NHS England

Financial Allocations 2016/17 - 2020/21

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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1 Contents

1 Policy statement 5
2 Allocation Rules 7
2 CCG formula 8
3 Primary Care (Medical) formula 8
4 Specialised formula 9
5 Pace-of-change 10
6 Results 12
7 Next Steps 13
ANNEX 1: Five Year Allocations – Circumstances for Review 14
Annex 2: A Guide to the Detailed Allocation Sheets 15

1 Policy statement

1. This document supports the publication of the detailed financial allocations for CCGs and commissioning areas for the period 2016/2017 to 2020/2021. It should be read in conjunction with the allocations board paper from December 2015 which is available on the NHS England website at https://www.england.nhs.uk/wp-content/uploads/2015/12/04.PB_.17.12.15-Allocations.pdf. The board paper includes greater detail on the allocation of resources to each commissioning stream and the development of the target formulae.

2. Our overall policy approach in this area is based upon achieving:

- Greater equity of access through accelerating alignment of allocations with target formulae with the result that:
    - in 2016/17 all CCGs are no more than 5% under target for CCG commissioned services;
    - in 2016/17 all CCG areas are no more than 5% under target for the total commissioning streams for their population; and
    - a three year transition to a similar position for primary medical care allocations is achieved.

- Closer alignment with population need through improved allocation formulae with the introduction of:
    - a new inequalities adjustment for specialised care and more sensitive adjustments for CCGs and primary care;
    - a new sparsity adjustment for remote areas.

- Faster progress towards our strategic goals through:
    - higher funding growth for GP services and mental health;
    - the introduction of a Sustainability and Transformation Fund, with a focus in 2016/17 on restabilising the NHS and a priority in subsequent years of accelerating transformational investment.

- Developing place-based allocations to support holistic collaborative and/or delegated local commissioning where this benefits patients.

- Stronger long-term collaboration between commissioners and providers stimulated and enabled through:
    - shared operational and strategic planning supported by visibility of projected commissioning resources by locality for the next five years, coupled with forward guidance on key tariff parameters in the planning guidance;

  - aligned incentives for effective integrated strategic planning;
  - opportunities to pilot shared financial control totals.

3. As set out in the December board paper, we are publishing three years of firm allocations (2016/17-2018/19) and two further years of indicative allocations. Whilst it is our intention that the firm allocations will not be reopened, there are a number of exceptional circumstances where this may prove necessary, and these are set out in Annex 1.

4. In looking at the specific allocations, there are two key drivers behind the differential growth funding for a locality/CCG: the progressive reduction of the distance between current funding and the target allocations which reflect the best possible estimation of both met and currently unmet need; and ensuring that all areas are funded appropriately for their expected population growth. These objectives are subject to further protections designed to ensure that allocation changes do not destabilise individual local health economies.

5. At the outset it is important to note that the establishment of a target allocation is only part of the allocation process. A specific allocation is also informed by historic expenditure in an area, and the key decisions are about how much growth to give to any area to bring them closer to target. It is accepted that it will never be possible to ensure all areas are at target. The continuing development and refinement of the formulae through the use of more relevant and timely data, combined with the use of updated assumptions for demographic changes, means that the actual value for a target will change over time.

6. We have therefore developed the pace of change policy for 2016/17 in the light of the established policy that an allocation within 5% (over or under target) is deemed to be reasonable and within appropriate statistical boundaries to conclude that an area is appropriately funded to meet health need. This means we have adopted an allocation approach which particularly targets those areas outside of the plus or minus 5% boundary. Within this range, individual growth rates and pace of alignment with target allocations will reflect a number of factors, including the precise mix of historic expenditure in relation to the individual commissioning stream targets and the minimum growth protections mentioned above. This inevitably brings an element of complexity to the interpretation of individual allocations, and NHS England Finance teams will support CCG colleagues as required to understand the detail and implications of their allocations.

2 Allocation Rules

7. In this section we describe a number of improvements we have made to the formulae which determine target allocations and our approach to pace of change.

