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Social and General Statistics

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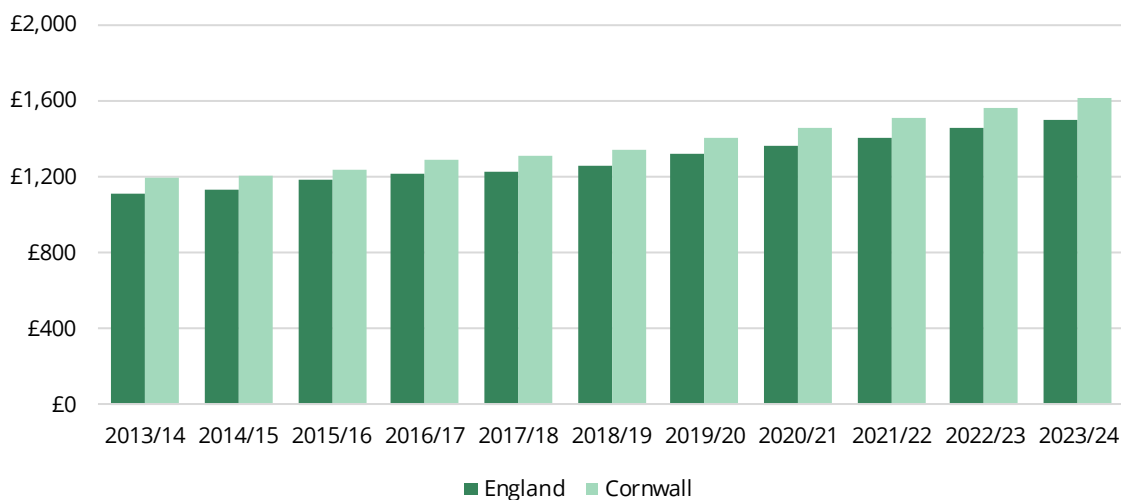
## Kernow CCG Funding

The latest CCG funding allocations were published in 2019 and cover a five-year period until 2023/24. NHS England publish the allocations in pdf format including the distance from target of each CCG [here](#).

Allocations for Kernow CCG are summarised in the table and chart below. The CCG receives above average funding per head compared with England as a whole. Kernow's funding increases are slightly above the national average for all but one of the next five years. The allocations shown in the table are presented at 2019/20 prices (taking into account the expected effects of inflation). The 'Distance from Target' (DFT) data is explained below.

- After accounting for the expected effects of inflation, **funding per head in Cornwall is due to increase by 7% between 2019/20 and 2023/24**. The average national increase over the same period is 6%.
- **Funding per head in Cornwall is 6.8% higher than the national average.**

### Kernow CCG funding per head, compared with England, 2013 to 2024



## Cornwall CCG Funding Allocations, 2019/20 to 2023/24

2019/20 prices - Taking into account the effects of inflation

	2019/20	2020/21	2021/22	2022/23	2023/24
Funding Allocation £m	815.4	836.3	856.0	875.6	894.4
Distance from Target	-1.7%	-2.1%	-2.5%	-2.8%	-3.0%
<i>Kernow increase %</i>	+1.4%	+2.5%	+2.3%	+2.2%	+2.0%
<i>England increase %</i>	+3.5%	+2.6%	+2.4%	+2.3%	+2.1%

Sources:

[January 2019 CCG allocations 2019/20 to 2023/24](#)

[HMT: GDP deflators June 2019](#)

## Mental Health Spending

Comprehensive and comparable information on mental health spending by CCGs is only available from 2016/17 onwards. An England-wide figure is also available for 2015/16. This data is published as part of NHS England's [Mental Health Five Year Forward View Dashboard](#). Note that the spending identified here includes learning disability services as well as mental health services. In addition to CCG spending on mental health, NHS England itself spends a further £1.8 billion each year on specialised commissioning of other mental health services.

