NHS ENGLAND - BOARD PAPER

Title: Allocation of resources to NHS England and the commissioning sector for 2019/20 to 2023/24

From: Matthew Style, Interim Chief Financial Officer, NHS England

Purpose of paper:

- This paper sets out our proposals for the quantum of funding to be allocated to different commissioning streams for 2019/20 to 2023/24.

- This allocation will support the Long Term Plan by providing a methodologically sound and efficient distribution of resources between different populations in England, according to need.

- This paper also sets out updates to the formulae which allocate resources to Clinical Commissioning Groups (CCGs) for 2019/20 to 2023/24.

- The NHS England Board and Commissioning Committee have already approved in principle the methodological changes and adjustments to allocations for 2019/20 to 2023/24.

- Following Board approval, we will confirm the first three years of allocations, covering 2019/20 to 2021/22, with allocations for the final two years of the settlement remaining indicative.

Patient and Involvement:

This paper provides the detail of the allocation of resources to NHS England and the commissioning sector for 2019/20 to 2023/24.

Full information on the financial position is available to patients and the public on a quarterly basis on the NHS England website.

Summary of Recommendations:

The Board is asked to confirm the draft CCG allocations published on 10 January.

Allocation of resources to NHS England and the commissioning sector for 2019/20 to 2023/24

Context

1. These allocations are part of the deployment of NHS England's five-year revenue funding settlement, averaging 3.4% a year in real terms and reaching £20.5bn extra a year by 2023/24. CCG allocations are being set on the basis of NHS England's five-year real terms revenue funding profile, which has now been set by Government as 3.6%, 3.1%, 3.0%, 3.0% and 4.1%. This provides over £1 billion more in cash terms than the settlement proposed in June.

2. On 7th January 2019, we published the NHS Long Term Plan, setting out the strategic development of the health system and for the decade ahead. This was followed by 201-/20 planning guidance and draft CCG allocations on 10th January 2019.

3. This five-year settlement gives NHS England the opportunity to set allocations for commissioners over an extended period, providing greater planning certainty and allowing local systems to develop more robust and sustainable plans.

4. This paper covers:

   - The proposed allocation of funds between commissioning streams.
   - Recommendations for methodological changes to the CCG allocations formulae from the Advisory Committee on Resource Allocation (ACRA).
   - Other proposed adjustments, including the proposal to update to the Market Forces Factor to align with the MFF changes proposed for National Tariff prices.
   - Our proposed pace of change rules which determine how quickly each CCG's allocations move towards their target share.

5. These proposals have been previously considered by the NHS England Board and the NHS England Commissioning Committee. Following publication of the Long Term Plan, and confirmation of NHS England's five-year revenue funding profile draft allocations were published on 10 January 2019. This paper requests Board approval for final allocations.

6. Subject to approval, we intend to confirm the first three years of CCG allocations, covering 2019/20 to 2021/22, with allocations for the final two years of the settlement remaining indicative

7. The assessment of the equalities impacts of the proposed allocations methodology is attached separately.

Split of Resources Between Commissioning Streams

8. Table 1 provides the NHS England settlement agreed with Government to fund the Long Term Plan, which we use as the basis for allocations.

Table 1: NHS England settlement (January 2019)

	2018/19*	2019/20	2020/21	2021/22	2022/23	2023/24	CAGR %
Nominal value							
Mandate (£m)	114,603	120,807	127,007	133,283	139,990	148,467	
Mandate annual increment (£m)	n/a	6,204	6,200	6,276	6,708	8,477	
Mandate growth (%)	n/a	5.4%	5.1%	4.9%	5.0%	6.1%	5.3%
Real terms value							
Real terms value (2018/19 prices, £m)	114,603	118,683	122,396	126,018	129,841	135,141	20,538
Real terms value annual increment (£m)	n/a	4,080	3,713	3,622	3,823	5,300	
Real terms growth (%)	n/a	3.6%	3.1%	3.0%	3.0%	4.1%	**3.4%**
In addition							
RDEL - ring-fenced for depreciation and impairment (£m)	166	166	166	166	166	166	
Total Mandate (£m)	**114,769**	**120,973**	**127,173**	**133,449**	**140,156**	**148,633**	

includes £800m additional funding related to 2018/19 pay awards

9. Our approach to distribution of funding between commissioning streams is based upon:

   i.   funding a realistic and sustainable level of activity for each commissioning stream;
   ii. appropriately funding commissioning streams for price pressures, including the impact of 2018/19 pay awards and the impact of putting £1bn of the Provider Sustainability Fund (PSF) into urgent and emergency care prices;
   iii. protecting funding for the implementation of existing Five-Year Forward View commitments, particularly in respect of mental health, primary care and cancer services;
   iv. reducing running costs, whilst also prioritising funding for transformation and service development; and
   v.   maintaining a prudent central provision given additional risks the Government is now requiring NHS England to manage, such as on income from the voluntary and statutory branded medicines pricing schemes.

10. In particular, we ensure that there are sufficient funds in the CCG commissioning stream to meet the following commitments:

   i. The Long Term Plan commitment that spending on mental health will grow as a share of NHS spending. As a result, mental health spending will increase at least £2.3bn a year in real terms by 2023/24. The delivery of this commitment is supported by the annual Mental Health Investment Standard (MHIS), which requires commissioners to allocate additional growth in funding for mental health.

   ii. The Long Term Plan commitment that funding for primary medical and community health services should grow faster than the

overall NHS revenue funding settlement, and reach at least an extra £4.5bn a year real terms by 2023/24.

More detail on the assumptions underpinning allocations is included in Annex A.

11. The Government is planning to increase employer pension contributions. The Department of Health and Social Care's (DHSC) consultation on proposed changes to the NHS pension scheme for 2019 closed on 28th January 2019. The Government committed in Budget 2018 to fund the direct costs to the NHS resulting from these changes. This funding is not yet reflected in the agreed settlement or local allocations, and the arrangement for distribution will be confirmed once final decisions have been made.

12. Allocations have been set on the assumption that NHS England receives the receipts[1], relating to sales in England, from the DHSC statutory scheme to control costs of branded health service medicines and the voluntary scheme for branded medicines pricing and access.

