GATEWAY REF: 06015

2017/18 and 2018/19 CCG allocation adjustments

1. NHS England published allocations for the years from 2016/17 to 2020/21 in January 2016. These comprised three years of firm and two years of indicative allocations. The December 2015 board paper on allocations set out the circumstances in which NHS England might reopen allocations.
2. Recurrent allocations are not being reopened for 2017/18 and 2018/19, the remaining years of fixed allocations.
3. However, this note sets out specific non-recurrent adjustments which are being made in respect of:
    - The modelled impact of the changes to prices in the 2017/18 and 2018/19 National Tariff (notably the move to HRG4+ and changes to the tool and method used for top-ups); and
    - Funding transfers between CCGs and specialised commissioning, following work to implement consistent identification rules (IRs).
4. The purpose of these adjustments is to seek, to the extent reasonably possible, to neutralise the cost impacts of the changes at commissioner level through commensurate adjustments to commissioner resource limits, thus maintaining commissioner "purchasing power" at the levels set out last December/January. This will avoid disruption to local spending plans, with £ for £ changes being made directly to allocations, rather than being influenced by further adjustments related to distance from target.
5. These adjustments will be made non-recurrently for 2017/18 and 2018/19, and then formally taken into account when recurrent allocations are revisited for 2019/20 and beyond.
6. Annex A sets out the methodology which has been used to calculate these adjustments. Further supporting material on the IR adjustments is being made available to CCGs. Annex B provides answers to frequently asked questions.
7. In addition to these changes;
    - Non-recurrent adjustments will be made in 2017/18 and 2018/19 for 22 CCGs to mitigate an error in the treatment of dispensing doctors, repeating the adjustment made for 2016/17.
    - Additional adjustments in respect of the impact of the NHS Property Services move to market rents will be notified at a later date and we will also be issuing further information on CCG contributions to the Better Care Fund.

NHS England
24 October 2016

Annex A: Methodology

Approach to producing National Tariff adjustments

8. The underlying data is taken from NHS Improvement's impact assessment, the method for which is set out on their website.[1] This takes each patient record, and applies appropriate tariff rules and prices to identify the cost of each patient. 2014/15 Hospital Episode Statistics (HES) activity is used, to which 2016/17 and 2017/18 tariff prices are applied in order to identify the changes in cost. All activity is assumed to follow tariff rules. The prices used are closely aligned to the final s118 prices and include changes from the 22 September planning guidance prices.

9. NHS England then internally processes the generated data to understand the impact on each CCG. The most recent version of the IR tool, with known amendments implemented, was used to identify the responsible commissioner (NHS England or CCG). This analysis therefore starts from the position that the IR rules are fully implemented. Other key elements of the analysis include:

10. *Ensuring quantum neutrality.* Tariff prices have been set such that the overall impact across the NHS is neutral. However, the IA analysis produces a residual increase in overall expenditure in the impact assessment because of the slightly different basis on which it is constructed. We make appropriate adjustments to adjust for this, in particular to:

    - remove independent sector providers who are not taken into account when considering quantum neutrality;
    - remove the small number of Welsh patients in the data who are not the responsibility of English commissioners; and
    - adjust for areas of activity excluded from the IA, notably nuclear medicine, changes in scope, and other changes in commissioning approach.

11. The residual of £8m is scaled across commissioners based on their share of expenditure.

12. *Making other modelling adjustments*. Some other adjustments are needed to align the outputs of the analysis with the intention of the adjustments, notably:

    - Effects of the Marginal Rate of Emergency Tariff (MRET) due to changing price levels have been excluded, because CCGs are required to invest retained funds in services to reduce emergency admissions;
    - The increase in prices for Clinical Negligence Scheme for Trusts (CNST) is removed since this is an inflationary pressure, already taken into account of total allocations;
    - Unbundled diagnostic imaging is not possible to model at an individual patient level. The change has been modelled overall, then allocated to CCGs based on their 2017/18 outpatient spend; and
    - Due to data limitations in the underpinning HES data, there is a small amount of change in CCG spend not attributed to known CCGs, where the impact has been distributed across CCGs.

[1] https://improvement.nhs.uk/uploads/documents/Final_preliminary_assessment_with_cover_Rd7NccW.pdf

13. *Price levels*: 2016/17 prices are used for the initial stage of the analysis and the adjustments have then been inflated so that changes are in 2017/18 real terms.

14. *Activity levels*: The underlying data is 2014/15 Hospital Episode Statistics (HES) activity. Spend in this analysis is uplifted to 2017/18 activity levels using national assumptions, described below.

Approach to producing Identification Rules adjustments

15. This set of changes arises from work to move to a consistent set of Identification Rules for specialised services across health economies, in line with legislation.