The table below shows that Kernow's spend per registered patient on mental health is higher than the national average, but has fallen since 2016/17. The per-head figures are unadjusted, so they may reflect differences in need rather than differential service provision.

Mental health spending isn't ring-fenced, but CCGs are expected to increase their mental health spending by a percentage matching or exceeding the increase in their overall funding allocation each year. This is called the 'Mental Health Investment Standard'. Kernow CCG met the standard in 2017/18. Expenditure per head in Kernow is higher than the national average in each year.

Year	Mental health & learning disability spending by CCGs			
	Spending £ millions		£ per head	
	England	Kernow	England	Kernow
2015/16	9,148.3	-	£160 -	
2016/17	9,722.8	126.2	£168	£223
2017/18	10,079.6	121.4	£172	£212
2018/19	10,289.0	134.6	£174	£234

Source: NHS England, [Mental Health Five Year Forward View Dashboard](#)

## Overview of the CCG allocations process

A detailed overview of NHS allocations can be found on the NHS England website [here](#). The information below provides a summary.

CCG allocations are based on the weighted capitation formulae recommended by the independent Advisory Committee on Resource Allocation (ACRA). The CCG allocations published by NHS England show details of the actual allocation each CCG receives as well as an indication of its “distance from target” (DFT). The distance from target figure reflects the fact that the target allocation determined by the funding formula is not always what a CCG receives.

The starting point for determining the target allocation is the latest population estimate for the CCG area. If all CCG populations had equal need, and costs didn’t vary across the country, the process could end here, with every CCG receiving a target share in proportion to their population size (i.e. an equal per capita allocation). However, health needs and costs do vary, and the population estimates are ‘weighted’ to reflect this.

The weights used in the formula are based on:

- need due to age (the more elderly the population, the higher the need per head, all else being equal);
- additional need over and above that due to age (eg health status);
- an adjustment for unmet need and health inequalities;
- unavoidable higher costs of delivering health care due to location alone, known as the Market Forces Factor (this reflects that staff, land and building costs are higher in e.g. London than the rest of the country).

The effect of the weighting means that, in general, CCGs with more elderly populations, those in urban and deprived areas etc will have higher target allocations than they would under a simple population-based formula.

The Department of Health has used a weighted capitation formula since 1977/78. Revisions to the funding formula are made to reflect such factors as changing population structures, increased understanding/estimation of health needs, deprivation etc.

If a revised formula results in substantial differences in funding allocations it may not always be practical to implement the ideal “fair share” according to a new formula. For example, the formula for 2016/17 to 2020/21 meant that some CCGs could have seen funding increases of around 10% (ie their DFT is currently -10%) while others could have seen decreases of as much as 34% (ie DFT is +34%). To avoid wide swings in year on year allocations, a political decision is taken by the Department of Health and Social Care to constrain increases in allocations where CCGs are determined to be under target.

CCGs typically move towards their target allocation over time. Each year all CCGs receive an increase in funding, however, the percentage increase varies depending on their DFT. CCGs that are above target generally receive less than the national average funding increase while those below target will receive more than the national average.

The pace at which CCGs move towards their target is set by ministers at the start of each funding round by something known as the 'pace of change'. The pace of change helps to ensure a steady move towards a target year on year without causing extreme disruptions to local health services or political outcry. The pace of change rules associated with the current formula are intended to ensure that:

- no CCG is more than 5% below target.
- Additional growth is applied to areas furthest below target.
- Areas more than 5% over target receive lower funding growth, but all CCG allocations are at least flat in real terms.

