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HEALTH AUTHORITY REVENUE RESOURCE LIMITS 2001/02

To:

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HEALTH AUTHORITY REVENUE RESOURCE LIMITS 2001/02

Summary

1. This HSC notifies Health Authorities (HAs) of their 2001/02 initial revenue resource limits.

2. The NHS Chief Executive is writing today to set out key priorities for next year. This will be supplemented by guidance in December on targets for NHS Plan implementation in 2001/02 and beyond.

Background

3. Attached at Annex 1 is a schedule showing how each HA's initial resource limit (IRL) is made up. The figure at line R is the indicative resource limit. This figure remains provisional until the coming into force of section 12 of the Government Resources and Accounts Act 2000, which inserts a new section 97AA of the National Health Service Act 1977. Under section 97AA(1) the Secretary of State will be able to specify a resource limit for each HA. The sum allotted for the purpose of section 97(3) and section 97A(1) of the NHS Act 1977 as amended is the figure at line U. The resource limit and financing requirement remain provisional until Parliament approves the relevant Supply Estimate, Class II Vote 1.

4. Also attached is a table showing HA unified allocations and distance from target positions (Annex 2).

5. The 2001/02 Exposition Book giving fuller details on the calculation of allocations and related issues will be issued to HA Directors of Finance and allocation leads in December.

Resource accounting and budgeting (RAB)

6. The Government Resources and Accounts Act 2000 introduces a statutory duty for HAs and PCTs. They are required to ensure that their use of resources in a financial year does not exceed their resource limit. Directions made under section 97AA will follow. Annex 3 gives further details on how provisions and impairments are treated within resource limits. Consolidated guidance on RAB is in preparation.

Resources for 2001/02

7. The sum available for HCFHS current in 2001/02 is £41,465m. This translates into resources for HAs as set out in Table 1.

Table 1

	2001/02 £m	% increase
HCFHS current	41,465	9.0
Capital charges and other funding adjustments	1,492	
Total available	42,957	
Deployed as:		
CFISSA[1]	5,880	
Total for HAs	***37,077***	***8.5***
Of which:		
Performance fund	100	
Cost of living supplements	65	
Health inequalities adjustment	130	

1. Centrally Funded Initiatives and Services and Special Allocations.

Implementing the NHS Plan

8. NHS Plan implementation guidance for 2001/02 will be published in December. It will give details of the limited earmarking of resources for specific aspects of modernisation.

Unified allocations

9. The elements of the allocation process are:

   (a) weighted capitation targets;

   (b) recurrent baselines;

   (c) distribution of extra resources.

Weighted capitation targets

10. Target allocations for 2001/02 reflect changes to population and other data used in the formula.

11. A wide ranging review of the formula is being undertaken to produce a new weighted capitation formula suitable for *The new NHS*. There is a freeze on further changes to the formula to maximise stability and certainty for HAs, Primary Care Trusts (PCTs) and Primary Care Groups (PCGs) while the review takes place.

Baselines

12. HA recurrent baselines have been adjusted to reflect a number of changes. These were detailed in AWP(01-02) HA 19, HA 27 and HA 31, which were checked and validated by HAs.

Distribution of extra resources

13. The distribution of the extra resources for 2001/02 is on the following basis:

(a) every HA will get a general increase to meet the pressures on pay, prices and the cost of implementing NICE recommendations etc that they all face calculated pro rata to baselines;

(b) funding for implementing the NHS Plan is being issued pro rata to weighted capitation targets.

Special allocations with weighted capitation formulas

14. The special allocations for drug misuse services, HIV prevention and HIV/AIDS treatment and care will be notified later.

Other special allocations

15. **Out of hours development fund**: allocations have been calculated on the basis of GP numbers as for previous years.

16. For 2001/02 the out of hours development fund will continue to be a separate ring fenced allocation at HA level.

PCT and PCG pace of change

17. Paragraph 99 of HSC 1998/171 set out the principles to be followed in moving PCTs or PCGs towards their fair share of resources. These principles will continue to apply for 2001/02 but are supplemented as follows:

(a) all PCTs or PCGs should be given a 2.5% uplift on their unified baselines;

(b) HAs should distribute the SR policy programme funds to PCTs or PCGs on the same basis that allocations have been made to HAs;

(c) within these parameters HAs are encouraged to make progress towards fair shares, particularly for those PCTs or PCGs that are most undertarget. This should take into consideration the service investment that all PCTs or PCGs will need to make next year.

