Frequently Asked Questions – Technical Briefing

Q1. This appears to be very complex. Is there a simple way to describe the policy?

The allocations are necessarily complex, as they cover three interlinked areas of commissioning across five years and are seeking to deliver ambitious aims with resources which are very constrained by historical standards. However, the key objectives we are tackling in these allocations are relatively simple:

1. to create greater equity of access and give equal chances of success to all health communities, in particular by rapidly addressing the most significant cases of underfunding, both at CCG and at 'total place' level;
2. to support the "stabilisation" of NHS finances, particularly in 2016/17;
3. to maximise the resources dedicated to transformational investment behind Five Year Forward View priorities and;
4. to support integrated planning and holistic collaborative commissioning within local health economies whilst ensuring that the resources available to each individual area of commissioning are adequate for their separate accountabilities.

Q2. How can I check my baseline is correct?

The baselines are derived from agreed 2015/16 allocations as updated at Month 7. In a small number of cases it has been necessary to make minor adjustments, and if CCGs cannot immediately reconcile these numbers, they should contact their local NHS England finance director in the first instance.

For CCG baselines we have used the Month 7 Inter Authority Transfer as adjusted. Specialised and primary care (medical) baselines are derived from detailed analysis of current expenditure by CCG population undertaken by the relevant NHS England finance teams.

Q3. How do the amounts shown in these documents for CCGs, Primary Care (Medical) and Specialised Services relate to the numbers in the December 2015 Board Paper on Allocations (Table 2)?

The vast majority of the budgets in these areas are directly allocated to individual geographies through the core allocations process, the output of which is shown in the documents published on 8 January 2016. The exceptions to this are set out below for each area of commissioning:

- CCGs: Quality Premium (£90m in 2016/17) is awarded to CCGs through a separate process reflecting their achievement of the key performance metrics in the preceding year. It is therefore not included in the CCG programme and running cost allocations shown here.
- Primary Care (Medical): The amounts shown in the board paper include a number of budgets, mainly related to transformation and infrastructure

improvement programmes, which are held centrally and allocated to local health economies through specific individual processes. In 2016/17 these amount to £319m of the total Primary Care Medical budgets of £7,652m, leaving £7,333m to be included in the core allocations process. The centrally administered budgets grow to £784m by 2020/21.

- Specialised Services: About 7% of our expenditure on Specialised Services covers programmes such as the Cancer Drugs Fund, Proton Beam Therapy and highly specialised transplant surgery which do not lend themselves to local commissioning. In total these budgets amount to £1,155m in 2016/17. The indicative CCG area allocations published in these documents cover the remainder of the £15,662m budget for Specialised Services.

Q4. What if I think the population estimates are wrong?

Population estimates start from actual registered populations as at October 2015.

Population growth by area is based on trends estimated by ONS, as these are the only consistent national projection available. For future years we will review actual population growth based on GP list sizes to ensure that the actual pressures arise as anticipated. Should there be material unexpected developments, allocations may be altered by exception in line with the arrangements set out in Annex 1 of the document: Financial Allocations 2016/17 to 2020/21.

Q5. The specialised distance from target is adversely impacting on funding growth for my locality/CCG. Why and what can be done about it?

This will be where specialised services are significantly over target and it has a material effect in a few geographies. It reflects usage by the local population (or coding by providers) of specialised services beyond the level indicated by fair shares based on need, and it is appropriate that this differential consumption of resource is reflected in the overall resource availability for local commissioners. In these areas we would encourage CCGs and NHS England Specialised commissioners to seek opportunities to work together to rebalance the portfolio over time in the context of collaborative commissioning.

Q6. The specialised allocation is significantly under target. What does this mean, and what is the impact on allocations?

This will have impacted upon the place-based distance from target and, subject to the pace-of-change rules, may result in additional funds being released to CCGs and Primary Care (Medical) allocations. This in effect compensates CCGs whose populations are using less specialised service resource in relation to their peers – whether through patient choice, medical practice, or commissioning decisions.

Q7. What is the interaction between the specialised allocation at a CCG / place level and the budget that will be allocated to a specialised commissioning hub?