13. Issues with the previous medicines pricing mechanisms have been addressed, to make the schemes more comprehensive and predictable for both industry and the NHS. Nevertheless, it may be necessary to adjust allocations in future years to take account of medicines expenditure outturn and the impact on industry rebates.

Outputs

14. On the basis of these plans, overall CCG programme spend is projected to grow above the GDP deflator in all 5 years. Growth is 5.7%[2] in 2019/20, partly due to the funding being provided for pay increases in 2018/19 which will flow through tariff for the first time in 2019/20 and the increase in urgent and emergency care prices of £1bn in 2019/20. Adjusting for these specific one-off impacts, CCG programme growth is 3.4%. CCG programme allocations grow between 3.5% and 4.1% in each of the remaining years.

15. CCG running costs allowances will be set in line with the expectation that CCGs deliver a real terms reduction of 20% from their 2017/18 running cost allowances by 2020/21.

16. General Practice, which covers the core GP contract and other related primary medical services, as well as funding to deliver further service development, grows at 6.2% per annum or greater in all years. Adjustments may be required to align with the new GP contract.

17. Other direct commissioning, which covers dentistry, community pharmacy and ophthalmology services, public health, health and justice and armed forces, grows at 3.5% in 2019/20, reflecting pay increases in 2018/19 which will flow through tariff in 2019/20, and additional public health immunisation and

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[1] The assumption is that receipts from the medicines pricing schemes will be net of the Pharmaceutical Price and Regulation Scheme (PPRS) rebate previously factored into the NHS mandate in 2018/19.
[2] All growth rates given are in cash terms.

screening investments.

18. The Provider Sustainability Fund will be reduced by £1.2bn in 2019/20. £1bn of this will be used to increase urgent and emergency care prices. The remaining £200m will be transferred to a new 'Financial Recovery Fund', totalling £1.05bn in 2019/20. From 2020/21, the Provider Sustainability Fund will be abolished, with funding used to further increase the size of the Financial Recovery Fund. The Financial Recovery Fund (FRF) is designed to support systems' and organisations' efforts to make all NHS services sustainable. As a result of this, we expect the number of trusts reporting a deficit to be reduced by more than half in 2019/20, and no trust to be reporting a deficit by 2023/24.

19. We have updated our assessment of wider pressures in each commissioning stream, and reflected these in our proposed allocations.

20. Table 2 below sets out our recommended distribution of funds at commissioning stream level.

Table 2: Commissioning stream allocations

	2018/19[1] £m	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m	2023/24 £m
Place Based Commissioning Budgets	**101,833**	**108,085**	**112,979**	**118,147**	**123,511**	**129,178**
Clinical Commissioning Groups	75,596	79,885	82,989	86,258	89,465	92,582
Commissioner Sustainability Fund	400	300	200	100	0	0
General Practice	8,162	8,786	9,378	9,958	10,590	11,340
Specialised Services	17,675	19,114	20,412	21,831	23,455	25,257
Provider Support	**2,450**	**2,740**	**2,490**	**2,490**	**2,490**	**2,391**
Provider Sustainability Fund[2]	2,450	1,250	0	0	0	0
Financial Recovery Fund[3]	0	1,048	2,048	2,048	2,048	1,949
Central MRET Funding[4]	0	442	442	442	442	442
Other Direct Commissioning[5]	**6,728**	**6,963**	**7,102**	**7,285**	**7,473**	**7,670**
Other Allocated System Funding (inc. LTP)[6]	**1,764**	**2,037**	**3,469**	**4,379**	**5,522**	**8,220**
NHS England Central Admin & Programme	**1,195**	**1,148**	**1,133**	**1,148**	**1,160**	**1,173**
Total	113,969	120,973	127,173	133,449	140,156	148,633

Notes:
1. 2018/19 baseline as at 30 October 2018
2. The Provider Sustainability Fund (PSF) is reduced by £1.2bn in 2019/20, with £1bn transferring into urgent and emergency care prices and the £200m targeted element of the PSF transferring into the Financial Recovery Fund.
3. The size of the Financial Recovery Fund beyond 2019/20 will depend on the agreed financial recovery plans and financial performance.
4. The plan for distributing MRET funding from 2020/21 will be determined in due course.
5. Other direct commissioning includes Public Health, Armed Forces and Health and Justice.
6. Other Allocated System Funding includes funding for Long Term Plan commitments and service development.

CCG Allocations

ACRA Recommended Methodological Updates

21. In this section we describe a number of improvements we propose to make to the formulae which determine target allocations. These have all been recommended by our long-standing independent advisory committee, the Advisory Committee on Resource Allocation (ACRA[3]). ACRA's letter of recommendations is included in Annex B. ACRA is an independent expert committee comprising academics (including health economists), public health experts, NHS managers and finance experts, and clinicians, which makes recommendations on the preferred relative geographical distribution of resources for health services. **We recommend that the Board accepts all recommendations made by ACRA, detailed below.**

Population and other demographic data

22. Population figures for all programme allocations are based on GP registered list sizes. Increases for future years are based on the Office of National Statistics (ONS) estimates of population trends for resident populations, which is the only consistent and robust national data set available to use for this purpose. ACRA has made two recommendations for changes to the way in which population data are used:

    i.   That we use the annual average registered list for the most recent year, rather than the size of the list at the time of allocations. This is intended to better reflect cyclical patterns in some areas, such as areas with large numbers of seasonal workers or large student populations.

    ii. That we use age and gender specific population projections produced by the ONS, so that if population growth in an area is disproportionately in a younger or older population - which will affect relative levels of need - this can be reflected in the changes in need-weighted populations over time.

Community services

23. To date there has been no separate allocations formula for community services due to a lack of suitable data. The need for community services has therefore been assumed to be proportional to the need for general and acute services when setting the target CCG allocations. Given that community services account for up to one sixth of CCG spend on core services, and the significance of this sector in the vision for the future of the NHS, there is a compelling case for adopting a more sophisticated approach.