16. The move is from the 2014/15 PSS Tool to a 2017/18 Planning Tool that is based on the 2015/16 Shadow Monitoring Tool and incorporates additional supplementary logic to better identify specialised activity and responsible commissioner. The 2014/15 PSS Tool was not universally adopted with many economies currently still using their original 2013/14 IRs and locally agreed deviations from the rules.

17. The revised IRs incorporate corrections to the original known errors and omissions from the 2013/14 PSS Tool and subsequent changes proposed by Clinical Reference Groups and the Prescribed Specialised Services Advisory Group, and taking on board feedback from other stakeholders.

Approach to national uplifts

18. For both the National Tariff analysis and the Identification Rules changes, the source data is based on values related to 2014/15 or (in some cases) 2015/16. To calculate the size of adjustments to allocations, we need to make appropriate uplifts for price and activity growth to project these figures forward to 2017/18 and 2018/19 positions.

19. The approach used applies a national growth assumption, based on NHS England modelling for the Five Year Forward View, and tariff assumptions.

Identification Rules – generating consistent years

20. The starting point is the data returned in templates from hubs. However, because of data availability issues in some areas, and the existence of DTO and ETR in 15/16, the data must first be adjusted to a consistent position. This is done in the following manner:

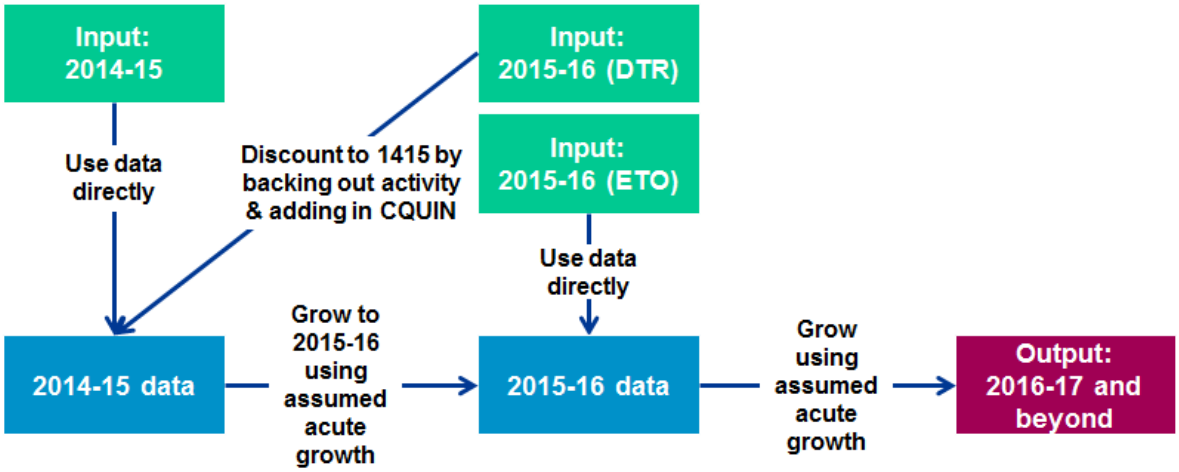
    - 2014/15 values. Most of the values generated by the exercise are for 2014/15 and no adjustment is required.
    - 2015/16 values from trusts on the DTR tariff. These are adjusted to a comparable 14/15 basis by adding back an average rate of CQUIN (since this was not available under DTR) and discounting for an average rate of activity growth (since DTR used 14/15 prices, but the values will include 15/16 activity).
    - 2015/16 values from trusts on the ETO tariff. These are added in at the 15/16 stage.

21. The second step is then to grow these figures at the calculated growth rate. A figure has been calculated based on underlying allocation growth for CCG acute

expenditure, less efficiency. This is considered to be a reasonable overall proxy for the services involved. The construction of this is set out below.

22. The resulting figures provide the allocation adjustment required.

23. This diagram summarises the approach.



National growth assumption – used for both adjustments

24. The national growth assumption is calculated by assuming expenditure grows each year by underlying price (as per tariff) and activity (as per assumptions used for allocations modelling and the Five Year Forward View) pressures, offset by efficiency (as calculated in our allocations modelling). The overall total growth is then used as the national growth assumption.

25. Further detail on the activity growth assumption is available in the Five Year Forward View technical note.[2]

	2015/16	2016/17	2017/18	2018/19
Assumed CCG acute expenditure growth	**1.1%**	**3.1%**	**1.6%**	**1.6%**
Made up from				
Cost growth	**4.3%**	**5.5%**	**4.6%**	**4.6%**
o/w activity	*2.4%*	*2.4%*	*2.5%*	*2.5%*
o/w price	*1.9%*	*3.1%*	*2.1%*	*2.1%*
Less efficiency	**-3.0%**	**-2.3%**	**-2.9%**	**-2.9%**

26. We considered the case for applying different growths depending on the commissioning stream where the funding is moving from/to (e.g. different uplift approach to spend currently in specialised commissioning and moving to CCGs compared to spend currently in CCGs and moving to specialised). We chose not to do so in order to adopt a straightforward approach which aligns to CCG allocation growth.