Inequalities

8. One of the ways in which NHS England looks to meet its legal requirement to reduce inequalities in healthcare provision is through its approach to allocations.

9. In previous years we have developed a core methodology and approach to achieving this, including appropriate adjustments to target allocations. In line with the recommendation of the Advisory Committee on Resource Allocation (ACRA), we have established that the Standardised Mortality Ratio for those aged under 75 (SMR<75) is the best indicator of unmet need, and thus current inequality in the provision of healthcare services. We also previously agreed a 15% adjustment within primary care and a 10% adjustment within CCG funding to meet these requirements.

10. This year we have undertaken a comprehensive literature review to investigate whether the evidence base has changed. Whilst work by Ben Barr from the University of Liverpool and colleagues show the benefit of targeting investment at areas with high levels of deprivation, evidence about the impact of additional investment based on inequalities is inconclusive, particularly in relation to the scope for marginal return and thus how much to invest.

11. We are therefore keeping the inequalities adjustment at current levels for CCGs and for primary care. In introducing a new target formula for specialised services (see below) we are introducing a 5% unmet need adjustment for specialised services on the basis that we would expect unmet need and the potential to impact on inequalities to be lower in this area.

12. We have also reviewed our methodology. We are adopting ACRA's recommendation that the application of the inequalities adjustment should move from a 10 tier to a 16 tier approach that better targets areas with the highest levels of deprivation. ACRA is planning to recommend a similar change to the public health formula used by Public Health England.

Population

13. Population figures for all programme allocations continue to be based on GP list sizes, now updated to October 2015. Increases for future years are based on trends estimated by the Office of National Statistics[1].

14. Using GP lists as a basis for the allocations requires these lists to be materially accurate. Following the allocation of funds in 2015/16, further list updating activity has been undertaken in all regions and is reflected in this allocation setting process. This programme of work will continue over the next three years and potentially inform any update to the proposed allocations for 2019/20 and 2020/21. Before any adjustment is made to reflect unexpected population growth in future years (as set out in the footnote to the preceding paragraph) we will require a full analysis of the reasons for the growth to ensure confidence in the local list updating procedures.

2 CCG formula

15. For this round of allocations the core structure of the CCG formula remains the same, but all underlying data have been updated. This means that the activity data used in the model have been brought forward by 4 years and model parameters re-estimated.

    We are making the following changes to the formula in addition to the strengthening of the inequalities adjustment set out above:

- introduction of a sparsity adjustment;
- refresh of the emergency ambulance cost adjustment (EACA).

These adjustments have been reviewed and agreed by ACRA and are set out in detail in the December board paper

3 Primary Care (Medical) formula

16. The existing allocation model for primary medical care is based on the contractual formula that is at the heart of the General Medical Services (GMS) contract, usually referred to as the Carr-Hill formula. This model has been frequently criticised in this context because it was developed more than ten years ago and is based on data that are around fifteen years old.

[1] Whilst many local authorities compile more detailed future population projections, the methodology is not consistent and this means they cannot be brought into a national formula. Hence areas of disproportionally high anticipated growth may be adversely impacted if the ONS does not fully capture this in its assumptions. To mitigate this risk we will review actual changes in population annually to see if any CCG is given an unfair or disproportionate challenge for this reason, and adjust if required.

17. The key change we are making to the primary medical care formula is the inclusion of new estimates of stratified workload per patient for GPs based on 2 million patient records from the Clinical Practice Research Datalink 2014. The previous data were based on information from 1999-2002. This has allowed us to re-estimate the importance of key drivers of primary medical care activity. We have not changed the way we then use these updated estimates to model the consequential cost variation.

18. ACRA has endorsed these changes but has been clear that this is for allocation purposes only and does not in itself imply any particular adjustments to GMS contracts. Work is underway to update the formula to influence such payments for subsequent years while ensuring that any future change to payment formulae is synchronised with the allocation formula developed here.