24. A new national dataset on community services, the Community Services Dataset (CSDS) has recently started to be produced. Previous experience suggests that, generally, at least two years of data is needed before a robust formula can be constructed. However, analysis of local data from early adopter areas containing

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[3] https://www.england.nhs.uk/allocations/#ACRA

a cross-section of populations has shown that in the case of district nursing services the data from different areas are very consistent. They are also consistent with the early returns from the CSDS, and have a high level of face validity. Given this work shows a needs distribution that is substantially different to the general and acute (G&A) distribution, ACRA have recommended that we implement a formula based on these data, which estimates need for community services using a combination of the age and deprivation profiles in a local area.

25. Our analysis has shown that utilisation of a wider range of community services is sufficiently closely related to district nursing such that ACRA have been able to recommend that this formula is applied to 50% of all spending on community services. The other 50% should continue to follow the formula for general and acute services.

26. The formula suggests that the need for community services is highest in those areas with higher proportions of people aged over 85, particularly rural and coastal CCGs, and areas with deprived older populations in the Midlands and North.

27. Further development and refinement of the community services formula is a priority for the future.

Mental health and learning disabilities services

28. In the allocations for 2014/15 we made a major step forward in estimating the need for mental services, moving from an approach that was based solely on utilisation of hospital inpatient services, captured in the Healthcare Episode Statistics (HES) dataset, to one based on individual level records, covering community, outpatient and inpatient mental health services. This was a major improvement in our approach to estimating need for these services.

29. ACRA has now recommended a further improvement to the approach, exploiting new collections of IAPT activity and linking to both GP registration and diagnoses from HES. It also contains an enhanced set of supply-side variables to control for varying levels of access around the country, varying approaches to the provision of care, and varying practices amongst providers in recording activity.

30. This analysis continues to show highest relative need in large urban centres with younger, deprived populations. However, it results in higher need indices for some coastal areas and areas with older populations, due in part to improved diagnosis, treatment and recording of dementia.

Health inequalities

31. NHS England has a strong commitment and legal duty to have regard to the need to reduce health inequalities. We look to meet some of this legal duty in part by reducing avoidable inequalities in healthcare provision through our approach to allocations. Further, we recognise that our utilisation-based approach to measuring healthcare needs will not necessarily fully capture needs that are not being met.

32. In order to take account of health inequalities and unmet need in the allocations formula, ACRA have recommended that the standardised mortality ratio for those aged under 75 (SMR<75) is the best available indicator. ACRA has in the past considered alternative measures of health inequalities, including Disability Free Life Expectancy (DFLE) and Disability-Adjusted Life-Years (DALY), and has found that these measures are highly correlated with each other and that SMR<75 has some significant technical advantages as it is regularly updated, based on a reliable source (death registrations), and available at a smaller spatial level.

33. As in previous years, ACRA have not made a recommendation on how much funding should be redistributed in the formulae using this metric. 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. The weighting is therefore a matter of judgement for NHS England. We propose to continue to apply a 15% adjustment within primary care, a 10% adjustment within CCG commissioned services and a 5% adjustment within the specialised services formula to meet these requirements. The differential reflects our assessment of the relative importance of these streams in addressing unmet need and health inequalities.

34. However, from 2019/20, in addition to data updates, ACRA are recommending technical changes to the way SMR<75 for small areas is aggregated to an overall CCG weighting. This change makes our approach more responsive to some of the most extreme SMR<75 values, where the latest data show a deterioration in a small number of areas, increasing the fair share of resources targeted at these areas. This involves little change to the vast majority of CCGs, but at the extreme, this change would increase Blackpool's CCG core target allocation by 5.13%, or £16m.

35. This approach increases the amount of redistribution compared to the weighting methodology implemented in 2018/19 allocations. For 2019/20 target allocations, this means that there will be £1.9bn of overall redistribution in CCG programme and primary care, over and above that already occurring due to the other components of the formula (which, in allocating according to need, are already highly redistributive), with £0.95bn moving from one half of the target distribution to the other. By 2023/24, we expect that overall there will be £2.2bn of redistribution within target allocations, i.e. £1.1bn moved from one half of the target distribution to the other.

36. Improving the way in which we target resources to address unmet need and health inequalities remains a high priority for further work on the development of our allocation formulae. There are three key areas for this:

- In the shorter term, work to consider alternative proxies for unmet need, especially where unmet need may not be reflected in premature mortality (e.g. for mental health). This is an area of active work, but the analysis has not reached a point where ACRA feel able to recommend a change in approach.

- In the longer term, with support from the Department of Health and Social Care (DHSC), we are developing a call for research proposals that the National Institute for Health Research (NIHR) will issue later this year and is expected to drive a two- to three-year programme of research.

- As set out in the Long Term Plan, NHS England will commission the Advisory Committee on Resource Allocation to conduct and publish a review of the inequalities adjustment to the funding formulae.

Other areas of the model

37. Other than data updates, ACRA have recommended no changes to the following sub-formulae:

- the general and acute model;
- the prescribing model;
- the maternity model;
- the emergency ambulance costs adjustment (EACA);
- the adjustment for unavoidably small hospital provision in remote areas; and
- the primary medical care model.

38. The EACA and remote hospitals adjustments are intended to reflect the differential costs of providing services in the most remote areas. As part of our work to develop the allocation formulae, we have explored whether there is evidence that further adjustments are necessary, but we have not found nationally consistent evidence that could form the basis of such adjustments. Nevertheless, as part of our forward work programme we will consider this further. In particular, while the improved community services model already moves resources towards rural communities, because they have a higher proportion of older people than average, we will further consider if an additional adjustment for the travelling time of staff providing home services in sparsely populated areas is warranted.

39. We have updated the expenditure weights used to combine the different elements of the CCG core target formula in order to better reflect the services covered by the mental health formula and to reflect movement of a proportion of PSF funding into CCG allocations. These changes increase the weight for the mental health formula from 13% of hospital and community spend (as used in allocations between 2016/17 and 2018/19) to 15% for 2019/20.