2002/03 and 2003/04

18. For 2002/03 and 2003/04 all HAs will receive a minimum increase of 6% each year. Final decisions on individual HA allocations for these two years will be taken later.

Cost of living supplements

19. Annex 2 shows each HA's share of the funding for cost of living supplements. This is calculated on a host HA basis. Further guidance will follow on how these supplements will operate.

Performance Fund

20. Annex 2 shows each HA's share of the Performance Fund. This is calculated on a host HA basis. Further guidance will follow on how the fund will operate.

Interim health inequalities adjustment

21. While the longer term work on the review of the formula takes place an interim health inequalities adjustment (HIA) is being introduced. This supplements the targeted funding for HAZs (£30m in 1999/00, £60m in 2000/01) to spend to tackle health inequalities. The HIA is based on years of life lost (YLL). For 2001/02 HAs that received the targeted funding will receive equivalent HIA funding. In addition £70m is being distributed to the 47 HAs that rank highest on the YLL index. Annex 2 shows each HA's share of the HIA.

Shared services

22. Allocations for 2001/02 include £31.5m cover for funding shared services pilots. Further details will follow in due course.

Primary care

23. Information on GMS investment floors, out of hours development fund ring fence arrangements, GMS local development schemes, additional pharmaceutical services and Primary Care Act pilot schemes can be found in Annexes 4-6.

Out of area treatments (OATS)

24. Non-recurrent adjustments for funding the cost of OATS will be notified shortly.

Enquiries

25. Enquiries about these allocations by HAs should be addressed to their Regional Allocation Contact and by Regional Offices to the Resource Allocation and Funding Team as detailed below:

Regional Allocation Contacts:

Northern & Yorkshire	Tom Poolton
Trent	Katherine Thompson
Eastern	Dave Self
London	Bridget Braham
South East	Ilyas Malick
South West	Neil Brent
West Midlands	Rupert Davies
North West	Ken Burns

Resource Allocation and Funding Team:
Unified allocations
Robert Yates
Jane Colman
Colin Grier
David Hubbard

Health Inequalities Adjustment	Alan Holman Stuart Perry
Cost of living supplements	Pat Urry
Performance	Martin Campbell
Primary care services	Lorraine Middlemas

This Circular has been issued by:

COLIN L REEVES
DIRECTOR OF FINANCE AND PERFORMANCE

Annex 1

Notes to the Initial Resource Limit (IRL)

All figures in the IRL are in £000s.

The starting point for these resource limits is line G of the 2000/01 revenue cash limits as set out in HSC1999/243. This is brought forward at line A;

A **2000/01 recurrent allocation for relevant population.** This is the recurrent allocation notified in the HSC.

B **allocations/adjustments made since the issue of the 2000/01 ICL**

B1 **inter authority transfers** These are recurrent transfers notified to RAFT and made between HAs since the issue of the ICL, up to and including 31 August 2000.

B2 **adjustments associated with central budgets** These are recurrent adjustments between central budgets and HAs.

B3 **adjustments associated with Modernisation Fund budgets** These are recurrent additions to HA baselines from Modernisation Fund central budgets.

B4 **Specific adjustments** These are individually identified.

C **2000/01 closing baseline** Sum of lines A-B4

D **recurrent adjustments affecting 2001/02 baselines at 2000/01 prices**

D1 **rebasing adjustments against national levies** These include recurrent rebasing adjustments between HA baselines and the MADEL, Dental SIFT and NMET levy as shared in AWP(01-02)HA24. Subsequent amendments to figures have been incorporated.

D2 **specific adjustments** These are individually identified.

D3 **Defence medical services adjustment** For Ministry of Defence Hospital Units (MDHUs) the "free good" has been replaced by new arrangements based on cash payments to the MDHU for the treatments of NHS patients. A recurrent Vote transfer has been made by the Ministry of Defence.

