Paper NHSE121305

BOARD PAPER - NHS ENGLAND

Title: Allocation of resources to NHS England and the commissioning sector for 2014/15 and 2015/16

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Purpose of paper:

- This paper sets out the recommendations regarding the allocation of resources for 2014/15 and 2015/16 to NHS England and the commissioning sector. These are designed to deliver an approach to future funding which is holistic and balanced with regard to the factors of population, age and deprivation which together define the need for healthcare. They also seek to offer an appropriate balance between stability and action on underfunding in the proposals regarding pace of change towards target allocations.

Key issues and recommendations:

The key decisions for the Board are:

- How to allocate funds between the areas of commissioning spend
- How to allocate funds within each area of spend
- The pace of change associated with any change in allocation policy

Actions required by Board Members:

The Board is asked to:

Overall Allocation

- Agree the proposed allocation of funds between commissioning areas of spend and the approach to allocation of running costs to clinical commissioning groups (CCGs)

Handling Inequalities

- Agree that NHS England should make a further adjustment for inequalities/unmet need when considering how to allocate funds
- Agree that this adjustment should be applied to the primary care and CCG formulae
- Agree that the quantum of the adjustment should be 15% for primary care and 10% for CCGs
- Agree that the metric used to make the adjustment should be SMR<75, weighted in a similar way to the local authority public health grant formula

Allocations to CCGs and Area Teams

- Agree that NHS England should introduce the proposed funding formula for primary care
- Agree that NHS England should introduce the proposed funding formula for CCGs

Pace of change

- Consider whether option 3 or option 4 should be adopted as the preferred pace of change option for CCGs
- Agree the recommendation regarding pace of change for primary care

Allocations

- Agree that the resulting allocations to CCGs and Area Teams for 2014/15 and 2015/16 should be published, together with the related target allocations.

Context

1. NHS England has responsibility for the allocation of the funding envelope that is agreed with the Department of Health (DH) alongside the mandate. For 2013/2014 this was £95.62bn.

2. Funding objectives contained within the Mandate require NHS England to run a transparent allocation process to ensure "equal access for equal need". But the 2012 act also requires NHS England to have regard to reducing inequalities in access to and outcomes from healthcare.

3. The NHS England Board decided in December 2012 to launch a fundamental review of allocation policy in order to ensure that a holistic approach was taken across all commissioning areas of spend. The review team has considered the balance between stability and action on underfunding along with the relative focus within any approach to funding allocation of population, age and deprivation factors. The review team includes representatives from Area Teams and CCGs and is advised by ACRA (the independent committee of experts on resource allocation who previously advised the DH).

4. In light of NHS England's commitment to transparency and the significant continuing interest in allocations policy reflected in correspondence and FOI enquiries, the review team has held four regional workshops on allocations over the last few months which have been attended by nearly 400 representatives from CCGs, local authorities and providers. There has also been ongoing dialogue with the Commissioning Assembly, and a Finance and Planning subgroup has recently been formed to collaborate with NHS England's finance leadership on the linked topics of allocations and the proposed strategic planning programme.

5. In order to support commissioners to develop strategic plans for local health economies NHS England is planning to announce this month a two year funding allocation for 2014/15 and 2015/16 as well as target allocations for future years[1]. This will enable commissioners to plan future investments and QIPP plans in the context of likely future funding adjustments.

6. The key decisions for the Board are therefore:
    - How to allocate funds between the five main areas of commissioning spend (public health, primary care, CCGs, specialised/health & justice/armed forces and the integration transformation fund)
    - How to allocate funds within each stream, i.e. the distribution between localities

[1] Note that 2015/16 could be subsequently amended on an exceptional basis depending upon the outcome of national contract negotiations and any significant update to the mandate.

- The pace of change associated with any change in allocation policy.

Allocation of funds between the areas of commissioning spend

7. The government has announced that the NHS will receive a minimum of real terms growth in 2014/15 and 2015/16. The total available funding uplift for NHS England has now been set at 3.1% for 2014/15 and 2.3% for 2015/16. These funds are intended to meet the real terms growth commitment, fund service priorities as set out in the mandate and allow for some pace of change for CCGs.

8. Table 1 below, sets out the overall level of resources that NHS England has agreed with the DH for the two years as part of the discussions on the mandate.

Table 1: NHS England funding envelope for 2014/2015 and 2015/2016

	2013/14 £bn	2014/15 £bn	2015/16 £bn
NHS England Recurrent Funding (including section 7a)	93.62	96.48	98.68
Add back depreciation in baseline for allocation	0.16	0.16	0.16
Recurrent allocation for distribution	**93.78**	**96.64**	**98.84**
Available Growth		*3.1%*	*2.3%*
Real Terms Growth		*2.1%*	*1.5%*
Surplus drawdown	0.65	0.40	0.40
Surplus carry forward	0.53	0.47	0.07
Winter Pressures (non-recurrent)	0.25	0.25	
Annually Managed Expenditure / Technical	0.66	0.66	0.66
Total Funding Available	95.87	98.42	99.97

Note: Depreciation is a ring-fenced allocation as part of the Mandate that NHS England includes within the total allocations.

9. Table 2 below sets out the proposed distribution of resources between the areas of commissioning spend. This distribution assumes that:
   - NHS England fulfils the funding commitments agreed in the mandate.
   - The CCG sector receives at least real terms growth plus an additional allocation of £250m in 2014/15 and £400m in 2015/16 to cover cost pressures and support pace of change towards target allocations in the various scenarios described in the section beginning at paragraph 53.
   - Payment of provisions relating to continuing healthcare, estimated at c£250m, constitute a pressure on the funding envelope for CCGs in 2014/2015. In 2013/2014 these costs were met from non-recurrent funds[2].

[2] CCGs will be required to count the utilisation of provisions as an utilisation of their allocated resource in line with HM Treasury accounting requirements.

- An assumption is made that CCGs achieve 75% of the quality premium in 2014/15 and 2015/16.
- A structural deficit of c £330m within specialised commissioning in 2013/2014 is included in the modelling as a cost pressure for 2014/2015.
- NHS England delivers a 17% saving in its central programme budget in 2014/15 in order to fund new mandate commitments and generate a £50m cash saving. This ambitious goal will need to be reflected in a zero-based budgeting round to be conducted in Q1 of 2014.
- The commissioning sector receives no additional funding for inflation in its admin budget in either year and needs to achieve a cost reduction of 10% in 2015/16. Furthermore, from 2014/15 there is no external funding for transition costs (c£0.14bn in 2013/14), meaning that any funding for transition will need to be found from savings elsewhere. The 10% assumption for 2015/16 is consistent with the overall reduction in admin spend for the DH group agreed with HM Treasury (HMT) in the latest Spending Round, and we have a common goal to maximise the amount of the available resource which is dedicated to patient care. However, the scale of the required reduction for the commissioning sector is yet to be agreed with the DH, and significant further work is required to address the Board's concerns as to whether this level of reduction in resources is consistent with fulfilment of the commissioning sector's legal duties and the delivery of the level of ambition implied by our strategy for transforming outcomes for patients.
- Funding available for NHS England and the commissioning sector reflects expected payments to be made by branded pharmaceutical companies to DH as part of the Pharmaceutical Price Regulation Scheme agreed between DH and the Association of the British Pharmaceutical Industry.

10. The forward projection of pressures in each commissioning area of spend is based on the work we have undertaken to model the future financial position of the NHS as part of the Call to Action and discussed with the DH (see Appendix A for further detail on assumptions). This leaves each area with an efficiency requirement to live within, having assumed a specified amount of funding growth.