Other Adjustments to Target Allocations

Need index adjustments

40. There can be situations in which data issues or changes to organisational arrangements result in formula outputs which are not a good reflection of genuine underlying need. For example, poor coding or a change in coding practice could reduce the information available on the conditions suffered by a CCG's population. While the model is designed to be robust to many data issues, some may result in a lower need weighting than is in fact justified.

41. We have developed a set of criteria for any off-model adjustments to be made to a GP practice or CCG's need index. These criteria require that there is a known issue where the outcome is such that:
    - the change in the overall need index is greater than plus or minus 5%;
    - the change in any component of the need estimate sits outside of statistical control limits; and
    - there is no other logical explanation as to why underlying need, or the accuracy of our estimation of it, would have changed in that particular area.

42. For 2019/20 allocations, we recommend that two off-model adjustments are made which meet these criteria:

    - An adjustment to the general and acute need index for Sunderland CCG. Analysis suggests its current need index was negatively influenced to a statistically significant degree by coding issues in the CCG's main acute provider while it transitioned to a new IT system.

    - An adjustment to the need indices for one of the GP practices within Hammersmith and Fulham CCG. This practice has undergone significant and rapid growth under a move to a digital-first model. This expansion means that the needs weightings of the original practice are unlikely to reflect the need of the practice now and we have therefore used the average need weightings of the CCG as a whole. The most material impact is on the primary medical care allocation, where we assume that new registrations are at a more typical level in the allocation period than has been the case during the practice's expansion. These adjustments may require further review in the light of future registration patterns.

Market Forces Factor

43. The CCG allocation formula takes account of unavoidable cost differences between areas which affect the cost of providing services by applying the Market Forces Factor to all services except for prescribing (as this is not affected by geographical cost differences).

44. In October NHS England and NHS Improvement published *2019/20 payment reform proposals[4],* which included a proposal to update the Market Forces Factor to ensure that tariff prices more accurately reflect the local costs faced by providers. Following further development, planning prices were published in December including final proposals for the Market Forces Factor.[5] These proposals are currently being consulted on before being confirmed.

45. As outlined in the planning prices, NHSI are proposing to phase in changes to tariff prices due to MFF improvements over five years to limit the annual impact. We propose to follow the outcome of the payment reform engagement, and take a consistent approach to factoring MFF changes into CCG allocations. Target allocations will therefore also change in a phased way over five years to reflect

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[4] https://improvement.nhs.uk/resources/201920-payment-reform-proposals/
[5] Ibid

the new MFF values. This will mean that target allocations move in-step with the change in prices. Pace of change will continue to apply to overall allocations.

Specialised Services

46. A new target allocations formula for specialised services was developed for the 2016/17 allocations round. It was combined with data on expenditure to form overall targets for specialised services. This expenditure data has now been updated and shows a similar pattern of variation. These targets are not used for commissioner allocations but are an important part of our ability to understand total expenditure on healthcare for the population of a place and are taken into account in the place-based element of pace of change (described below).

Overall Impact of Formula Changes

47. Table 3 summarises the impact of the revised targets on **core CCG** distance from target. In this table, we show the opening target for 2019/20, once the new target formulae have been applied, but before the new quantum has been applied. It shows that based on opening distance from target, 40% of CCGs are below target, and 60% over target. The section on pace of change, below, sets out how we take this into account when distributing the quantum of funding available for 2019/20 and beyond.

Table 3: Distribution of CCGs by *opening* distance from target, CCG commissioned services

Distance from target (DFT bands)	2019/20 new formulae **Opening** distance from target	% of CCGs in DFT Band
<-5%	6	3%
-5% to -2.5%	20	10%
-2.5% to 0	50	26%
0 to 2.5%	60	31%
+2.5% to +5%	38	20%
>+5%	18	9%
Total	192	-

48. As expected, the methodological and data updates described above would, without further action, have some significant impacts on the position of individual CCGs relative to their target allocation, with a number of CCGs moving to more than 5% below target. Preventing volatility in movements in target allocations feeding through into CCG budgets in an unsustainable way is one of the reasons for adopting a pace of change approach.

Pace of change

49. Key considerations for the Board include:

    i.   the minimum floor growth we can expect any CCG to manage without short term destabilisation of service provision;
    ii. the maximum growth that any CCG can invest in a value for money way in a given year;
    iii. the extent to which the growth rate of the typical CCG should reasonably differ from the overall average growth rate, whilst also allowing differentiated growth rates to bring CCGs closer to target.

50. 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. We recommend that we keep these objectives and therefore:

    i.   Additional growth is applied to those areas most below target, with an aim that we maintain no area being more than 5% below target (our plans have no CCG more than 3.5% below target by 2023/24). Given uncertainties in the target model, we have historically, and continue to, judge any CCG +/-5% from target to be consistent with the target.
    ii. Areas close to target receive equal funding growth per capita. We aim to give this group of 'typical' CCGs as close to average growth as possible given this reflects our overall assessment of the pressures facing CCGs. This applies to all CCGs between -2.5% and +5% in 2019/20, and CCGs between 0% and +5% in all later years.
    iii. Areas more than 5% above target receive a lower level of funding growth, tapering down to floor growth for those more than 10% above.

51. This approach is set out graphically in Figure 3 below.

Figure 3: Distribution of core CCG growth per capita (y-axis) relative to opening distances from target (x-axis) in 2019/20.
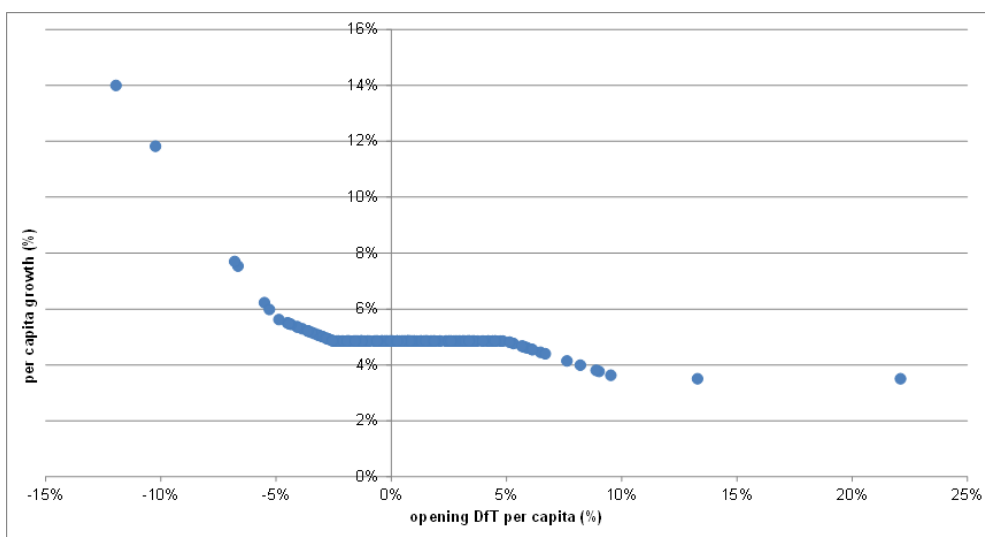
Core CCG allocations

