THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1996)84

NHS Management Executive
St. Andrew's House
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Dear Colleague

GUIDANCE ON SETTING GP FUNDHOLDER BUDGETS FOR 1997/98: THE NATIONAL FRAMEWORK

Summary

1. This guidance is principally directed at Health Boards and GP Fundholders and sets the framework within which GP Fundholders' budgets should be set for 1997/98. The guidance itself relates to only the HCHS allocation, although reference is made to the setting of prescribing and staffing budgets. Separate guidance will be issued in relation to prescribing budgets.

2. This guidance requires boards to move away from traditional historic based budgets towards budgets set with reference to weighted capitation principles. It offers a process which health boards can work through to calculate target weighted capitation budgets, while recognising that individual practice budgets should be discussed and agreed locally. We will provide boards with centrally calculated weighted capitation benchmarks for all practices separately. Some boards have made significant movement towards implementing weighted capitation budgets; we are keen for them to continue this process.

3. The timetable to which all parties to the budget-setting process should adhere is set out in this year's "Priorities and Planning Guidance for the NHS in Scotland".

4. It is important that GP fundholders are fully involved in the process as practice budgets will be affected by this change. We recommend that a short-life working group be established in boards to take forward this work. The setting of allotted sums should take place on the basis of shared information between health boards, providers and GP fundholders with the continuing aim of establishing fair budgets. In recognition of the new work involved, we are prepared to work with boards individually to assist in the calculation process.

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Action

5. 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.

6. Health Board staff should use this guidance as the framework within which to set GP Fundholder budgets for 1997/98.

Yours sincerely

Agnes Robson.

AGNES ROBSON
Director of Primary Care

GUIDANCE ON SETTING GP FUNDHOLDER ALLOTTED SUMS FOR 1997-98: THE NATIONAL FRAMEWORK

1. Introduction

1.1 This document sets out the national framework within which Health Boards should set GP Fundholder budgets. It applies only to the HCHS component of fundholders' budgets.

1.2 In this context, Health Boards are reminded that they are required by statute (the NHS and Community Care Act (1990) which amends the NHS (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 expected to apply consistently the principles set out in this note.

2. Key principles and responsibilities

2.1 The key principles which should be adhered to every year are: equitable budget setting; effective communication; and the use of robust information.

2.2 The responsibilities of health boards and GP fundholders are set out in Annex D of "Commissioning Better Health" - the Shields report. It remains the responsibility of providers to work with health boards and fundholders to establish robust information systems, and to produce prices to the timetable in the priorities and planning guidance on the basis of notified purchasing intentions.

3. The process last year

3.1 Our review of the budget setting process highlighted many difficulties. The four most relevant were late budget offers, paucity of information on community activity, uncertainty with regard to the treatment of preserving savings and excessive time and effort spent in the budget setting process. The current process is very resource-intensive. At a time when boards are being asked to closely examine their management costs, it seems sensible to move to a budget-setting system which, once implemented, will require significantly less time and effort from health boards, trusts and practices.

3.2 The current approach reflects historical patterns rather than an allocation of funding based on patient need. This is not tenable in the medium-long term. Budgets based on historical patterns will become increasingly irrelevant to current practice needs with each succeeding year. Further, the "activity x price" approach does not consider non-fundholders and hence leads to perceptions of inequity.

3.3 The methodology shown takes account of provider prices; the percentage spend calculations will fully account for any differential pricing of fundholding procedures that persist. In order to ensure that a link remains with provider prices, we

will repeat the percentage spend calculations on an annual basis to ensure that fundholder budgets continue to reflect prices being charged locally for fundholder procedures.

4. The process this year

4.1 Equity and practicality requires that we move away from historically based budgets. We therefore expect each health board to use weighted capitation methods to calculate **target** fundholders budgets this year. Several health boards have already made significant progress in weighted capitation budget setting and we would expect this work to continue. The methodology in this note is to assist those boards where difficulties have been encountered either in identifying a suitable weighted capitation methodology or in implementing changes. Boards which can demonstrate a significant shift towards weighted capitation principles, and where they have reached local agreement with their fundholders to do so, should notify the ME by 8 November that they intend to progress their own formulae this year.