E **subtotal** Sum of lines C-D3

F **Existing Liabilities Scheme** These recurrent deductions are to fund the extra funds required by the NHSLA as notified in para 13 of AWP(01-02)HA26.
The adjustment is based on an actuarial assessment of the requirement for the year. The deductions have been made pro rata to 2001/02 initial baselines.

G **initial 2001/02 cash baseline** Sum of lines E and F.

H **Working balance adjustment** These adjustments are to neutralise the effect of the change in definition of HA capital charges from a 6% charge on fixed assets to a 6% charge on net assets. PCT capital charges have similarly been adjusted for assets formerly belonging to HAs. The figures were collected and shared in AWP(01-02)RO6 and RO11 respectively.

I **Initial 2001/02 resource baseline** Sum of lines G and H.

J **Recurrent resource increase** The distribution of the extra resources for 2001/02 is on the following basis:

(a) every HA will get a general increase to meet the pressures on pay, prices and the cost of implementing NICE recommendations etc that they all face calculated pro rata to baselines;

(b) apart from two items with skewed distribution, the SR policy programme funding is being issued pro rata to weighted capitation targets.

K **2001/02 recurrent allocation for relevant population** Sum of lines I and J.

L **Special allocations**

L1 Health inequalities

L2 Cost of living supplement

L3 Out of hours

L4 Drugs misuse

L5 HIV prevention

L6 HIV/AIDS treatment and care

M **Total 2001/02 HA funding** Sum of lines K to L6.

N **Centrally funded initiatives and services** These are allocations to HAs from a CFISSA budget.

O **Specific adjustments**

O1 **inter authority adjustments (IAAs)** These are arranged by ROs to fund activities affecting particular HAs.

O2 **old long stay adjustments** These are the distributional adjustments to HA baselines for old long stay. The adjustments reflect the 1999 data collection exercise.

O3 **regional recosting adjustments** These are the distributional adjustments to HAs to reflect the recosting exercises carried out to realign prices to match costs. The adjustments will be notified later, when the level of uplift has been agreed.

O4 **out of area treatment adjustments** These are the distributional adjustments to HAs for out of area treatments. The adjustments will be notified later.

P **Resource limit excluding separate element for forecast movements in non-cash provisions** Sum of lines M to O4.

Q **Separate element for forecast movements in non-cash provisions** this is the difference between the 2000/01 and 2001/02 year-end balances in HA provisions.

R **2001/02 net revenue resource limit** Sum of lines P and Q.

S **Capital charges**

S1 HA capital charges HA estimated 2001/02 capital charges due on their own estate, to be paid to the NHS Executive.

S2 PCT capital charges PCT estimated 2001/02 capital charges due on their own estate, to be paid to the NHS Executive.

S3 Capital charges on retained estate Capital charges on retained estate operational.

S4 Quasi capital charges The equivalent of capital charges payable on the residual estate non operational.

These figures were collected and shared in AWP(01-02)RO6 and RO11 respectively.

T **Separate element for forecast movements in non-cash provisions** These are deductions of the figures at line Q from the revenue resource limit in order to calculate the financing requirement.

U **2001/02 financing requirement** Sum of lines R to T. *HAs will be notified of their total 2001/02 financing requirements once the capital resource limits have been announced.*

Annex 3

RESOURCE ACCOUNTING AND BUDGETING: PROVISIONS & IMPAIRMENTS

Provisions

1. Initial Resource Limits contain an earmarked amount for the forecast movement in provisions declared in response to AWP (01-02) RO6. We will require the figures for both new provisions and forecast cash payments to be updated when financial plans are submitted. RLs will then be adjusted. There will be no adjustment to cash limits.

2. Details of new provisions will be sought each quarter as part of the financial monitoring process. RLs will be adjusted (up or down) for declared changes in new provisions.

3. The RL cover for provisions is not available for any other purpose. A final RLA will be made to align this element of the RL with the amount of new provisions in final accounts.

4. The Department needs to seek separate cover in Supply Estimates for provisions and therefore we will need the best possible forecast at Q2 to inform our revised Estimate.

Impairments (FRS11)

1999/2000 and 2000/01

5. The effect on NHS Trust I&E positions arising from changes in impairments in 1999/2000 and further changes in 2000/01 have been neutralised by creating a HA debtor for the amounts involved. The effect on HAs has been likewise neutralised by creating a debtor with the Department to match the creditor with the NHS Trusts. HAs will be given specific cash limit adjustments during the course of 2001/02 to enable them to settle the NHS Trust creditors. There are no resource limit implications.

