**TECHNICAL ADVISORY GROUP ON RESOURCE ALLOCATION**

**Note of 23rd meeting held at 13:00, 27th August 2015**

**Waverley Gate, Edinburgh**

|  |  |
| --- | --- |
| **Attendees**  | **Apologies** |
|  |  |
| John Matheson (Chair) – Scottish GovernmentAngela Campbell (Co-Chair) – Scottish GovernmentPaudric Osborne - Scottish GovernmentChris Dodds - Scottish GovernmentLynda Nicholson – Scottish GovernmentTom Russon – Scottish GovernmentKirsty MacLachlan – National Records of ScotlandAndrew Daly – NHS Greater Glasgow & ClydeNick Kenton – NHS HighlandJohn Raine – NHS BordersAlan Gray – NHS GrampianJudith Stark - Information Services DivisionLynne Jarvis – Information Services DivisionTing Yang - Information Services DivisionRoger Black - Information Services DivisionSarah Touati – Information Services Division | Matt Sutton – Uni. of ManchesterHelene Irvine - NHS GG & CDiane Skåtun – HERUGarry Coutts – NHS HighlandGeorge Walker – NHS LothianKaren Facey – TAGRA memberRichard McCallum – Scot. Gov. |

**By Video Conference**

Alan McDevitt – BMA

John Ross Scott – NHS Orkney

**AGENDA ITEM 1 – Welcome and apologies**

John Matheson (JM) welcomed the group and noted apologies from those listed above. Lynne Jarvis (LJ) and Sarah Touati (ST) were welcomed as new TAGRA members and Ting Yang (TY) was welcomed as an attendee.

**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 3 – Presentation on the future of the GMS Contract**

Lynda Nicholson (LN) welcomed Dr. Alan McDevitt (AMcD) to TAGRA and explained that this presentation was in response to an offer made at the August meeting. The Scottish Government and the Scottish General Practitioners Committee (SGPC) of the BMA have been delivering joint presentations the country over the past few months on the future of the GMS contract and the current presentation will largely follow this same format. It was noted that TAGRA would have a particular interested in the Scottish Allocation Formula (SAF) aspect of the contract, but explained that the presentation was intended more as an overview on the broader landscape and future challenges.

AMcD thanked TAGRA for the invitation to present and delivered a presentation on the SGPC view of the future of the GMS contract (slides will be circulated to TAGRA members). It was explained that this was intended as an invitation to further discussion and that the SGPC would welcome views from other parties. It was, however, noted that no substantial alternative models had been suggested to date. Key themes of the presentation included;

* The current contract model not being considered sustainable in the face of workload pressures and recruitment / retention challenges;
* A proposed future model in which GPs are viewed as ‘expert medical generalists’ within the wider context of IJB-led health and social care delivery. This would entail a redefinition of the role of GPs in the context of primary care teams, such that they focus on ‘undifferentiated presentations’;
* A view that an independent contractor based model should be retained, but only if a suitable model for this can be agreed upon;
* The need for a re-evaluation of the risk/reward balance for GPs, in particular that they should be involved in financial planning and decision making at IJB level if they are to retain responsibility for the care of patients discharged into the community. If such authority is not made available to them, then this responsibility should shift to the wider IJB team, with the role of a GP being defined in terms of a source of expert medical advice within such a team;
* A question as to whether even an ‘ideal’ allocation formula can provide a suitable mechanism to fund general practice, with an alternative model being elements of core funding combined with NRAC-based allocations at the IJB level.

Chris Dodds (CD), as chair of the Expert Technical Group for the present SAF Review, observed that the present allocation formula was only used to fund core GMS services as they are delivered now. As such, any future changes to the wider contract structure would not be captured by the formula review in itself.

LN responded to the presentation by saying that there was an appetite for change in the Scottish Government as regards GP services. They are now working with SGPC to make this happen in practice, with the contract negotiation process due to occur over the coming year. It was emphasised that the analytical work associated with the SAF Review is helpful, as it provides a first stage towards understanding an evidence base for the issues around GMS funding. However, it was acknowledged that there will also be other pieces of evidence, outwith of the formula review, that need to be developed over the coming year to inform the wider issues raised in the presentation.