52. Our proposed approach on each of the three key considerations set out above for core CCG allocations is:

    i.   That floor growth for CCGs with distances of target of above 10% is set at the average growth per head of population less a "challenge" of 1.5 percentage points. This provides a more generous level of growth for over target areas than in the previous allocations round (where the additional challenge was equivalent to 2.2 percentage points), but reflects higher assumed price and activity growths as well as higher policy pressures in 2019/20. An absolute floor of GDP deflator on overall funding (i.e. not per head of population) also applies.

    ii.   That the maximum growth rates (for all except Bradford City CCG and Blackpool CCG) are consistent with those in previous allocations rounds[6], at broadly 1.5 times the England average.

    iii.   That in 2019/20 we provide additional growth for all areas more than -2.5% below target. This balances the desire to bring those furthest below target closer to target, whilst also allowing the growth rate of the typical CCG to be as close as possible to the overall average growth rate. From 2020/21 and beyond, once the range of distances from target has been further narrowed, we recommend providing additional growth to all CCGs below target.

Primary care allocations

53. For primary care, we propose to take the same approach, but setting the challenge for areas more than 10% above target at 1.25% below average growth reflecting the fact that flexibility in this commissioning stream is more limited by the structures of the primary care contract.

Place-based pace of change

54. In the last allocation round, we adopted a pace of change policy that took a more holistic view of pace-of-change at a place-based level while applying rules that limited the volatility and unintended consequences in individual commissioning streams. This took account of funding streams for primary medical, CCG commissioned and specialised services. We recommend continuing to distribute an element of the available resources on a place-based basis.

55. The principles of the proposed approach are that first and foremost, funding is applied within the core CCG and primary care commissioning streams to ensure that pace of change rules are met. A small balance of 0.1% from each of those two streams is then redistributed to those CCGs which, in aggregate, across all three streams, remain below target. This also ensures that no CCG is more than 5%

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[6] Bradford City CCG and Blackpool CCG's high growth is necessary to bring their Core CCG allocation into -5% from target given revised health inequalities methodology.

below target on a place-based level. Our view is that the size of the amount used for redistribution balances the desire to take account of the overall resources available to a health economy with the need to meet pace of change rules for core CCG and primary care allocations and the more indicative nature of the specialised services target allocation.

56. More detail on final growth rates and closing distance from target are set out in Table 4 below.

Table 4: Impact of pace-of-change principles on allocation growth rates

		2019/20			2020-21			2021-22			2022-23			2023-24		
		CCG	PMC	Total	CCG	PMC	Total	CCG	PMC	Total	CCG	PMC	Total	CCG	PMC	Total
Closing Distance from target	<-5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	-5 to -2.5%	41	43	29	38	37	26	33	35	24	28	26	23	26	19	22
	-2.5% to 0	53	51	76	63	53	78	73	50	85	80	65	84	86	74	87
	0 to +2.5%	56	51	59	52	58	58	46	65	53	45	60	55	45	60	52
	+2.5 to +5%	29	24	19	26	21	24	27	25	24	25	28	23	22	29	25
	>5%	13	23	9	13	23	6	13	17	6	14	13	7	13	10	6
	min	-4.99%	-4.99%	-4.99%	-4.62%	-4.61%	-4.64%	-4.25%	-4.25%	-4.25%	-3.87%	-3.88%	-3.87%	-3.50%	-3.50%	-3.50%
	max	19.61%	24.41%	14.76%	18.33%	23.17%	13.59%	17.00%	21.97%	12.41%	16.04%	20.83%	11.51%	15.32%	19.73%	10.78%
Programme Growth	0-2%	0	0	0	0	0	0	1	0	0	1	0	0	1	0	0
	2% to 4%	1	0	0	83	62	13	95	2	9	140	95	23	169	95	36
	4% to 6%	159	67	91	109	128	179	96	162	183	51	97	169	22	97	156
	6 to 8%	28	114	99	0	2	0	0	28	0	0	0	0	0	0	0
	8%+	4	11	2	0	0	0	0	0	0	0	0	0	0	0	0
	min	3.60%	4.57%	4.36%	2.14%	2.52%	2.91%	1.93%	3.49%	2.90%	1.94%	2.22%	2.94%	1.90%	2.22%	3.00%
	max	15.25%	15.94%	12.98%	5.11%	6.33%	5.55%	4.95%	7.09%	5.48%	4.73%	5.91%	5.24%	4.56%	5.24%	5.11%
Per capita growth	0-2%	0	0	0	0	0	0	2	0	0	2	0	0	3	0	0
	2% to 4%	6	0	0	173	135	124	179	4	109	183	170	134	186	174	149
	4% to 6%	181	147	186	19	57	68	11	187	83	7	22	58	3	18	43
	6 to 8%	3	36	4	0	0	0	0	1	0	0	0	0	0	0	0
	8%+	2	9	2	0	0	0	0	0	0	0	0	0	0	0	0
	min	3.50%	4.57%	4.27%	2.10%	2.56%	2.87%	1.92%	3.55%	2.89%	1.78%	2.29%	2.97%	1.78%	2.31%	3.07%
	max	15.31%	16.18%	13.04%	4.70%	5.69%	4.83%	4.50%	6.35%	4.80%	4.36%	5.16%	4.68%	4.12%	4.49%	4.55%

Notes:
- The number of CCGs more than 5% above target increases from 13 in 2019/20 to 14 in 2022/23. This is driven by the phased implementation of changes to the Market Forces Factor (MFF).

