**TECHNICAL ADVISORY GROUP ON RESOURCE ALLOCATION**

**Note of 25th meeting held at 14:00, 10th May 2016**

**Victoria Quay, Edinburgh**

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| **Attendees** | **Apologies** |
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| Christine McLaughlin (Chair) – SGAngela Campbell (Co-Chair) – SGPaudric Osborne – SGEvan Williams – SGDaniel Hinze – SGDuncan Miller – SGLynne Jarvis – ISDRoger Black – ISDSarah Touati – ISDPeter Martin – ISDTing Yang – ISDAndrew Daly – NHS Greater Glasgow & ClydeHelene Irvine – NHS Greater Glasgow & ClydeJohn Raine – NHS BordersFiona Ramsay – NHS Forth ValleyDiane Skåtun – HERUAndrew Buist – BMAGeorge Bagdatoglou – DeloitteMihaela Solcan – Deloitte | Martin Cheyne ­– Ayrshire & Arran Health BoardAlan Gray ­– NHS GrampianNick Kenton ­– NHS HighlandKirsty MacLachlan ­– NRSRichard McCallum ­– SGAlan McDevitt – BMALynda Nicholson ­– SGMatt Sutton – Uni. of ManchesterGeorge Walker – NHS Lothian |

**By Audio Conference**

Karen Facey – TAGRA member

David Garden ­– NHS Highland (on behalf of Nick Kenton)

Stephen Logan – Grampian Health Board

**AGENDA ITEM 1 – Welcome and apologies**

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

George Bagdatoglou (GB) and Mihaela Solcan (MS) were welcomed as special attendees to present the SAF review update item.

**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 – Update from the Scottish Allocation Formula (SAF) Review**

Duncan Miller (DM) provided a summary of the agreed governance arrangements for the SAF review, including: the role of the Expert Technical Group (ETG); that the expertise of TAGRA would be sought; and the need for confidentiality given the contract negotiations that will take place. This information was set out in the Paper for Information distributed prior to the meeting.

GB presented the initial results from the Workload component of the SAF review.

Key themes of the presentation included:

* Methodology: differences and similarities between the 2004 SAF and the 2016 review;
* Model specification;
* Key challenges;
* Descriptive statistics of the sample used and data representativeness;
* Model selection and the initial SAF weights that are implied.

Helene Irvine (HI) inquired why supply-side factors are used in the modelling stage but not when calculating the SAF weights. GB clarified that supply-side factors are necessary to select the best model which includes the indicators of need that are associated with workload. The supply-side factors are then removed when calculating the weights as supply-side factors don’t reflect need for primary care. The same approach is used by NRAC.

Karen Facey (KF) inquired why the Scottish Index of Multiple Deprivation (SIMD) was being considered in the analysis given the methodological issues identified in the NRAC review. Daniel Hinze (DH) clarified that the SAF review is using the SIMD as a categorical as opposed to a continuous variable which deals with the issue identified.

Peter Martin (PM) asked for more information on the workload proxy. GB clarified that the available data permits the use of read codes or number of consultations and that there is an open question regarding which proxy is theoretically superior. Roger Black (RB) suggested that there might exist a weak perverse incentive with regards the use of read codes, but HI responded that the opposite could be true in that it would incentivise practices to record properly. DH pointed out that read codes were the dependent variable – consequently, they will not enter the calculation of practice weights and therefore no incentive problem existed with the use of read codes in the analysis. DH informed TAGRA that the ETG had determined that further analysis of the read codes was required, and that the SAF review will therefore look into this issue further.

**Action** – SAF review to look into the details of the workload proxies (read codes and consultation rates)

KF inquired about the process of identifying potential variables to capture additional need relating to health status. GB clarified that this is partly a data availability issue but that Deloitte would be open to guidance. KF suggested that the Acute MLC subgroup could share the flow diagram established for the Acute MLC review, which details one method for moving from a long-list to a short-list of variables. RB welcomed this suggestion.

**Action** – Acute MLC subgroup to share Acute MLC flow diagram with Deloitte.

HI inquired about the possibility of investigating unmet need within the current SAF review. The recent McLean et al. (2015)[[1]](#footnote-1) paper, for example, suggests that there is unmet health need in more deprived areas in Scotland. Nicola Sturgeon and Shona Robinson, furthermore, are on public record indicating that health inequalities and unmet need will be investigated for the SAF review. John Raine (JR) noted that, in addition to paying GPs fairly, the SAF needs to in part reflect the objectives of the Government. KF noted that the NRAC review checked for unmet need and so it would be advisable for the SAF review to do so.

DH underlined that the SAF is structurally distinct from NRAC, as it has a dual role of being both a practice payment as well as a primary care resource allocation mechanism, whereas NRAC has a single purpose of allocating resources according to need at the health board level. Unmet need might be best addressed by additional payments outwith the SAF itself.