John Raine (JR) asked to what extent it was considered realistic to save money from the acute sector, assuming that this would be required in order to raise total spend on primary care? AMcD responded that the SGPC was not saying where any additional resource should come from. It was observed that the vision outlined was unlikely to represent a cost neutral solution, but that it should be a more cost effective one.

JM stated that any rebalancing of expenditure would be more likely to occur via a reduction the rate of increase in acute spending and/or consideration of ring-fencing of resources for primary care. It was observed that connectivity between the contract review and other strategic programmes, such as Prescription for Excellence, the Out of Hours review and the National Clinical Strategies would be important in delivering a vision for primary care.

Nick Kenton (NK) asked for more detail on how the proposed model, in which a GP represents the expert medical generalist within a wider IJB team but does not necessarily constitute the sole source of responsibility, might work in practice? AMcD noted that team working within health and social care partnerships already exists. It was observed that there was a tension between management-led and clinical-led structures within existing organisations and that the advent of IJBs should be seen as an opportunity to develop new models for this.

Alan Gray (AG) observed that some of the main issues raised relate to workforce and asked whether the model envisioned would be likely to cost more? It was acknowledged that the answer to this question may not be straightforward, as existing hospital based models should also be challenged with a view to bringing certain activities closer to the community. AMcD responded that the evidence they are aware of suggests that when other professionals take on the work traditionally done by GPs, this does not seem to lead to any net reduction in costs. It was acknowledged that if GPs are to adopt the wider leadership roles outlined in the present vision, this would necessarily reduce the proportion of patient-facing time and this would then require more GPs and some increase in net cost.

JM queried what the role of technology might be within the SGPC vision for primary care? AMcD responded that there were large opportunities, but that these necessarily had associated developmental costs. Lots of good work exists in terms of directing people to information sources and encouraging self-management, but there is a need to balance such approaches with the face-to-face element of primary care.

John Ross Scott (JRS) explained that his experience in Orkney supported AMcD’s statement that putting other professionals in to do the work of GPs did not prove to be any cheaper. It was also observed that video consultations had proven effective in that area and that the principal limitations were not the technology itself but infrastructure.

JM concluded the discussion by thanking AMcD for his presentation, which had clearly stimulated interest in TAGRA. AMcD left the meeting.

**AGENDA ITEM 4 – Update from the SAF Review**

CD presented paper TAGRA(2015)08, explaining that the main work of the Expert technical Group for the SAF Review since it’s last update to TAGRA had been as follows; completing a review of data availability, developing resource specifications to commission academic work on the workload/need and excess costs component of the formula, undertaking an impact assessment of the formula to updating the small area reference files.

In terms of data availability, a substantial paper summarizing this has been drawn up (available to TAGRA members on request). The previously identified risk posed by the gap in GP workload data between the PTI and SPIRE data collections remains valid, but the review is exploring two alternative sources: a one-off collection as part of an existing Scottish Government funded research project and an extract from the CPRD database.

In terms of commissioning research, it is felt to be necessary to buy in capacity to undertake the more detailed pieces of analytical work. The research specifications will be finalized over the course of September, with a view to the projects then reporting back c. March 2016. In the meanwhile, the Expert Technical Group will function as more of a steering group for the researchers undertaking the commissioned work.

In terms of the impact assessment, it was explained that the three updated small area reference files are the Arbuthnott Indices (as used in the Morbidity and Life Circumstances weighting) and the population density / sparsity indices (as used in the Rurality / Remoteness weighting). The purpose of this work was to test how sensitive the current formula is to updates and to provide a comparison point to other models that may be developed as the review progresses. Initial results show that the reference file update has very little impact on the distributional properties of the SAF. Further work is being undertaken to explore these results more fully, including the effect of a definitional change in the census variables that make up part of the Arbuthnott index.

Andrew Daly (AD) observed that it was interesting that there were not greater systematic differences arising from the reference file update. It was, however, noted that such an update did not address whether the formula is using the right (or best) indicators. CD agreed with this comment and explained that the commissioned work would look at a range of potential indicators.

