**TECHNICAL ADVISORY GROUP ON RESOURCE ALLOCATION**

**Note of 26th meeting held at 13:00, 25th August 2016**

**Room 7, Waverley Gate, Edinburgh**

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| **Attendees** | **Apologies** |
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| Christine McLaughlin (Chair) – SGAngela Campbell (Co-Chair) – SGPaudric Osborne – SGEvan Williams – SGDaniel Hinze – SGFiona Howe – SGLynne Jarvis – ISDSarah Touati – ISDPeter Martin – ISDAlasdair Pinkerton – PSDKirsty MacLachlan ­– NRSKaren Facey – AMLC ChairMartin Cheyne ­– Ayrshire & Arran Health BoardAndrew Daly – NHS Greater Glasgow & ClydeHelene Irvine – NHS Greater Glasgow & ClydeJohn Raine – NHS BordersDiane Skåtun – HERUAlan McDevitt – BMA | Fiona Duff – SGRichard McCallum ­– SGRoger Black – ISDMatt Sutton – Uni. of ManchesterStephen Logan – Grampian Health BoardFiona Ramsay – NHS Forth ValleyGeorge Walker – NHS Lothian |

**By Audio Conference**

George Bagdatoglou – Deloitte

**By Video Conference**

Alan Gray ­– NHS Grampian

Nick Kenton ­– NHS Highland

**AGENDA ITEM 1 – Welcome and apologies**

Christine McLaughlin (CMcL) – welcomed the group and noted apologies from those listed above.

Daniel Hinze (DH) and George Bagdatoglou (GB) were welcomed as special attendees to present the SAF review agenda items.

Fiona Howe (FH), Alasdair Pinkerton (AP) and Alan McDevitt (AMcD) were welcomed as special attendees for the SAF review agenda items.

**AGENDA ITEM 2 – Minutes of last meeting and updates on actions**

The minutes were accepted as a clear and accurate record of the last meeting.

**AGENDA ITEM 5 – Scottish Allocation Formula (SAF) review Workload model final report**

DH presented Paper TAGRA(2016)07, which summarises the SAF review’s commissioned research relating to the workload dimension of the SAF. The following aspects of the review were covered: methodology; data; and results.

DH explained that – in contrast to the 2004 SAF – the current review quantifies the impact of patient demographics and Morbidity and Life Circumstances (MLC) simultaneously in the same model. This approach is preferable given the existence of collinearity between the two. Another key difference is the use of read codes to measure workload, as opposed to consultation rates. Read codes are preferable as they better capture multimorbidity, though the results presented in the paper are similar whatever workload proxy is used.

The results of the preferred model indicate that practices with higher proportions of ethnic minorities utilise fewer resources. This result is consistent with empirical evidence on health and ethnicity, and with the findings of the Acute MLC review of the NRAC formula. Despite its statistical significance, however, there is a question regarding whether the result should be implemented. Amongst other concerns, additional workload associated with providing for ethnic minority communities may not show up in the data, such as dealing with language barriers. AMcD agreed that removing the variable from the model would be preferable: certain ethnic minorities attend GP services less often but have higher demands in terms of specialist services.

Helene Irvine (HI) noted that there was a large difference between the relative utilisation of resources for those aged 85+, when comparing the 2004 SAF and the 2016 review weightings. DH explained that this is driven by the shape of the underlying data, which is consistent with findings in England and for the Acute MLC review of the NRAC formula. AMcD added that older patients are often visited at home and are therefore less likely to be consistently recorded by GPs.

DH noted that the results imply more funds moving to more deprived areas when compared to the 2004 SAF. Even small percentage shifts imply significant amount of resources, though the eventual outcome will be agreed in the negotiations between the SG and the BMA.

HI requested clarification of the SAF review’s treatment of unmet need in primary care. DH highlighted the discussion detailed in the report itself and conversations had with Primary Care experts such as Professor Watt and Professor Mercer from the University of Glasgow. The key barrier to addressing unmet need is how to define the concept in such a way that it can be measured and operationalized. AMcD suggested that unmet need might be best tackled outwith the formula using targeted funding.

**TAGRA noted the update, which now goes to the contract negotiations**

**AGENDA ITEM 6 – SAF review Unit Cost report**

DH presented Paper TAGRA(2016)08, which summarises the SAF review’s commissioned research relating to the Unit Cost dimension of the SAF. The review considers the methodology underpinning the current unit cost formula, in particular the rurality and remoteness (R/R) adjustment and the Market Forces Factor (MFF). Due to a lack of data availability, the review provides a theoretical assessment of the current unit cost formula and provides recommendations on how to improve it. It was highlighted that it was for the SG and BMA to decide whether further work on the unit cost formula should go ahead.

AMcD highlighted that key issues related to data availability and the desire to maintain stability in the funding arrangements for GP practices. Karen Facey (KF) added that the TAGRA core criteria provide a useful decision making framework. John Raine (JR) noted that change within the formula will always be difficult without increases in funding and resource – the process of health and social care integration relies on the goodwill of GPs to be successful, and this context should be born in mind with future changes to the formula.