Table 2: High level allocation of NHS England resources

	FY 13/14 Recurrent Allocation £bn	FY 14/15 Recurrent Allocation £bn	Efficiency Requirement	Budget Growth	FY 15/16 Recurrent Allocation £bn	Efficiency Requirement	Budget Growth
Total	**93.78**	**96.64**	**3.8%**	**3.1%**	**98.84**	**4.9%**	**2.3%**
CCG Programme Costs	62.75	64.34	3.3%	2.5%	65.69	5.9%	2.1%
Social Care / Better Care Fund	0.86	1.10		28.1%	1.10		
CCG Admin / Running Costs	1.35	1.35	2.1%	0.0%	1.22	11.3%	(10.0%)
Quality Premium	0.00	0.20			0.20		
CCG / Local Funding	64.96	66.99	3.2%	3.1%	68.20	5.9%	1.8%
Specialised	12.96	13.52	6.2%	4.4%	14.33	3.1%	5.9%
Primary Care (to be allocated)	11.76	12.02	2.5%	2.1%	12.22	2.2%	1.7%
Primary Care (other budgets)	0.19	0.28		48.4%	0.28		
Other Direct Commissioning	0.43	0.44	1.6%	2.1%	0.45	1.8%	1.7%
Public Health s7a	1.71	1.80		5.1%	1.80		
NHS England Programme	0.98	0.93	18.5%	(5.1%)	0.96	2.6%	3.4%
NHS England Admin / Running Costs	0.67	0.54	2.6%	(18.8%)	0.49	11.3%	(10.0%)
Other	0.12	0.12			0.12		

Notes:

- The efficiency requirement includes provider efficiency delivered through the tariff deflator (assumed to remain at c4% in 2014/15 and 2015/16), with the remainder delivered through commissioner QIPP initiatives
- Primary care (other budgets) includes GP IT expenditure and investment in a number of national pilot schemes for GPs and dentists.

11. In 2015/2016 the Better Care Fund (BCF) becomes operational. The total amount of funding that has been allocated to the BCF will reach £3.8bn in 2015/2016. This comprises the £1.1bn of investment by the NHS in social care in 2014/2015 (see social care/integration fund line above), with a further £1.9bn of investment by the NHS in 2015/16 and £430m of money already in CCG baselines for reablement and carers grant funding (within CCG programme cost line). Finally £400m of capital grants provided directly by the DH and the Department for Communities and Local Government is included within the BCF but not included in this analysis.

12. Within the available funding envelope we have sought to begin to align funding to our emerging strategic objectives as set out in the planning guidance. Over time this will require a shift in the balance of resources from acute care settings to primary, community and social care. This shift is reflected in the introduction of an expectation in 2014/15 that CCGs will provide new funding for primary and community care (see Appendix A) and in 2015/16 with the introduction of the BCF.

13. As set out in the table, the implication of the distribution of resources in this option is that different commissioning areas of spend will face a differing level of efficiency challenge in 2014/15 and 2015/16. In 2014/15, specialised commissioning remains the area with the most challenging efficiency requirement despite receiving 4.3% growth. In contrast, in 2015/16, with the

introduction of the BCF, CCGs face the highest efficiency challenge. Over the two years the level of efficiency challenge for both CCGs and specialised commissioning is similar at 9.2%.The efficiency requirement includes provider efficiency delivered through the tariff deflator (assumed to remain at c4% in 2014/15 and 2015/16), with the remainder delivered through commissioner QIPP initiatives.

14. In order to support commissioners to manage this challenge over the two year period we propose to prioritise access to surplus drawdown for specialist commissioning in the first year and CCGs in the second year.

15. As described above, the commissioning sector will receive a reduction in admin resources over the two year period. For CCGs the total amount of admin resources available will be the same in 2014/15 as 2013/14 with a 10% assumed reduction in cash terms in 2015/16. Having accounted for projected population growth, the £25 per head admin allocation for 2013/14 would therefore become £24.78 per head in 2014/15 and £22.11 per head in 2015/16. Two alternative options have been developed for the future allocation of the admin resource envelope to CCGs. The first assumes that the existing admin envelope at CCG level is used as the baseline and adjusted for the overall percentage change in budget in each year. This option would maximise stability but break the link between admin budgets and population size. The second option assumes that individual CCG admin budgets continue to be set on the basis of their share of total population, ensuring that the level of funding per head of population remains consistent across the country.

16. The Board is asked to agree the proposed distribution of resources across commissioning streams for 2014/15 and 2015/16 and the approach to allocation of running costs to CCGs.

Addressing inequalities

17. Before deciding how to allocate funds within areas of commissioning spend a decision is required on how to reflect NHS England plans to discharge its responsibilities regarding inequalities.

18. Inequalities resulting in needs which are currently being met by the NHS (appropriately or otherwise) are already captured in baselines and target allocation formulae for public health, primary care and CCG allocations. For instance, looking at opposite ends of the deprivation spectrum (and prior to any adjustment for unmet need), in 2014/15 Knowsley has a core target allocation per head that is 38% greater than Richmond-upon-Thames, which rises to 61% when adjusted for local purchasing power differences.

19. Prior to 2013/2014 the PCT funding formula was further adjusted to take into account the impact of unmet or inappropriately met need (i.e. the fact that some of the most deprived communities do not access healthcare in the most optimal way, resulting in poorer health outcomes). The total adjustment was originally 15% but in recent years was reduced to 10%.

    NHS England therefore needs to consider:

    - Whether an additional adjustment should be made for unmet/inappropriately met need
    - Which elements of commissioning spend should be adjusted
    - The quantum of any adjustment
    - What adjustment methodology or metric should be used

    Whether

20. Our recommendation is that NHS England does make such an adjustment. This is on the basis that although our current approach takes into account met need, without a further inequalities adjustment we may not be adequately funding unmet need. Although the evidence on the cost impact of unmet need is limited, ACRA supported making an adjustment to CCG commissioned services at their meeting in November. ACRA is unable at this time to make a recommendation on other commissioned services. ACRA is clear that their recommended adjustment is an interim position, and further research is needed. In a broader sense such an adjustment would also target additional resource to areas with poorer outcomes, enabling them to make additional investment to close the gap in outcomes.

    Which

21. We are recommending for 2014/2015 and 2015/2016 that an adjustment for inequalities is applied to primary care and CCG spend on the basis that it is in these areas of healthcare spend that we would wish to target any adjustment for unmet need.

22. We are not proposing making a further inequalities adjustment to public health funding (under the section 7a agreement), as NHS England spend on public health is to be distributed on a targeted programme rather than locality basis. It should also be noted that both the local authority public health formula and the social care formula have strong deprivation components included within them.

23. With regard to CCG allocations, two options have been developed:
    - Option 1: focussed on areas of CCG spend where investment is likely to be targeted on interventions that will have an impact on inequalities

(predominantly primary care and community services, including those relating to mental health). The total amount of CCG spend that is linked to services which could have a direct impact on inequalities is estimated to be c29%. In this context it is worth noting that CCG funding does not include public health responsibilities, which were reflected within the previous PCT formula and would have been a major component of the rationale for the inequalities adjustment under the previous arrangements.

- Option 2: all CCG spend.

24. We recommend option 2, as this gives a more significant impact and errs on the side of protecting the most vulnerable communities.

Quantum

25. ACRA is unable to provide any evidence regarding the optimum quantum of adjustment.

26. For CCGs we recommend maintaining the quantum of adjustment at the same level as the previous PCT formula i.e. 10%. When applied to the two options set out at paragraph 23, this results in an adjustment to the CCG formula of either 2.9% or 10%, as shown below.

27. For primary care we have developed two options (10% and 15%) but recommend making an adjustment of 15%. This is on the assumption that if NHS England is to focus on addressing unmet need, this can be more effectively addressed through primary and community than through secondary care, which suggests a stronger concentration on primary care allocations.

What adjustment methodology

28. The PCT formula was adjusted by using a factor reflecting the disability free life expectancy (DFLE) profile of each PCT area to represent potential unmet health need relating to deprivation.