Specialised Commissioning hubs commission services from a portfolio of providers in their area for all populations who use their services rather than commissioning for specific local populations. The total specialised commissioning budget will be managed by the specialised finance team and allocated between commissioning hubs to reflect anticipated cost pressures for each of their provider portfolios, as in previous years.

The population-based allocations by CCG geography are intended to provide transparency of utilisation and ensure equity of total resource consumed by populations. In the context of collaborative commissioning we will maintain this transparency and develop commissioning approaches which optimise the use of the total resource for each local community.

Q8. Why is primary care (non-medical) not part of the place-based allocation?

The underlying formulae to calculate target allocations in these areas are not yet robust enough to be disaggregated beyond sub-regional level. In addition, these areas are generally not currently included in collaborative commissioning arrangements.

Q9. Will errors be amended?

By exception, it is possible to move allocations between commissioning streams (with the agreement of all parties impacted), where errors of attribution are identified or commissioning practice/responsibilities change.

Q10. The CCG Distance from target reported here is significantly different from the previous amount. Why is this?

The CCG allocations reflect a number of movements in distances from target. These have been driven by:

- Baseline changes, where the proportionate share of the baseline has moved as a result of local allocation transfers and changing responsibilities, particularly with regard to specialised services.
- Changes to the formula including:
    - sparsity adjustment, reflecting unavoidable cost of remoteness; and
    - inequalities/unmet need adjustment change from 10 to 16 tiers.
- Refreshing the underlying activity data of the modelling including:
    - change in national spend weightings used to combine G&A, mental health maternity and prescribing formulae. If a CCG has significantly different levels of need between these components from the national

average, updating the national spend weightings impacts on distances from target;
    - prescribing formula refresh;
    - maternity formula refresh; and
    - emergency ambulance cost adjustment refresh (reflecting increased travel time for ambulances in sparsely populated areas).
- Refreshing the underlying demographic data of the modelling including:
    - the difference between actual 2015 registrations and predicted 2015 registrations derived by uplifting 2013 registrations by ONS population projections;
    - changes in the age-sex profile of the local population, such as latest registered population data showing it is typically younger or older than previously estimated; and
    - SMR<75 data update (used for the inequalities/unmet need adjustments).
- In a small number of areas, adjustments to correct previously under reported mental health activity.

Should any CCG require assistance in understanding these changes, or any other aspects of their allocations, they should approach their local NHS England finance director in the first instance.

Q11. What is the minimum level of cash growth which all CCGs receive and what are the key components?

All CCGs receive a minimum cash growth equal to real terms growth plus specific non-routine policy pressures 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 programme DfT of +5% and +10%.

The relevant numbers are set out below:

	2016/17	2017/18	2018/19	2019/20	2020/21
GDP Deflator	1.7%	1.8%	1.9%	2.1%	2.2%
Non-routine policy pressures	1.4%	0.2%	0.1%	0.0%	1.5%
GDP deflator plus non-routine policy pressures	**3.0%**	**2.0%**	**2.0%**	**2.1%**	**3.7%**

The pressures are higher in 2016/17 and 2020/21. In 2016/17 the main components are: national insurance changes related to pensions, transfer out of general practice information technology and transfer out of extra funding for child adolescent mental health services. In 2020/21 the increase is almost entirely driven by the feeding of funding for seven day services into CCG allocations, this funding having been

retained centrally for distribution to the service in the early years via the Sustainability & Transformation Fund.

Q12. What is the minimum level of cash growth which all areas receive for Primary Care (Medical) and what are the key components?

All areas also receive a minimum cash growth equal to real terms growth plus specific non-routine policy pressures (predominantly reflecting national insurance changes relating to pensions and CQC fees) unless the CCG is more than 10% above target, when its cash growth is capped. This cap is phased in between a programme DfT of +5% and +10%.

The relevant numbers are set out below:

	2016/17	2017/18	2018/19	2019/20	2020/21
Non-routine policy pressures	1.9%	0.0%	0.0%	0.0%	0.0%
GDP deflator plus non-routine policy pressures	**3.6%**	**1.8%**	**1.9%**	**2.1%**	**2.2%**

Q13. What are the combined effects on my geography?

