**Paper NHSE121403**

**BOARD PAPER - NHS ENGLAND**

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

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**Purpose of paper:**

- In December 2013 the Board approved allocations to the commissioning sector for 2014/15 and indicative allocations for 2015/16.
- The Autumn Statement on 3 December 2014 announced additional funding for front-line services and transformation amounting to £1.98bn, and this paper seeks the Board's approval for revised allocations for 2015/16 incorporating this increased resource.

**Summary:**

- The Autumn Statement announced on 3 December will enable NHS England to deploy £1.98bn of additional funding next year for frontline health services and to help kick start the transformation agenda set out in the NHS Five Year Forward View. This paper sets out detailed proposals for allocating these resources. These proposals suggest that:
    - £1.5 billion of the extra funding should be used to support frontline services, and £480 million should be used to support transformation in primary care, mental health and local health economies.
    - Primary care funding should be increased by at least as much as local CCG-commissioned community and hospital allocations.
    - The extra frontline funding routed via CCGs should particularly be used to move parts of the country furthest below their 'fair share' of NHS funding towards it at a faster pace than was possible under the previously notified 2015/16 allocations. This would be a pro-equity decision, and would be taken using the previously published weighted capitation formula with its additional health inequalities adjustments. This also has the

benefit of targeting extra NHS purchasing power to geographies with substantial deficit pressures on both the commissioner and provider side of the equation.

- To avoid the risk of any in-year top slicing of CCG allocations, specialised commissioning growth should be funded at a realistic level - while also, crucially, providing CCGs for the first time with the ability to share in-year savings in 2015/16 if they can help manage actual specialised services growth to below the budgeted amount (using the new joint CCG/NHS England specialised co-commissioning offer).

**Actions required by the Board:**

The Board is asked to:

- Agree the proposed allocation of funds between areas of commissioning spend;
- Agree the proposed methodologies for allocations to CCGs and primary care teams; and
- Note the impact of intended changes to commissioning scope and endorse our approach to supporting these.

## Background

1. At its meeting in December 2013 the NHS England Board agreed allocations for 2014/15 and 2015/16, noting that the latter might need to be amended to reflect the outcome of national contract negotiations and/or in the event of any significant update to the Mandate. The Board agreed to:
    - Set overall allocations on the basis of an equal scale of efficiency challenge over the two year period for the largest commissioning streams: CCGs and specialised commissioning;
    - Introduce new target funding formulae for CCGs and primary care;
    - Introduce an adjustment to both the CCG (10%) and primary care (15%) funding formulae to take into account unmet need and inequalities; and
    - Provide a minimum of real terms growth in funding for all CCGs, with higher growth for those furthest below target allocations.

## 2015/16 Mandate allocation

2. The provisional Mandate quantum for 2015/16 as at December 2013 was £99,900m[1], of which the recurrent amount allocated was £98,840m. Following further discussions with the Government, £1.98bn of additional investment in the NHS in England was announced by the Chancellor of the Exchequer in the Autumn Statement on 3 December 2014. This funding, described by the Chancellor as a "down payment" on the recently published *Five Year Forward View* is intended:
    - To kick start the transformational programmes set out in the Forward View through a year one budget of £200m;
    - To make a step change in primary and community care infrastructure through an investment fund of £250m for each of the next four years;
    - To increase from £80m to £110m the already planned investments in mental health access; and
    - To cover £1.5bn of funding pressures on front-line services.

3. The make-up of the additional funding is set out in Table 1, below.

[1] Excluding surplus to be carried forward to 2016/17

Table 1: Breakdown of additional funding in 2015/16

| | £m |
|---|---|
| Additional revenue funding to the NHS England Group | 1,755 |
| Additional capital allocation for primary/community care infrastructure | 75 |
| Efficiencies and reprioritisation of planned NHS England central expenditure | 150 |
| | |
| Total increase in spending power | 1,980 |

4. This leads to a revised Mandate quantum of £101,664m, which represents real terms growth of 1.6% - in line with the 1.5% real terms growth funding scenario set out in the Forward View. £100,604m is available for general allocation, with an additional £400m of historical surplus drawdown to be allocated separately and £660m available for Annually Managed Expenditure (e.g. provision movement) and technical budget (e.g. capital grant) requirements.