Status of allocations

57. We recommend that allocations for 2019/20 to 2021/22 should be set on a firm basis, with the final two years being indicative. NHS England reserves the right to reopen allocations in some circumstances, as set out in Annex C.

Quality Assurance

58. The various components of the work have been through a range of quality assurance processes including:

- methodological review by the Advisory Committee for Resource Allocations, the Allocations Steering Group and other independent stakeholders;
- continuous validation and sense checking during development;
- independent internal review by other NHS England analysts; and
- independent external review, particularly focusing on the implementation of pace-of-change policy.

59. Although the sensitivity of the underlying datasets means we cannot publish them, we will publish full details of our methodology, including a full range of the technical underpinnings and, for the first time, proactively publishing ACRA papers and minutes. This will continue to support external input to our ongoing development programme.

Summary of Recommendations

60. The Board is asked to:

i. Approve the proposed allocation of funds between commissioning streams.
ii. Agree that we should adopt all Advisory Committee on Resource Allocation (ACRA) recommended methodological changes to the CCG allocations formulae.
iii. Approve our other proposed adjustments, including the proposal to update to the Market Forces Factor to align with the MFF changes proposed for National Tariff prices.
iv. Approve our proposed pace of change rules.
v. Approve final CCG allocations covering the first three years of the financial settlement, with allocations for the final two years of the settlement remaining indicative.

Matthew Style
Interim Chief Financial Officer

Annex A: Assumptions Underpinning Allocations

CCG allocations

Overall, CCG programme cash growth is 5.7% in 2019/20. This is based on the following assumptions:

- Tariff inflation net of 1.1% efficiency factor, including pay, non-pay, tariff drugs and indemnity costs. This includes funding for 2018/19 pay deals previously funded to trusts directly.

- Acute activity growth including non-elective growth and elective growth consistent with meeting the requirements set out in planning guidance.

- Medicines expenditure including the expected impact of agreement between the DHSC and the Association of British Pharmaceutical Industries (ABPI) in respect of branded medicines.

- Other changes to National Tariff prices as reflected in planning prices, including increased non-elective prices, changes to CQUIN, funding for the overhead costs of centralised procurement arrangements, indemnity costs and transfers between commissioners.

- Other funding transfers including:
  - ambulance resilience funding
  - ambulance paramedic rebanding
  - Health and Social Care Network costs for CCGs and GPs

Without the increase in UEC prices and inclusion of 2018/19 pay deal (both of which have a one-off impact on 2019/20 tariff prices), overall CCG programme growth in 2019/20 would be 3.4%.

Mental health commitment

The Long Term Plan commits to grow investment in mental health services faster than the NHS budget overall for each of the next five years. This means mental health will receive a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24.

This commitment is made on a 2018/19 baseline[7] made up of:

- CCG expenditure on mental health services (excluding learning disabilities and dementia)
- Specialised commissioning expenditure on mental health services
- National expenditure on mental health programmes

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[7] Figures are based on planned expenditure in 2018/19

Table 5: Mental health Long Term Plan commitment

	2018/19 £bn	2023/24 £bn	Minimum increase from 18/19 to 23/24 Cash £bn	Real £bn
Mental health commitment	**8.9**	**12.3**	**3.4**	**2.3**
Share of NHS England settlement*	**7.8%**	**8.3%**		

* Non-ringfenced revenue settlement

International definitions of mental health expenditure typically incorporate a broader set of services, for example including learning disabilities and dementia. On this basis, mental health expenditure is more than 10% of the NHS England settlement in each year of the Long Term Plan.

Primary medical and community services commitment

The Long Term Plan commits to increase investment in primary medical and community health services as a share of the total national NHS revenue spend across the five years from 2019/20 to 2023/24. This means spending on these services will be at least £4.5 billion higher in five years' time.

This commitment is made on a 2018/19 baseline[8] made up of:

- Funding for general practice and primary medical services from CCGs and national programmes funded by NHS England
- Commissioned expenditure on community services (excluding mental health) and continuing healthcare

The split between primary medical and community services expenditure in 2023/24 is not set out as this is subject to national and local commissioning discretion.

Table 6: Primary medical and community services Long Term Plan commitment

	2018/19 £bn	2023/24 £bn	Minimum increase from 18/19 to 23/24 Cash £bn	Real £bn
Primary medical services	9.7	n/a	n/a	n/a
Community services (inc. Continuing healthcare)	12.0	n/a	n/a	n/a
Primary medical and community services commitment	**21.7**	**28.8**	**7.1**	**4.5**
Share of NHS England settlement*	**19.1%**	**19.4%**		

* Non-ringfenced revenue settlement

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[8] Figures are based on planned expenditure in 2018/19

ANNEX B: LETTER FROM PETER SMITH, CHAIR OF ACRA, TO SIMON STEVENS

28 November 2018

Simon Stevens
Chief Executive, NHS England

Dear Simon,

ACRA's recommendations on 2019/20 CCG target allocations

The Advisory Committee on Resource Allocation (ACRA) is an independent, expert committee with a remit to provide recommendations and advice on the formulae that inform target allocations. Our remit covers providing recommendations to NHS England on NHS allocations and to the Secretary of State for Health on public health allocations.

I am writing to you to set out the recommendations from ACRA on CCG target allocations for 2019/20 onwards. These recommendations are the culmination of the Committee's work programme over the past three years. During that time, the Committee has also separately provided advice to the Department of Health and Social Care on public health allocations.

Below, in section A, I set out the areas on which the Committee has agreed to make formal recommendations. For completeness, the issues that have been discussed by the committee but are not part of our recommendations are then listed in section B. I then provide a brief summary of our priorities for investigation into methodological improvements for the next round of allocations in section C, concluding with two broader recommendations that the committee would like to make in support of high quality approaches to allocations in future.

