THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1997)85

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

23rd December 1997

Dear Colleague

GUIDANCE ON SETTING GP FUNDHOLDER BUDGETS AND FOR GP FUNDHOLDING CONTRACTING FOR 1998/99

Summary

1. The budget setting guidance is principally directed at Health Boards and GP Fundholders and sets the framework within each GP Fundholder's budget should be set for 1998/99. The guidance relates to both the HCHS and prescribing elements of the allotted sum. The contracting guidance refers to Boards, Trusts and Fundholders and proposes changes in line with the signals given in the Priorities and Planning Guidance (NHS MEL(1997)44).

2. The White Paper "Designed to Care: Renewing the NHS in Scotland" has signalled the end of standard fundholding after 1998/99. This guidance has been written to reflect the transitional aspect of 1988/99.

3. The budget setting guidance continues the move towards weighted capitation in setting the HCHS budgets and proposes that practice level weighted "shares" should be used to inform the setting of target prescribing budgets. Boards should discuss with fundholders the pace of change towards weighted capitation in both HCHS and prescribing budgets.

4. The new financial regime which was notified to Boards in June has been re-stated in the budget setting paper. The main change is to allow fundholding overspends to be off-set against either uncommitted savings or future year's allotted sums. Boards must not, however process any possible off-sets mechanistically, but review with the practice why the overspend occurred and also where the practice budget stands in relation to its overall weighted capitation target.

AMI07212

Addressees

For action:
General Managers, Health Boards

Chief Executive, NHS Trust

For information:
General Manager,
Common Services Agency

General Manager,
Health Education Board for Scotland

General Manager,
State Hospitals Board for Scotland

Executive Director, SCPMDE

Enquiries to:

Neil Billing
Management Executive
Directorate of Primary Care
Room 54A
St Andrew's House
EDINBURGH
EH1 3DG

Tel: 0131-244 2415
Fax: 0131-244 2326

For Technical Queries:

Mike Muirhead
ISD Scotland
Room B018
Trinity Park House
South Trinity Road
EDINBURGH
EH5 3SQ

Tel: 0131-551 8972
Fax: 0131-551 1392

Action

5. General Managers are asked to ensure that copies of this guidance are distributed to Directors of Finance, Directors of Primary Care and GP Fundholding Liaison Officers and that copies are issued to all 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 1998/99.

Yours sincerely

AGNES ROBSON
Director of Primary Care

GUIDANCE ON SETTING GP STANDARD FUNDHOLDER AND PRIMARY CARE PURCHASING PRACTICES ALLOTTED SUMS FOR 1998-99: THE NATIONAL FRAMEWORK

1. Introduction

1.1 Boards, fundholders and Trusts will be aware that the White Paper "Designed to Care: Renewing the NHS in Scotland" (Cm3811), which was published on 9 December, has an impact on the fundholding scheme and that 1998/99 should therefore be seen as a transitional year.

1.2 This guidance is split into three parts. The first two relate to setting the allotted sum budget while the third gives further information and guidance on the new financial regime for fundholders.

1.3 In relation to all aspects of budget setting, 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 framework and to follow the specific Direction attached at Annex A.

2. Key principles and responsibilities

2.1 The key principles which should be adhered to are; equitable budget setting; effective communication; and the use of robust information. The responsibilities of Boards and GP fundholders are set out in NHS MEL(1996)97, "Accountability Framework for GP Fundholding".

2.2 Factors which apply to the HCHS component of the budget are:

- weighted capitation (see para 3.1)
- the total health board allocation (see para 3.2)
- actual (or forecast) overspends incurred in 1997/98 unless met by savings (see para 9.3)
- in recouping 1997/98 overspends from the budget for the following year, notice should be taken of the position of the practice's fund in relation to "target budget". In applying this principle, the causes of the overspend and the need for each practice to have a realistic budget set for each year must be taken into account(see paras 9.4 & 9.5)

PART 1 - FUND SETTING FOR THE HCHS ELEMENT OF THE ALLOTTED SUM

3. The process last year

3.1. Great improvements were made in the budget setting process last year with many boards managing, to a greater or lesser degree, to move fundholders away from historic-based budgets towards budgets set with reference to weighted capitation principles. The intention is that this work continue. It is anticipated that for existing fundholders, target budgets will not be recalculated; fundholders will move towards their target budget as calculated last year at the rate agreed within the pace of change policy.