5. The revised funding envelopes are set out in Table 2 below.

Table 2: Revised NHS England Group Mandate Revenue Funding

| **£m unless specified** | **Per Dec 13 board paper** | | | | **Dec 14 Mandate updates** | |
|---|---|---|---|---|---|---|
| | 2013/14 | 2014/15 | 2015/16 | | 2014/15 | 2015/16 |
| **Allocation for distribution** | **93,779** | **96,642** | **98,840** | | **96,642** | **100,604** |
| *GDP deflator* | | *2.1%* | *1.5%* | | *2.1%* | *1.4%* |
| *Additional real terms growth* | | *0.9%* | *0.8%* | | *0.9%* | *2.7%* |
| | | | | | | |
| In addition | | | | | | |
| Winter resilience | 250 | 250 | | | 700 | |
| Reducing waiting list backlog | | | | | 250 | |
| Mental health system resilience | | | | | 40 | |
| Agreed surplus drawdown | 650 | 400 | 400 | | 400 | 400 |
| | | | | | | |
| Other adjustments | | | | | | |
| AME/technical | 660 | 660 | 660 | | 660 | 660 |
| | | | | | | |
| **Total revenue#** | **95,339** | **97,952** | **99,900** | | **98,692** | **101,664** |
| *GDP deflator* | | *2.1%* | *1.5%* | | *2.1%* | *1.4%* |
| *Additional real terms growth* | | *0.6%* | *0.5%* | | *1.4%* | *1.6%* |
| | | | | | | |
| Memo: | | | | | | |
| Initial plan surplus carryforward* | 534 | 467 | 67 | | 467 | 67 |
| Adjustment for previous year outturn | 333 | | | | 326 | 326 |
| Revised plan surplus carryforward | 867 | | | | 793 | 393 |

# Difference to published provisional 2015/16 Mandate revenue funding of £99,909m is due to roundings in the December board paper

* Surplus to be carried forward for future years was included in the Total Revenue Resource Limit in the December 2013 document but is shown here as a memo item to align with DH presentation of the Mandate and to reflect the fact that it cannot be drawn down for in year expenditure.

## Allocation of revised Mandate envelope

6. In deploying the additional funding we are seeking to fulfil the following objectives:
    - To create momentum in the implementation of Forward View strategies by creating a £200m investment fund to promote transformation in local health economies, with a particular focus on investment in the new care models set out in the Forward View document. The first year of this fund will allow us to pump-prime a number of test sites during 15/16. More detail on the arrangements for this fund will be set out in the planning document to be published shortly.
    - To deliver on the promise of a new deal for primary care by funding the first tranche of a £1bn four-year investment programme in primary and community care infrastructure, whilst also doubling the level of the Prime Minister's Challenge Fund to £100m and ensuring that the overall level of total funding growth for Primary Care is, for the first time in recent years, in line with that provided for other local services. Within this, core funding growth for local primary care service commissioning will be increased by 0.6% to 2.3%.
    - To provide a total of £110m additional funding for recent announcements on the introduction of mental health access standards and improvements to services for those with eating disorders (see paragraph 8 below).
    - To favour pace-of-change options for CCGs which accelerate progress towards our stated goal of bringing all CCGs receiving less than their target funding to within 5% of target by 2016/17[2] whilst also directing funding towards distressed health economies.
    - To provide full cover for expected cost growth (net of efficiencies) for each commissioning stream. *Inter alia*, this requires the elimination of the structural deficit in specialised commissioning, reflecting the rapid growth in these services. In turn this funding will provide CCGs with a credible opportunity to share in any financial benefits from managing activity growth through the 50/50 local CCG/NHS England specialised services gain share arrangement which we are proposing to introduce to encourage commissioners to work more effectively together across the patient pathway.
    - To enable earlier and more effective planning for seasonal resilience by including recurrent up-front funding of £400m in CCG, specialised and central allocations.
    - To reconfirm plans to deliver 10% cash savings in CCG and NHS England administration costs for redeployment to the front line.

[2] In this context, Board members will recall that the September 2014 NAO report *Funding Healthcare: Making allocations to local areas* concluded that the approach to allocating funding has been improved and is now generally robust but advocated faster progress in moving local areas towards their target allocations.

- To give CCGs priority access to the £400m drawdown available. The more accelerated pace-of-change options which we are now able to model should leave greater capacity to focus drawdown on strategic investments by CCGs. The arrangements for prioritising proposed drawdown will be set out in the planning document.

7. In the light of these objectives, Table 3 below sets out the proposed recurrent allocations by commissioning stream and the year-on-year growth this implies. A more detailed table is provided as Annex A.

