Equality and Health Inequalities Analysis

For 2019-20 to 2023-24 revenue allocations to Clinical Commissioning Groups

Equality and Health Inequalities for 2019-20 to 2023-24 revenue allocations to Clinical Commissioning Groups

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PART A: General Information
1. Title of project, programme or work:
2019-20 to 2023-24 revenue allocations to Clinical Commissioning Groups
2. What are the intended outcomes?

To support equal opportunity of access for equal need and contribute to the reduction of health inequalities amenable to healthcare.

Draft financial allocations for Clinical Commissioning Groups (CCGs) covering 2019-20 to 2023-24 were published on 10 January 2019. These are subject to final NHS England Board approval.

This equality and health inequalities analysis covers the allocations for:
- core CCG allocations;
- specialised services allocations;
- primary medical care allocations; and
- total allocations (the sum of the core CCG, specialised and primary medical care).

Steps in setting allocations

Once the national budgets are known, there are four steps in the calculation of actual allocations:
- determine target allocations based on relative need and relative unavoidable costs;
- establish baselines (the previous year's allocations plus any adjustments);
- calculate opening distances from target (baseline minus target);
- determine pace of change policy, that is how far CCG areas are moved closer to their target allocation each year through differential growth. Pace of change policy balances, within the available resources, providing stability in funding for all organisations with moving those furthest under target closer towards their target.

Target shares

The national weighted capitation formulae are used to calculate CCG areas' target shares of the available resources. Target shares are in proportion to each CCG's population weighted by the need for health care services (such as that due to the age profile of the population). There are also weights to account for differences in unavoidable costs due to location in providing healthcare services between geographical areas across England.

The target shares of the available national budget give each CCG's target allocation in monetary terms.

There are separate weighted capitation formulae for CCGs' core responsibilities, specialised services and primary medical care.

Advisory Committee on Resource Allocation

The weighted capitation formulae are recommended by the Advisory Committee on Resource Allocation (ACRA). ACRA is an independent, expert, technical committee and its membership includes GPs, academics, public health experts and NHS managers.

ACRA's recommendations are evidence based from research and statistical modelling.

Equality

Equality is at the heart of the weighted capitation formulae. The formulae recommended by ACRA aim to allow local organisations to commission similar levels of health services for populations with similar levels of need (horizontal equity), and appropriately higher levels of health services for populations with higher levels of need (vertical equity).

The principle of a weighted capitation formula was established in 1976 following the Report of the Revenue Working Party (RAWP). RAWP interpreted its terms of reference as being: "to reduce progressively, and as far as feasible, the disparities between the different parts of the country in terms of the opportunity for access to health care of people at equal risk."

Weighted capitation formulae

Components

The weighted populations for CCGs' areas are based on:
- the population base – a count of the population each CCG is responsible for;
- a weight, or adjustment, for higher need for health care services due to age (areas with more elderly populations receive higher allocations per head, all else being equal);
- a weight, or adjustment, for additional need for health services over and above that due to age (areas with poorer health receive higher allocations, all else being equal);
- an adjustment for unmet need and health inequalities;
- a weight, or adjustment, for unavoidable differences in the costs of providing health services due to location alone – the Market Forces Factor (areas where the cost of living, land etc are higher receive higher allocations, all else being equal);
- in the formula for core CCG allocations, an adjustment for the higher costs of providing emergency ambulance services in sparsely populated areas, and an adjustment for the higher costs faced by unavoidably small hospitals in remote areas providing 24 hour accident and emergency services.

Accounting for differences in need for different services

The values of the weights per head differ between the formulae for CCG core allocations, primary medical care and specialised services due to differences in relative need across the country for the respective health services.

The weighted capitation formula for CCG core allocations also has separate components for general and acute, mental health, maternity and prescribing. This is because need varies differently across the country for each of these services.

The research developing general and acute and mental health models used data at the individual level (anonymised) to provide accurate estimates of the different needs of different individuals and population groups. The exception to this was the prescribing formula, as data were only available at GP practice level. Previous formulae typically estimated need for small areas, which may not have fully captured differences in need within small areas, and this is the approach used for the new community services model.