Allocation decisions are not made on a geographical basis. We seek to ensure that the growth in funding reflects as closely as possible the pressures from population growth and improved alignment of resources with need (met and unmet), as reflected in the target formula. The allocation growth for any particular geography will reflect these factors.

Q14. How is deprivation taken into account?

We have reflected deprivation in the target allocations both through the demographic factors within the core formulae and through the use of specific adjustments to the output of these formulae to reflect the unmet need they are unable to capture directly. As indicated in the answer to the previous question, the allocation growth for any particular geography will reflect a variety of factors, including the distance between current allocations and these targets.

Q15. Are all areas getting real terms growth?

All total place allocations receive at least real term growth in 2016-17. Some areas (8 in 2016/17) receive less than real terms growth for the subset of their CCG core services because they are significantly over target (and have been identified as being over target for a number of years). These CCGs are consuming more than their fair share of the available resource at the expense of other parts of the country,

and the pursuit of greater equity means that it is important to ensure that there is equal access for equal need across the whole country.

Q16. How will people invest growth wisely?
Places getting high levels of growth currently have funding levels substantially below their fair share. They have typically been substantially below target over many years.

They need the additional funding in order to provide services for their growing communities and/or to rectify financial deficits which have arisen due to their inability to fund this growth in the past. As part of the assurance of local plans, NHS England will put additional focus on ensuring that commissioners receiving substantial growth in funding are investing it in a manner which delivers value for money.

Q17. What allowance have you made for the move by Property Services to introduce market rents from 2016/17 in CCG allocations?

Given the differential impact upon CCGs of the move by Property Services to introduce market rents for CCG occupied property we have not included an adjustment for this in the 2016/17 allocations. Instead we plan to deal with any pressures next year through non-recurrent funding adjustments. For 2017/18 onwards CCGs will meet the costs of the move to market rent from within their allocations and we have adjusted upwards the overall quantum of the CCG funding envelope to reflect this fully.

Annex 1: Running Cost Allowances (RCA) 2016-17 to 2020-21

Overall envelope

The overall envelope is £1,210,678 in each year 2016-17 to 2020-21. This is the same as in 2015-16.

The figures for 2019-20 and 2020-21 are indicative.

The RCA per head are:

2016-17	£22.07
2017-18	£21.91
2018-19	£21.75
2019-20	£21.60
2020-21	£21.46

Calculation of Running Cost Allowances

The same approach has been used as for the calculation of 2013-14 to 2015-16 RCAs.

RCAs have been set on the basis of 'unweighted' population. There is unlikely to be a relationship between the items of expenditure covered by the allowance (i.e. the CCG's management costs and the costs of commissioning support) and traditional determinants of population need (e.g. age / sex / deprivation) that form the basis of 'weighted' populations.

The three populations used in the calculation are:

a. number of registrations with CCGs' member GP practices as published by the Health and Social Care Information Centre for October 2015;

b. the latest Office of National Statistics' (ONS) population projections for 2016 to 2020 for CCGs;

c. estimates of military personnel included in the ONS estimates.

ONS population data are based on place of residence. CCGs are responsible for patients registered with their member GP practices, irrespective of where the patients reside. There are significant net 'cross boundary patient flows' of patients registered with one CCG but residing in another CCG's geographical area. The starting point for the calculation of RCAs is therefore the number of registrations with CCG's member GP practices to ensure that the distribution of running costs takes account of cross-boundary patient flows.

The number of registered patients who are resident in each CCG, irrespective of where they are registered, is calculated. This is compared with the ONS projected population for the CCG (minus military personnel). A scaling factor for each CCG area is calculated, which is the ONS projected population divided by the number of

registered patients resident in the CCG. A scaling factor is calculated for each year 2016-17 to 2020-21, where the numerator is the ONS projected population for the relevant year. The denominator is the number of registered patients resident in October 2015. These scaling factors are then applied to each CCG's registrations resident in each CCG area to produce a constrained population for each CCG.

The national envelope divided by the sum of the populations constrained to ONS populations for all CCGs gives the RCA per head. The RCA per head is multiplied by the constrained population for each CCG and rounded to the nearest thousand pounds to give each CCG's RCA.

Unlike programme spend allocations, there is no "pace-of-change" for running cost allowances and so any changes in the population of a CCG are immediately reflected.