Andrew Buist (AB) agreed with this latter suggestion. GB added that the data available allows the investigation of met need – the investigation of unmet need requires different tools. DH added that since we only have data on met need we do not know which GP practices suffer unmet need – although, for example the McLean paper shows a steep gradient of multimorbidity against deprivation, the same relationship is not seen between practice use (measured by consultations or read codes) and deprivation. It is this discrepancy that indicates that there might be need that remains unmet. Unmet need itself is not defined which makes it difficult to determine to what extent the differences in, for example, multimorbidity should determine the relative allocation to practices in the formula. In the first instance, the review is based on the available practice-level data to estimate a fair allocation between practices in terms of the work they actually undertake.

DM added that the main purpose of the review is to bring the SAF up-to-date with newer data, and for this to be taken to the contract negotiations with GPs. JR recognised the role of the contract negotiations but emphasised that judgements need to be made on the basis of an in-depth assessment so that we can better identify which mechanism achieves the outcomes that we want.

**Action** – SAF review to establish in what way unmet need could be reflected in the formula.

HI noted that McLean et al. (2015) used an expanded version of PTI (the dataset being used by the SAF review for the workload proxy) and this should be considered.

Paudric Osborne (PO) noted that the PTI data used by Mclean et al. is simply extrapolated across Scotland and does not include more information than the PTI data used for the SAF review. The use of read codes, furthermore, should be able to capture multimorbidity.

**Action** – SAF review to investigate the PTI issue.

AB added that, separate to unmet need and deprivation, age is an important factor that needs to be taken into account. GP practices in affluent areas serving large populations of older people are currently struggling to provide services, and could potentially stop running if there are shifts in resources away from them. He noted that the effect of age was dampened in 2004. Andrew Daly (AD) noted that the formula should be as technically correct as possible and that discussion of the results should follow on the back of that – in this context, the effect of age should not be dampened within the 2016 review.

Diane Skåtun (DS) noted that the 2004 SAF modelled the impact of gender-age separately from the effect of additional need whereas the two are combined for this review – this will have an impact on the modelling stage. KF noted that the Acute MLC subgroup considered combining the two but decided against it and offered to share a copy of the draft report being produced by the Acute MLC sub-group. The Core Criteria can be helpful in guiding decisions. DS noted that the Core Criteria where used in situations in which statistical criteria were not giving a clear answer.

**Action** – the SAF review should seek technical guidance outwith TAGRA meetings with a smaller set of TAGRA members. This will help establish and justify what is different in the current review from the 2004 SAF and what topics are feasible to explore within the time-frame of the review and which beyond the remit of the SAF review itself.

**TAGRA noted the update.**

HI, AB, DH, DM, GB and MS left the meeting.

**AGENDA ITEM 4 – Update from Acute MLC subgroup**

Lynne Jarvis (LJ) presented Paper TAGRA(2016)04, which summarises the main work of the Acute MLC subgroup since its last update to TAGRA.

In particular, LJ explained that the work of the subgroup has included:

• Investigation of diagnostic groups – the decision has been made to keep the diagnostic groups, on the grounds of being able to take into account geographic variation in the prevalence of certain conditions, better granularity and relevance to a range of stakeholders;

• Indicator selection – the work to select the variables to be included in the new needs index has been completed. Several options are being discussed and tested against TAGRA’s core criteria, before deciding on the final index.

• Age and urban / rural testing – the potential final indices have been tested to see if they perform equally well across different age splits and urban and rural categories. This has been found to be the case.

LJ noted, furthermore, that the new model – once decided – will be tested for unmet need and a decision made on how to adjust for this in the formula. A final report will be provided to TAGRA at the meeting in August.

**TAGRA noted the update.**

**AGENDA ITEM 5 – Work Plan**

Evan Williams (EW) presented Paper TAGRA(2016)05, which represents a routine update to the TAGRA analytical work plan (which runs through to April 2017). There have been no substantial changes to the structure of the work plan itself since the time of the last meeting.

PM noted that as the Acute MLC subgroup reaches the end of its work, uncertainty will rise regarding future capacity and workload.

CMcL noted that it would be useful to look at priorities overall, including the issue of the GAE and NRAC funding formulas and integration. A greater sense of policy direction will be known as the new SNP government begins, as will the implications for funding.

**TAGRA noted the update.**

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

PO provided a verbal update on the implications for the work plan on the requirements surrounding the Integrated Change Fund Allocations. The current allocation uses a mix of GAE and a version of NRAC – there is a suggestion that the suitability of this method should be reviewed. Time should go into the work plan to consider this.

CMcL noted that the next meeting has been arranged for Thursday 25th August 2016.

The other TAGRA meeting for 2016 is: Thursday 15th December.

1. McLean, G., Guthrie, B., Mercer, S.W. and Watt, G.C., 2015. General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland. Br J Gen Pract, 65(641), pp.e799-e805. [↑](#footnote-ref-1)