29. ACRA has reviewed this and considers that, if an adjustment is to be made to the CCG formula, then the best available option to reflect unmet need is the Standardised Mortality Ratio (SMR) < 75.

30. SMR, like most health status measures, is strongly correlated with deprivation. Unlike other measures, however, it is available for small areas – reflecting population groups of about 7,000 – and updated frequently. Using the measure for small areas allows deprived communities within otherwise affluent areas to be recognised. The relative weighting of areas facing

different levels of challenge is non-linear, with the small areas facing the greatest challenge seeing a target that is five times greater than those facing the least challenge, all else being equal.

31. The DFLE-based approach for PCTs was frequently criticised as failing to capture such pockets of deprivation in otherwise affluent areas. For instance, the community served by NHS Ipswich and East Suffolk CCG is relatively affluent, but, in Ipswich in particular, there are neighbourhoods that are in the most deprived quintile in the country (see map at Appendix B). This approach matches funds to pockets of deprivation but it will be important that CCGs and Area Teams ensure that these funding adjustments for unmet need are then focussed upon the relevant specific communities.

32. SMR is also updated frequently. Furthermore, following a significant period of engagement, the public health formula uses SMR<75, so adoption of SMR within the CCG formula would ensure consistency and support development of a holistic approach to allocating funds across areas of commissioning spend.

33. Our analysis indicates that, with the adoption of the SMR adjustment, the most deprived and the least deprived areas are left in a similar position to the previous approach, but the gradient between them becomes flatter, reflecting a more nuanced approach to local deprivation.

34. Table 3 below sets out the implications of adopting the two CCG options outlined above in paragraph 26 in comparison to the alternative of making no unmet need adjustment. The 10% option moves more resources towards deprived areas (IMD deciles 7 to 10) compared to the 2.9% option.

Table 3: CCG allocations with unmet need adjustment options

	13/14 allocation (actual)		14/15 target allocations						Difference to target allocation through applying 10% SMR	
	14/15 population									
			0% SMR<75 weighting		2.9% SMR<75 weighting		10% SMR<75 weighting			
IMD Decile	£000	£ per head	£000	£ per head	£000	£ per head	£000	£ per head	£000	£ per head
1	4,786,373	989	5,017,589	1,037	4,985,795	1,030	4,907,951	1,014	(109,638)	(23)
2	6,593,690	997	7,013,809	1,060	6,975,748	1,055	6,882,556	1,041	(131,254)	(20)
3	6,247,711	1,025	6,631,305	1,088	6,602,122	1,084	6,530,670	1,072	(100,635)	(17)
4	6,614,461	1,107	6,802,895	1,139	6,768,946	1,133	6,685,824	1,119	(117,072)	(20)
5	6,209,183	1,109	6,264,993	1,119	6,254,258	1,117	6,227,973	1,112	(37,021)	(7)
6	6,143,174	1,133	6,067,593	1,119	6,057,971	1,117	6,034,412	1,113	(33,181)	(6)
7	6,010,394	1,102	5,866,582	1,075	5,883,111	1,078	5,923,580	1,086	56,998	10
8	6,131,760	1,261	5,706,743	1,173	5,729,453	1,178	5,785,056	1,189	78,313	16
9	7,111,246	1,186	6,772,479	1,130	6,821,612	1,138	6,941,912	1,158	169,434	28
10	6,895,720	1,166	6,599,723	1,116	6,664,696	1,127	6,823,779	1,154	224,056	38
England	62,743,712	1,105	62,743,712	1,105	62,743,712	1,105	62,743,712	1,105	-	-

Note: Index of Multiple Deprivation (IMD) decile 1 is the most prosperous and IMD decile 10 is the most deprived.

35. Market Forces Factor (MFF) is included in the CCG formula, as it was in the PCT formula. MFF adjusts for the relative cost of providing services in different parts of the country – in particular the significantly lower purchasing power in urban areas in the south east of the country relative to areas in the north and west. MFF ranges from 0.93 in Hull, Kernow and South Devon CCGs to 1.16 in Camden, Central London and West London CCG. When adjusted for equal purchasing power (by excluding MFF), the range of 14% between the least and most deprived communities increases to 18%. The variation between individual CCGs is even greater, with the range quoted above between Richmond-upon-Thames and Knowsley excluding MFF rising to 69% when the proposed unmet need adjustment is included. Richmond-upon-Thames has an allocation of £968 per head (£867 excluding MFF) whilst Knowsley has an allocation of £1398 per head (£1462 excluding MFF).

36. Table 4 below sets out the impact of introducing an adjustment for unmet need into the primary care allocation. At 15% this introduces an increase at one end of the range of £5.65 per head (Greater Manchester) with a reduction of £3.99 per head at the other end of the range (East Anglia and Devon, Cornwall & the Isles of Scilly).

Table 4: Primary care allocations with unmet need adjustment options

	13/14 Actual allocationa		14/15 target allocations						allocation through applying 15% SMR adjustment	
	14/15 population									
			0% SMR<75 weighting		10% SMR<75 weighting		15% SMR<75 weighting			
Area Team	£000	£ per head	£000	£ per head	£000	£ per head	£000	£ per head	£000	£ per head
Cheshire, Warrington & Wirral	283,722	220	282,972	220	281,865	219	281,311	219	(1,661)	(1.29)
Durham, Darlington & Tees	296,675	240	289,374	234	289,719	234	289,892	234	517	0.42
Greater Manchester	665,127	228	655,416	225	666,401	228	671,894	230	16,478	5.65
Lancashire	334,160	217	340,652	222	343,449	223	344,848	224	4,196	2.73
Merseyside	306,197	243	302,080	240	305,711	243	307,526	244	5,447	4.33
Cumbria, Northumb, Tyne & Wear	445,052	222	458,410	228	458,698	228	458,842	228	432	0.21
North Yorkshire and The Humber	377,491	221	362,710	212	361,358	212	360,682	211	(2,029)	(1.19)
South Yorkshire and Bassetlaw	355,310	233	348,129	229	347,841	229	347,697	228	(432)	(0.28)
West Yorkshire	547,011	220	520,636	210	526,703	212	529,737	214	9,101	3.67
Arden, Herefordshire & Worcestershire	350,085	204	349,083	204	348,134	203	347,659	203	(1,424)	(0.83)
Birmingham and the Black Country	553,570	210	570,008	216	576,766	218	580,146	220	10,137	3.84
Derbyshire and Nottinghamshire	430,672	207	436,960	210	437,779	211	438,189	211	1,229	0.59
East Anglia	503,200	198	515,510	203	508,736	200	505,348	199	(10,162)	(3.99)
Essex	346,925	189	365,468	199	362,268	197	360,668	196	(4,800)	(2.61)
Hertfordshire and the South Midlands	547,321	190	562,943	196	561,735	195	561,131	195	(1,813)	(0.63)
Leicestershire and Lincolnshire	367,908	199	369,748	200	370,415	200	370,748	200	1,000	0.54
Shropshire and Staffordshire	333,982	208	339,097	211	338,553	211	338,281	210	(815)	(0.51)
London	1,894,700	203	1,832,341	196	1,839,849	197	1,843,602	197	11,261	1.21
Bath, Gloucester, Swindon & Wiltshire	291,155	189	293,194	190	290,682	189	289,426	188	(3,767)	(2.45)
Bristol, North Somerset, Somerset & South Glos	309,581	202	309,399	202	306,896	201	305,645	200	(3,754)	(2.45)
Devon, Cornwall and the Isles of Scilly	381,297	215	370,572	209	365,869	207	363,518	205	(7,054)	(3.99)
Kent & Medway	355,951	194	362,000	198	361,501	198	361,251	197	(749)	(0.41)
Surrey & Sussex	551,991	193	563,111	197	556,942	195	553,858	194	(9,253)	(3.24)
Thames Valley	387,784	176	401,742	183	399,928	182	399,022	181	(2,720)	(1.24)
Wessex	550,327	195	565,641	200	559,396	198	556,274	197	(9,367)	(3.31)
England	11,767,196	206	11,767,196	206	11,767,196	206	11,767,196	206	0	0.00