4.2 The calculations referred to in this guidance relate to HCHS budgets. Most health boards have already agreed a profile for staffing budgets, based on capitation and quality factors. It is expected that local arrangements for agreeing staffing budgets will continue to be developed and used. Specific guidance on prescribing budgets will be issues separately. Management allowance calculations are also covered by separate guidance.

4.3 Calculating total spend on fundholding services

- In adopting a weighted capitation approach, it is necessary for health boards to identify total expenditure on all activity covered by the fundholding scheme. This total spend is to cover fundholders and non-fundholder alike. The total spend figures are calculated by adding the costs of all activity carried out within the health board area of all services listed in the fundholding list of goods and services. The most recent list of goods and services should be used for this purpose. The total spend should be calculated separately for hospital activity and community activity.

4.4 Calculating the percentage spend on hospital and community services

- Once the total amounts spent on fundholding services have been determined, it will then be necessary to calculate the percentage of health board expenditure which these figures comprise. For hospital services, the percentage will be the overall spend on fundholding services compared with the total spend on hospital services . For community services, the percentage will be the overall spend on fundholding services compared with the total spend on all community services.

4.5 **Boards calculate the percentage spend**

- To calculate the percentage of the total spend in relation to services within the fundholding scheme in 1996-97 for (a) hospital services and (b) community services, boards should use prices and referral data from the most recent year available. The exact total expenditure figure obtained from this calculation is less important than the estimated percentage spend on fundholding activity. It is important, however, that the prices and activity levels used to estimate total spend on fundholding services are from the same year as the total overall spend figures used. This will ensure that the estimated percentage spend on fundholding services is not over or under estimated. Boards should make these calculations by 8 November.

4.6 **ME calculates the percentage spend**

- where boards are unable to meet the 8 November deadline, the ME will determine the appropriate figures using known activity levels and blue book costs.

4.7 **Calculating expected expenditure in 1997/98 using the percentage spends**

- Once the percentage spend of hospital and community services has been determined, and once the health board allocations for 1997/98 have been made, boards will calculate the expected spend on fundholding procedures in 1997/98. It is expected that boards will use the percentage spend figures calculated using earlier years data to estimate likely spend next year. Where there has been a significant change to the scope of the fundholding scheme, an upward adjustment will have to be made to the percentages used. This should be discussed and agreed locally. This can be done by applying the percentage spend calculation for both hospital services and community services to the appropriate overall allocations for 1997/98. For example, if 20% of a health board's budget is spent on fundholding services in hospitals and the board's portion of its HCHS allocation for hospital services is £24 million, the total fundholding spend on hospital services is estimated to be £4.8 million. Similar calculations will be made for spending in the community.

4.8 **Calculating the "pool"**

- Boards will then calculate first cut "budgets" for all practices using weighted capitation principles. Standard fundholders will have two elements to their budget, a hospital services element and a community services element. PCPI practices will have only a community element. Calculating budgets for all practices ensures equity in the budget setting process, although the individual practice "budgets" determined at this stage are for information; this is only a step in the calculation process. Practice target budgets can be determined at this stage with reference to whatever weighted capitation formula has been adopted and agreed locally, or else the weighted practice populations provided by ISD. The "budgets" for all fundholding practices will be totalled; this sum

will be the target fundholding pool at health board level. Calculating a fundholding pool in this way eliminates some of the perceived difficulties in using weighted capitation principles for very small populations. It should also encourage the use of risk sharing arrangements between fundholders and health boards.

4.9 Determining practice budgets

- The fundholding pool is the target budget at health board level. We recognise that there are difficulties in using weighted capitation principles at practice level, and urge boards and fundholders to use the mechanistic calculations for practice budget setting with caution. It will be essential to take account of local circumstance when determining individual budgets each year. Where there are significant differences between the target weighted capitation budget and the historically based budget, agreement should be reached locally on the timetable for moving to target budgets.