Our recommendations continue to be based on the principles that the formulae support equal opportunity of access for equal need and contribute to the reduction in avoidable health inequalities. ACRA continues to assess and test the evidence base for the formulae, making our recommendations on the best evidence available, and also noting when judgements have necessarily been made where the available data are limited.

I should like to thank members of ACRA, members of ACRA's Technical Advisory Group (TAG) and the NHS England Analytical Team for all their excellent contributions to delivering the work programme.

Section A: ACRA's recommendations for methodological changes to 2019/20 CCG target allocations

The committee would like to make the following recommendations on six key components of CCG target allocations.

Recommendation 1: A refreshed model for mental health and learning disabilities is adopted

The current adult mental health formula was developed by the Manchester Centre for Health Economics in 2011 and 2012. In refreshing the formula we have adopted a similar methodology and re-estimated the models using more recent data. We have also been able to use linked data at the patient level, covering the utilisation of mental health, IAPT and learning disability services. The committee has considered over sixty different formulations of a refreshed person-based statistical model, and has selected the model that provides the best fit to the data whilst also being parsimonious and stable when applied to different samples of

data.

Our recommended mental health model covers the need for secondary mental health services, learning disability services and improving access to psychological therapies (IAPT) services. Our recommended model contains a set of need variables based on demographic information about the local population (age, gender and ethnicity), household formation, levels of worklessness in the local area, and relevant morbidity information based on hospital diagnoses. It also contains an enhanced set of supply-side variables to control for varying levels of access around the country, varying approaches to the provision of care, and varying practices amongst providers in recording activity.

We also recommend an updated adjustment for children and young people within the mental health component of target allocations, based on analysis of the latest available patient level mental health data.

Recommendation 2: A new model for community services is adopted

The need for community services is currently estimated using the general and acute model as a proxy. The committee recommends adoption of a new community services model that uses age and deprivation as the key drivers. It has been built from person-level data from Kent and the West Midlands, and validated against data from Leeds and against early results from the new National Community Services Dataset (CSDS). Our analysis suggests that the need for certain community services – notably district nursing and intermediate care - is distributed in a way that is sufficiently different to the need for general and acute services that a new model is warranted. This is due primarily to very high utilisation rates of those particular services amongst older (75+) age groups compared to the rest of the population.

The committee recommends that the new community services formula is applied to target allocations using an expenditure weighting based on 50% of national community spend, while the remaining 50% is modelled using the general and acute model - which we believe remains a good predictor for the other types of community services such as physiotherapy and musculoskeletal (MSK) services.

Recommendation 3: An update is made to the methodology used in the combined adjustment for health inequalities and unmet need

The health inequalities and unmet need adjustment is currently based on a measure of premature mortality – the standardised mortality ratio for those aged under 75 (SMR<75). These data are available at a small area level and thus allow the adjustment to take into account inequalities within as well as between CCGs. To form the adjustment, a weighting is applied to the standardised mortality ratio of each small area before the results are aggregated to CCG level.

The committee has considered the latest available data on premature mortality at small area level as well as investigating the stability of results over time. We have concluded that SMR<75 remains the best available data to use in this adjustment and that a preferable weighting methodology would involve weighting the premature mortality scores in a continuous fashion, rather than by grouping each small area into one of 16 clusters, as in the current methodology. We also recommend that weights of 1 to 25 are applied instead of 1 to 10, to better capture the extent of the gap between the small areas with the highest and lowest levels of premature mortality.

The impact of this adjustment depends on the weighting of the inequalities component within overall target allocations. ACRA has previously been asked to advise on that weighting, but there is a lack of evidence on which ACRA can make a recommendation, so the weights chosen by the NHS England Board are judgement-based. We have seen no new evidence to

suggest that the weights move from the current approach of 10% of core CCG allocations, 15% of primary care allocations and 5% of specialised services allocations.

Recommendation 4: No further adjustments are made at this time on unmet need

The committee's Technical Advisory Group has set up a specific sub-group to investigate unmet need in the context of resource allocations. Significant progress has been made in developing analysis on unmet need in the form of a lack of access to care. There is some evidence from this analysis that the variation in unmet need is different to that of met need, but further work is needed to update the indicators in question and to ensure there is sufficient coverage of key physical and mental health conditions. The committee is therefore of the view that this line of analysis is promising but we recommend that further work is carried out prior to the implementation of any additional adjustments.

Recommendation 5: Baseline populations are estimated using GP registrations averaged over time, and are projected forward using age-sex specific population projections

Allocations are currently set based on the latest available point estimate of the size of the GP registered list in each CCG. There is some seasonality in GP registrations. For example, in some areas with proportionately large student populations, those populations peak in October and then fall during the summer months. Further, list cleansing activity is not necessarily uniform and thus populations may vary from month to month. The committee therefore recommends that baseline populations of CCGs are estimated using GP registrations averaged over 12 months.

Population projections are now available from the Office of National Statistics that project future CCG populations on an age-sex specific basis. This is pertinent to allocations given that age is such a key driver of need, and we recommend their use.

Recommendation 6: No further adjustments are made at this time to account for the unavoidable costs of providing services in remote areas

There are three key adjustments within CCG core target allocations to account for the unavoidable costs of providing services in remote areas. They are the remote hospitals adjustment, the emergency ambulance cost adjustment, and the adjustment for supply induced demand in urban areas, which helps ensure that remote areas are not under-allocated funds relative to need.

Over the past two years the committee has investigated whether there is evidence for any additional adjustments. However, we have been unable to find evidence of unavoidable costs faced in remote areas that are quantifiable and nationally consistent such that they could be factored into allocations.

As noted above, the committee endorses the introduction of a new community services formula, that has the effect of better recognising needs in some rural, coastal and remote areas that on average tend to have much older populations, and higher needs for certain community services. We are planning further work next year to extend this new formula to include an adjustment for home visits by community nurses that will take account of any increased travel times in remote areas.