2001/02

6. The effect on NHS Trust I&E positions arising from changes in impairments in 2001/02 will similarly be neutralised by creating a HA debtor. HAs will be given a corresponding resource limit adjustment. There will be no cash implications in 2001/02 for these impairments. These will be dealt with by specific adjustments to 2002/03 cash limits.

7. HAs will also be allocated resource limit adjustments in respect of any impairments to their own assets and those of their PCTs. The HA will need to onward allocate to their PCTs any RLAs received in respect of impairments to PCT assets. HA and PCT impairments have no cash implications.

8. Information on 2001/02 impairments will be collected from NHS Trusts and HAs (covering PCTs) as part of financial monitoring returns.

9. The RL cover for impairments is not available for any other purpose. A final RLA will be made to align this element of the RL with the creditor for impairments in final accounts.

10. The Department needs to seek separate cover in Supply Estimates for impairments .We will need the best possible forecast at Q2 to inform our revised Estimate.

Annex 4

PRIMARY CARE SERVICES

HA and PCG 'GMS' expenditure floors

1. Health Authorities (HAs), Primary Care Trusts (PCTs) and Primary Care Groups (PCGs) are each required to guarantee that a minimum level of expenditure within the unified budget is used for GMS infrastructure costs.

   At HA level there is a guaranteed level of expenditure (or floor) covering the whole of GMS infrastructure costs (previously referred to as GMS Cash Limited). This excludes the Out of Hours Development Fund (OOHDF). The GMS element of the unified budget for 2001/02 is the 1998/1999 GMS-CL allocation uplifted annually for the forecast of inflation at the time annual allocations are made. This represents a benchmark against which each Regional Office can monitor each HA's performance. An HA may, of course, through the implementation of the proposals set out in its constituent PCTs'/PCGs' PCIPs, spend more than this floor on GMS infrastructure.

   If an HA's PCTs and constituent PCGs agree (through the aggregated effect of the relevant expenditure proposals set out in each of their Primary Care Implementation Plans (PCIP)) then the HA's spend on GMS infrastructure (as represented by the aggregation of its constituent PCTs'/PCGs' spend on these items) can be less than this floor.

2. HAs must consult Local Medical Committees (LMCs) about the contents of their PCTs' and constituent PCGs' PCIPs, particularly:

   i. any proposals under the arrangements to use their unified budget or out of hours development resources to fund pilot schemes made under section 6 of the 1997 Act; and

   ii. about the amount of their allocation available to fund services provided under Part II of the 1977 Act.

3. At PCT/PCG level there is another guaranteed level of expenditure (or floor) covering recurrent GMS reimbursements for staff and IT maintenance (net of the annual cost of any amounts transferred to the HA's budget for PMS to support first or second wave pilots) set at the 1998/99 level of expenditure uprated by the increase in the GDP deflator in each successive year. Again, this represents a benchmark against which the HA can monitor the PCT's/PCG's performance. A PCT/PCG can, of course, spend above the floor. The PCT/PCG may, however, propose through its PCIP to reduce GMS recurrent infrastructure spend on staff or IT maintenance below this floor.

4. Any relevant amounts transferred from funding cash-limited GMS reimbursement under the SFA to fund the costs of contracts with PMS pilot sites reduce the PCT/PCGs or HA floor(s), as appropriate, by the same amount as the value of the amounts transferred.

5. Formal directions under Section 45 of the 1977 Act confirming these arrangements are in preparation.

OOHDF ring fence arrangements

6. The independent review of GP out of hours services and the Government's response were published on 31 October. Both envisage a key role for PCTs in the development of GP OOH services locally. However, the arrangements for managing the OOHDF in 2001/02 are to remain the same as for the current year 2000-01, ie separately ring fenced by Direction and managed at HA level.

7. HA functions relating to the OOHDF (in paras 59 and 60 of the Statement of Fees and Allowances (SFA)) are not delegable to PCTs/PCGs. PCTs/PCGs are not directly involved in managing the OOHDF unless they wish to add locally to the OOHDF by returning part of their unified budget to the HA for virement to the OOHDF budget, if the latter is exhausted. Such proposals should feature in the PCT's/PCG's PCIP.