3.2 Budgets need only be recalculated where there have been significant shifts in either the overall health board allocation or the funding of specific care programmes which impact on fundholding. Where there have been major shifts, boards may wish to recalculate the overall fundholding pool as this is the target budget at health board level. None-the-less the time and effort spent on calculating budgets will be significantly reduced this year.

4. The process this year (for new fundholders only)

4.1. Health boards and fundholders are required to agree the process to be used in devising weighted capitation budgets. A pathway was suggested in last year's guidance (MEL(1996)/84); this should be followed for new fundholders only this year. Much of the work done last year can be used to inform the process this year.

5. Implementation

5.1 The timetable given in the annex to last year's guidance should be used when funds for new fundholders are being calculated. For existing fundholders whose budgets are being moved towards target, the only deadline set is that all funds must be agreed by 31 March 1998 at the latest. Where Boards have new fundholders they can contact ISD to obtain new weightings for all their practices. Boards with no new fundholders may also contact ISD if they believe that their weighted capitation benchmarks should be updated.

5.2 The local pace of change policy should continue to be implemented. 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.

5.3 The methodology proposed does not cover all aspects of fundholding, for example direct access services. Boards will have to ensure that fundholders are neither advantaged or disadvantaged with regard to such services.

PART 2 - FUND SETTING FOR THE PRESCRIBING ELEMENT OF THE ALLOTTED SUM

6.1 Decisions with regard to the method of Board level funding for 1998/99 have now been taken, with allocations being based on 95% of projected 1997/98 spend and with the remaining 5%, plus uplift, being allocated on a weighted capitation basis. The weighted capitation model which has been used is most robust in setting Board level allocations. Practice level weighted "shares" based on data at enumeration district level are now available. The model used differs from the national weighted capitation formula in the treatment of temporary residents. These are included in the demographic weighting rather than the needs index as in the national model.

6.2 These "shares" are provided for information and may be used as one of the factors which can inform the budget setting process. It will continue to be for Boards, in conjunction with both fundholding and non-fundholding practices, to agree equitable local policies for setting prescribing budgets for all practices within their area. Boards should, however, consider setting target budgets for all practices using "shares" as well as other locally determined factors.

6.3 Boards are also required to review the prescribing budgets of fundholding practices in respect of protected savings. Practices that have underspent, and are "overfunded" in terms of their target allocation, should have their budget adjusted to an appropriate level. Boards will have to negotiate with practices, which are underspent and "underfunded" in terms of the target set, to establish if there is any reason why they should receive additional funding.

6.4 It is recognised that practices which have consistently saved from their prescribing budgets may have allocated such savings to purchase of services. For this reason, Boards should agree a rate of change policy that takes into account any such virements and also the impact of any move towards a target allocation.

6.5 In respect of movement towards target budgets, Boards should take into account the overall position of the fund, in HCHS and prescribing, before making final budget offers.

PART 3 - NEW FINANCIAL REGIME

7.1 A joint letter from primary care and finance directorates was issued on 11 June which outlined the new financial regime for fundholders. This guidance gives further information and explains how the new system will work. There are four elements to this.

8. Ensuring equity between services provided for patients of fundholders and non-fundholders

8.1 For at least two years, most GP fundholders have had their budgets determined with reference to weighted capitation principles. All health boards should have implemented a pace of change policy which will, over time, move fundholders from their historical funding position to fair-shares funding.

8.2 However, if emergency activity across a health board area increases significantly this will give rise to inequity between fundholders and non-fundholders. This is because fundholding budgets have been set either on historic activity or using weightings which reflect past norms in elective/emergency activity levels. Emergency needs must be met first and foremost. If circumstances required such action, boards would automatically alter plans for elective procedures for patients of non-fundholders but have not, in the past, had any authority to influence such activity for patients of fundholders. In recognition that increased emergency activity affects all GPs, health boards are asked to ensure that the funding of this increased activity is paid for, where necessary, by an across the board reduction in elective activity. In some circumstances, this may require an in-year (in reality this is likely to be an end-of-year) reassessment of the budget of a GP fundholder. If this situation arises, boards will be expected to undertake this exercise in a fair and even-handed manner, taking into account such factors as the extent to which fundholders' budgets are above or below their fair share of weighted capitation.