## Changes to the allocation formula in the NHS Long Term Plan

The [NHS Long Term Plan](#) made a number of changes to the overall allocations formula, including increasing the importance of deprivation in determining relative allocations:

*2.25. NHS England will continue to target a higher share of funding towards geographies with high health inequalities than would have been allocated using solely the core needs formulae. This funding is estimated to be worth over £1 billion by 2023/24. For the five-year CCG allocations that underpin this Long Term Plan, NHS England will introduce from April 2019 more accurate assessment of need for community health and mental health services, as well as ensuring the allocations formulae are more responsive to the greatest health inequalities and unmet need in areas such as Blackpool. Furthermore, no area will be more than 5% below its new target funding share effective from April 2019, with additional funding growth going to areas between 5% and 2.5% below their target share. NHS England will also commission the Advisory Committee on Resource Allocation to conduct and publish a review of the inequalities adjustment to the funding formulae.*

NHS England's [Note on CCG allocations 2023/24](#) contains further information on changes to target allocations (section 2).

## Details of the weights used in the allocations formula

The basic approach in calculating need-weighted populations is to multiply the population for each age-sex group for each GP practice by the relative need per head estimated by academic researchers. The products for each age-sex group are summed to give the relative need-weighted population for each GP practice. The weighted populations for GP practices are summed to give the relative need-weighted populations for each CCG.

The approach for weighting for unmet need is based on the standardised mortality ratio for those under 75 years of age (SMR<75). This is applied at small-area level to take account of inequality in health outcomes within CCGs as well as between CCGs.

Two adjustments for unavoidable costs due to location are made: the market forces factor and the emergency ambulance cost adjustment (EACA). The SMR<75 weighted population combined with the need and unavoidable cost weighted population gives the relative overall weighted population for each CCG.

#### **Unmet need adjustment: SMR<75**

In the absence of robust quantitative evidence which is comprehensive and consistent between services and across the country, ACRA's recommendation of the measure used for the unmet need adjustment is largely based on judgement. ACRA was unable to recommend the share of the overall weighted capitation formula that should be based on the unmet need adjustment. The NHS England Board meeting of 17 December 2013 determined the share should be 10%.

ACRA considered a range of measures of population health for the adjustment for unmet need. These were found to be highly correlated with each other. The preferred measure was the SMR<75 which 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 for all age groups.

The SMR<75 is a measure of how many more or fewer deaths there are in a local area compared with the national average, having adjusted for the differences in the age profile between local areas. It is applied at small area level (middle layer super output area (MSOA)) and then aggregated to CCGs. This allows for inequality within, as well as between, CCGs to be taken into account.

Each MSOA was assigned to one of 10 groups based on its SMR<75 value - those with the lowest SMR<75 values were in group one, and those with the highest SMR<75 values in group ten. The groups had an equal span of SMR<75 (subject to at least 5% of MSOAs being in the group). The alternative of having equal numbers of MSOAs in each group would have meant very small differences in the SMR<75 values between the middle groups.

Each of the ten groups is assigned a weight per head, with the MSOAs in group 10 having a weight five times higher than the MSOAs in group 1. The weight for the intermediate groups increases exponentially, so that group one has a weight of 1.00, group two a weight of 1.20, group three a weight of 1.43, up to group ten with a weight of 5.00. The exponential increase in the weights means the impact of the SMR<75-based adjustment between CCGs depends on how many of its MSOAs are in each of the 10 groups.

Each MSOA's population is given a weight of between 1 and 5, and the MSOA weighted populations are then summed to CCG level.

### **Market Forces Factor (MFF)**

The MFF adjusts for the unavoidable cost differences between areas due to their geographical location alone. For example it typically costs more to run a hospital in a city centre than in other areas due to higher staff, buildings and land costs.

There are four components to the MFF, covering unavoidable differences in cost across the country due to each of the following:

- medical and dental staff;
- other staff;
- land; and
- buildings.

The 'other staff' component (non-medical and dental) is based on the HERU research report *The Staff Market Forces Factor component of the weighted capitation formula: new estimates*. In the NHS, pay rates are determined by national pay structures and therefore differences across the country are relatively small. However, indirect pay costs faced by providers differ significantly across the country, such as vacancy rates, staff turnover rates and use of agency staff. The HERU research report used differences in pay rates across the country in the private sector, which were found to be highly correlated with these indirect staff costs faced by NHS providers.