Table 3: Proposed allocations by commissioning stream

| | 15/16 proposed allocation<br>£m | Budget growth on 14/15 baseline (cash)<br>% |
|---|---|---|
| CCGs | 69,212 | 3.4% |
| Primary Care | 12,826 | 4.1% |
| Public Health | 1,718 | 3.2% |
| Specialised | 14,634 | 8.4% |
| Other Direct Commissioning | 540 | 3.9% |
| NHS England Internal Budgets | 1,476 | -13.7% |
| Transformation | 200 | N/A |
| | | |
| **Total** | **100,604** | **4.1%** |

**2015/16 costs and pressures factored into modelling**

8. To inform the proposed allocations set out above, we have fully updated our assessment of projected costs and pressures. This now takes account of our latest financial plans, the Forward View, our assessment of policy and Mandate requirements, and the proposed 2015/16 National Tariff (including the introduction of a marginal rate for reimbursement of specialised services and an increase to the marginal rate for emergency services). Particularly significant elements of this modelling that the Board may wish to note are:
    - **Mental health:** NHS England is committed to work towards parity of esteem between mental and physical health services. As part of this wider effort, in 2015/16 NHS England will invest £80m to deliver waiting time standards for mental health services for the first time. £40m of this spending will be on Early Intervention in Psychosis services, and will, as set out in *National tariff payment system 2015/16 – a consultation notice*, be funded through local contracts, recognising that it will require a combination of improving services and increasing activity. The

remaining £40m is for improving liaison psychiatry services and reducing waiting times under the Improving Access to Psychological Therapies (IAPT) programme. This will be managed centrally and targeted towards those areas with greatest need. In addition, £30m of additional funding has been provided to improve treatment for children and young people with eating disorders, which will also be distributed on a national basis. The majority of mental health spending is in CCG allocations, where our expectation is that mental health spend will grow at least in line with overall CCG allocation growth.

- **Better Care Fund:** Changes to the delivery approach for the Better Care Fund (BCF) mean that at least £1bn of the £1.9bn additional NHS contribution to the BCF must be spent on NHS-commissioned services or linked to a reduction in total emergency admissions. The remaining £900m minimum additional CCG contribution to the BCF is included as a pressure in the CCG cost modelling.
- **Winter resilience and other non-recurrent funding:** The model takes account of £400m of cost pressure to allow for the fact that there will be no separate provision of seasonal resilience funding in 2015/16. £350m of this is attributable to CCGs. CCGs (and other relevant budget holders) will be required to show in their Operating Plans how this money will be deployed for maximum impact in the provider sector. The £250m for waiting list reduction was for non-recurrent purposes, and as such is not reflected in our pressures analysis or allocations.
- **Specialised services growth:** On top of a modest increase for routine growth and cost pressures (net of efficiencies and the impact of the new marginal rate included in the tariff proposals), the budget growth requirement reflects three main specific cost increases:
    - The current forecast deficit on specialised services has been funded through non-recurrent drawdown of historic surpluses. In 2015/16 this needs to be recognised in the starting position as recurrent activity. This is estimated at £368m including the full year effect of current year QIPP and investment programmes, equivalent to 2.7% of the 8.4% budget growth shown.
    - We have made a detailed assessment of drug cost pressures in specialised services, including the Cancer Drugs Fund. In addition, our analysis of the costs of new treatments which will become available in 2015/16 suggests there will be a significant increase above the trend rate of expenditure growth, owing to the approval by NICE of new treatments for conditions such as Hepatitis C. This represents 3.7% of the budget growth.
    - We have added a further £10m to our funding for the Commissioning through Evaluation scheme, which provides early access to promising new treatments prior to NICE evaluation.

- **Litigation costs:** Funding has been included in tariff to reimburse providers for a 35% increase in premia under the Clinical Negligence Scheme for Trusts (CNST) scheme, reflecting increasing claim rates and the unwinding of previous central subsidies. This affects both CCG and specialised commissioning costs in 2015/16.
- **Legacy continuing healthcare claims:** Annual funding of £250m was included in CCG allocations for 2014/15 to cover the cost of historic claims relating to continuing healthcare costs. This funding has been left in baselines for 2015/16, meaning that a further £250m is available for settlement claims next year.
- **Other direct commissioning:** The budget increase reflects specific policy requirements and the transfer of responsibilities from other Government departments.