Angela Campbell (AC) asked whether it would be useful for TAGRA to give a view on what level of geographic basis to use for the small area indicators? CD acknowledged TAGRA’s extensive experience with such matters, which the SAF Review would welcome learning from. However, the manner in which this would be sought will have to depend on the timings of the review. AC accepted this, noting that it should also be possible to obtain input directly from TAGRA members between the time of meetings. Judith Stark (JS) offered that ISD could make a presentation to the Expert Technical Group on learning from the NRAC perspective, which was welcomed by CD on behalf of the Review.

AG queried whether the SAF Review analysts were surprised to have not seen greater changes from the present update. CD and TY emphasised that the analysis remained to be finalized, and that they were still waiting on certain responses from the organisations supplying the update data. A final version of the analytical results can be brought to a future TAGRA meeting, or circulated to members upon request.

**TAGRA noted the update.**

CD and LN left the meeting.

**AGENDA ITEM 5 – Final report from Prisoner Healthcare working group[[1]](#footnote-1)**

JS presented paper TAGRA(2015)09, which provides a summary of the findings of the Prisoner Healthcare working group. A more detailed technical report has also been produced and is available to TAGRA members upon request.

It was explained that the group had moved away from making recommendations on a cost-per-prisoner basis in favour a cost ratio approach, consistent with the wider NRAC working method. The key recommendations are summarized in the table on page 1 of the report, with the costs for male young offenders (age 16-21) and female prisoners (age 16+), expressed as ratios to that for adult male prisoners. The mechanism by which resources could be allocated to, or transferred between, health boards is also summarized in the paper. It was acknowledged that the proposed model has many limitations, principally as a result of limitations to the availability of data.

JM expressed surprise that the relative cost of healthcare for female prisoners was so much higher than that for men. JS and AD responded that this ratio was consistent with the expectations of Andreana Adamson (chair of the National Prisoner Healthcare Network) and that there were a range of factors that could plausibly contribute to such a difference.

AG queried that the comparison of the model-derived allocations to baseline funding provided in the paper seemed to omit the new (post - 2014) prison at HMP Grampian? JS and AD explained that the figures shown were for a period prior to the opening of the new institution and so would not be expected to capture this. When the prison population data ‘catches up’ with each reconfiguration, the proposed model is intended to capture the resource allocation implications.

A discussion then followed as to how the recommended cost-ratio model would be implemented. It was agreed that Prisoner Healthcare should remain within the NRAC baseline, effectively forming a new ‘care programme’ component within the formula. The size of this component would initially be based on the current levels of resource and then be uplifted at the same rate as the baseline as a whole. The board shares for the Prisoner Healthcare component would be updated each year, according to the most recently available prison population data and the cost-ratio model recommended here.

JM concluded the discussion by thanking the TAGRA members on the Prisoner Healthcare working group for their contribution to this work.

**TAGRA accepted the recommendations of the working group.**

**AGENDA ITEM 6 – Update from Acute MLC Subgroup**

LJ presented paper TAGRA(2015)10, which constitutes an update from the AMLC subgroup on its progress in terms of; timespan, geography and age grouping, unmet need analysis and development of the list of potential candidate variables. The next steps for the review will be the main regression analysis to determine the new index variable, with a more substantive update to be brought to the December TAGRA meeting. The review will report in August 2016, followed by an impact assessment and then the implementation of the recommendations into the 2017 formula run (2018/19 target shares).

A discussion followed as to whether there was any scope for this time-scale to be adjusted for earlier implementation. It was agreed that the existing process and time-scale would be followed.

NK raised the question as to whether the review was looking at issues of oversupply, as well as those of unmet need? Sarah Touati (ST) and Tom Russon (TR) responded that the review was following the same approach as the 2007 NRAC review in only considering adjustments for unmet need at the end of the spectrum that is a-priori considered likely to have the greatest needs (e.g. the most deprived areas).

AD queried whether the review was considering issues related to the supply variables, in particular how these relate to unmet need? ST and TR responded that this was a good question and one that the Analytical Support Team (AST) would consider further.

**Action** – AST to consider how supply variables are handled within the formula and whether there is a need for these approaches to be reviewed as part of the AMLC Subgroup’s work?