The private sector pay rates used were adjusted for differences across the country in age and sex of employees, occupation, industry and level of responsibility of the job. Indirect staff costs for medical and dental staff were found not to differ across the country as they do for other staff. Instead the medical and dental component was based on the direct, higher costs of employing medical and dental staff in London, i.e. on the London pay weighting.

The building component is based on relative location factors calculated by the Building Cost Information Service (BCIS) from an analysis of tender prices for public and private contracts at local authority level. The land component is based on the land value per hectare calculated for each Trust.

### **Changes to the Market Forces Factor**

The current MFF values have not been updated since 2010. Consequently, NHS Improvement argue that they no longer accurately account for the differences in unavoidable costs between providers and it is highly likely that some providers have been over reimbursed for the services they provide and others under reimbursed.

The proposed changes to the MFF involve:

1. updating data on wage differentials to use 2016/17 data rather than the 2007-09 data used in the current MFF.
2. using travel to work areas (TTWAs) in place of primary care trust (PCT) areas to estimate the non-medical-and-dental staff component
3. including an adjustment for the medical and dental staff component for providers on the fringe of London (as well as those in London, as in the current MFF)
4. introducing business rates as a new component
5. using a more consistent method to combining the components into a single index.

[Source: NHS Improvement - National tariff 2019/20 consultation](#)

Overall, the proposed payment MFF values have a narrower range (1.000 to 1.211) than the MFF values in the 2017/19 national tariff (1.000 to 1.298) indicating that the regional variation has narrowed. NHS Improvement have published details of the proposed new tariff at trust level. This information is shown in the attached excel file. Both Cornwall trusts see an increase in MFF values in these plans – of 1.6% for Royal Cornwall Hospitals NHS Trust and 0.7% for Cornwall Partnership NHS Foundation Trust.

### **Emergency Ambulance Cost Adjustment**

The Emergency Ambulance Cost Adjustment (EACA) adjusts for unavoidable variations in the cost of providing emergency ambulance services in different geographical areas, and in particular sparsely populated and metropolitan areas.

### **Previous revisions to the allocation formula (2016/17 to 2020/21)**

The formula used for the previous five-year funding allocation period included the following changes:

1. Introduction of a sparsity adjustment
2. Update to the Emergency Ambulance Cost Adjustment (EACA)
3. Revised application of inequalities data.

#### *Sparsity adjustment*

The sparsity adjustment provides funding to CCGs to meet the unavoidably higher costs of remote hospital sites, where the costs are higher because the level of activity is too low for the hospital to operate at an efficient scale.

The package of recommendations had three key elements:

- the criteria for considering a provider's site remote;
- the cost curve for assessing the unavoidable impact of scale on efficiency; and
- the reference point on the cost curve used as the basis for deriving a cost adjustment.

There are three criteria that a hospital providing Type I A&E services must meet for its commissioning CCG to be considered eligible for the uplift to its target:

- there must be 200,000 or fewer population within a one-hour travel time. A population served of 200,000 is the estimated scale at which a hospital can achieve close to national efficiency levels. This ensures that a large provider that is geographically remote but operating at efficient scale does not receive extra support;
- the next nearest provider must be one hour or more by normal road travel times (including ferry times where relevant). This is a measure of whether or not consolidation of services on to fewer sites is feasible; and
- for at least 10% of the population in the hospital's catchment area, this must be the closest provider, with the next nearest provider over an hour away. An adjustment to target allocations for the relevant CCG is only made when this percentage is 10% or higher. This avoids giving very small (immaterial) adjustments to a large number of providers.

A relevant cost curve was created by analysing the costs of all hospital sites relative to their size as measured by activity levels. The estimated relative costs were adjusted to remove the impact of differences in case mix and in costs that are already compensated through the market forces factor.

National average costs at the point representing the average size of hospital sites were used as the reference point for deriving the size of individual adjustments.