37. In summary on inequalities we are recommending that:
    - NHS England does apply a further adjustment for inequalities
    - This adjustment is applied to the primary care and CCG formulae
    - The quantum of the adjustment is 10% for CCGs and 15% for primary care
    - The metric used to make the adjustment is SMR<75

Allocation within commissioning areas of spend

38. Having set the distribution between the commissioning areas of spend and determined a policy for unmet need adjustment, the next step is to decide how to distribute funds within each of the five areas of spend for 2014/15 and 2015/16. For two of the five areas the decision making process is relatively simple:
    - Specialised care is nationally commissioned so funding automatically follows need
    - Public health funding (section 7a) is to be allocated on the basis of programme budgets

39. The BCF will be allocated in line with the equivalent funding streams in 2014/2015, i.e. the c£2.3bn of CCG contribution (including current reablement and carers' funding) will be allocated using the CCG funding formula, with the c£1.1bn of existing social care transfer being allocated using the social care needs formula (and then mapped from local authorities to CCGs).

40. Therefore for 2014/2015 and 2015/2016, active decisions regarding the distribution of funds within the area of spend are required for two areas:
    - Primary care
    - CCGs

Primary care

41. Primary care resources are allocated to area teams to cover five broad areas (with baseline allocation for 2013-2014):
    - primary medical services (£6.4bn)
    - primary dental services (£2.7bn)
    - community pharmacy services (£2.0bn)
    - primary ophthalmic services (£0.5bn)
    - primary care IT services (£0.2bn)

42. The formula for target allocations for primary care has been developed including three major components, General Practice, dental and pharmaceutical services. There is no proposed separate component for ophthalmic services, as spend on this service is judged not to be material. In addition, we are not aware of relevant data on which to base a formula. The target formula for primary care is based on:
    - The Carr-Hill formula, which estimates GP workload and is at the heart of the contractual framework for primary medical services
    - Estimates of how spending on NHS dentistry varies with the age of the population, gender and IMD small area of residence

- Assuming that spending on pharmaceutical dispensing services is in proportion to spending on primary care prescribing
- GP IT being excluded from the allocation formula on the assumption that need and utilisation of funds will follow a different pattern

43. The formula will require significant development over the next two to three years, in particular to ensure it stays in step with any changes in the General Medical Services and General Dental Services contracts.

44. Table 5 summarises the current allocation and the proposed target allocation derived from the formula.

Table 5: Primary Care Target Allocations (prior to application of growth funding)

	13/14 Baseline		14/15 opening target		Distance
		£ per	15% SMR<75 weighting		from
Area Team	£000	head	£000	£ per head	target
Cheshire, Warrington & Wirral	283,722	220	281,311	219	0.86%
Durham, Darlington & Tees	296,675	240	289,892	234	2.34%
Greater Manchester	665,127	228	671,894	230	(1.01%)
Lancashire	334,160	217	344,848	224	(3.10%)
Merseyside	306,197	243	307,526	244	(0.43%)
Cumbria, Northumb, Tyne & Wear	445,052	222	458,842	228	(3.01%)
North Yorkshire and The Humber	377,491	221	360,682	211	4.66%
South Yorkshire and Bassetlaw	355,310	233	347,697	228	2.19%
West Yorkshire	547,011	220	529,737	214	3.26%
Arden, Herefordshire & Worcestershire	350,085	204	347,659	203	0.70%
Birmingham and the Black Country	553,570	210	580,146	220	(4.58%)
Derbyshire and Nottinghamshire	430,672	207	438,189	211	(1.72%)
East Anglia	503,200	198	505,348	199	(0.43%)
Essex	346,925	189	360,668	196	(3.81%)
Hertfordshire and the South Midlands	547,321	190	561,131	195	(2.46%)
Leicestershire and Lincolnshire	367,908	199	370,748	200	(0.77%)
Shropshire and Staffordshire	333,982	208	338,281	210	(1.27%)
London	1,894,700	203	1,843,602	197	2.77%
Bath, Gloucester, Swindon & Wiltshire	291,155	189	289,426	188	0.60%
Bristol, North Somerset, Somerset & Sou	309,581	202	305,645	200	1.29%
Devon, Cornwall and the Isles of Scilly	381,297	215	363,518	205	4.89%
Kent & Medway	355,951	194	361,251	197	(1.47%)
Surrey & Sussex	551,991	193	553,858	194	(0.34%)
Thames Valley	387,784	176	399,022	181	(2.82%)
Wessex	550,327	195	556,274	197	(1.07%)
England	11,767,196	206	11,767,196	206	0.00%

CCGs

45. We are recommending that the Board adopts the CCG funding formula previously recommended by ACRA. This includes the following adjustments:
    - Updated practice lists
    - Updating target allocations for future population growth allowing multi-year allocations

- Adjusting the formula to take into account unmet need resulting from inequalities (see discussion above).

46. Using GP practice lists in the allocation formula allows us to use a person based approach. For each individual on the practice list their age and recent diagnostic history (based on hospital records) is considered and they are assigned a weight. These are brought together to estimate a target share of resources for each practice in the CCG. Increased need for healthcare in deprived areas is captured in the base formula in two ways:
    - The prevalence of many diagnoses is greater in deprived areas, and the formula will directly take account of much of the increased need in deprived groups.
    - In addition, further adjustments are made for factors, such as the claimant rate for key benefits. This ensures that the model captures increased need that is linked to deprivation, but is not linked to earlier utilisation of hospital services.

47. The formula incorporates a combination of population, age and deprivation factors. Some academics have criticised the previous formula as being excessively focussed on deprivation at the expense of the other factors. The view of the review team, supported by ACRA, is that the proposed formula strikes an appropriate balance between them.

48. Table 6 compares the target allocations with 13-14 allocations. It shows that the new formula, including the adoption of an unmet need adjustment based on SMR, leaves the most deprived and the least deprived areas in a broadly similar position, but the gradient between them becomes flatter, reflecting amongst other factors a more nuanced approach to the reflection of local deprivation and differential rates of population growth in recent years.

Table 6: Impact of new formula by IMD decile

	13/14 allocation		14/15 target allocations		Distance-from-target
IMD Decile	£000	£ per head	10% SMR<75 weighting £000	£ per head	Per capita
1	4,786,373	989	4,907,951	1,014	(2.48%)
2	6,593,690	997	6,882,556	1,041	(4.20%)
3	6,247,711	1,025	6,530,670	1,072	(4.33%)
4	6,614,461	1,107	6,685,824	1,119	(1.07%)
5	6,209,183	1,109	6,227,973	1,112	(0.30%)
6	6,143,174	1,133	6,034,412	1,113	1.80%
7	6,010,394	1,102	5,923,580	1,086	1.47%
8	6,131,760	1,261	5,785,056	1,189	5.99%
9	7,111,246	1,186	6,941,912	1,158	2.44%
10	6,895,720	1,166	6,823,779	1,154	1.05%
England	62,743,712	1,105	62,743,712	1,105	0.00%

49. IMD decile eight (moderately deprived) is particularly noticeable, having a 13-14 allocation that is 5.99% above target. The next furthest above target is decile 9, at 2.44% above. Examination of decile eight shows that it has a particularly significant number of substantially over target members, including NHS West London which, for historical reasons, is 34% above target. CCGs in this decile also have significantly lower population growth than average (as reflected in 2014/15 growth of 0.57% compared to the national average of 0.89%). The impact of this over recent years will have been significant dislocation between allocations and relative change in population. Together these would place this decile substantially above target under many choices of target formula.