- Boards should support fundholders in their area to work together to even out differences from target budget at practice level. Particular attention may need to be given to outliers; the reasons for their significantly different spending patterns may require further investigation.

5. Implementation

5.1 The timetable for implementing the changes this year is set out in Annex 1. A weighted capitation methodology requires a robust agreement between health boards and GP fundholders on both the methodology for achieving target budgets and the timescale for completing the move to weighted capitation budgets. The method of weighting also requires local agreement. We will issue separately weighted capitation benchmarks for all practices; if local ones are adopted, these must be agreed by all parties.

5.2 The total resources available to the group of fundholders is likely to change next year, as will the budgets for individual practices. In order to ensure that key issues are agreed at the start of the process, including the use of suitable weightings, the pace of change policy and the treatment of outliers, we recommend that a short-life working group be set up within the next month to resolve such issues and establish a local plan for implementing weighted capitation budgets. In developing and agreeing local pace of change policies, health boards and GP Fundholders should begin by seeking to establish, as far as possible, the reasons for the historic variations between GPs' practices in their patients' use of NHS services. These variations may results from a range of factors such as; differences in the health needs of the population; well established differences in the way these needs are met; and differences in clinical practice. It will be important for boards to continue to improve their knowledge of service costs and cost drivers to ensure that refinements can be made both to the methodologies used and the specific budgets set for fundholders.

5.3 We are aware that some practical difficulties remain in implementing weighted capitation based practice budgets, particularly at practice level, and it is important to remember that figures calculated should be treated as target budgets and not as absolute amounts. Where there is a significant difference between the historical budget and the target weighted capitation budget, it will be essential to agree a timetable for moving towards target budget. This applies equally to the target fundholder pool at health board level and to practice budgets. Experience in England has shown that an annual shift of no more than 2% either way is acceptable. In order to minimise the amount of work involved in the next year, boards and fundholders may wish to consider using uplifted historical budgets for comparison purposes, rather than recalculating a new historical budget for each practice. New fundholders will normally have their budget set using a weighted capitation method.

5.4. In taking forward the budget-setting process, health boards and GP fundholders should collaborate in developing risk-sharing and appropriate financial management methods to ensure that any changes are implemented smoothly and without adverse consequences.

6. Future work

6.1 The methodology proposed does not cover all funding elements, such as direct access services. Boards, fundholders and trusts will be expected to work towards introducing such elements into a weighted capitation methodology in future years. In the interim, boards will have to take account of such services and ensure that fundholders are not disadvantaged with regard to such services.

6.2 The ME will follow-up the implementation of these guidelines in a budget setting wash-up meeting next spring. Boards experiencing difficulties are advised to contact Elinor Mitchell, Telephone Number 0131-244 2415, in the Primary Care Development Unit for further advice and assistance.

Annex 1

PROPOSED TIMETABLE FOR WEIGHTED CAPITATION BUDGET SETTING

Milestone	**Deadline**
Boards set up a short-life working group involving GP fundholders to discuss and agree a local implementation plan.	during October
Health boards calculate percentage spend on fundholding services split into hospital and community services in their area	8 November
Boards which can identify a significant shift towards weighted capitation note that they intend to progress their own formulae with local agreement	8 November
For those boards unable to calculate percentage spends on fundholding schemes, ME/ISD calculate these using blue book costs and centrally held activity data	end November
ISD calculate appropriate weighted capitation percentages for all practices and issue to boards	29 November
Health boards receive their allocations from ME	mid December
Health Boards calculate the first cut budgets for all practices and calculate the health board fundholding target budget pool. Standard fundholders receive an element from both the hospital services and the community services fundholders pot while PCPI practices receive an element from the community services fundholding pot only.	end January

Health boards discuss this information with GP groups and local discussions on individual practice budgets begin	end January
Practice budgets agreed	31 March

Annex 2

GPFH Budget Setting Process : Worked Example For Health Board 'X'

The following example illustrates the weighted capitation budget setting process.