Adjusting for different characteristics

Modelling utilisation

Observing need per head directly has not proved possible to date. Instead statistical modelling by academic researchers has examined the relationship between the utilisation of health services on the one hand, and the characteristics of individuals (including diagnoses data) and the area where they live on the other hand. These models have been used to decide which factors to include in the formula to predict future need per head.

Need related to age and sex

People do not have identical needs for health care services. A key difference is that need varies according to age and sex, and in particular the very young and elderly, whose populations are not evenly distributed across the country, have a higher need for health services than the rest of the population. The weighted capitation formulae therefore take into account the relative need per head of different age-sex groups and the different age-sex profiles of local populations.

Additional need (over and above that related to age and sex)

Even when differences related to age and sex are accounted for, populations with the same age profiles display different levels of need. An additional adjustment to reflect the relative need for health services over and above that related to age and sex is therefore necessary. This adjustment is based on morbidity indicators and characteristics, such as deprivation, associated with morbidity.

Need related to age, sex and additional need over and above that due to age and sex are estimated as a single set of weights rather than two separate sets of weights in the general and acute, mental health, maternity, primary medical care, and specialised services models. This is because additional need varies by age-sex group and differentially across the country by age-sex group. The prescribing formula estimated need related to age-sex separately to additional need due to data availability.

Additional need for general and acute, mental health, specialised services was estimated using morbidity data based on the diagnoses for hospital inpatient admissions for each patient.

The Index of Multiple Deprivation (IMD) was used in the primary medical care formula due to the absence of other information in the data set available for the modelling. The prescribing formula also used the IMD, and proxies for morbidity mainly from the Population Census.

Supply side variables

The models also include 'supply' variables to take account of the greater availability of health care services generally leading to higher use. While the supply variables are included in the models, they are set to the national average when calculating weighted populations. This means areas are not penalised in the formula for lower utilisation due to relatively lower capacity.

Unmet need and health inequalities adjustment

The models typically assess need as it is currently met by NHS services and therefore may not capture unmet need or inappropriately met need. Typically, the most deprived communities do not access health care in the most appropriate way, resulting in poorer health outcomes. NHS England also has a duty to have regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services.

There is an adjustment for unmet/inappropriately met need and health inequalities in the weighted capitation formula. This is based on a measure of population health (the standardised mortality ratio for those under 75 years of age (SMR<75)). The adjustment is calculated for the population of each small area and then aggregated to CCG level. Applying the measure at the small area level takes into account unmet need/health inequalities within as well as between CCGs.

ACRA's recommendations are principally based on research and modelling. However, due to the lack of robust quantitative evidence on unmet need which is comprehensive and consistent between services and across the country, ACRA's recommended measure to be used for the unmet need and health inequalities adjustment was largely pragmatic and based on judgement.

ACRA considered a range of measures of population health for the adjustment. These were found to be highly correlated with each other. The SMR<75 has the advantage that it can be updated regularly at small area level, while other measures can only typically be updated at small area level using data from the 10 yearly Census. The SMR<75 was recommended as an indicator of the health of the whole population of areas, including morbidity and all age groups.

The adjustment for unmet need and health inequalities has been refined to give a higher weight per head than previously to the small areas with the worst SMR<75s.

ACRA was unable to recommend the share of the overall weighted capitation formula that should be based on the unmet need and health inequalities adjustment. The NHS England Board meeting of 17 December 2015 decided that the share should be 15% for primary medical allocations, 10% for CCG core allocations, and 5% for specialised services. We have decided to continue using these weightings in the proposed allocations.

The share is highest for primary medical care as it is expected that unmet need and health inequalities can be more effectively addressed through primary medical care than through secondary care. The share is lower for specialised services on the basis that unmet need and the potential to impact on inequalities is likely to be lower in this sector.