50. In summary the review team is recommending that NHS England:
    - Adopts the proposed funding formula for primary care
    - Adopts the revised funding formula for CCGs

Pace of change

51. Having made a decision regarding the allocation formulae for Area teams (for primary care) and CCGs, a decision is required by the Board regarding how quickly Area Teams and CCGs should move towards the new target formula (pace of change).

52. The whole purpose of allocation policy is to reflect the needs of changing populations, in this case as reflected at practice list level. Given several years

of largely undifferentiated resource growth, allocations have become significantly detached from the populations to which they refer. For these reasons the review team is recommending that pace of change options are considered by the Board on a per capita basis alongside consideration of changes in absolute (£m) funding.

CCGs

53. CCGs are not starting from the same position, with the most over target CCG (NHS West London) being 36% above target on a per capita basis and the most under target CCG (NHS Hounslow) being 12% below target on a per capita basis. Therefore any decision to move towards the new target formula must consider the issue of how quickly any transition can be achieved, taking into account the speed at which local health economies can invest or disinvest in services in a manner which ensures value for money and the ongoing sustainable operation of services for patients. The options examined by the review team are described below, and their impact is set out in the tables which follow. In each case, the same approach is taken in both years, with the descriptions below focussing on 2014/15 numbers unless otherwise stated.

54. The **first option** the review team has developed is a uniform growth scenario. In this scenario the core 2.54% funding uplift available to CCGs is applied consistently. In this option there is no pace of change. However, in the context of differential rates of population growth (from -0.15% to 2.48%), this is not a neutral decision, as funding per capita increases from as little as 0.1% to 2.6%, with half of those receiving increases of less than 1% being already underfunded by more than 5%.

55. Options two to four are all based on per capita allocations and take as their first step the adjustment of current resources for growth in expected population. In **option two**, 0.89% is consumed by population growth, leaving 1.66% for all CCGs. In terms of individual CCG £m allocations, the combination of variable population growth and a flat general increase creates a maximum uplift of 4.18% and a minimum uplift of 1.50%.

56. As a next step (**option three**) we have maintained the population growth uplift of 0.89% but sought to maximise the pace of change for the most underfunded CCGs. We have done this by limiting total growth in £m allocation for significantly (>5%) overfunded CCGs to 2.14% (real terms protection per GDP deflator) and differentiating the residual growth levels to reflect distance from target. This results in £300m being used for pace of change, reflected in 3.3% per capita growth for those 5% or more under target, reducing progressively to 1.22% for those less than 3% under target or over target but not subject to the cap.

57. For 2015/16 the approach is similar, but the reference point for capping growth for significantly overfunded CCGs is set at 1.7% (above the GDP deflator of 1.48% to reflect the specific challenges faced by all CCGs in 2015/16).

58. Under option three some CCGs, particularly those that are above target and have low population growth, can see very low absolute £m allocation growth. For instance, the CCG with the lowest population growth (-0.15%) sees total growth of only 1.07% in 2014/15. As a final step, (**option four**) we have introduced a floor, which would ensure that all CCGs see their total £m allocation grow by at least 2.14% (GDP deflator) in 2014/15 and 1.7% (above GDP deflator of 1.48%) in 2015/16. However, this reduces the resources available for the most under target CCGs. Pace of change funding is limited to £180m, and the maximum per capita growth falls to 2.64% in 2014/15. This approach seeks to balance the challenge of directing additional funding to those CCGs most under target on a per capita basis whilst managing the pace of any relative disinvestment required of others.

59. Finally, we have developed for comparison three scenarios showing an accelerated pace of change. These are:
    - **0-5%**: where CCGs most above target receive flat cash and those furthest below target receive 5% funding growth, with the position of the transition between the two determined by affordability until target is reached.
    - **Cap and collar**: where increases to CCGs more than 6.33% above target are limited to 0.89% in 2014/15 (matching average population growth). This rises progressively to 2.14% (in line with GDP deflator), which then applies for all CCGs within 5% of target, while CCGs more than 5% below target receive a real terms increase of up to 10% for the most underfunded CCGs.
    - **5 years**: where growth is set at a pace that, all else being equal, would bring each CCG to within 5% of target within 5 years.

60. The advantage of these three accelerated pace of change scenarios is that they increase the amount of funding available for the most underfunded, but they also significantly increase the required speed of disinvestment from overfunded CCGs.

61. In all scenarios we have assumed that the pace of change principles are consistent across 2014/15 and 2015/16, although the specific growth available for a particular distance from target does vary between years.

62. Tables 7-9 below set out the relative performance of each of the scenarios described above.

Table 7: Two year impact of pace of change scenarios on Distance from Target

		Number of CCGs and respective closing Distance from Targets after 2015/16						
		Uniform	Population based options			Accelerated pace of change options		
No of CCGs	2013/14 Current	Option 1	Option 2	Option 3	Option 4	0-5	Cap and collar	"Five years"
More than (5)% under target allocation	**51**	51	47	18	34	14	53	49
Between (5)% and 0% under target allocation	**55**	56	59	101	79	106	59	58
Between 0% and 5% over target allocation	**58**	55	68	57	60	76	76	52
More than 5% over target allocation	**47**	49	37	35	38	15	23	52
Total	**211**	211	211	211	211	211	211	211

Table 8: In year allocation maximum and minimum uplifts

Total Allocation Growth 2014/15	**Uniform**	**Population based options**			**Accelerated pace of change options**		
Percentage (%)	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**0-5**	**Cap and collar**	**"Five years"**
Maximum Increase	2.54%	4.18%	5.60%	4.92%	5.00%	10.00%	4.27%
Minimum Increase (Decrease)	2.54%	1.50%	1.07%	2.14%	0.00%	0.89%	-4.12%

Total Allocation Growth 2015/16	**Uniform**	**Population based options**			**Accelerated pace of change options**		
Percentage (%)	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**0-5**	**Cap and collar**	**"Five years"**
Maximum Increase	2.09%	3.60%	5.61%	4.49%	5.00%	4.93%	4.34%
Minimum Increase (Decrease)	2.09%	1.08%	0.50%	1.70%	0.00%	0.98%	-3.20%

Table 9: In year allocation distribution of increases

Total Allocation Growth 2014/15 & 2015/16 (Quantum)

	Uniform		Population based options						Accelerated pace of change options					
	Option 1		Option 2		Option 3		Option 4		0-5		Cap and collar		"Five years"	
Year / Model	14/15	15/16	14/15	15/16	14/15	15/16	14/15	15/16	14/15	15/16	14/15	15/16	14/15	15/16
No of CCGs receiving:														
More than real terms growth	211	211	171	202	78	113	77	211	112	100	50	184	187	195
Real terms growth uplift (2.14%/ 1.48%)	0	0	2	1	21	1	134	0	0	0	114	0	0	0
Less than real terms growth	0	0	38	8	112	97	0	0	99	111	47	27	24	16
Total	**211**	**211**	**211**	**211**	**211**	**211**	**211**	**211**	**211**	**211**	**211**	**211**	**211**	**211**

63. It is beyond ACRA's remit to provide any evidence regarding the pace a local health economy could disinvest or invest in a safe way in value for money terms.

64. A key consideration of the proposed approach to the CCG formula and pace of change is the impact it has on financially challenged health economies (see Appendix C for CCGs forecasting or at risk of a deficit at month 6). As funding becomes more constrained, there is already a pattern emerging between those CCGs which are under target and the financial performance of local health economies. Table 10 below sets out the link between funding in relation to target and the current financial position for CCGs and health economies

Table 10:- Current relationship between target allocations and challenged CCGs and health economies

	Total	More than 5% under target	Between 5-3 % Under target	Between 3 -0% under target	**All under target**	Between 0-3% over target	Between 3-5% over target	More than 5% over target	**All over target**
CCG at Risk	**37**	16	6	9	**31**	2	2	2	**6**
		43.2%	*16.2%*	*24.3%*	*83.8%*	*5.4%*	*5.4%*	*5.4%*	*16.2%*
CCGs operating where a provider is at financial risk	**84**	24	8	12	**44**	14	7	19	**40**
		28.6%	*9.5%*	*14.3%*	*52.4%*	*16.7%*	*8.3%*	*22.6%*	*47.6%*

- 16 of the 37 CCGs forecasting/at high risk of deficit are on average 5% below the proposed formula target.
- 31 of the 37 CCGs forecasting / at high risk of deficit are under target.