8. Expenditure counting as being within the GMS floor can be spent on OOH if the HA's OOHDF has been exhausted, as before.

"Section 36" GMS Local Development Schemes

9. HAs, PCTs and PCGs should be aware that, as in 1999/00, their allotment can be used to fund General Medical Services Local Development Schemes. These schemes are provided for in regulation 34B of, and Schedule 7A to, the National Health Service (General Medical Services) Regulations 1992 (S.I. 1992/635) as amended by the National Health Service (General Medical Services) Amendment (No. 3) Regulations 1997 (S.I. 1997/2468). HA or PCT/PCG spend on such local development schemes will not count against their GMS expenditure floor.

10. These arrangements depend on:

    (a) the Secretary of State's designation of HAs or, where a PCT has been established, the PCT as determining authorities for the remuneration in question, and

    (b) his designation of the remuneration as falling within section 97(3A)(d) of the National Health Service Act 1977 (as substituted by section 36 of the National Health Service (Primary Care) Act 1997).

11. The first designation is included separately with this HSC; the second designation is set out at Annex 6.

12. The result is that HAs and PCTs have the power to make local determinations of remuneration for the purposes of GMS Local Development Schemes whereby locally determined incentives are paid to GPs providing GMS under Part II of the 1977 Act. The funding is both for payments under the five model local development schemes to GMS GPs and for PMS GPs providing similar enhanced services within their PMS contracts. Such remuneration is to be funded out of general allocation.

13. HAs' statutory functions of determination relating to "Section 36" Local Development Schemes are not delegable to PCGs. PCGs may propose such schemes for approval by the HA. Where a PCT exists the PCT rather than the HA is the determining authority.

14. The NHS (General Medical Services) Amendment (No.3) Regulations 1997 contain the amendments to the 1992 Regulations which set out the conditions which apply to remuneration made under these arrangements.

15. The purpose of these arrangements is to improve the quality and responsiveness of General Medical Services and to help address local health inequalities through improved GMS provision. In particular, they can be used to provide primary health care services to groups of patients such as asylum seekers, homeless people and those sleeping rough, and substance abusers. HAs should consider how funding improvements in the development of general medical services might lead to more cost-effective use of the secondary sector.

16. HAs', PCTs' or PCGs' spend on "Section 36" Local Development Schemes will not count as GMS expenditure in the context of their delivery of the GMS floors.

17. From 1999/00 up to £5 million of spend on certain qualifying local development schemes counts towards GPs' intended average net income (IANI). Circular HSC 1999/107 explained what these qualifying schemes were, and that only spend net of GPs' expenses counted towards IANI. HAs should note that overall allocations include funding for this £5 million and for the associated expenses, which together will make up the spend with GPs on qualifying LDS schemes and that each HA's allocation takes account of this funding.

18. A growing proportion of GPs are employed under PMS arrangements. HAs or PCTs may therefore also use these funds to fund PMS GPs providing enhanced services within their PMS contracts which deliver the objectives of one of the 5 GMS qualifying schemes.

Primary Care Act Pilots (PCAPs) – Medical and Dental

19. Revenue allocations for PCAPs (both for existing pilots and for new pilots beginning in 2000/01) will be made through non-recurrent additions to initial allotments. Further details for PMS pilots are set out in the second edition of the PMS pilots comprehensive guide (issued in December 1998). The principles for PDS funding are set out in the guidance on establishing and running PDS pilots (issued in December 1998).

Additional Pharmaceutical services

20. Funding for Pharmaceutical Advisory services for Care Homes and Additional Pharmacist Access services is included within Health Authorities' main allocations, in line with the arrangements described in HSC 1999/076.