Unavoidable costs

The weighted capitation formula includes adjustments for unavoidable costs due to location, so that areas with higher costs are not disadvantaged in their allocations. The adjustments for higher unavoidable costs include the market forces factor (MFF), the emergency ambulance cost adjustment (EACA) and an adjustment for remote hospitals.

The MFF adjusts for unavoidably higher unit staff and premises costs, which are higher in particular in London. The EACA adjusts for the longer journey times of ambulances in sparsely populated areas, and the final adjustment is for the higher costs of hospitals because of unavoidable smallness due to remoteness.

Pace of change policy

Pace of change policy sets actual allocations by determining how far CCG areas are moved closer to their target allocation each year through differential growth. Pace of change policy balances, within the available resources, providing stability in funding for all organisations with moving those furthest under target closer towards their target. The overall approach to pace of change for 2019-20 to 2023-24 allocations is based upon achieving greater equity of access through accelerating alignment of allocations with target allocations with the result that:
•	in 2019-20 all CCGs are no further than 5% under target for CCG commissioned services;
•	in 2019-20 all CCG areas are no more than 5% under target for the total commissioning streams for their population; and
•	those CCGs more than 10% above target receive lower levels of per capita growth in their allocations.

Local Commissioning and Provider Decisions

NHS England provide Clinical Commissioning Groups with allocations based on the principles outlined above. However, ultimately the commissioning decisions of individual CCGs and the operational decisions of individual providers are a key determinant of the impact on protected groups.

3. Who will be affected by this project, programme or work? Please summarise in a few sentences which of the groups below are very likely to be affected by this work.

Staff
Patients
Service users, and carers
Partner organisations
Others.

Patients, Service users and Carers, Partner organisations

4. Which groups protected by the Equality Act 2010 and/ or groups that face health inequalities are very likely to be affected by this work?

The policy models expected need for healthcare on a range of characteristics that include:
- age;
- sex;
- race;
- disability;
- household composition (included those married or in a civil partnership);
- pregnancy and maternity; and
- deprivation.

PART B: Equalities Groups and Health Inequalities Groups

5. Impact of this work for the equality groups listed below.

Focusing on each equality group listed below (sections 5.1. to 5.9), please answer the following questions:

a) Does the equality group face discrimination in this work area?
b) Could the work tackle this discrimination and/or advance equality or good relations?
c) Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?
d) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
e) If you cannot answer these questions what action will be taken and when?

5.1. Age

The weighted capitation formulae specifically takes into account the different needs for health care services by age group, which are especially higher for older age groups and significantly greater for the oldest age groups.
For example, the general and acute formula gives a weight per head 11 times higher for those aged 65-70 compared with those aged 20-25, and 20 times higher for those aged 85 and over compared with those aged 20-25.

The needs of the most elderly have been better reflected in this work than previously by the development of a specific adjustment for community services. We have found

that need for these services increases much more rapidly with age than had previously been assumed

The increased need of young children is also reflected in the model, although this is less significant than for older people.

5.2. Disability

The aim of the formula is to equalise allocations relative to health needs across CCGs, and therefore directly reflect need due to disability. For example, the general and acute and mental health models are largely based on past patterns of morbidity at the individual level as measured by diagnostic data for hospital admissions. The prescribing formula also includes morbidity measures, such as the proportion of the local population with activity limiting health conditions. The data available for the primary medical care formula did not include data on disability, but the Index of Multiple Deprivation (IMD) was used as proxy for poorer health.

There is also a separate unmet need/health inequalities adjustment based on the SMR<75 for small areas (Middle Level Super Output Areas - MSOAs). This is because the models typically assess need as it is currently met by NHS services and therefore may not capture unmet need or inappropriately met need. Typically, the most deprived communities do not access health care in the most optimal way, resulting in poorer health outcomes.

In the current round the unmet need/health inequalities adjustment has been adjusted to ensure it is sensitive to the most severe challenges, and more resources are thus targeted at those communities.

A criticism of this approach is that it may be less sensitive to inequalities associated with mental health conditions and learning disabilities. Despite an active research programme, we have not yet identified a suitable alternative measure. This work will continue.