19. The key impacts of the changes are to reveal an increase in the relative need for primary medical care in London and to reduce the range of the most extreme relative needs in the model, two of the most common criticisms of the Carr-Hill model.

20. Only primary medical care is included in our place-based commissioning allocations by locality, as other areas of primary care (principally community pharmacy, dentistry and optical services) are not currently within the scope of collaborative commissioning, and the allocation formulae are not yet sufficiently robust to use for individual CCG geographies.

4 Specialised formula

21. The analysis of the specialist service budget at a CCG level is not, in itself, intended to result in the transfer of responsibility for commissioning, but it will promote equitable allocations by reflecting differential utilisation of specialised services in the overall balance of allocations through pace-of-change, support greater understanding and transparency and facilitate collaborative commissioning between CCGs and NHS England where appropriate.

22. A needs-based specialised formula has been developed, using a similar approach to the CCG formula (Person Based Resource Allocation). Specialised services are represented variably in the source data used for modelling (SUS-PbR). Only categories of care with a reasonable level of coverage are used in estimating or applying the target formula. This covers c.50% of all specialised services spend. The remaining services have been included within the target for each CCG geography based on historic expenditure. This historic expenditure analysis has been strengthened over the last 18 months, including a number of detailed review and updating procedures designed to build confidence in its validity for use as part of the

allocation process. The inclusion of a historic spend element within the formula also at this stage dampens some of the issues identified in the current pattern of specialised service utilisation and needs-based projections of utilisation.

5 Pace-of-change

23. In previous years the NHS England Board has agreed a pace-of-change policy that has sought to:

- bring all CCGs to target funding over time and specifically bring all CCGs within 5% of target as quickly as possible (in 2015/16 we halved from 34 to 17 the number of CCGs who were more than 5% below their target funding); and
- bring all primary care geographies to target funding over time.

24. Key additional considerations for the Board have included:

- the minimum floor growth we can expect any geography to manage without short term destabilisation of service provision;
- the pace at which over target geographies can adjust their spending to their needs based target; and
- the maximum growth that any geography can invest in a value for money way in a given year.

25. To date, discussions regarding pace-of-change have predominantly focussed upon CCG allocations. With the development of primary medical care and specialised formulae at CCG level we are now able to take a more holistic view of pace-of-change at a place- (or local health economy) based level.

26. Our pace-of-change policy for this allocation round is based upon a hybrid approach. This focuses on alignment with holistic place-based targets but subject to applying rules limiting the volatility and unintended consequences in individual commissioning streams.

27. The following high-level steps are taken to implement the hybrid approach:

    i. we apply funding at each commissioning stream level to meet specific rules for minimum growth and caps in line with the policies set out above;
    ii. any funds that are not needed to meet these commissioning stream aims are then used to support pace-of-change for the place-based allocation;
    iii. any additional funding which a CCG area accrues in step ii. is then redistributed back to the allocations for the CCG and primary medical care commissioning streams.

28. The rules for the initial allocations to individual commissioning streams (referred to as “minimum allocations”) are set out in table 2 below and build on the principles agreed by the Board for the allocations for 2015/16:

Table 1: pace-of-change allocative decision rules by commissioning stream

	Allocative decision rules
CCG	• no CCG is more than 5% below target; • all CCGs receive a minimum per capita growth that is equivalent to real terms cash growth at the average population growth (in 2016/17 this equates to 0.91%, being 1.66% GDP deflator less 0.75% average population growth) ; • all CCGs receive a minimum cash growth equal to real terms growth plus specific non-routine policy pressures (predominantly relating to pensions and 7 day services); unless • the CCG is more than 10% above target, when its cash growth is limited to the specific policy pressures. This cap is phased in between a DfT of +5% and +10%.
Primary care medical	• a minimum allocation is set that ensures maximum progress is made towards ensuring no locality is more than 5% below target, constrained by allowing no CCG area more than 10% per head growth in this step of the process; • all CCG areas receive a minimum per head growth that is equivalent to real terms cash growth at the average population growth (as defined above); and • all CCG areas receive a minimum cash growth equal to real terms growth plus specific policy pressures; unless • the CCG area is more than 10% above target, when its cash growth is limited to specific policy pressures plus 1%. This cap is phased in between a DfT of +5% and +10%.
Specialised	• all CCG areas receive the same per head uplift that utilises all the resources allocated to this stream, ensuring that at a national level the allocated funds for NHS England specialised services are maintained and to mitigate any risks relating to the target formula as described above.