9. Responsibility for Overspends

9.1 Health boards have a statutory duty to remain within cash limits. Likely causes of overspends in relation to fundholding include:

- unilateral changes in clinical practice by providers;

- imperfections in fundholder budget setting whereby too low a share is allocated to some practices;

- failure by practices to manage their funds properly; and

- significant changes to provider prices.

9.2 With the growth in fundholding, the risk from fundholder overspends has increased. At present, health boards have no direct control over fundholder spending but they are still obliged to find the cost of overspends in-year, as well as having to ensure their ability to fund the spending of fundholder savings in the current or any future year. It is recognised that there are difficulties in managing small budgets on an annual basis, but this must be weighed against the general principle that all budget-holders should take responsibility for their own overspends.

9.3 With effect from 1 April 1998, fundholders will be required to cover all overspends with any uncommitted savings they have. The attraction of this is that the risks and benefits of budget holding rest with the same group of people. Uncommitted savings are those savings for which a programme of spending has not been discussed and agreed with the health board. It should be noted that where a practice savings plan has been agreed by a health board, this will constitute a commitment on behalf of the board to the savings being used in this way. Where a practice is heading for a probable overspend, health boards may only consent to the use of savings where they exceed the expected overspend. However, refusal of consent on these grounds should occur only where it is clear that an overspend is likely to be (or has been) incurred; a board's desire to establish a contingency in case an overspend should occur is not a sufficient reason to refuse consent.

9.4 It is anticipated that the majority of overspends will be covered in this way. However, in the small number of instances where there are no, or insufficient, uncommitted savings, boards should discuss with the fundholder why the overspend position arose. Boards and fundholders should also agree how this deficit will be made up; this will normally be through budget reductions in future years (see Direction on Determining Allotted Sums at Annex A). Since the final overspend position will not be known until after the following years budget is set, the allotted sum offer should be made subject to the possibility of a reduction in respect of the projected overspend. If the magnitude of the overspend would mean that an unrealistic budget remained for the following year, the practice's fitness to continue in fundholding should be questioned.

9.5 The only exception to this general rule is where GP fundholders are significantly under target funding. In this instance, the board and the GPs should work together to clarify whether the overspend was unavoidable; if so, boards should not seek to recover overspent amounts through budget deductions in future years.

10. Fundholder Savings

10.1 Fundholder savings will usually form part of the Health Board's carry-forward but are outside their direct control. The potential to make and accumulate efficiency savings which may then be spent for the benefit of patients over the following four years is a central part of the fundholding scheme. However, not all savings made are through efficient management. (Definitions of types of savings are given in Annex B.) In respect of any savings generated after 1 April 1998, only planned savings can be used as now. Windfall and unplanned savings should be returned to the Health Board and should not be vired in-year to other budget headings. Boards may decide to hold this funding as a contingency against any future overspends by fundholders. The return of windfall and unplanned savings and the use of

uncommitted planned savings to offset overspends should assist in reducing the amounts of savings held at Health Board level.

10.2 Savings have been used imaginatively around the country in projects where groups of fundholders have pooled savings to effect a bigger local change, or to introduce a service which benefits everyone in the locality. This has several benefits - it allows fundholders to work together on substantial projects, thus ensuring the best possible return from savings, and it speeds up the rate at which savings can be spent on patient services. The added advantage is that benefits are enjoyed by the whole community.

10.3 Fundholders may only use savings to improve services which are included in the fundholding scheme. Sometimes it is more effective to use savings to improve different services or to introduce completely new services in an area. This can only be achieved through joint working with health boards. An agreement is reached about what local services should be introduced or enhanced. Fundholders either individually or in groups voluntarily return savings to the health board who implement the agreed plan, often supplementing fundholder savings with additional health board funding. Possible advantages are; channelling of money into services with the greatest need of a cash injection; introduction of new services where there is perceived need; and wider spread of the benefits.

10.4 Such arrangements can only be voluntary, but the ME strongly encourages the investment of savings in services and developments which benefit the entire locality. Health boards are asked to encourage fundholders to work co-operatively and collectively with other practices when savings plans are drawn up.

11. Risk Management

11.1 The Fundholding Manual gives detailed guidance on how risk management should be handled between health boards and GP fundholders. Boards are responsible for ensuring such arrangements are adequate and in place.

ANNEX A

GP FUNDHOLDING (SCOTLAND)

DIRECTION ON DETERMINING ALLOTTED SUMS

The Secretary of State, in exercise of his powers under section 87B(1) of the National Health Service (Scotland) Act 1978 ("the 1978 Act") hereby directs Health Boards as follows:-

1. In determining allotted sums under section 87B of the 1978 Act to be paid to members of recognised fundholding practices a Health Board shall take into account any overspends incurred or likely to be incurred in the year preceding the year for which the allotted sum is to be determined.