5.3. Gender reassignment

These groups' treatment needs, as for all population groups, will be included in the diagnostic information used in the general and acute and mental health services formulae. Beyond this, there is a lack of data on the groups' needs suitable for consideration for use in an allocations formula and so there is no specific adjustment in the formulae. As for other groups, local commissioners and providers are subject to the public sector equality duty.

5.4. Marriage and civil partnership

Marital and civil partnership status was tested in developing the formulae and found to be statistically significant in general and acute and not statistically significant in the mental health or specialised services formula.

In the mental health formula we use a new variable that allows us to characterise the household that an individual lives in. Broadly we find that those in communal

establishments, such as care homes, have the highest need, followed by people living alone. People living in multi-adult households, including married couples or those in civil partnerships, have on average lower levels of need.

The available data did not permit marriage and civil partnership to be tested as an additional variable in the primary medical care workload formula.

5.5. Pregnancy and maternity

There is a separate maternity formula within the formula for CCG core allocations to take into account the specific health care needs related to pregnancy and maternity.

5.6. Race

The mental health, prescribing and maternity formulae include ethnicity variables. The modelling for the mental health formula had data available on ethnicity at the individual level for users of mental health services. The modelling tested 16 ethnicity variables, of which 3 or 4 were found to be statistically significant, the number varying between the working age and older adults' models.

For some groups the mental health modelling suggested lower than typical need. This was not supported by any other evidence, and so we have interpreted this as unmet need, removing this lower than typical need from the model. This uses a standard statistical approach, the sterilisation of counter intuitive variables.

The research for the prescribing and maternity formulae did not have data on ethnicity for each individual. Instead the proportion of people by ethnic group in each individual's place of residence was used from the Population Census (place of residence was defined by Lower Level Super Output Area – LSOA). A number of variables for ethnicity were tested and the proportion of non-white people in the prescribing formula and the proportion of black African ethnic groups for maternity were found to be statistically significant with a positive coefficient, indicating higher need.

The research for the general and acute and specialised services formulae tested a wide range of variables on ethnicity but none were found to be statistically significant over and above the person based diagnostic data in the models.

5.7. Religion or belief

Religion or belief were tested for inclusion in the general and acute and specialised services formulae and found not to be statistically significant (over and above the other variables in the model, such as diagnoses). It was tested for a previous version of the mental health model, with the same result.

5.8. Sex or gender

The weighted capitation formula directly takes account of the different needs of males and females in each age-group. For example, the need for general and acute services

for women in their 30s is higher than that for men, while the need for general and acute services for men aged 85 and over is higher than for women.

The mental health component has separate formulae for men and women of working age as their needs were found to be different.

5.9. Sexual orientation

These groups' treatment needs, as for all population groups, will be included in the diagnostic information used in the general and acute and mental health services formulae. Beyond this, there is a lack of data on the groups' needs suitable for consideration for use in an allocations formula and so there is no specific adjustment in the formulae. As for other groups, local commissioners and providers are subject to the public sector equality duty and the health inequality duty

The sexual orientation monitoring information standard has the potential to improve recording of sexual orientation and we will adjust our approach as the data quality and coverage allows it.

6. Implications of our work for the health inclusion groups listed below.

Focusing on the work described in sections 1 and 2, in relation to each health inclusion group listed below (Sections 6.1. To 6.12), and any others relevant to your work[1], please answer the following questions:

f) Does the health inclusion group experience inequalities in access to healthcare?
g) Does the health inclusion group experience inequalities in health outcomes?
h) Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes?
i) Could the work assist or undermine compliance with the duties to reduce health inequalities?
j) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
k) As some of the health inclusion groups overlap with equalities groups you may prefer to also respond to these questions about a health inclusion group when responding to 5.1 to 5.9. That is fine; please just say below if that is what you have done.
l) If you cannot answer these questions what action will be taken and when?