Annex 5

ALLOTMENTS UNDER SECTION 97(1) AND 97(3) OF THE NHS ACT 1977

1. Section 97 of the NHS Act 1977 (*the 1977 Act*), as substituted in part by section 36 of the NHS (Primary Care Act) 1997 (*the 1997 Act*) and amended by section 4 of the Health Act 1999 (*the 1999 Act*) requires the Secretary of State to make separate payments to HAs under sections 97(1) and 97(3) as follows:

(i) **section 97(1)**

an amount to meet HAs' *general Part II expenditure* which paragraph 1 of Schedule 12A of the 1977 Act defines as expenditure attributable to the remuneration paid to Part II practitioners, other than any expenditure falling within the definition of a HA's *main expenditure* which is covered by paragraph 2 of Schedule 12A. In other words s97(1) expenditure is demand led or "non-discretionary" expenditure on GMS, PhS, GDS and GOS;

(ii) **section 97(3)**

an amount not exceeding the sum allotted for that year towards meeting HAs' (and PCTs') *main expenditure*. Paragraph 2 of Schedule 12A explains that this comprises:

a. expenditure attributable to:

(i) the reimbursement of certain expenses (as designated) incurred by practitioners providing services under Part II of the 1977 Act. This comprises GMS discretionary expenditure on directly reimbursed expenses and GMS Out of Hours Development Fund expenditure (see paragraph 2 below);

(ii) remuneration paid to chemists providing such additional pharmaceutical services as HAs have been directed or authorised to arrange under section 41A of the 1977 Act, as inserted by the 1997 Act, and which have been designated for the purposes of paragraphs 1(2)(c) and 2(2)(b) of Schedule 12A of the 1977 Act (as inserted by the 1999 Act) (see paragraph 3 below);

(iii) remuneration falling within paragraph 2(2)(c) of Schedule 12A of the 1977 Act (as inserted by the 1999 Act): in practice remuneration paid to GPs taking part in GMS Local Development Schemes (see Annex 2 paragraphs 10-18);

b. any other expenditure which relates to a HA's or PCT's functions other than *general Part II expenditure* and remuneration referable to the cost of drugs (see below);

c. expenditure relating to "remuneration referable to the cost of drugs" for which the authority are accountable. The Secretary of State hereby determines "remuneration referable to the cost of drugs" to be:

- basic price of drugs and appliances dispensed in the community, by contractors on the list of English health authorities
- less cost of prescriptions written on the form FP10(HP)
- less the estimated level of discount
- plus container allowances
- plus broken bulk payments
- plus out of pocket expenses
- plus VAT.

(See the *Drug Tariff* for detail about the above terms)

In practice, HAs (PCGs) and PCTs, are basically accountable for drugs bill costs arising from prescriptions written by GPs (or other primary care practitioners) in their areas.

Designation of certain expenses for the purposes of paragraphs 1 and 2 of Schedule 12A of the 1977 Act

2. The following expenses (which are reimbursed to GPs in accordance with the National Health Service General Medical Services Statement of Fees and Allowances ('SFA')) are hereby designated for the purposes of section 97(3A)(b) of the 1977 Act as inserted by s.36 of the National Health Service (Primary Care) Act 1997 and amended by section 4 of the Health Act 1999.

   i. cost rents and local authority economic rents (payable under paragraph 51of the SFA);

   ii. practice staff (paragraph 52 of the SFA);

   iii. payments to surrender lease (paragraph 55 of the SFA);

   iv. improvement grants (paragraph 56 of the SFA);

   v. the computer reimbursement scheme (paragraph 58 of the SFA);

   vi. out of hours development scheme (paragraphs 59 and 60 of the SFA);

   in so far (in all cases) as sums payable under those paragraphs are reimbursements of actual expenditure by the practitioner.

3. The following services (provided in accordance with directions under section 41A of the 1977 Act) are hereby designated for the purposes of paragraphs 1(2)(c) and 2(2)(b) of Schedule 12A of the 1977 Act (as inserted by the Health Act 1999):

   i. Pharmaceutical Advisory Services for Care Homes

   ii. Additional Pharmacist Access Services.

Section 97(6) directions

4. The Secretary of State may also issue directions under section 97(6) of the 1977 Act on the application of sums paid to HAs under section 97(3). The Secretary of State intends that the allocations for out of hours development should be used only for the purposes, and in the ways, described above. Accordingly, each HA in England is hereby directed as follows in relation to the application of sums paid to them -

   (1) Sums allotted in respect of the Out of Hours Development Fund are to be used only for;

   a. the purposes of that Fund, in which case the sums are to be managed in accordance with paragraphs 59 and 60 of the SFA; or

   b. contributing towards the funding of pilot schemes made under the 1997 Act, under which personal medical services are provided but only in so far as such funding reflects the cost of the out-of-hours personal medical services provision element of those pilot schemes and may not be used for any other purpose except with the Secretary of State's written consent.