The process is in three stages. Stages 1 and 2 determine the fundholding pot of money which covers services included in the scope of the fundholding scheme. In Stage 3 the weighted capitation percentages are then applied to this pot to give target allocations.

If boards can devise a more appropriate local method of identifying this pot of money then Stages 1 and 2 can be bypassed.

Stage 1 : Dividing the health board HCHS allocation into hospital and community services

The health board HCHS allocation is split into hospital and community services according to the information contained in the Scottish Health Service Cost book. This split is then applied to the 97/98 allocation to get the 97/98 hospital and community pots of money.

Health Boards may wish to calculate their own pots based on locally held information.

1. Health Board 'X' had an HCHS allocation of £50,000,000 in 95/96. There are ten practices in this health board, four of which are fundholders.

2. This allocation was broken down as follows according to the 95/96 cost book:

	Cost	%
Hospital services expenditure	£45,000,000	90%
Community services expenditure	£ 5,000,000	10%
Total HCHS expenditure	£50,000,000	100%

Therefore in 95/96 90% of the health board's allocation was spent on hospital services. 10% was spent on community services.

3. If the 97/98 allocation for health board 'X' has been set at £55,000,000 then the estimated split for hospital expenditure is £49,500,000 (90% of £55,000,000) and for community expenditure an estimated £5,500,000 (10% of £55,000,000).

Stage 2 : Dividing the hospital and community expenditure into fundholding and non-fundholding elements

4. This stage involves dividing the 95/96 hospital expenditure into the amount spent on services within the scope of the fundholding scheme and services outwith this scheme.

   This is done using the 95/96 cost book hospital speciality average costs and applying them to the activity within the scope of the fundholding scheme for 95/96.

   For health board 'X' the spend on fundholding services was calculated to be £9,000,000 in 95/96. From step 2. the hospital expenditure was £45,000,000. Therefore this £9,000,000 equates to 20% of the hospital expenditure.

5. The percentage calculated above can then be applied to the estimated 97/98 hospital expenditure to give the estimated spend on fundholding services for 97/98.

   So for health board 'X' the estimated spend on services within the scope of the fundholding scheme is 20% of £49,500,000 i.e. £9,900,000 for 97/98.

N.B. If boards can identify this hospital "pot" locally then the above two stages can be ignored.

Stage 3 : Allocation of fundholders' budgets

6. This fundholding "pot" of £9,900,000 is then split across the ten practices in health board 'X'. The split is based on the weighted capitation percentages provided by ISD Scotland or by those determined locally by the health board.

   The weighted capitation figures calculated by ISD Scotland for the ten practices within health board 'X' were as shown below :

	Percentage	Money (£s)
Practice 1	**6.26**	**619740**
Practice 2	11.36	1124640
Practice 3	12.70	1257300
Practice 4	**3.66**	**362340**
Practice 4	11.59	1147410
Practice 6	**4.69**	**464310**
Practice 7	**7.52**	**744480**
Practice 8	14.31	1416690
Practice 9	10.09	998910
Practice 10	17.82	1764180
Total	100.00	9900000

7. The figures in bold relate to fundholding practices. These figures are to be used only as a starting point for local discussions where actual allocations from the "pool" will be finalised. The sum of the practice budgets in bold is the hospital element of the target "pool". In this case the hospital element of the "pool" is £2,190,870. This figure combined with a similarly calculated community element will give the overall target "pool" for fundholders.