6.1. Alcohol and / or drug misusers

A number of diagnostics that are linked to alcohol and drug misuse were considered for inclusion in the model, although most proved not to be statistically significant indicators of future need for healthcare. However, in the mental health model we found a significant relationship with the diagnostic "poisoning by adverse effect of and under dosing of drugs, medicaments and biological substances (ICD-10 codes T36-T50)"

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[1] Our guidance document explains the meaning of these terms if you are not familiar with the language.

6.2. Asylum seekers and /or refugees

There is no specific adjustment in the formulae for asylum seekers and/or refugees.

Where asylum seekers or refugees present with higher levels of need this will be reflected in the diagnostic flags and may attract a higher weight. As for other groups, local commissioners and providers are subject to the health inequality duty and public sector equality duty.

6.3. Carers

There is no specific adjustment in the formulae for carers. Data on voluntary care was tested for inclusion in the general and acute formula but was not found to be statistically significant.

Where carers present with higher levels of need this will be reflected in the diagnostic flags and may attract a higher weight. As for other groups, local commissioners and providers are subject to the health inequality and public sector equality duty.

6.4. Ex-service personnel / veterans

There is no specific adjustment in the formulae for ex-service personnel or veterans.

Where ex-service personnel or veterans present with higher levels of need this will be reflected in the diagnostic flags and may attract a higher weight. As for other groups, local commissioners and providers are subject to the health inequality duty and public sector equality duty.

6.5. Those who have experienced Female Genital Mutilation (FGM)

There is no specific adjustment in the formulae for those who have experienced FGM.

Where those who have experienced FGM present with higher levels of need this will be reflected in the diagnostic flags and may attract a higher weight. As for other groups, local commissioners and providers are subject to the health inequality duty, public sector equality duty and Safeguarding Children Guidelines.

6.6. Gypsies, Roma and travellers

There is no specific adjustment in the formulae for Gypsies, Roma and travellers.

Where Gypsies, Roma and travellers present with higher levels of need this will be reflected in the diagnostic flags and may attract a higher weight. As for other groups, local commissioners and providers are subject to the health inequality duty and public sector equality duty.

The basis of our allocations is the registered population of the CCG; we have been unable to identify suitable data to make an adjustment for unregistered people. Studies of rates of GP registration show wide variation (from 50-91% - Aspinall, 2005, A Review of the Literature on the Health Beliefs, Health Status, and Use of Services in

the Gypsy Traveller Population, and of Appropriate Health Care Interventions, Health ASERT Programme Wales Report Series, see https://kar.kent.ac.uk/9170/1/Aspinall_GypsyTraveller_ASERT.pdf) and it is likely that overall Gypsies, Roma and travellers are less likely to be registered with a GP, and so their need may not be adequately reflected in the utilisation based element of the formula.

This is part of our rationale for including a component for unmet need and health inequalities in our formula. This element of the formula is under active and continuing development, including a commitment in the Long Term Plan to commission the Advisory Committee on Resource Allocation to conduct and publish a review of the inequalities adjustment to the funding formulae.

6.7. Homeless people and rough sleepers

There is no specific adjustment in the formulae for homeless people and rough sleepers.

Where homeless people and rough sleepers present with higher levels of need this will be reflected in the diagnostic flags and may attract a higher weight. As for other groups, local commissioners and providers are subject to the health inequality duty and public sector equality duty.

The basis of our allocations is the registered population of the CCG; we have been unable to identify suitable data to make an adjustment for unregistered people. There is evidence that, despite NHS guidelines, homeless people may face greater challenges registering with a GP (eg https://www.healthwatch.co.uk/news/2018-03-23/improving-access-gp-services-people-who-are-homeless) and, for this and other reasons, studies have shown that they are less likely to be registered with a GP (eg, Elwell-Sutton, Fok, Albanese, et al, 2017, Journal of Public Health, 39, 26–33, https://academic.oup.com/jpubhealth/article/39/1/26/3065715) and so their need may not be adequately reflected in the utilisation based element of the formula.

