of the guidance issued to Boards on 21 October 1992, ie the use of whole-time equivalents. Boards are also encouraged (as last year) to include the proportion of locality and central overheads attributable to management and headquarter costs within the fund. This will allow fundholding practices to negotiate with the NHS provider of their choice, as required by the regulations, but on the basis that this can involve the

development of a locally planned and managed service close to the needs of the fundholders' patients.

Prescribing Element

7. At national level for 1995/96 the prescribing element will be based on a similar methodology as applied for 1994/95. This emphasises a number of points where it is essential that Boards apply the principles fairly, consistently, and transparently with their GP fundholders so that Boards and fundholders negotiate on the basis of shared information

- the MPA and the fundholder should discuss the prescribing element and agree a recommendation to the Board;

- the Health Board is responsible for setting the prescribing element for practices' taking account of the MPA's report and recommendations;

- where the MPA's recommendation is not fully accepted, Boards should offer a full explanation to the fundholders involved of the adjustments proposed and why these are necessary. Any adjustments between individual practices in the Board area should be consistent and fair.

8. The Management Executive is prepared to consider in principle proposals by individual Boards to use alternative methods but in such cases will require to be satisfied that the formula proposed can be applied by all practices (and not just fundholders); is seen to be equitable and fair; and is not potentially disruptive of existing arrangements, pending the outcome of Ministers' overall review of the future direction of the Fundholding Scheme. Any such proposals from Health Boards should also involve an overall management approach which is consistent with MEL(1993)12 on the Management of the Drugs Bill. Any Board wishing to propose an alternative method should notify us without delay with details of their proposals.

B. IMPLEMENTATION AND MANAGEMENT ISSUES

9. The main principles to be kept in mind during the implementation and management of the setting of the allotted sum are:

- the need to ensure that all timetables are properly adhered to;

- the need to involve GP fundholders early in the process of setting the allotted sum;

- the need to make the data underlying the setting of allotted sums available for GP fundholders;

- where GP data and provider data disagree, the need to aim to reconcile these as far as possible as an urgent priority.

A number of valuable lessons have already been learned during the process of setting the allotted sums during the last 2 financial years. Relevant issues arising are summarised below.

10. Effective communication: This means involving fundholders from the outset of the budget setting process. Boards should consult fundholders

on the detail of the local methodology and give clear outlines of what input will be expected from practices. Information about developing the process should be disseminated fully to fundholders. Boards should also ensure that their own purchasing teams are kept closely in touch with developments and that where possible they are involved in the process. There is a need to establish shared views on local priorities where possible, and there should be meetings between fundholders and the Board's purchasing team prior to budget setting being completed. (compare also FIN(CON)(1994)8 in relation to the contracting timetable).

11. Agreed Data: Achieving agreed data between the Board and fundholders is an important way to address the poor quality of data which thus far has been the major obstacle in the way of setting allotted sums. Boards should collect data early from both practices and providers and reconcile this data as far as possible by involving the fundholders, the providers and the Board's purchasing team. The objective should be to reach an agreed dataset acknowledged by all; or, if necessary, for such an agreed dataset to have explicit caveats shared by all.

12. Negotiating "fair" funds: While much can be done to improve the quality of the data and to identify more appropriate and objective indicators which will inform the budget setting process, management judgement by the Board will always remain an important factor in the process of setting allotted sums for GP fundholders. Boards should aim to achieve budgets which are fair to fundholders and non-fundholders alike. This requires negotiations and sharing of information. It also implies that - once allotted sums are agreed that are perceived as reasonable by all sides and look fair in the light of historic information and/or capitation benchmarks - these should be taken as giving the activity baselines for roll-forward budgets in future years.

13. Applying weighted capitation benchmarks more systematically: For the reasons explained in paragraph 2 we are not encouraging Boards to accelerate the pace of change in using capitation benchmarks as the starting point for budget setting for GP fundholders this year. Nevertheless there remain opportunities for developing the use of capitation benchmarks more systematically for the longer term. In particular if such benchmarks can be used more widely by Boards in their own budgeting work, this may assist the overall process. For example, Boards may wish to calculate the impact of such benchmarks on all their GP practices, and look at the levels of "fundholding" procedures which the Board would be able to purchase for patients of non-fundholders to allow useful comparisons with benchmark indicators for GP fundholding practices. Use of the benchmarks for this purpose could assist in ensuring equity and would be based on the actual volumes of activity delivered in the Board's area as a whole historically. (Arguably for those Boards with large numbers of fundholders operating in their area this will become, over time, an essential rather than optional activity).