## Allocation within commissioning streams

*CCG allocations*

9. In December 2013 the Board agreed to adopt the newly developed formula for CCG allocations (including a specific adjustment for unmet need and inequalities) and to allocate resources between CCGs so as to provide a minimum total funding increase of at least the GDP deflator (slightly higher in 2015/16) for all CCGs, with additional resources focused on those CCGs most under target. Increases for those more than 5% over their funding target were capped at the same level as the minimum increase. Over the two years, the number of significantly under-target CCGs was to drop from 51 to 34.

10. We are proposing to set three principles for the £1.1bn of additional programme funding to CCGs on top of the previously published allocations for 2015/16:
    - Firstly, no CCG should receive less funding in cash terms than was previously agreed in December 2013 (subject to any recurrent baseline changes agreed in 2014/15);
    - Secondly, all CCGs should receive at least real terms growth (1.4%, the revised GDP deflator) and their fair share of the now recurrent £350m resilience funding for CCGs on their recurrent baseline;
    - Thirdly, the remaining funding should be applied to accelerate the pace of change towards target allocations.

11. We have then shortlisted two options for consideration by the Board, the results of which are set out in detail in Annex B:[3]
    - Option 1: The extra money newly available for CCGs is distributed uniformly on top of the previously announced allocations in proportion to their unweighted population.[4]
    - Option 2: A funding floor of 1.94% is introduced, which is the combination of real terms growth and all CCGs receiving their fair share of the £350m resilience funding for CCGs. The additional resources are used to provide more resources for pace-of-change, allowing us to reduce the number of CCGs more than 5 percentage points below their target allocations from 34 to 17. There is also more scope to extend the range of CCGs receiving higher levels of growth, so additional resources are also provided for the moderately under target and slightly over target on a sliding scale.

12. We recommend that the Board adopt Option 2 on the basis that in this scenario:
    - All three principles set out above are met;
    - The number of CCGs who are more than 5% below target is halved (from 34 to 17); and
    - The number of under-target CCGs whose distance-from-target position deteriorates and over-target CCGs moving to an under-target position is significantly reduced. These (albeit relatively small) movements were an inevitable but unwelcome consequence of targeting limited pace-of-change funding on the most under-target CCGs in the December 2013 proposals, but can now be significantly reduced with the higher level of funding growth available.

*Health economy impact analysis*

13. The December 2013 paper set out the clear relationship between CCG deficits and distance-from-target. The conclusion that this needed addressing through accelerated pace-of-change was strongly endorsed by the National Audit Office in its recent report on *Funding Healthcare: Making allocations to local areas*, and the current relevance of the issue is reflected in the fact that 17 of the 18 forecast CCG deficits as at Month 6 2014/15 are in under-target CCGs.

[3] As is usual in the later years of a multi-year allocation cycle, we have not updated the CCG 2015/16 weighted population estimates, which determine the target share of resources for CCGs; both model parameters and data have been held as they were when indicative 2015/16 allocations were announced in December 2013. We are currently developing a project to develop a full model update, aiming at 2016/17 allocations.
[4] Subject to a number of individual CCG recurrent baseline adjustments agreed during 2014/15, which have been applied in all scenarios.

14. In assessing the options for CCG funding in this paper, we have considered the impact of the two main alternative approaches to pace-of-change on the economic position of the wider heath economies funded by the CCGs. We have looked in particular at the impact on those CCGs which operate in challenged economies. For a CCG's health economy to be classified as challenged, one (or more) of the following conditions has to be met:
    - The CCG itself is forecasting a deficit at M6;
    - One or more of the NHS Trusts and/or NHS Foundation Trusts commissioned by the CCG is forecasting a deficit of more than £5m at M6, or is in receipt of provider support or PDC support in 2014/15.[5]

15. Table 4 below illustrates the options associated with the allocation of the additional Mandate funding to the 211 CCGs. 107 CCGs have been identified as operating in challenged health economies. The recommended Option 2 results in an additional investment in these CCGs of £71m compared with the uniform uplift options. Thus it not only delivers additional monies directed towards CCGs under target (for equitable funding purposes) but also supports the objective set out in paragraph 6 above of directing funding where possible to those health economies under financial pressure (for sustainability purposes). The difference is more starkly delineated if the focus is limited to those CCGs who are under target and operating in challenged economies – where the financial status of the CCG is more likely to be a key factor in the difficulties facing the wider economy. Viewed in this way, Option 2 channels additional funding of £243m to these troubled economies compared to the neutral approach in Option 1 and, importantly, does so in a way which is entirely consistent with allocating commissioner resources equitably based on the needs of the populations they serve.