29. Focus then turns to the total of these three streams. The total allocation to each locality must at least meet the sum of the three minimum allocations (CCG core, primary medical care and specialised). The remaining available growth is used as follows:

- we ensure that the total allocation to each locality is no more than 5% below target;
- as for the individual streams, total allocations must in aggregate follow the relevant minimum and maximum growth rules; and
- any remaining funds are channelled into pace-of-change aimed at bringing under target areas closer to target.

30. The additional resources are distributed back across the CCG and primary medical care commissioning streams as follows:
- where the minimum CCG core allocation is below target and the minimum primary medical care allocation is above target, any available resources are used to bring the CCG allocation as close as possible to target. If the opposite applies, the resources are focused on the primary medical care allocation;
- if resources remain after this step, or if the minimum allocations are both above or both below target, resources are distributed to move both individual allocations the same number of percentage points towards their respective target allocations.

Better Care Fund

31. Better Care Fund projections at CCG level for 2016/17 have been included in CCG Allocations and are shown in the detailed worksheets described below. Information regarding years after 2016/17 will be published alongside the strategic planning guidance in due course.

Running Cost Allocations

32. CCG running cost allowances for England as a whole will remain flat to 2020/21, as determined by HM Treasury's Spending Review settlement. Individual CCG allowances have been rebased to adjust for changing share of population and are shown in the detailed worksheets described below.

6 Results

33. We publish the financial allocations for 5 years alongside this document in two formats:
    i. Detailed worksheets for each year covered by these allocations, showing the key data for each of the following commissioning streams:
        - Total Place (being the combination of the streams below by CCG geography);
        - CCG;
        - Primary Medical Care; and
        - Specialised Care.
    ii. Allocation summary statements showing the key data for each CCG geography on a single page.

34. In Annex 2 to this paper we provide guidance on these sheets, explaining the various terms and data sources used.

35. A set of Frequently Asked Questions has also been developed and is available alongside this document. This covers both technical issues and wider implications and will be regularly updated.

7 Next Steps

36. We intend to publish the detailed technical supporting papers behind the development of these target formulae and outputs by the end of February 2016.

37. As set out in the board paper we will continue to develop our approach to allocations. In particular we plan to undertake further work in the following areas:
    - community service provision, where lack of reliable robust data currently prevents detailed needs-based modelling, as well as updating the mental health services component of the model and continuing our developmental work on the impact of sparsity;
    - further development of our approach to allocations for Primary Care (non-medical) services; and
    - supporting the completion of ACRA's review of the methodology adopted for specialised services.

ANNEX 1: Five Year Allocations – Circumstances for Review

We are giving three year firm allocations with a further two years of indicative allocations to assist planning.

However, NHS England may need to change firm allocations in a number of specific exceptional circumstances, particularly if the financial stability of the commissioning system is challenged or it becomes clear that the allocations are no longer fair in their distribution to health economies. These potential circumstances include:

- a disproportionate financial imbalance in any part of the commissioning system;
- a new government policy with additional funding creating an additional pressure in one area;
- a disproportionate increase or decrease in the share of the national population caused by a change to underlying population statistics;
- a new national contract or pay award established by Government that requires additional funding or redistribution of resources; and
- any other significant change in mandate funding.

NHS England may also need to review allocations in the light of:

- changes to commissioning responsibilities (e.g. relating to the identification rules for specialised services);
- the need to ensure minimum contractual growth to GP practices through the primary care allocations; and
- changes to payment currencies which cause significant shifts in funding pressures between commissioning streams (for example in the context of the planned move to HRG 4+ in 2017/18).

