Note on Clinical Commissioning Group (CCG) Allocations 2019/20-2023/24

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1 Introduction

This document sets out the changes made to target CCG allocations for 2019/20, our pace of change rules, and the assumptions used to set the overall CCG allocations growth rate. The CCG allocations for 2019/20 to 2023/24 published alongside this document are draft and subject to final approval by the NHS England Board on 31 January 2019.

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%.

If you have any comments or questions on the allocations, or changes set out in this note, please contact england.revenue-allocations@nhs.net.

2 Changes to Target Allocations

2.1 ACRA recommended methodological changes

Target allocations are based on a revised target formula following changes recommended by our long standing independent advisory committee, the Advisory Committee on Resource Allocation (ACRA[1]). ACRA's letter of recommendation to Simon Stevens is included as Annex A.

2.1.1 Population and other demographic data

Population figures for all programme allocations are based on GP registered list sizes, as they have been since 2013/14. 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. We are making two changes to the way in which population data are used:

- 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.

- We use age and gender specific population projections produced by 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.

2.1.2 Community Services

Until now 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

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

assumed to be proportional to the need for general and acute services when setting the target CCG allocations.

However, analysis of data from early adopters of the new Community Services Dataset shows a needs distribution for district nursing services that is substantially different to the general and acute (G&A) distribution. We are therefore implementing 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. Analysis suggests that utilisation of a wider range of community services is sufficiently closely related to district nursing such that this formula will be applied to 50% of all spending on community services. The other 50% will continue to follow the formula for general and acute services.

2.1.3 Mental health and learning disabilities services

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 significant improvement in our approach to estimating need for these services.

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. We are therefore implementing a refreshed mental health and learning disabilities formula which takes account of these new data.

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, potentially resulting from improved diagnosis, treatment and recording of dementia.

2.1.4 Health inequalities

NHS England has a strong commitment and legal duty to have regard to the need to reduce health inequalities Our approach to allocations supports this. Further, we recognise that one of the limitations of a utilisation-based approach to measuring healthcare needs is it will not necessarily fully capture needs that are unmet.

Therefore to take account of health inequalities and unmet need in the allocations formula, we make an adjustment using the standardised mortality ratio for those aged under 75 (SMR<75). This has been recommended by ACRA as the best available indicator.

We 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 health inequalities and the likelihood of unmet need.

In addition, from 2019/20, in addition to data updates, we are making 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 largest SMR<75 inequalities values, where the latest data show a deterioration in a small number of areas, increasing the fair share of resources targeted at these areas.

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.

2.1.5 Other areas of the model

Other than data updates, we have not made any 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.

The EACA and remote hospitals adjustments are intended to reflect the differential costs of providing services in the most remote areas. During this round we have explored whether further adjustments are justified. We have found no nationally consistent evidence that we could use to form the basis of any further adjustments.

However, as part of our forward work programme we remain open to considering whether further adjustments are needed for services in rural, remote or sparse areas. In particular, we will consider if an additional adjustment for the travelling time of staff providing home services in sparsely populated areas is material.

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.

2.2 Primary Care

We are publishing revised primary care (GP) allocations taking account of data and population updates. No changes have been made to the formula used to determine target allocations.

2.3 Specialised services

A new target allocations formula for specialised services was developed for the 2016/17 allocations round and combined with expenditure data 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 allocations to specialised commissioners but are an important part of our ability to understand total expenditure on healthcare for the population of a place. We have published the results of this analysis at CCG level and used it in the place-based element of pace of change.

2.4 Market forces factor

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

Subject to consultation, we propose to update the method and data for calculating MFF values, with the new values to be introduced over five years. More information on the updated MFF values has been published by NHS Improvement.

We are taking a consistent approach to factoring MFF changes into CCG allocations and target allocations are therefore also updated in a phased way over five years. Pace of change is applied to overall target allocations, including changes resulting from the updated MFF.

3 Pace of change

Pace of change prevents movements in target allocations leading to volatility in terms of final allocations. Our pace of change policy is built on a number of key objectives:

- Additional growth is applied to those areas most below target, with an aim that we maintain no area being more than 5% below target. This is achieved is 2019/20 and every year thereafter.

- 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% from target in 2019/20, and CCGs between 0% and +5% from target in all later years.

- Areas more than 5% above target receive a lower level of funding growth, tapering down to floor growth for those more than 10% above.

- For Core CCG allocations, growth for CCGs more than 10% above target will be set at a floor. This will be equal to the average growth per head of population less 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 set at 2.2 percentage points), but reflects higher assumed price and activity growths as well as higher policy pressures in 2019/20. For Primary Care, the floor for areas more than 10% above target will be set at 1.25 percentage points below average growth reflecting the fact that flexibility in this commissioning stream is more limited by the structures of the primary care contract.

- An absolute floor of GDP deflator on overall funding (i.e. not per head of population) also applies.

- 0.1% of CCG programme and primary care allocations are distributed on a place-based basis. This continues the approach adopted in the last allocations round and is intended to take a more holistic view of allocations for a place (including CCG, primary care and specialised funding).

4 Other assumptions

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%.

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 are included in Annex B.

5 Running cost allocations

CCG running cost allocations have been issued in line with the expectations set out in the letter of 23 November 2018.

In 2019/20, individual CCG running cost allowances have been maintained in cash terms at the same amount as in 2018/19. In 2020/21, allowances are 20% lower in real terms than in 2017/18 after adjusting for the estimated additional pressure from the three-year Agenda for Change pay deal. Running cost allowances have not been adjusted for population changes.

Admin funding previously provided separately in relation to market rents adjustments is now included in these allocations.

Annex A: Letter from Professor Peter Smith, Chair of Advisory Committee on Resource Allocation 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.

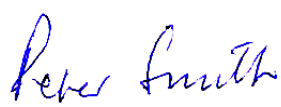
The second recommendation is that **access to high quality patient level data should form a core part of the long term NHS plan**. From the ACRA perspective there are two key issues. Firstly, irrespective of how pricing and contracting arrangements develop over time, there should be a duty on providers 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 B: Examples of circumstances in which 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 PPRS scheme 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.