With regards the R/R adjustment, the review focussed on ‘access and alternative settings of care’ and ‘unavoidable smallness’. The review noted that access and alternative settings of care issues could be accounted for within the workload component of the SAF, whereas an alternative analysis would be necessary to account for unavoidable smallness. DH noted that unavoidable smallness might be best dealt with on a case by case basis outwith the formula. AP noted, furthermore, that issues relating to unavoidable smallness are already partly accounted for by the correction factor. Nick Kenton (NK) emphasised that any proposed changes should be sense-checked with actual rural / small practices in order to ensure face validity.

Diane Skåtun (DS) noted that the NRAC formula does not include a MFF and that consideration needs to be given to the issue of consistency across separate funding formulas.

**TAGRA noted the update, which now goes to the contract negotiations**

DH, GB, FH, AP and AMcD left the meeting.

**AGENDA ITEM 3 – Development of the NRAC Formula**

Christine McLaughlin (CMcL) led discussion around future development of the NRAC formula. As outlined in a discussion note prior to the meeting, such discussion is required given: the desire to provide a more stable funding perspective for boards; and the potential impact on funding arrangements of transformational change. The NRAC formula is currently run each year, but there have been suggestions to either: calculate a 3-year rolling average of target shares; or provide boards with firm allocations for the next three-year period. The latter of these two proposals is arguably preferable given its emphasis on stability and its ability to take account of population change using population projections.

Andrew Daly (AD) and Alan Gray (AG) welcomed the idea of moving to fixed three-year allocations. JR welcomed suggestions to provide more stability though emphasised that it was important to get buy-in from NHS board Chairs and DoFs. CMcL indicated that the proposal would be discussed with chairs.

**Action:** CMcL to discuss with chairs.

Paudric Osborne (PO) highlighted that one option would be to run the formula annually for the third year ahead – giving boards two years notice of the target shares. This would provide boards with a rolling three year time horizon for planning purposes and serve to retain the skills and knowledge base necessary to run and improve the formula. Peter Martin (PM) welcomed attempts to maintain ISD’s formula skill-base and noted that it would be important to agree the extent of any formula development for work planning purposes. AD pointed out that it was important to keep the formula up to date for the other funding streams which use the NRAC formula. KF noted that, in considering which work was worthwhile, it would be important to take account of the scale of the impact of such work.

NK queried whether the current approach for moving towards parity with target shares would be maintained in the context of three-year fixed shares – CMcL expressed the view that three-year fixed shares would help with this process.

**TAGRA welcomed the initial discussion regarding the future of the NRAC formula** – relevant to any agreement are the recommendations of the Acute MLC review (see next agenda item)

**AGENDA ITEM 4 – Acute MLC review final report**

KF presented Paper TAGRA(2016)06, the final report of the Acute MLC (AMLC) review. The report details various aspects of the AMLC subgroup’s work, including: costing method; model specification; supply model; needs index development; additional variables; unmet need; and health inequalities impact assessment. Much of this detailed material had been presented to TAGRA at previous meetings .

**TAGRA members thanked Karen for a very comprehensive and well-presented report, and were content to accept the recommendations in the report based on the expertise of the Sub-Group.**

TAGRA focused its discussion on the issue of carrying out an impact assessment of the review recommendations. Angela Campbell (AC) explained that it is customary to bring an impact assessment of the review recommendations to TAGRA for discussion, so that, having accepted the report’s recommendations in principle, TAGRA can then carry out face validity and stability checks based on their implications. The initial plan had been for the impact assessment to be discussed at TAGRA in December 2016. However, if there was an agreement to provide boards with three-year fixed allocations, there might also be a desire to incorporate the AMLC recommendations now. This would ensure that the three-year target shares are calculated on the best statistical basis and avoid delaying the introduction of the review findings until 2020/21 – at which point they would be out-of-date – though this would involve not having an impact assessment discussion at TAGRA before implementation.

Sarah Touati (ST) noted that the update itself (having not been carried out for ~6 years) along with changes to the datazone geographical level, would be necessary even if the report’s recommendations are not carried out. As such, some form of impact assessment seems required. KF noted that some clarification would be needed regarding what comparison should be carried out in order to gauge impact.

Martin Cheyne (MC) noted that an impact assessment would be welcomed as it provides a degree of assurance that the change to target shares would not be too large. PM agreed that an impact assessment provides a sense check, indicating whether the changes that occur to the target shares are those that would be expected.

CMcL recognised that TAGRA wished to understand the impact of the AMLC review recommendations and the relevance of this to agenda item 3.

**Action: SG and ISD to consider what information could be made available to TAGRA over relevant timescales to help understand the impact of the AMLC review recommendations.**

**AGENDA ITEM 7 – A.O.B. and date of next meeting**

Kirsty Maclachlan (KM) gave an update on NRS population projection developments of relevance to TAGRA. She referred to the methodoglical revisions for the sub-national projections, which have been run on the 2012-based subnational projections, and will used for the 2014-based sub-national projections which will be available at the end of October. She also mentioned the bespoke project on sub-council area populations and suggested that this could be repeated if there was sufficient demand. AC suggested that it would be useful to have population data available for IJB localities.

The next TAGRA meeting is scheduled for Thursday 15th December 2016.