14. Efficiency Gains: In principle, there is the same requirement on fundholders as on other purchasers to contribute to efficiency gains in the NHS; and this should be taken into account when Boards are setting funds. Fundholders should be expected to demonstrate to Boards how they are achieving increased efficiency at a rate consistent with that required of others managing NHS resources. However, Boards should be flexible in acknowledging fundholder efficiency improvements, some of which will not be easily measurable (for example, when resources are

vired into prescribing or staff budgets and away from the purchase of hospital based activity). Health Boards should not automatically reduce funds by the efficiency target for 1995/96 but should discuss with fundholders what level of efficiency gains can be achieved in each individual fundholder's particular circumstances and how these will be measured and monitored.

C. TREATMENT OF PLANNED SAVINGS IN FUND SETTING

15. Boards are reminded that they will not normally be entitled to make reductions in the allotted sum for a GP fundholder for 1995/96 where in the current, or any previous, financial year that practice made planned savings on its allotted sum under one or more of the 3 elements of the fund. The fundholders should continue, year on year, to have the flexibility to use efficiency gains (for example, in the hospital or prescribing elements) to apply to other parts of the allotted sum for the benefit of their patients.

16. The guidance in paragraph 15 relates to planned savings only. Part or all of any savings which arose as the result of an error in calculating the original budget, or any erroneous factors which may have entered the initial calculation in the previous year (ie data/pricing), can legitimately be excluded by the Board in recalculating the element of the fund (whether prescribing, HCH or staff costs) for 1995/96. As Boards move towards more systematic discussions with their GP fundholders on their development (or business) plan for fundholding, it should prove possible for Boards to identify early with individual practices the proposals for planned savings in any given year, and the eventual use of such savings within the practice; this availability of savings will be recognised so that fundsetting for the efficiency improvements are not penalised. Such a process of "performance review" around the business or health care plan for the practice, will also be of assistance to Boards in satisfying themselves on such matters as efficiency gains (compare paragraph 15 above). Further work is in hand on how such approaches to planning, and performance management, etc should be developed.

Consequential Issues

17. The guidance in this letter supersedes and cancels our letter of 15 December 1993 and updates Sections 7.5 - 7.8 of the "Procedural Manual on General Practice Fundholding". An update of Section 7 of the Manual, to reflect the revised guidance on this letter, will be issued as soon as possible.

18. Enquiries about the supply of data for calculating the weighted capitation benchmarks for HCHS services (see Annex A) should be directed to Mike Muirhead of ISD. ISD will also advise separately in due course about the prospects of supplying indicative data for the development of weighted capitation benchmarks for outpatient services; and whether this would be available in time to assist Boards and fundholders in budget setting discussions for 1995/96.

HCHS Element of the Allotted Sum

1. For 1995-96 the HCHS element will be set using the following approaches.

1.1 Boards will be expected as a minimum requirement to produce capitation benchmarks for in-patient and day cases;

1.2 costs should be Board averages for provider units from providers final prices as provided under the contracting timetable for 1995-96 in FIN(CON)(1994)8;

1.3 to allow planning to commence at an early date with GP fundholders, a 2 stage progress should be used. Boards should in the first instance agree with fundholders the activity levels on which the HCHS element of the fund will be set, based on the methodology set out in this Annex. This can then be revisited in early 1995, when provider prices are available in accordance with the contracting timetable for 1995-96, to negotiate and agree this element of the fund;

1.4 Boards which are able to produce more accurate local data for these items or to add further elements of capitation would be encouraged to do so provided this was done within a framework agreed with the fundholders;

1.5 there will be no central data to establish a capitation benchmark for out-patients, direct access services, diagnostic tests and community nursing. Budget setting for these elements will need to be based on historic costs with minor adjustments for any known developments other than where 1.4 applies.

2. The capitation benchmark for in-patient and day cases will be built up by ISD using a formula based on Health Board utilisation rates (but not costs). ISD data on utilisation rates based on SMR forms will be used. A summary of the methodology used is set out in Appendix 1. This data will be provided to Boards and to existing and prospective fundholders during the budget setting process. Boards are invited to contact Mike Muirehead of ISD (Tel: 031-552 6255) to obtain the information they will need. Boards are recommended to proceed on the basis of the data available from ISD, unless they can demonstrate to fundholders in their area that they have more accurate information on utilisation rates than is currently available from ISD in establishing the weighted capitation benchmarks.

3. The formula amount derived from paragraph 2, and multiplied by the relevant costs (paragraph 1.2), will need to be adjusted to establish the capitation benchmark after considering the importance for each practice of a number of local factors. These can be summarised in 3 main categories:

- factors which may influence the activity levels for some procedures but are not quantifiable at the practice level.

- factors common across the country, but whose importance varies significantly locally.