65. Table 11 considers the impact of the pace of change options for these financially challenged organisations and health economies.

Table 11: Pace of change scenarios and CCG financial resilience

Total Allocation Growth 2014/15

At Risk of Deficit' M06	Uniform	Populations Based Options			Accelerated Pace of Change		
	Option 1	Option 2	Option 3	Option 4	0-5	Cap and Collar	"Five Years"
Equal to or more than '5.00%	0	0	2	0	26	11	0
4.00% - 4.99%	0	0	12	6	2	2	1
3.00% - 3.99%	0	8	7	13	3	4	12
2.00% - 2.99%	37	28	9	18	1	18	24
1.00% - 1.99%	0	1	7	0	1	2	0
0.00% - 0.99%	0	0	0	0	0	0	0
Less than 0%	0	0	0	0	4	0	0
CCGs with link to distressed Trusts & FTs							
Equal to or more than '5.00%	0	0	5	0	36	18	0
4.00% - 4.99%	0	1	17	11	3	2	2
3.00% - 3.99%	0	17	8	16	9	4	18
2.00% - 2.99%	84	61	25	57	5	48	59
1.00% - 1.99%	0	5	29	0	5	2	4
0.00% - 0.99%	0	0	0	0	2	10	1
Less than 0%	0	0	0	0	24	0	0

66. The review team is recommending to the Board that it adopts either option three or option four as the preferred pace of change option on the basis that these options provide the best balance between the challenge of directing additional funding to those CCGs under target on a per capita basis whilst managing the pace of any relative disinvestment.

67. Based on the decisions made by the Board, the proposed allocation by CCG for 2014/15 and 2015/16 will be published before Christmas.

68. The Board is asked to consider whether option three or option four should be adopted as the preferred pace of change option for CCGs.

Primary care

69. Around 90 per cent of primary care funding is set through national contracts or national contractual frameworks, which leave limited scope for local health economies to respond to a change in the funding formula. The remaining

funding is generally linked to local contracts for services which allow greater scope for local changes in the profile of investment, but for which the pace of change needs to be reasonable and proportionate. While there is some scope to move towards the proposed target distribution, the pace of change for primary care funding will, therefore, need to be very measured, as reflected in the following proposals.

70. Table 12 below proposes the following pace of change for primary care. It is based on a minimum growth of 1.6%, with growth increasing in a linear fashion for Area Teams that are below target, so that Birmingham and the Black Country, the most under target Area Team, has a growth of 3.01%.

71. Primary care allocations are set at Area Team level. However in order to aid transparency and support local health economy planning, Area Teams will publish primary care locality budgets and will in particular need to account to local stakeholders for how the patterns of deprivation reflected in their allocation have been reflected in their investment choices.

Table 12: Primary care pace of change

	14/15 opening target		Distance from target	14/15 allocation		15/16 allocation		Closing distance from target
	15% SMR<75 weighting							
Area Team	£000	£ per head		£000	Growth	£000	Growth	
Cheshire, Warrington & Wirral	281,311	219	0.9%	289,137	1.91%	293,289	1.44%	0.8%
Durham, Darlington & Tees	289,892	234	2.3%	301,422	1.60%	305,040	1.20%	1.6%
Greater Manchester	671,894	230	(1.0%)	680,637	2.33%	693,111	1.83%	(0.5%)
Lancashire	344,848	224	(3.1%)	343,282	2.73%	350,618	2.14%	(1.7%)
Merseyside	307,526	244	(0.4%)	313,002	2.22%	318,003	1.60%	0.3%
Cumbria, Northumb, Tyne & Wear	458,842	228	(3.0%)	457,123	2.71%	466,780	2.11%	(1.6%)
North Yorkshire and The Humber	360,682	211	4.7%	383,531	1.60%	388,134	1.20%	3.9%
South Yorkshire and Bassetlaw	347,697	228	2.2%	360,996	1.60%	365,392	1.22%	1.4%
West Yorkshire	529,737	214	3.3%	555,764	1.60%	562,434	1.20%	2.2%
Arden, Herefordshire & Worcestershire	347,659	203	0.7%	356,918	1.95%	362,517	1.57%	0.4%
Birmingham and the Black Country	580,146	220	(4.6%)	570,244	3.01%	584,146	2.44%	(2.9%)
Derbyshire and Nottinghamshire	438,189	211	(1.7%)	441,295	2.47%	449,937	1.96%	(1.0%)
East Anglia	505,348	199	(0.4%)	514,376	2.22%	523,534	1.78%	(0.3%)
Essex	360,668	196	(3.8%)	356,865	2.87%	365,329	2.37%	(2.6%)
Hertfordshire and the South Midlands	561,131	195	(2.5%)	561,598	2.61%	573,818	2.18%	(1.9%)
Leicestershire and Lincolnshire	370,748	200	(0.8%)	376,318	2.29%	383,249	1.84%	(0.6%)
Shropshire and Staffordshire	338,281	210	(1.3%)	341,938	2.38%	348,264	1.85%	(0.6%)
London	1,843,602	197	2.8%	1,925,016	1.60%	1,949,795	1.29%	1.2%
Bath, Gloucester, Swindon & Wiltshire	289,426	188	0.6%	296,916	1.98%	301,595	1.58%	0.4%
Bristol, North Somerset, Somerset & South Glos	305,645	200	1.3%	315,130	1.79%	319,839	1.49%	0.6%
Devon, Cornwall and the Isles of Scilly	363,518	205	4.9%	387,398	1.60%	392,047	1.20%	3.9%
Kent & Medway	361,251	197	(1.5%)	364,563	2.42%	371,770	1.98%	(1.1%)
Surrey & Sussex	553,858	194	(0.3%)	564,158	2.20%	574,175	1.78%	(0.3%)
Thames Valley	399,022	181	(2.8%)	398,162	2.68%	406,845	2.18%	(1.9%)
Wessex	556,274	197	(1.1%)	563,225	2.34%	573,676	1.86%	(0.6%)
England	11,767,196	206		12,019,014	2.14%	12,223,337	1.70%	

2016/17-2018/19

72. Whilst this paper does not recommend any decisions regarding pace of change beyond 2015/16 we would anticipate further movement towards published target allocations for both CCGs and Primary care between

2016/17 and 2018/19. The pace of further movement will need to reflect the circumstances regarding the overall financial settlement for the NHS during this period. The 5 year planning process presents an opportunity for CCGs and Area Teams to begin aligning future expenditure to anticipated resources.

Assurance

73. During the last year our modelling has undergone an intensive quality assurance. This built on some of the processes that were recommended in the audit conducted last year. More importantly, the CCG target model has been through a rebuild both in the team and, for the key components, by an independent group of analysts. This has given us confidence that the model is robust and fit-for-purpose.

Bringing it all together

74. During its discussion on allocations in September the Board requested that a holistic analysis of the impact of decisions on allocations be brought together into an analysis at local health economy level.

75. Appendix D, using pace of change option four as an example, brings together the impact of the proposed changes in the CCG and primary care formulae at Area Team level, together with the public health allocations that have already been announced. In future analysis we would also ideally include changes to social care funding in this local area assessment; however the social care funding formula for 2014/15 is not yet available.

76. Appendix D demonstrates that the overall pattern of funding change follows the CCG formula. This is principally due to the relative weighting of CCG funding within the combined total.