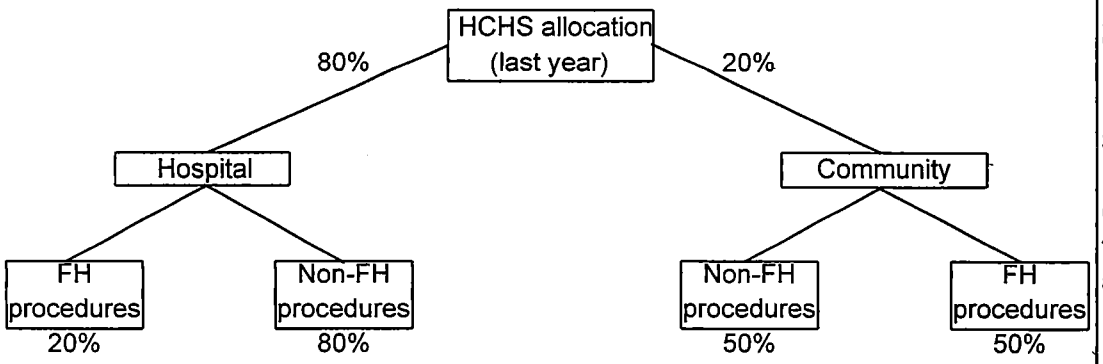
8. In health board 'X' practices 1,4,6 and 7 are standard fundholders, therefore the hospital element of the fundholding pool at health board level is 22.13% of the boards 97/98 fundholding allocation i.e. £2,189,870. Adding the community element, for standard and PCPI fundholding practices will give the overall fundholding pool at the health board. For simplicity, calculations for community services have not been shown in this example.

9. If there is little difference between the historic budget either for a health board or an individual practice then they may move directly to the new budget provided there is local agreement. From experience in England it is suggested that a shift of no more than 2% should be made in one year. Where the difference is greater, a pace of change plan should be devised to move towards the new allocation over an agreed period.

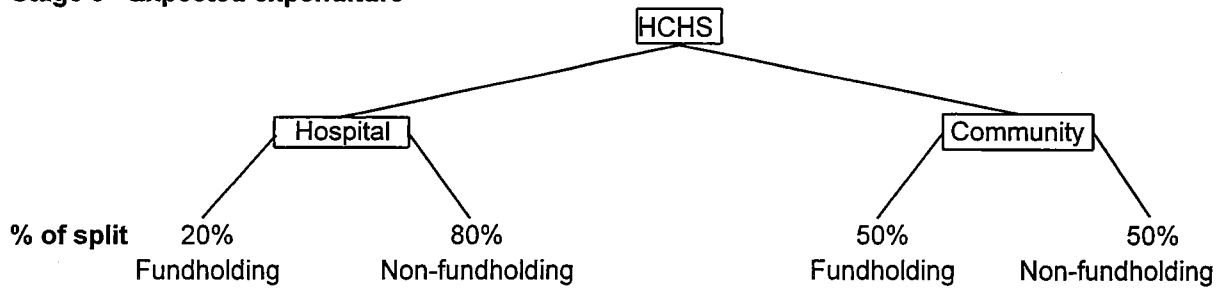
10. The allocation given to standard fundholders will be made up partly from the hospital element of the "pool" and partly from the community element of the "pool".PCPI fundholders will receive their allocation from the community element of the "pool" only.

Weighted capitation simplified

Stage 1 and 2 - Splitting of the HCHS allocation



Stage 3 - Expected expenditure



Stage 4 - Constuction of the Pool

First cut hospital budgets by practice

Practices	Budget
1	**a**
2	b
3	c
4	d
5	e
6	**f**

First cut community budgets by practice

Practices	Budget
1	**g**
2	h
3	**i**
4	j
5	k
6	**l**

Stage 1 - Splitting of HCHS
Using last years activity figures split HCHS allocation between hospital and community services.

Stage 2 - FH and Non-FH split
Hospital and Community are then split into two further elements. These are the expenditure associated with fundholding procedures/services and the expenditure associated with non-fundholding procedures/services.

Stage 3 - Expected expenditure
The expected new allocations are calculated using percentage splits derived from the actual expenditure from last year. These percentage splits are applied to the new HCHS allocation.

Stage 4 - Calculation of the pool
The practice budgets are derived from the fundholding element of hospital and community services. The first cut practice budgets are constructed using the same weighted capitation formula as agreed by the board and practices.
The practices in **bold** are fundholders (1,3 & 6). 1 & 6 are standard fundholders. 3 is a PCPI practice. The sum of budgets a, f, g, i and l is the fundholding pool for this health board. A first cut budget is calculated for all practices to ensure equity amongst all GPs.