   (2) Sums allotted otherwise than for the Out of Hours Development Fund may not be used for the purposes of that Fund until the sums specifically allotted for the purposes of that fund have been exhausted. Where the sum specifically allocated for the purpose of the out of hours development fund has been exhausted and it is proposed to use funding that has been allocated to PCTs or PCGs as part of their agreed budgets, the agreement of the PCT or PCG should be obtained before such funds are used for out of hours development.

<u>Movement of funds between section 97(3) allotments</u>

5. The effect of the above directions (paragraph 4) combined with the designation in paragraph 2 is that:

   i. HAs may add to their allocation for out of hours development from their allocations for other purposes but only where Out of Hours Development Fund has been exhausted and where their PCTs or constituent PCGs agree to release the funds from their budgets

   ii. where HAs do add to their out of hours development allocation, the conditions in paragraphs 59 and 60 of the SFA apply also to the additional funds added to the health authority's original allocation for out of hours development; and

   iii. HAs may not reduce their allocations for out of hours development to add to their allocations for other purposes without the prior agreement of the Secretary of State.

Local consultation

6. HAs, PCTs and PCGs should be aware of the amendment to section 45 of the 1977 Act which now formalises the practice by which the Secretary of State places (or varies) a requirement on HAs to consult local representative committees by Direction or other statutory instrument.

Annex 6

DESIGNATION OF REMUNERATION AS FALLING WITHIN SECTION 97(3A)(d) OF THE NATIONAL HEALTH SERVICE ACT 1977

By authority of the Secretary of State remuneration paid to doctors under a GMS Local Development Scheme pursuant to regulation 34B of and Schedule 7A to the National Health Service (General Medical Services) Regulations 1992 is hereby designated in relation to the allotment to each Health Authority or Primary Care Trusts, for the purposes of section 97(3A)(d) of the National Health Service Act 1977 (as substituted by section 36 of the National Health Service (Primary Care) Act 1997) and amended by section 4 of the Health Act 1999.

APPOINTMENT OF HEALTH AUTHORITIES AND PRIMARY CARE TRUSTS AS DETERMINING AUTHORITIES

By authority of the Secretary of State, in pursuance of powers set out in sections 43A and 43B of the National Health Service Act 1977 as read with section 7 of the Health and Social Security Act 1984, I hereby appoint each Primary Care Trust or (where no Primary Care Trust is operating in that area) each Health Authority in England as the determining authority for the remuneration of doctors for whom it is the relevant PCT* or (where there is no PCT) whose names are included in the Health Authority's medical list for the purposes of any GMS Local Development Scheme established under regulation 34B of and Schedule 7A to the National Health Service (General Medical Services) Regulations 1992 (S.I. 1992/635).

(These provisions were inserted by the National Health Service (General Medical Services) Amendment (No. 3) Regulations 1997 (S.I. 1997/2468) and each Health Authority must exercise its power of determination in line with those provisions.)

DIRECTIONS TO HEALTH AUTHORITIES AND PCTS

In exercise of the Secretary of State's power of direction under section 17 of the National Health Service Act 1977, by authority of the Secretary of State I hereby direct each Primary Care Trust (or where no PCT is operating in that area) each Health Authority in England to include in each determination made by the PCT or Health Authority under the above designation the arrangements for claiming the remuneration in question, and to publish the determination (and any amendment or revocation) in a suitable way for bringing it to the attention of the doctors who are eligible for the remuneration.

Rob Webster on behalf of the Secretary of State

14 November 2000

EXPLANATORY NOTE

This designation gives the Health Authority the power to make determinations in respect of GMS Local Development Schemes and the separate designation set out at Annex 6 designates the remuneration to be paid in respect of such schemes as coming out of the Primary Care Trust's or Health Authority's main expenditure.

* "relevant PCT" is defined in regulation 2(1) of the Primary Care Trusts (Functions) (England) Regulations 2000/695.