Annex 2: A Guide to the Detailed Allocation Sheets

Note: These definitions cover the detailed allocation worksheets but are also applicable to the 1-page summaries provided.

Total place-based allocations

The tables cover the total allocation for the place, incorporating the CCG, primary care (medical) and specialised services commissioning streams. There is a separate table for each of the five years of allocations (three years of firm allocations and two years of indicative allocations).

Baseline or 2015-16 position

Column 1 shows the 2015-16 allocation as published in December 2014. This has been updated in column 2 to reflect in year agreed adjustments and add in the previously separate allocation of resources for contribution to the BCF and GP IT funding. These are based on the Month 7 position. This is the starting point for our allocations.

Column 3 shows the distance between this allocation and the target based on the revised CCG formula.

2016-17 position

The next group of columns shows how the 2016-17 allocations are built up.

Column 4 shows the opening distance-from-target (DfT). This is distance from target of the CCG area using the 2016-17 target distribution, but if no further money was allocated. Population changes between the years mean that this does not sum to zero: the population in 2016-17 is higher than in 2015-16 and so the average per capita allocation in 2016-17 is lower than in 2015-16. It is this per capita DfT that drives the pace-of-change algorithm, as it allows us to more explicitly build population change in to the approach. The opening distance from target is calculated as the difference between the opening allocation and opening target. Opening allocation is the previous years' per head cash allocation. This is not adjusted for any population changes between the years. Opening target is calculated using the prior year national total quantum, distributed using the current year populations and target distribution. This results in the overall national opening distance from target being positive.

We need to ensure that the total allocation has at least sufficient resource to meet the commitments associated with the individual commissioning streams as set out in para 28 above (e.g. for CCG allocation no CCGs being more than 5% below target). The minimum funding to achieve this is shown in column 5.

Relevant caps for over target areas are also reflected in this number Column 6 shows the growth to achieve this minimum position in percentage terms.

As noted above, additional funds can be allocated to CCG areas based upon their overall DfT at a place level. The combined impact of the minimum allocation and this additional allocation are shown in columns 7 and 8 for the total allocation, and 9 and 10 for the per capita allocation.

Column 11 shows the closing distance-from-target for that year: an estimate of how close that place's funding is to the fair shares formulae in that year based upon the actual total allocation (column 7). Comparing columns 11 and 3 gives an indication of how the position of the place has changed as a result of the implementation of the allocation policy.

Opening and closing distances-from-target are not comparable; however, it is possible to compare across years the trends in either opening or closing DfTs.

Columns 12 and 13 provide two supporting fields. Column 12 is the minimum contribution to the BCF from the CCG area. This is included in the allocation shown at column 7. Column 13 shows our estimate of the registered population for 2016-17.

Later years

Columns 14-49 show the position for 2017-18 to 2020-21 inclusive, using the same definitions.

CCG allocations and Primary Medical Care

The CCG allocation tables follow a very similar format. The key difference is that columns 5 and 6 show the allocation that the CCG requires to meet the financial policies for the CCG commissioning stream set out in paragraph [28] of this paper (such as minimum distance-from-target and minimum programme growth). Columns 7- 11 then show the allocation after any additional growth from the place-based DfT adjustment has been made as set out in paragraphs 29 and 30. It is column 7 that is the actual allocation for 2016/17.

Column 12 in the CCG table repeats the minimum Better Care Fund contribution from the total allocation table. As before, this is included in the allocation at column 7. The Primary Care (Medical) tables follow the same format as for CCGs, but neither BCF nor CCG management cost is relevant.

For subsequent years the same structure is repeated, with the omission of the BCF minimum contribution.

Running Cost Allowances by CCG are included as Annex 1 to the Frequently Asked Questions, published alongside this document.

Specialised Services

These follow the same format as for Primary Care (Medical) for consistency. However, in line with the methodology set out earlier in this paper, there is no additional allocation as a result of the place-based pace-of-change adjustment, so columns 5 and 7 contain the same figures.