2. This determination shall come into force on 23 December 1997.

Dated: 23 December 1997

Signed: Agnes Robertson.

The Scottish Office
Department of Health

AMI08211

ANNEX B

Planned savings - achieved through planned purchasing, clinical practice (including prescribing) and/or organisational changes. Such savings can be made from the HCHS, prescribing or practice staff elements of the allotted sum. Practices should have identified, at the outset of the financial year, those areas that will be targeted for savings and the arrangements for generating such as planned savings. These areas should be clear and shared with the health board.

Unplanned Savings - result from random variations in the need for, and the use of, NHS services (including HCHS and prescribing) or from unforeseen changes to the practice staffing arrangements and/or unforeseen changes to the demands for management allowance finance.

Windfall Savings - caused by deficiencies in the budget setting process or through hospitals failing to produce invoices for services that have been provided.

GUIDANCE FOR GP FUNDHOLDING CONTRACTING 1998/99

1. Introduction

1.1 This guidance is issued to fundholders, Boards and Trusts in respect of the changes arising from this year's Priorities and Planning Guidance (NHS MEL(1997)44) and the implications for fundholding set out in the White Paper "Designed to Care: Renewing the NHS in Scotland" (Cm3811) which was published on 9 December.

1.2 Since 1998/99 is a transitional year every attempt should be made to ensure that changes are facilitated, but that the basic fundholding processes are implemented properly for the whole year. It is the responsibility of fundholders, Boards and Trusts to ensure that systems are in place, and maintained, to ensure that fundholding continues to be able to function adequately.

2. Areas of Change

2.1 The Priorities and Planning Guidance, issued in August, signalled that the NHS is moving away from contracts and towards collaborative agreements between Trusts, Boards and fundholders. The Guidance also made it clear that fundholders would take an active part in the preparation of the Health Improvement Programme, which requires open discussion and the sharing and agreeing of all relevant information.

2.2 Fundholders should agree with their providers, and the Board, exactly what they will commit from their budget for:

NHS Trusts services
in-house services
privately provided services
planned savings

showing clearly how the whole of the allotted sum is allocated.

2.3 The change in emphasis, signalled by the Priorities and Planning Guidance, must be followed by a change in the method of contracting, with a move away from cost per case contracts towards block contracts. If fundholders are clearly stating to Trusts the limits of their resources, and agreeing the appropriate level of funding for each service/speciality, there is no need to have cost per case contracts. Agreements will centre around quality and service provision, with adequate time being allowed for any proposed changes. Fundholders must also accept that services cannot be moved at full cost where this would leave fixed costs to be covered by the Board.

2.4 Trusts should not however, take this guidance as proposing that service provision cannot and should not be changed.

2.5 Contracts form part of the fundholding system and will therefore be required in 1998/99. Most fundholders have a standard format contract and it is suggested that, for use in 1998/99, this contract is:

a) amended to take account of the changes proposed in this guidance
b) further simplified, if at all possible.

2.6 Contracts should be negotiated with Trusts by groups representing all fundholder users, wherever possible. Alternatively, negotiations may be carried out by groups of fundholders; Trusts should not be expected to meet individual practices.

2.7 Apart from the benefits of closer collaboration, these changes should bring about a significant reduction in the level of bureaucracy necessary to maintain the system. It is recognised that many improvements have been made to processes, however, there are still too many invoices and too much work associated with the checking and paying of them.

2.8 For this reason, cost per case contracts are no longer acceptable for anything other than the highest cost specialities; even these should be moved to simpler contracts if possible. Cost and volume contracts can be interpreted in different ways, and in some cases can be as complex and time consuming as cost per case contracts. Fundholders and Trusts are therefore urged to make the fullest use of block contracts and where cost and volume contracts are felt to be essential, these should be as straightforward as possible.

2.9 Fundholders should also recognise that co-operation means that information regarding outstanding accruals should be sent on a regular basis to their providers. The "six week rule" should not be applied unless it is established that the Trust is making no effort to meet invoicing deadlines. It is expected, however, that the move of virtually all contracts to a block basis will mean that the significance of outstanding accruals lists and the "six week rule" will be significantly reduced.