Recommendations

77. The review team is recommending that the Board adopts the proposed funding formula for primary care as well as the changes to the funding formula for CCGs outlined above. In both cases an adjustment is proposed for unmet need to take into account NHS England's duties regarding inequalities. The proposed changes to the CCG funding model would allow NHS England to reflect population change more accurately and take account of unmet need in its funding allocations. These proposed changes are supported by ACRA. There is a significant variance in CCG funding on a per capita basis, some of which is justified and some of which is not. For this reason a greater degree of pace of change is required than in previous years in order to move the system towards equal access for equal need on a per capita basis. However, the recommended pace of change options aim to balance the need for movement in funding patterns with the imperative to maintain sufficient stability for local

health economies in order that they can invest and disinvest in a safe way in value for money terms.

78. The Board is asked to:

Overall Allocation

- Agree the proposed allocation of funds between commissioning areas of spend and the approach to allocation of running costs to clinical commissioning groups (CCGs)

Handling Inequalities

- Agree that NHS England should make a further adjustment for inequalities/unmet need when considering how to allocate funds
- Agree that this adjustment should be applied to the primary care and CCG formulae
- Agree that the quantum of the adjustment should be 15% for primary care and 10% for CCGs
- Agree that the metric used to make the adjustment should be SMR<75, weighted in a similar way to the local authority public health grant formula

Allocations to CCGs and Area Teams

- Agree that NHS England should introduce the proposed funding formula for primary care
- Agree that NHS England should introduce the proposed funding formula for CCGs

Pace of change

- Consider whether option 3 or option 4 should be adopted as the preferred pace of change option for CCGs
- Agree the recommendation regarding pace of change for primary care

Allocations

- Agree that the resulting allocations to CCGs and Area Teams for 2014/15 and 2015/16 should be published, together with the related target allocations.

Paul Baumann

Chief Financial Officer

December 2013

Appendix A: High level planning assumptions

This appendix sets out the core assumptions which have been used when calculating the cost pressures, used as part of the allocations exercise, on the key areas of NHS England spend.

Core pressures

The table below shows the % pressure against each allocations area for FY14/15. These pressures align to our Call to Action modelling.

		FY14/15 Core Pressures %									
	FY13/14	Demo-graphic	Non-Demo-graphic	Pay		NPND		Drugs		Other Price Pressure	
				Gross	weighted	Gross	weighted	Gross	weighted	Gross	weighted
	£bns	%	%	%	%	%	%	%	%	%	%
CCG Programme Costs	62.75	1.5%	0.9%	1.5%	0.9%	2.8%	0.5%	3.2%	0.6%	2.1%	0.1%
Social Care / Better Care Fund	0.86	-	-	-	-	-	-	-	-	-	-
Admin CCG Running Cost	1.35	-	-	-	-	-	-	-	-	2.1%	2.1%
Quality Premium	-	-	-	-	-	-	-	-	-	-	-
Specialised	12.96	1.7%	3.4%	1.5%	1.0%	2.8%	0.6%	14.0%	1.9%	2.1%	0.0%
Primary Care (to be allocated)	11.76	1.3%	0.6%	1.5%	0.8%	2.8%	0.3%	3.2%	0.0%	2.1%	0.8%
Primary Care (other budgets)	0.19	-	-	-	-	-	-	-	-		-
Other Direct Commissioning	0.43	1.3%	0.6%	1.5%	0.8%	2.8%	0.3%	3.2%	0.0%	2.1%	0.8%
Public Health s7a	1.71	-	-	-	-	-	-	-	-	-	-
NHS England Programme	0.98	-	-	-	-	-	-	-	-	2.1%	2.1%
NHS England Admin Running Cost	0.67	-	-	-	-	-	-	-	-	2.1%	2.1%
Other	0.12										
Total	93.78										

		FY15/16 Core Pressures %									
	FY14/15	Demo-graphic	Non-Demo-graphic	Pay		NPND		Drugs		Other Price Pressure	
				Gross	weighted	Gross	weighted	Gross	weighted	Gross	weighted
	£bns	%	%	%	%	%	%	%	%	%	%
CCG Programme Costs	64.34	1.5%	0.9%	1.6%	0.9%	2.7%	0.5%	3.3%	0.7%	1.5%	0.1%
Social Care / Better Care Fund	1.10	-	-	-	-	-	-	-	-	-	-
Admin CCG Running Cost	1.35	-	-	-	-	-	-	-	-	1.5%	1.5%
Quality Premium	0.20	-	-	-	-	-	-	-	-	-	-
Specialised	13.52	1.7%	3.4%	1.6%	1.1%	2.7%	0.6%	14.0%	2.0%	1.5%	0.0%
Primary Care (to be allocated)	12.02	1.2%	0.6%	1.6%	0.8%	2.8%	0.3%	3.3%	0.0%	1.5%	0.6%
Primary Care (other budgets)	0.28	-	-	-	-	-	-	-	-		-
Other Direct Commissioning	0.44	1.2%	0.6%	1.6%	0.8%	2.7%	0.3%	3.3%	0.0%	1.5%	0.6%
Public Health s7a	1.80	-	-	-	-	-	-	-	-	-	-
NHS England Programme	0.93	-	-	-	-	-	-	-	-	1.5%	0.1%
NHS England Admin Running Cost	0.54	-	-	-	-	-	-	-	-	1.5%	1.5%
Other	0.12										
Total	96.64										

Note: NPND:- non-pay, non-drugs.

- Demographic pressure - these have been calculated using ONS population projections and estimated resulting growth in cost.
- Non-demographic pressure – these have been calculated using historical activity trends excluding the element attributable to demographic growth.
- Pay – in line with anticipated pay settlement for 14/16 and 15/16. This has been weighted given the proportion of each area which is made up of pay.
- Non pay non drugs – based on historic trends, then weighted given the proportion of each area which is made up of NPND.
- Drugs - based on historic trends, then weighted given the proportion of each area which is made up of drugs.
- Other price pressure - for costs which could not be aligned to pay, NPND or drugs, a global inflation assumption of GDP deflator was used.

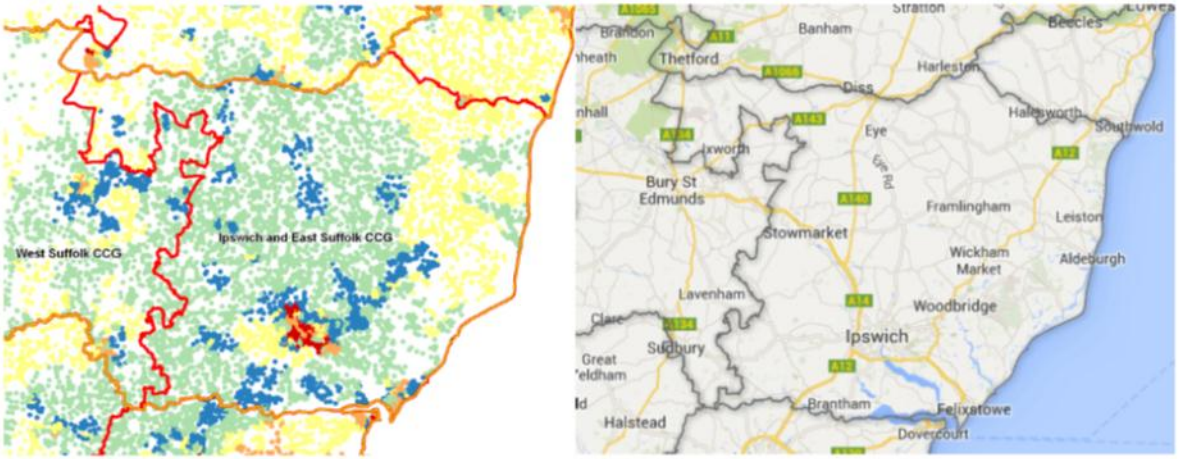
Other pressures

As well as the above core pressures, we have also included specific known pressures which would be outside of the above assumptions. These are:

- Mandate pressures where available have been included in the modelling. These are relatively small for CCGs in 2014/15 but include the BCF in 2015/16.
- Payment of provisions relating to continuing healthcare, estimated at c£250m, constitute a pressure on the funding envelope for CCGs in 2014/2015. In 2013/2014 these costs were met from non-recurrent funds.
- Specialised Services - we have included the 2013/14 structural deficit as an additional pressure in 2014/15.
- CCGs – we have included a £150m pressure for service development to fund acute providers through tariff on an interim basis to respond to the emerging additional pressures associated with the implementation of the Francis and Berwick recommendations.
- Pensions costs – in 2015/16 we anticipate a £400m pensions pressure. This has been included within allocations areas weighted by their pay bill.
- The planning guidance to be published in parallel with this paper refers to an expectation that CCGs will provide new funding for primary and community services centred on proactive and coordinated care amounting to at least £5 per head. However this has not been included as a pressure as it is assumed that it will lead to a reduction in emergency admissions.