This is part of our rationale for including a component for unmet need and health inequalities in our formula. This element of the formula is under active and continuing development, including a commitment in the Long Term Plan to commission the Advisory Committee on Resource Allocation to conduct and publish a review of the inequalities adjustment to the funding formulae.

6.8. Those who have experienced human trafficking or modern slavery

There is no specific adjustment in the formulae for those who have experienced human trafficking or modern slavery.

Where those who have experienced human trafficking or modern slavery present with higher levels of need this will be reflected in the diagnostic flags and may attract a higher weight. As for other groups, local commissioners and providers are subject to the health inequality duty, public sector equality duty and safeguarding vulnerable children and adults' guidelines.

6.9. Those living with mental health issues

A specific component of the formula is designed to estimate need for mental health services and so support equal opportunity of access for those services. In addition, we have increased the importance of this component, relative to other aspects of care, aligning it with the latest comprehensive information on mental health spending.

We expect mental health services to be an area of continuing research interest in future allocation cycles, particularly as data quality improves.

6.10. Sex workers

There is no specific adjustment in the formulae for sex workers.

Where sex workers present with higher levels of need this will be reflected in the diagnostic flags and may attract a higher weight. As for other groups, local commissioners and providers are subject to the public sector equality duty.

6.11. Trans and non-binary people

There is no specific adjustment in the formulae for trans or non-binary people.

Where trans and non-binary people present with higher levels of need this will be reflected in the diagnostic flags and may attract a higher weight. As for other groups, local commissioners and providers are subject to the health inequality duty and public sector equality duty.

6.12. The overlapping impact on different groups who face health inequalities

We specifically test in our model for overlapping and reinforcing effects,
Where these prove to be significant they are included in our models.

7. Other groups that face health inequalities that we have identified.

Have you have identified other groups that face inequalities in access to healthcare?

Does the group experience inequalities in access to healthcare and/or inequalities in health outcomes?

Short explanatory notes - other groups that face health exclusion.
As we research and gather more data, we learn more about which groups are facing health inequalities. If your work has identified more groups that face important health inequalities please answer questions 7 and 8. Please circle as appropriate.

If you have not identified additional groups, that face health inequalities, just say not applicable or N/A in the box below.

Yes Complete section 8	No Go to section 9	N/A

Yes

8. Other groups that face health inequalities that we have identified. Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes in relation to these other groups that face health inequalities? Could the work undermine compliance with the duties to reduce health inequalities and, if so, what action should be taken to reduce any adverse impact? Is the work going to help NHS England to comply with the duties to reduce health inequalities? If you have identified other groups that face health inequalities please answer the questions below. You will only answer this question if you have identified additional groups facing important health inequalities.
Areas with greater socio-economic disadvantage typically have poorer health after accounting for age and higher health care needs. This is reflected in the formulae through the inclusion of morbidity data or indicators. Morbidity data were not available for the primary medical care formula, and the Index of Multiple Deprivation was included instead. As noted above, there is also a separate unmet need/health inequalities adjustment based on the SMR<75 for small areas (MSOAs). This adjustment is included because the models typically assess need as it is currently met by NHS services and therefore may not capture unmet need or inappropriately met need. Typically the most deprived communities do not access health care in the most optimal way, resulting in poorer health outcomes.

PART C: Promoting integrated services and working with partners

Short explanatory notes: Integrated services and reducing health inequalities.

Our detailed guidance explains the duties in relation to integrated services and reducing health inequalities. Please answer the questions listed below.

9. Opportunities to reduce health inequalities through integrated services.

Does the work offer opportunities to encourage integrated services that could reduce health inequalities? If yes please also answer 10.

Yes Go to section 10	No Go to section 11	Do not know
Yes		

10. How can this work increase integrated services and reduce health inequalities?

The models typically assess need as it is currently met by NHS services and therefore may not capture unmet need or inappropriately met need. Typically, the most deprived communities do not access health care in the most appropriate way, resulting in poorer health outcomes. NHS England also has a duty to have regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services.