**TAGRA noted the update.**

**AGENDA ITEM 7 – Update from Community Health Activity Data Project**

JRS presented paper TAGRA(2015)11, explaining that progress was being made on all three current phases of the project. In terms of District Nursing (phase 1), the complexities of different recording systems found in different areas had proved a challenge, but was now largely overcome. The first full financial year of data will be available in summer 2016. In terms of Mental Health Nurses (phase 2), discussions regarding how to adapt the template derived for District Nursing to accommodate the team-based nature of mental health work has led to some delays, but the full data collection will commence on 1st April 2016 (i.e. one year behind phase 1). Phase 3 of the project is likely to focus on data for Health Visiting Services, although this remains to be confirmed. It is anticipated that future phases of the project will proceed more easily that the early ones, especially now that the template has been created. JRS explained that the CHAD project continues to intend to align with the Health & Social Care Data Integration and Intelligence Project (HSCDIIP). The current expectation is that this will occur by the end of the year.

JM noted that JRS will be standing down as Chair of NHS Orkney at the end of November, such that this will be his final TAGRA meeting. JM extended his thanks to JRS for his lively and valued contributions to TAGRA over the course of 22 meetings and noted that his work on the CHAD project represents a fine manner in which to conclude.

**TAGRA noted the update.**

**AGENDA ITEM 8 – Work Plan**

TR presented paper TAGRA(2015)12, which represents a routine update to the TAGRA analytical work-plan (now running though to April 2017). The main alterations from the previous version are the removal (following closure) of the Population Estimates Comparison project and Prisoner Healthcare items. The approximate spend data in the table showing the NRAC formula breakdown by care programme has been updated to 2013/14, with a total figure added and placed in the context of wider Scottish Government budgets.

**TAGRA noted the update.**

**A.O.B. and date of next meeting**

LJ provided an update on the 2016/17 NRAC formula run, which is now almost complete. The initial target shares will be passed to Scottish Government colleagues for Quality Assurance on 31st August, with publication of the target shares as an Official Statistic being pre-announced for 29th September.

Kirsty MacLachlan (KM) provided an update on the closure report from the Population Estimates Comparison Project. A draft has been circulated to the project board for comments and the collation of lessons learned. There is a recognised need to phrase the report carefully, given the nature of the analysis which underlies the conclusions. A suitably redrafted version will be circulated to TAGRA members once it becomes available.

KM provided a further update on two pieces of new work within NRS looking at the methodologies associated with population projections. The first element relates to sub-national (e.g. health board) level projections and follows on from a revision to the methodology used by ONS. In essence, the revision involves a shift from a numbers-based approach to a rate-based approach for estimating net migration between regions / countries. The revised method will be used for the 2014-based projections (to be published in summer 2016) and will become routine from them on. The second element is looking at small area (e.g. sub-council) population projections, and is aiming to produce a one-off set of projections in March 2016. The preferred geography for this work remains to be determined, but multi-member wards are favoured by many local authorities. TAGRA members queried whether there was a potential linkage to be made, in terms of health boards having input to this process alongside local authorities.

JR provided an update to TAGRA on an issue that has been raised by the board Chairs involved in the Finance Portfolio Group, which is chaired by Alex Linkston (NHS Forth Valley). This group had raised the concern that, from a financial management perspective, boards need as much stability as possibility in terms of allocations going forwards. Alex Linkston and JR met with JM and other Scottish Government officials on 28th May to discuss this. One possibility that was raised in terms of offering greater stability, whilst recognizing the need to continually update and improve the formula and the political importance of the 1% parity target, was that of shifting to the use of a rolling 3-year average of target shares. Exploratory analysis of such an approach will be undertaken by Health ASD. The importance of the buy-in of all boards to any change was emphasised. JM agreed that TAGRA should seek to provide an update on its activities to the Chairs, as well as to the DoFs, over the coming year. He affirmed that the purpose of the 3-year rolling average approach would be to smooth out year-to-year changes in target shares and that the formula would still be run on an annual basis. TAGRA will be kept informed of developments going forwards.

The next meeting of TAGRA will be held on Tuesday 9th February 2016 at Waverley Gate, Edinburgh.

1. *Post meeting note: in follow up to a previous TAGRA action, Andreana Adamson has confirmed that the National Prisoner Healthcare Network has “established an outcomes and quality work stream”.* [↑](#footnote-ref-1)