In addition to the modelled pressures those commissioners who have not been able to create non-recurrent headroom in 2013/14, notably in specialised commissioning, will face an additional challenge in 2014/15.

Appendix B: Example Deprivation map



Deprivation Map - The map below (left) shows the levels of deprivation in and around this CCG, based on the Index of Multiple Deprivation 2010 (IMD2010). The IMD2010 is calculated at LSOA level, However, in this map each postcode (residential postcode centroids) within the same LSOA has been given the same colour, rather than shade the entire LSOA area. This presentation emphasizes where people live rather than open countryside. Taken from NHS England CCG information packs (2013) http://www.england.nhs.uk/ia-ccg-data/#ccg-info .
The Google Fusion map below (right), showing CCG boundaries, has been included to assist with orientation.

NHS Ipswich & East Suffolk CCG

The largely rural NHS Ipswich & Suffolk CCG is in decile 3 of IMD2010 score in England (moderately affluent). Moderate to high levels of affluence follow the market towns, extending in all directions from Ipswich - for example, Woodbridge, Stowmarket, Brantham, Framlington and Wickham Market. However, some parts of Ipswich have very high levels of deprivation.

"Ipswich has highly mobile residents with nearly 50% changing their household details every 4-years. There has been a decline in the rate of home ownership from 65.1% (32,450) households in 2001 to 57.3% (32,850) households in 2011. This is significantly below the rest of Suffolk average rate of 70.3% (178,250) households in 2011. As a result renting from private landlords has increased by 8.9% to 10,750 (18.8%) households over this period. 4,300 (7.5%) households in Ipswich contain lone parents which is 23.7% of the total in Suffolk. (42.5%) 1,850 of these households are unemployed which is a significantly higher rate than the rate for the rest of Suffolk (34.6%) 4,800. **According to the Index of Multiple Deprivation (2010) 26.6% (35,500) of the town's population lives within the most deprived fifth of areas in England, with Ipswich ranking 72nd out of 294 local authorities in terms of the extent of deprivation. 9 areas of the town are ranked within the top 10% most deprived areas nationally.** 7425 children live in households where no-one works."

State of Ipswich v2.0 2013 (Executive Report), Ipswich Borough Council - http://www.ipswich.gov.uk

Appendix C: List of CCGs forecasting/at risk of deficit – Month 6

Region	CCGs with planned deficits	CCGs with unplanned forecast deficits	CCGs with greater than >0.1% adverse variance on surplus plan in YTD or full year forecast with risk assessment that would move CCG into deficit	CCGs reporting on plan in YTD and full year forecast with net risks that would create a FOT deficit
North		Bury North Tyneside	Northumberland Warrington	Eastern Cheshire
South	Coastal West Sussex East Surrey Eastbourne, Hailsham & Seaford North Hampshire	North Somerset Oxfordshire South Gloucestershire	Surrey Downs	
Mids & East		Cannock Chase Stafford & Surrounds SE Staffs and Seisdon and Peninsular East Staffordshire Warwickshire North Cambridgeshire & Peterborough Luton Mid Essex Basildon & Brentwood Castlepoint and Rochford	Corby Southend South Worcestershire Thurrock West Essex	Solihull
London	Barnet Croydon Harrow Hillingdon	Haringey	Redbridge	Waltham Forest Bexley

Appendix D: Comparison of Primary care, CCG and public health

Note: CCG projections are based on option 4

	13/14 Baseline £000				14/15 Growth With SMR<75 adjustments			
Area Team	CCG	Primary Care	LA Public Health	Total	CCG	Primary Care	LA Public Health	Total
Cheshire, Warrington & Wirral	1,494,489	283,722	61,662	1,839,873	2.65%	1.91%	4.99%	2.61%
Durham, Darlington & Tees	1,569,082	296,675	99,039	1,964,796	2.14%	1.60%	2.80%	2.09%
Greater Manchester	3,405,133	665,127	170,745	4,241,006	2.34%	2.33%	6.70%	2.52%
Lancashire	1,869,866	334,160	88,224	2,292,250	2.14%	2.73%	3.01%	2.26%
Merseyside	1,761,721	306,197	96,836	2,164,754	2.14%	2.22%	2.80%	2.18%
Cumbria, Northumb, Tyne & Wear	2,616,254	445,052	107,132	3,168,438	2.14%	2.71%	3.85%	2.28%
North Yorkshire and The Humber	1,957,006	377,491	72,086	2,406,583	2.14%	1.60%	4.76%	2.13%
South Yorkshire and Bassetlaw	1,893,024	355,310	81,623	2,329,957	2.14%	1.60%	3.47%	2.10%
West Yorkshire	2,812,637	547,011	122,540	3,482,189	2.14%	1.60%	7.54%	2.25%
Arden, Herefordshire & Worcestershire	1,803,201	350,085	72,606	2,225,893	2.41%	1.95%	4.57%	2.41%
Birmingham and the Black Country	2,972,821	553,570	161,299	3,687,690	2.14%	3.01%	3.31%	2.32%
Derbyshire and Nottinghamshire	2,336,248	430,672	103,632	2,870,552	2.20%	2.47%	3.71%	2.30%
East Anglia	2,660,171	503,200	86,165	3,249,537	2.50%	2.22%	4.15%	2.50%
Essex	1,972,243	346,925	63,617	2,382,785	2.71%	2.87%	3.63%	2.76%
Hertfordshire and the South Midlands	2,814,812	547,321	96,552	3,458,685	3.53%	2.61%	9.26%	3.55%
Leicestershire and Lincolnshire	1,921,106	367,908	68,788	2,357,801	2.90%	2.29%	6.76%	2.92%
Shropshire and Staffordshire	1,772,124	333,982	71,576	2,177,683	2.14%	2.38%	3.82%	2.23%
London	9,721,467	1,894,700	553,472	12,169,639	3.07%	1.60%	4.34%	2.90%
Bath, Gloucester, Swindon & Wiltshire	1,582,475	291,155	49,158	1,922,787	2.41%	1.98%	6.25%	2.45%
Bristol, North Somerset, Somerset & South Glos	1,603,558	309,581	55,473	1,968,613	2.74%	1.79%	7.39%	2.72%
Devon, Cornwall and the Isles of Scilly	2,078,232	381,297	56,968	2,516,497	2.14%	1.60%	5.49%	2.13%
Kent & Medway	1,968,912	355,951	63,013	2,387,877	2.59%	2.42%	9.67%	2.75%
Surrey & Sussex	3,156,934	551,991	90,813	3,799,738	2.44%	2.20%	4.55%	2.46%
Thames Valley	1,983,999	387,784	67,333	2,439,116	3.48%	2.68%	7.49%	3.46%
Wessex	3,016,197	550,327	99,647	3,666,171	2.31%	2.34%	6.41%	2.43%
England	62,743,712	11,767,196	2,660,000	77,170,908	2.54%	2.14%	5.00%	2.56%