Section B: Issues that are not part of this set of recommendations

Over the past two years, the committee has given consideration to both the update to the market forces factor and to additional analysis carried out on the primary medical care workload formula. We have previously recommended that the market forces factor in CCG

allocations follows the approach taken in the tariff, which is applied to all services within target allocations except for prescribing. Having looked at the proposed update, we see no reason to move away from that approach. We stand ready to provide further advice on the primary care formula should that be required.

We recommend that the remaining components of CCG target allocations that are not covered in section A above are modelled as in previous rounds, where appropriate using updated data. These components are the general and acute formula, the prescribing formula, the maternity formula, the primary medical care formula, the approach to other primary care and the specialised services formula.

Section C: Our priorities for methodological improvements for the next round of allocations

We are confident the recommendations resulting from our work programme over the past two years will improve the efficiency and equity of the target allocation formulae. The committee has identified a number of areas it intends to consider further for use in future allocations. They are:

1. *Mental health*: we are pleased that the data and analysis sitting behind the mental health formula have now been brought in-house, meaning that the model can be more easily updated and refined as newer patient-level mental health data become available. Further, whilst the adjustment within the mental health component for children and young people has been updated for this round, with patient-level data on children and young people's utilisation of mental health services now available for two years, it may be feasible to develop a more sophisticated formula, taking into account the specific needs of this group. However, we should flag that further improvements in this area will to a large extent be contingent in improvements in data quality (see below).
2. *Community services:* the analysis presented to the committee suggests that the local datasets used to build the new community services model are sufficiently representative of the national picture to be used with confidence for national allocations. The committee will continue to work to improve and enhance the model over time as more national data become available. As noted above, we should also like to examine the case for making an adjustment to take account of increased travel times and costs in remote areas for community nurse visits. This would be analogous to the adjustment made for health visitors within the set of recommendations we made in 2015 on public health allocations.
3. *Unmet need*: As discussed above, the committee has agreed that additional adjustments for unmet need may have merit, and we should like to oversee further refinement of the condition-specific estimates that are being developed, in particular to bring some of the estimates of prevalence more up-to-date and to look further into generating estimates for key mental as well as physical health conditions.
We are pleased that, following representations by ACRA, the importance of unmet need in the context of resource allocation has been recognised by the Department of Health and Social Care as a valuable area for further research and suitable for funding. The planned in-house analysis on unmet need will therefore sit alongside a longer term academic research programme co-ordinated through the National Institute of Health Research (NIHR) over the next two to three years, with the aim of supporting primary research to quantify unmet need and its geographic variation.
4. *Prescribing*: patient-level data on prescribing are now routinely collected and we should therefore like to explore whether the prescribing formula can now reliably be based on patient-level rather than small area level data.
5. *Primary medical care and other primary care*: the recent work investigating the inclusion of key morbidity variables within the primary medical care workload formula suggests welcome improvements and, should it be required, this formula could be further updated. Other primary care (which includes community pharmacy, dental, and

ophthalmology services) is not currently modelled at a patient level and the committee will look to develop a more sophisticated approach to these issues if the data allow.

6. *Expenditure weights*: the way in which components are combined within overall target allocations is a decision for NHS England. However, our recent analysis demonstrated the importance of expenditure weights on target allocations and we would like to look into this topic further, bearing in mind the policy considerations implicit within these weights.

Section D: Two concluding recommendations

I should like to conclude by making two broader recommendations that the committee is unanimous in believing would make a significant impact on the service's ability to support fair and efficient resource allocation in future.

The first is that **a high priority is given to maintaining and enhancing the accuracy of GP registered lists.** These are fundamental to allocations, being the key driver of the distribution of resources to different parts of the country, and any loss of trust in the quality of lists presents a threat to the credibility of the allocations process as a whole.

The second recommendation is that **access to high quality patient level data should form a core part of the long term NHS plan**. From the ACRA perspective there are two key issues. Firstly, irrespective of how pricing and contracting arrangements develop over time, there should be a duty on providers to record accurate information on what services are being provided to whom, in order to support a host of policy, managerial and research needs, including resource allocation. We identified significant inconsistency between providers in their recording of mental health diagnoses and clusters (with some capturing up to 90% of patients and some less than 10%), meaning that we could not use those data to enhance mental health needs model.
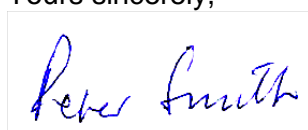
Alongside a focus on high quality data recording, we ask that efforts are made to ensure that measures to assure the public of the protection of their data do not undermine the ability to provide access to high quality, patient level linked datasets for NHS analysts and researchers. The future effectiveness of our allocation formulae will be critically dependent on having in place an information governance framework that minimises barriers to the sharing of suitably anonymised data in secure settings.

In this regard, we would particularly emphasise the importance of successfully delivering NHS Digital's plans for a new GP dataset that can be connected to secondary data. To allow analysts to measure resources and impacts for patients through primary care into secondary and tertiary settings would represent a major step forward, especially if it can draw in information from non-health datasets - such as on social care and on income, wealth, employment and interactions with the welfare system.

We hope that our recommendations are helpful to the decisions that the NHS England Board needs to make on CCG allocations. I should be happy to discuss further with you if you would find this helpful.

I am copying this letter to the Secretary of State for Health and Social Care, for information.

Yours sincerely,

Peter Smith
Emeritus Professor of Health Policy, Imperial College London
Chair of the Advisory Committee on Resource Allocation

Annex C: Examples of circumstances in which CCG allocations may be changed

NHS England reserve the right to change allocations in a number of specific circumstances where the financial stability of the commissioning system is challenged or it is clear that the allocations are no longer fair in their distribution to health economies. Examples of these 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 or changes in the pattern of GP registration;

- a disproportionate increase or decrease in the need-weighted share of the total need-weighted population caused by a change to underlying age structures or populations or relative levels of deprivation;

- a new national contract or pay award established by the Government that changes the level or distribution of resources, (for example the 2019/20 GP contract);

- Expenditure on branded drugs and associated income from the voluntary and statutory branded medicines pricing schemes being different to that anticipated when setting allocations;

- Impact of public sector pensions revaluation and need to distribute this funding to providers;

- the need to ensure minimum contractual growth to GP practices through the primary care allocations; and

- any other change in mandate funding.