- purely local factors which cannot be included in a national formula. Important examples are the local split of in-patient and day cases, and the activity growth locally since 1994-95.

4. An increasingly important local factor which will impact on decisions on fundsetting, will be Health Board purchasing priorities in the coming year, particularly where these are shared and agreed with local fundholders as individuals or where consortia exist. Examples will include the funding of waiting list initiatives involving GP fundholders; the facilitation of fundholder involvement to support new services or change priorities locally, or to support initiatives to accelerate the shift of activity from secondary or long-stay sectors to primary and community health services where it is agreed that fundholders have a significant role to play. This must however be on the basis of local agreement between the Board and fundholders. Boards should not seek to impose their own views on strategic priorities, and seek to set funds accordingly, since to do so would inhibit the fundholders' freedom to use their funds in the best interests of their patients.

5. For all categories of local factors as described in paragraphs 3 and 4, it will be necessary for Boards to make judgements based on their knowledge of individual practices and the areas in which they are located. An important tool in forming these judgements will be the historic pattern of activity in the practices. Where, for example, a practice's historic activity is significantly lower than that suggested by the formula element of the benchmark, boards should consider whether this could be explained by local factors and adjust the benchmark accordingly. Similarly, where historic information shows higher than predicted activity boards should consider whether this is due to local factors and make a judgemental allowance for this in the benchmark.

6. Boards should also bear in mind that the use of Health Board utilisation rates in calculating a capitation benchmark will inevitably reflect activity of an earlier period (in this case 1992 data). A number of factors may influence utilisation rates (and also costs) and therefore should be taken into account when setting the capitation benchmark:

- local waiting list funding activities may have been purchased at marginal cost and may distort utilisation rates;

- costs used in setting the capitation benchmark should take account of provider efficiency gains since the base period on which the Health Board costs are based;

- local utilisation rates and costs will be influenced by changes in the Health Board HCH allocation in respect of growth monies or moves towards parity;

- it should be clear that the available information on the individual practice list size is as accurate and up to date as possible.

Using the Benchmark to Agree the Fund

7. Having established a benchmark for each fundholding practice Boards will then need to negotiate and agree with fundholders the activity levels/utilisation ratio which will form the basis of an offer or a fund on the HCHS element once provider prices are available and can be assessed

and confirmed. Such negotiations should take into account the capitation based benchmark, the practice's historic expenditure, and the appropriate pace of change (also allowing for a fair allocation between fundholders and non-fundholders).

8. The key tasks of Boards will be to ensure, as far as possible, that the HCHS element of the allotted sum is set on a basis which is fair both to GP fundholders and other GP practices. This will be a matter of judgement for Boards in order to determine that the allotted sums set for each fundholder are reasonable, and that the overall resources allocated to fundholders are not disproportionate. It is not possible to prove mechanistically that Board and GPFH budgets are entirely consistent as a different range of services is being covered for a heterogenous population, and the purchasing scale for a Board and a GP practice is very different (for this reason it was not appropriate to simply use the same formula for Boards and GP fundholders).

9. The main circular highlights the considerations which Boards should take into account in accelerating the pace of change towards the use of the capitation benchmark, and the need for application of management judgement to ensure a fair outcome of the negotiations of their GP fundholders. On the latter point, Boards will need to demonstrate that the process they use for budget setting is based on equitable considerations. In making an offer of an allotted sum, the Board will also have to be transparent and provide full information to the fundholder on the following:

- the capitation based benchmark used
- the historic costs
- information about the assumptions on the pace of change
- information about the local or other factors taken into account by the Board and information as to why these are seen to be relevant.

This information is essential to ensure that fundholders are equipped to decide whether the allotted sum offered is acceptable and whether the board's decisions are based on equitable principles which properly reflect the fundholder's own circumstances.

DETERMINATION OF A WEIGHTED CAPITATION BENCHMARK ALLOCATION FOR CERTAIN HCHS SERVICES, FOR GP FUNDHOLDERS IN 1995-96

1. A weighted capitation model has been developed to determine the benchmark allocation for GP fundholders in respect of in-patient and day case services for the year 1995-96. The model utilises Health Board specific bed use rates for each age/sex group and average Health Board costs per in-patient bed day and day case, devised from final provider prices supplied in accordance with the terms of FIN(CON)(1994)8.

2. The expected number of in-patient bed days and day cases, within each fundholding specialty for which the fundholder is liable for charge, is estimated by applying the Health Board utilisation rate to the practice population for each age/sex category. The estimated cost for each specialty group is determined by multiplying the estimated number of bed days by the average cost for the Health Board. The benchmark allocation is determined by aggregating the cost over all 6 fundholding specialty groups. (See Figure 1A.)