There is an adjustment for unmet/inappropriately met need and health inequalities in the weighted capitation formula. This is based on a measure of population health (the standardised mortality ratio for those under 75 years of age (SMR<75)). The adjustment is calculated for the population of each small area and then aggregated to CCG level. Applying the measure at the small area level takes into account unmet need/health inequalities within as well as between CCGs.

This adjustment will support and encourage services, including integrated services, that could reduce health inequalities.

PART D: Engagement and involvement

11. Engagement and involvement activities already undertaken.

How were stakeholders, who could comment on equalities and health inequalities engaged, or involved with this work? For example in gathering evidence, commenting on evidence, commenting on proposals or in other ways? And what were the key outputs?

The weighted capitation formulae are recommended by the Advisory Committee on Resource Allocation (ACRA). ACRA is an independent, expert, technical committee and its membership includes GPs, academics, public health experts and NHS managers.

ACRA's recommendations are evidence based from research and statistical modelling.

12. Which stakeholders and equalities and health inclusion groups were involved?
Members of ACRA have a broad range of interests and expertise.

13. Key information from the engagement and involvement activities undertaken. Were key issues, concerns or questions expressed by stakeholders and if so what were these and how were they addressed? Were stakeholders broadly supportive of this work?
The recommendations are made by the committee; their questions, concerns and proposals drive the research and development programme.

14. Stakeholders were not broadly supportive but we need to go ahead. If stakeholders were not broadly supportive of the work but you are recommending progressing with the work anyway, why are you making this recommendation?
N/A
15. Further engagement and involvement activities planned. Are further engagement and involvement activities planned? If so what is planned, when and why?
The development of allocations methodologies is a continuous project that will continue, with ACRA's guidance.

PART E: Monitoring and Evaluation

16. In relation to equalities and reducing health inequalities, please summarise the most important monitoring and evaluation activities undertaken in relation to this work
The weighted capitation formulae are regularly reviewed and updated to take account of changing patterns of need and the latest data. All components of the formula have at least seen data updates for allocations from 2019-20. The equality and health inequalities analysis will be reviewed as part of future reviews of the formulae.

17. Please identify the main data sets and sources that you have drawn on in relation to this work. Which key reports or data sets have you drawn on?
Data sets and sources used in the models, explored for inclusion but rejected or used for cross checking and validation include SUS-PbR (inpatient, outpatient, A&E) Hospital Episodes Statistics Mental Health Minimum Dataset IAPT dataset Census 2011 local area characteristic measures including: • Ethnicity • Household type

- Household tenure
- Residents of communal establishments
- Marital status
- Car or van availability
- Religion
- Long-term health problem or disability
- Working status
- Routine occupation
- Schoolchildren and students living away from home.

DWP
- Working age benefit claimants

Office for National Statistics
- General Health (very good, good, fair, bad, very bad) by age group
- Long-term health problem or disability
- Approximate social grade

QOF
- Atrial fibrillation
- Cancer
- Cardiovascular disease
- CKD
- Coronary heart disease
- Dementia
- Depression
- Diabetes
- Epilepsy
- Heart failure
- Hypertension
- Hypothyroidism
- Learning disabilities
- Mental health
- Peripheral artery disease
- Palliative care
- Stroke and TIA

Indices of multiple deprivation 2015
- IMD score

Population data

- Resident from ONS
- GP Registered populations from PDS
- new registration data from NHS Digital

GP Patient Survey

18. Important equalities or health inequalities data gaps or gaps in relation to evaluation.

In relation to this work have you identified any:
- important equalities or health inequalities data gaps or
- gaps in relation to monitoring and evaluation?

Yes	No

Yes

19. Planned action to address important equalities or health inequalities data gaps or gaps in relation to evaluation.

If you have identified important gaps and you have identified action to be taken, what action are you planning to take, when and why?

As highlighted in the NHS Long Term Plan, allocations policy is a key part of the NHS England strategy to reduce avoidable health inequalities, but the evidence base to support the design of a financial adjustment remains incomplete.