NB: Percentages do not sum due to compounding effects

[2] https://www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf.

Annex B: Q&A

Can I see the details underpinning the National Tariff analysis for my CCG?

- The impacts of National Tariff are set out as part of the impact assessment accompanying the National Tariff consultation. This will be available on the NHS Improvement website on publication of the consultation.

How I can get more information on the calculation of the IR adjustments?

- Templates will be provided to each CCG showing how their baseline adjustments break down, and separately information can be provided which shows how these net adjustments have been inflated to allow for price and activity growth.
- Lead CCGs have access to the more detailed template submitted by the provider and may have access to a more detailed HRG level analysis where made available by the provider

Can the IR adjustments be amended?

- The adjustments have been calculated from information produced through the process of local calculation and engagement by specialised commissioning hubs with lead CCGs and relevant providers. However, we recognise that there may be some areas where detailed work continues on certain aspects.
- The national specialised team will complete the detailed collation and review exercise for the small number of outstanding hubs/providers where revised templates were received at a late stage. For these areas only, they will produce a schedule of additional necessary changes to reconcile the adjustments published today to the revised agreed position.
- CCGs and their local specialised commissioners are encouraged to continue to work collaboratively and pragmatically on this issue. Where any further review identifies material errors in the data used, then changes can be made where there is local agreement. Any further locally proposed changes will need to be material (we would suggest a materiality threshold of c£0.5m), be neutral overall, and agreed locally between the relevant parties. They should adhere to the current national IR and the permitted deviations outlined in relevant guidance.
- All detailed review work should be completed by mid-November as part of the contracting and planning discussions taking place at that time in each health community. Agreed changes received from regions by 15 November can then be actioned prior to the 24 November plan submission. By exception, it may be possible to action agreed changes received by 6 December prior to final plan submission.
- CCGs should contact their regional specialised commissioning hub in the first instance to discuss any issues.

Will there be further adjustments in respect of morbid obesity?

- Following Ministerial approval, the work to implement the PSSAG recommendation on transferring morbid obesity services to CCGs will continue and further guidance will be issued separately. The baseline (14-15 uplifted to 17-18 levels) has been transferred to CCGs as part of the IR work. However, it is recognised that there is further work required to understand the volatility of activity over the last three years at the 42 commissioned providers. It is also likely

that CCG risk sharing arrangements based around the commissioned providers may need to be agreed due to the service being relatively high cost/low volume.
- Additional guidance will be issued separately, but it is expected that CCGs will contract for Morbid Obesity in the 2017-18 planning round.

Can the National Tariff adjustments be amended?

- We do not intend to change these adjustments unless very material changes are identified. They have been calculated on the best available data using the National Tariff impact assessment, aligned closely to the final s118 prices.

How have the impacts of tariff changes been taken into account in provider control totals?

- NHS Improvement have included tariff impacts in control totals based on the draft prices released with the planning guidance on 22 September. Any further material changes to prices will be considered before finalising control totals.

Has CCG/place distance from target been recalculated and will allocation growth rates be changed as a result?

- No. Decisions on the approach to pace of change were made in December 2015 in order to set fixed allocations and have not been reopened.
- The intention of the adjustments set out here is – to the extent reasonably possible – to maintain commissioner "spending power", by neutralising the impact of the changes in tariff and the application of the identification rules. This is different from the intention of allocations policy and pace of change, which is, over time, to adjust commissioner spending power in order to provide equal funding for equal need. Therefore we have not taken distance from target or pace of change into account in setting the value of these adjustments.
- The impact of the adjustments will be considered when allocations are reconsidered and confirmed for 2019/20 and beyond, at which point we will consider distance from target and apply a pace of change policy.

Do these adjustments take account of practices which have or are expected to move between CCGs?

- Except in some very specific local circumstances, no. The National Tariff adjustments are based on CCG level data from 2014/15, based on CCGs as they were configured at that point. For the IR adjustments it depends on how the data for the templates was constructed locally, but in almost all cases this has not been included. There are no prospective practice moves built into the adjustments.
- Therefore, local adjustments will need to be agreed where there have been practice moves in the meantime, or will be in the future, as these cannot be calculated nationally using available data.

Will you be making adjustments for population changes?

- Not at this stage. We have considered the latest GP list data and how it compares to the projected populations which underpin allocations. Whilst there have been some movements, we do not consider these are sufficiently large to warrant the reopening of allocations that would be necessary to correct them. However, we will keep this under review.