Calculation of Health Board Utilisation Rates

3. The in-patient and day case activity attributable to liable procedures for the Health Board residents is determined from the 1992 SMR1 national dataset. Each liable procedure has been assigned to one of 6 fundholding specialty groups. The total fundholding activity (bed days) in each age/sex category is calculated for each specialty group. The utilisation rates are determined by dividing the total activity by the 1992 Health Board population for the relevant age/sex category (see Figure 1B).

Figure 1A

METHOD OF DETERMINING BENCHMARK ALLOCATION FOR FUNDHOLDING PRACTICES FOR YEAR 1994/95

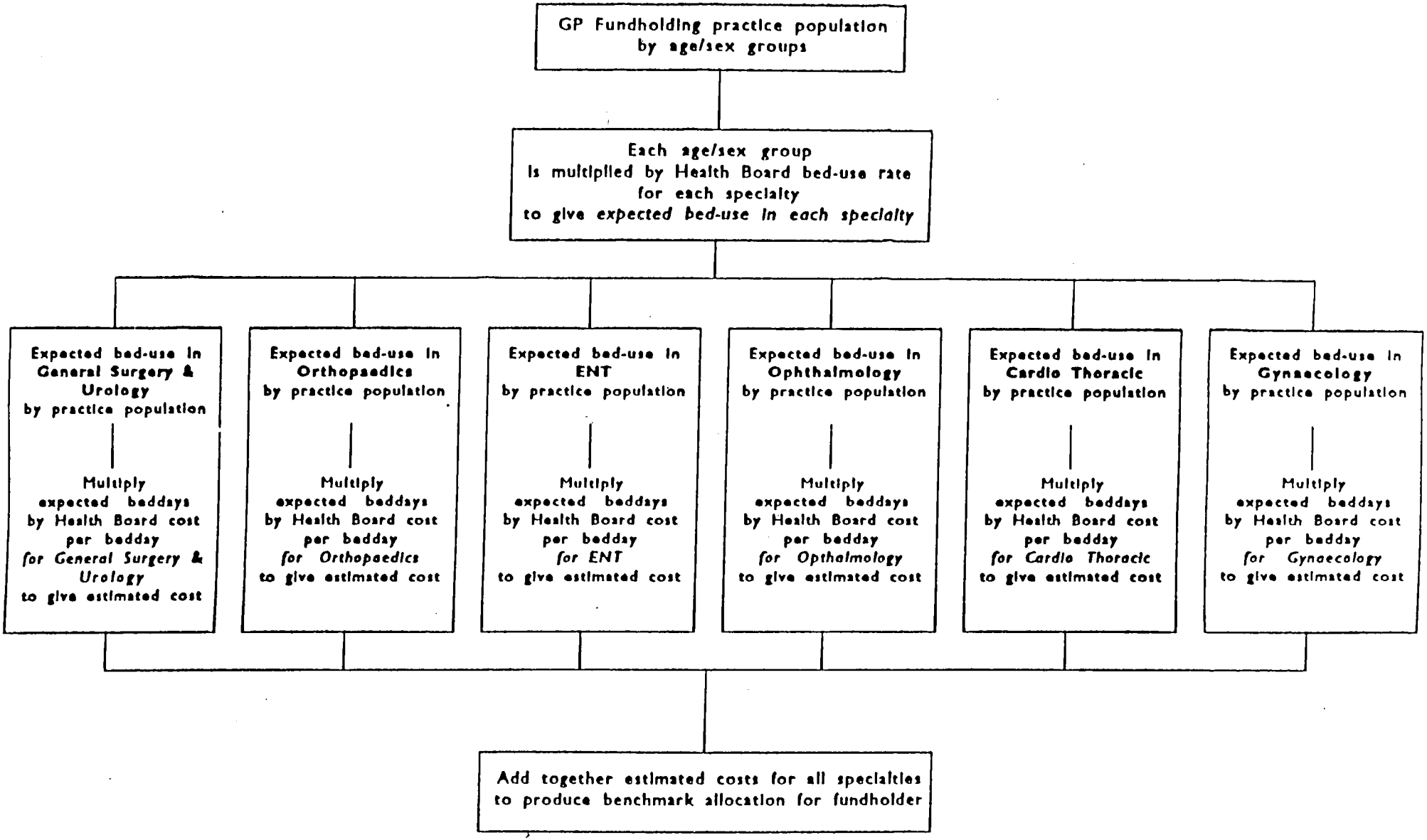

Figure 1B

METHOD OF DETERMINING HEALTH BOARD UTILISATION RATES FOR EACH FUNDHOLDING SPECIALTY GROUP