We will commission the independent Advisory Committee on Resource Allocation to conduct and publish a review of the inequalities adjustment to the funding formulae.

We are also working with NIHR to develop an invitation for academic groups to propose longer term work to help us to understand how unmet need in particular is distributed, with a focus on how our allocations policy should be adjusted in the longer term to reflect it.

PART F: Summary analysis and recommended action

20. Contributing to the first PSED equality aim.

Can this work contribute to eliminating discrimination, harassment or victimisation?

<u>Yes</u>	No	Do not know

If yes please explain how, in a few short sentences

Yes. By ensuring that CCGs with different population and geographies i.e. rural/urban characteristics have appropriate levels of resources for their healthcare need we reduce the risk of effective discrimination between groups in providing access to healthcare.

21. Contributing to the second PSED equality aim.

Can this policy or piece of work contribute to advancing equality of opportunity? Please circle as appropriate.

<u>Yes</u>	No	Do not know

If yes please explain how, in a few short sentences

Yes. By ensuring that CCGs with different population characteristics have appropriate levels of resources for their healthcare need we support equal opportunity of access to healthcare for people with equal need.

22. Contributing to the third PSED equality aim.

Can this policy or piece of work contribute to fostering good relations between groups? Please circle as appropriate.

Yes	<u>No</u>	Do not know

If yes please explain how, in a few short sentences

23. Contributing to reducing inequalities in access to health services.

Can this policy or piece of work contribute to reducing inequalities in access to health services?

<u>Yes</u>	No	Do not know

If yes which groups should benefit and how and/or might any group lose out?

Supporting equal opportunity of access for equal need is the fundamental aim of this policy.

24. Contributing to reducing inequalities in health outcomes.

Can this work contribute to reducing inequalities in health outcomes?

<u>Yes</u>	No	Do not know

If yes which groups should benefit and how and/or might any group lose out?

The second of the two aims of this policy is to support the reduction of avoidable health inequalities,

25. Contributing to the PSED and reducing health inequalities.

How will the policy or piece of work contribute to the achieving the PSED and reducing health inequalities in access and outcomes? Please describe below in a few short sentences.

By aligning resources to need for healthcare and the potential to reduce avoidable health inequalities.

26. Agreed or recommended actions.

What actions are proposed to address any key concerns identified in this Equality and Health Inequalities Analysis (EHIA) and / or to ensure that the work contributes to the reducing unlawful discrimination / acts, advancing equality of opportunity, fostering good relations and / or reducing health inequalities? Is there a need to review the EHI analysis at a later stage?

Action	Public Sector Equality Duty	Health Inequality	By when	By whom
Commission the independent Advisory Committee on Resource Allocation to conduct and publish a review of the inequalities adjustment to the funding formulae		X	Commission included in NHS Long Term Plan. To be included in ACRA's work programme for the next allocations cycle Any subsequent recommendations in time for next allocations round.	Analysis & Insight for Finance team.
Work with NIHR to develop an invitation for academic groups to		X	Call for proposals expected in early 2019	Analysis & Insight for

propose longer term work to help us to understand how unmet need in particular is distributed, with a focus on how our allocations policy should be adjusted in the longer term to reflect it.				Finance team with NIHR
Ongoing review of allocations methodology in preparation for next allocations round.	X	X	Research programme proposals developed during first half of 2019 Any subsequent recommendations in time for next allocations round.	Analysis & Insight for Finance team.

PART G: Record keeping	
27.1. Date draft circulated to E&HIU:	11 January 2019
27.1. Date draft EHIA completed:	23 January 2019
27.2: Date final EHIA produced:	23 January 2019
27.3. Date signed off by Director:	23 January 2019
27.4: Date EHIA published:	
27.5. Review date:	

28. Details of the person completing this EHIA		
Name	Post held	E-mail address
Stephen Lorrimer	Head of Analysis & Insight for Finance	Stephen.Lorrimer@nhs.net

29: Name of the responsible Director	
Name	Directorate
Ben Day	Finance