Table 4: Impact of CCG allocation options

| | Option 1<br>Distribution of additional resource | | Option 2<br>Distribution of additional resource | | Option 2<br>Variance from Option 1 |
|---|---|---|---|---|---|
| | £m | | £m | | £m |
| **All CCGs** | 1,100 | | 1,100 | | 0 |
| **All CCGs under target** | 654 | | 1,058 | | 404 |
| **CCGs in challenged economies** | 619 | | 690 | | 71 |
| **CCGs under target in challenged economies** | 402 | | 645 | | 243 |

[5] By establishing a £5m deficit bar we have sought to apply a materiality threshold and mitigate natural prudence in the M6 forecasts.

*Primary care allocations*

16. The recurrent baseline for primary care coming forward from 2014/15 is £12,074m, a net increase of £55m on the allocation of £12,019m made in December 2013 for the 2014/15 year. As in-year recurrent allocation adjustments are made in response to local commissioning decisions, they have not arisen equally across the country.

17. The proposals earlier in this paper would lead to a total allocation to local teams for primary care in 2015/16 of £12,352m. In deploying this resource we have maintained the indicative allocations for 2015/16 which were made in December 2013 for £12,223m and propose the following changes:
    - An adjustment to each geography to reflect the net change in their recurrent baseline made during 2014/15 (£55m);
    - A correction to the financial value of the unmet needs adjustment to reflect a minor error in its application identified subsequent to the 2014/15 allocation decisions (£13m);
    - A further increase in the allocation to local primary care teams in proportion to their unweighted populations (£61m).

18. The reason for this approach to the £61m is that, as set out last year, it is more appropriate to limit the pace-of-change within primary care because of the high value of contractual arrangements, which need to be influenced over a longer period of time than in other areas of commissioning. The distances-from-target are also much narrower than for CCGs.

19. Given that the direction of travel is to localise primary care commissioning as far as possible, we are not proposing to recalculate target and actual allocations based on the more consolidated sub-regional organisation being implemented for 2015/16, but rather to aggregate the allocations made to current Area Teams in order to create combined totals for each new NHS England commissioning geography.

20. The new primary care transformation funding announced as part of the Autumn Statement (£175m revenue in addition to £75m capital) is specifically for investment in infrastructure and will not form part of the recurrent baseline for allocation. We anticipate that, as this programme commences in early 2015, a prioritisation process will be adopted to assess individual primary care infrastructure schemes on their merits and allocate funding to commissioning teams on that basis, ensuring that capital and revenue investments are linked where appropriate.[6]

[6] The precise balance overall between revenue and capital funding requirements within the £250m annual fund will also be reviewed in the light of this process.

## Changes to commissioning scope

21. Over the last year NHS England, in collaboration with relevant partner organisations, has announced potential or agreed changes to the scope of primary care, specialised services and public health commissioning responsibilities. These are not reflected in the allocations discussed elsewhere in this paper and will require updated allocations once final decisions have been made. The Board is asked to note the following:
    - CCGs are due to return expressions of interest in primary care co-commissioning in January 2015. For those CCGs who opt for the delegated option, we have agreed that the budget for general medical services will be delegated to them as part of their overall allocation. In order to support co-commissioning on a wider scale we will publish a breakdown of notional primary care allocations for each CCG.
    - The Prescribed Specialised Services Advisory Group (PSSAG) recommended to Ministers the transfer of four services from specialised commissioning to CCGs in 2015/16, with final decisions to be made following the end of the current DH consultation period in January.[7] We are working with specialised commissioners to develop accurate allocations for these services at CCG level based on uplifted historic expenditure in a way that is accurate and fair, and these will be added to core CCG allocations as appropriate depending on the post-consultation decision. We will also publish notional allocations of remaining specialised commissioning expenditure attributable to each CCG to facilitate the proposed 50/50 gain share arrangements with CCGs at commissioning hub level.
    - We have agreed to transfer to local authorities responsibility for the 0-5 age group within the Section 7A agreement covering public health services. This will take place on 1 October 2015, and in advance the Department of Health will reopen the Mandate funding limits to remove an estimated £422m from the Section 7A allocation to reflect the change in responsibilities.

## Next steps in development of allocation formulae

22. The allocations work programme is aiming to develop a "place-based" allocation process at CCG level for primary care, CCG and specialised commissioning streams for 2016/17, including the development of enhanced formulae for this purpose. Work is also continuing to improve our understanding of health inequality impacts with a view to updating our approach to unmet need adjustments as appropriate. As previously agreed, we are also reviewing potential methodologies for addressing the additional

[7] The four services are renal dialysis, morbid obesity services, specialist wheelchairs and GP-referred neurology outpatients

costs faced by rural areas. Whilst rural deprivation issues are picked up in the CCG formula through the adjustment for unmet need based on the Standardised Mortality Rate under the age of 75[8] and there is a specific adjustment to the ambulance funding formula to reflect the challenges of rural geographies, there is a prima facie case for a more comprehensive approach to adjusting for rurality/sparsity, and we will therefore make this a priority within our development programme over the coming year.

23. As previously discussed, we would like to move to multi-year allocations from 2016/17 and in the Autumn Statement, the Government has announced its support for such multi-year budgets as soon as possible after the Spending Review.

## Recommendations and next steps

24. The Board is asked to:
    - Agree the proposed allocation of funds between areas of commissioning spend;
    - Agree the proposed methodologies for allocations to CCGs and primary care teams;
    - Note the impact of intended changes to commissioning scope and endorse our approach to supporting these.

25. Subject to the decisions made by the Board, we intend to publish allocations at CCG level for CCG programme costs in the coming week. Allocations for running costs for CCGs were published last year [http://www.england.nhs.uk/2014/02/06/costs-allowances/] and are unchanged. We will publish the allocations for primary care at the same time, including notional allocations at CCG level. We will also publish an analysis of specialised services allocation / expenditure by CCG, and this will be followed in due course by a quantification of the impact of any ministerial decision to transfer services to CCGs as outlined in paragraph 21.

[8] 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.

## Annex A: Detailed commissioning stream analysis

The table below shows the more detailed breakdown of allocations underlying table 3 in the main paper.

Table A1: Proposed allocations by detailed commissioning stream

| | 15/16 indicative allocation<br>£m | 15/16 proposed allocation<br>£m | Budget growth on 14/15 baseline (cash)<br>% |
|---|---|---|---|
| CCG Programme Costs | 66,787 | 67,887 | 3.7% |
| CCG Admin | 1,215 | 1,215 | -9.7% |
| Quality Premium | 200 | 110 | N/A |
| **CCGs (sub-total)** | **68,202** | **69,212** | **3.4%** |
| Primary Care (to be allocated) | 12,223 | 12,352 | 2.3% |
| Primary Care (other budgets) | 276 | 473 | 90.5% |
| **Primary Care (sub-total)** | **12,499** | **12,826** | **4.1%** |
| Public Health | 1,796 | 1,718 | 3.2% |
| Specialised | 14,330 | 14,634 | 8.4% |
| Other Direct Commissioning | 447 | 540 | 3.9% |
| Mental Health (held centrally) | 0 | 70 | N/A |
| Winter Resilience (held centrally) | 0 | 39 | N/A |
| NHS England Programme | 960 | 828 | -10.8% |
| Other | 120 | 53 | N/A |
| NHS England Admin | 486 | 486 | -7.6% |
| NHS England Internal (sub-total) | 1,566 | 1,476 | -13.7% |
| Transformation | 0 | 200 | N/A |
| **Total** | **98,840** | **100,604** | **4.1%** |

## Annex B: CCG allocation option analysis

The table below shows the results of the options for CCG allocations considered in the main paper.

Table B1: CCG allocation option results

| | | | Options | |
|---|---|---|---|---|
| | | **Published** | **1** | **2** |
| DfT distribution | <-5% | 34 | 36 | 17 |
| | -5% to -2.5% | 42 | 40 | 46 |
| | -2.5% to 0 | 37 | 37 | 60 |
| | 0 to +2.5% | 22 | 27 | 38 |
| | +2.5% to +5% | 38 | 32 | 23 |
| | >5% | 38 | 39 | 27 |
| | | | | |
| Programme growth | Maximum | 4.49% | 6.49% | 8.03% |
| | Mean | 2.09% | 3.74% | 3.74% |
| | Median | 1.70% | 3.40% | 3.33% |
| | Minimum | 1.70% | 2.93% | 1.94% |
| | # within 0.1% of minimum | 140 | 8 | 79 |
| | | | | |
| Per capita growth | Maximum | 2.33% | 4.41% | 5.98% |
| | Mean | 1.21% | 2.85% | 2.85% |
| | Median | 1.11% | 2.69% | 2.46% |
| | Minimum | -0.63% | 0.99% | -0.39% |