#### *EACA update*

The previous EACA formula was unchanged since its inception in 1998/99 - apart from mapping to the different commissioning organisations over time. The old formula was based on the volume of activity, the case-mix of activity and a measure of rurality. The updated version models the time taken by ambulances to reach incidents, provide treatment and convey patients to hospitals by MSOA across a combined data set from four of the 10 Ambulance Trusts.

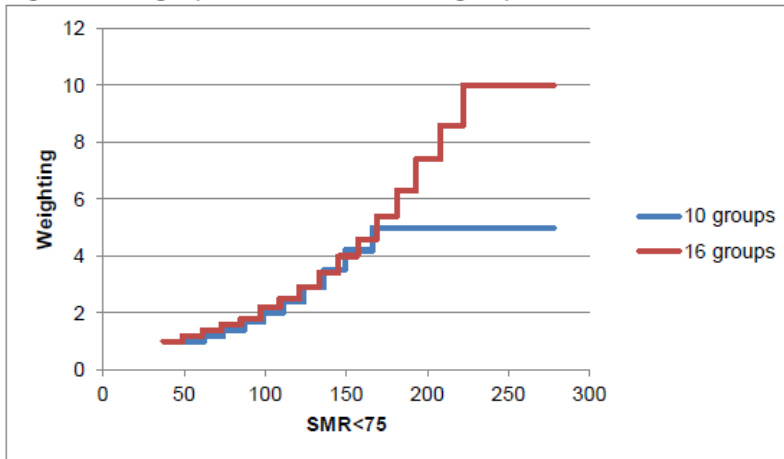
#### *Inequalities adjustment*

The unmet need adjustment in the previous formula used the standardised mortality ratio under 75 (SMR<75) for small geographical areas – Middle Layer Super Output Areas (MSOAs) – of which there are 6,791 in England. The MSOAs were placed into 10 groups according to the value of their SMR<75. All MSOAs in the same group received the same weight per head, with the MSOAs in the group with the highest SMR<75s receiving a weight per head 5 times higher than those in the group with the lowest SMRs. The intermediate 8 groups receive a weight per head between 1 and 5.

The revised current formula increases the number of groups for the unmet need adjustment to the CCG formula from 10 to 16 and increases the weight per head across these to a range of 10 to 1. The impact of moving to 16 groups is to increase the target allocations to the areas with the very worst SMR<75. This can be seen from the steeper curve for the 16 group model compared to the 10 group model in Figure 1, which show the weights per head for the MSOA groups.



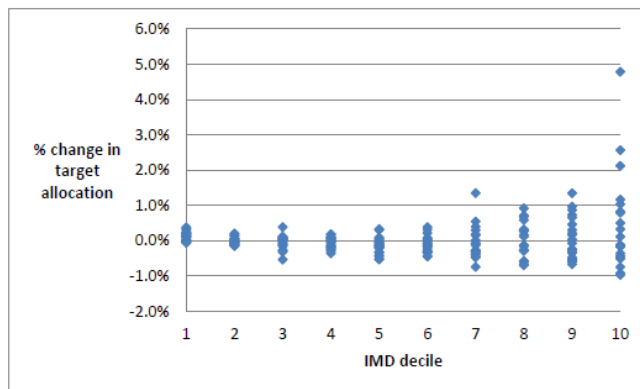
Figure 1: Weight per head for 10 and 16 groups



The general impact of this more sensitive approach is to increase or decrease individual target allocations by up to 1%. Six CCGs see an increase in their target allocation of more than 1% (up to 4.8% in one case) because they have a high proportion of small areas with the worst SMR<75s, which are now given a higher weight.

Figure 2 shows for CCGs the change in total target allocations by reference to their Index of Multiple Deprivation (IMD) decile, with decile 1 being the least deprived. This indicates that by changing the formula more resources are being directed to the CCGs which have areas with the very poorest health. The dispersion in the higher deciles is due to differences between CCGs in the number of small areas with the highest SMR<75s and the number of small areas with a high but not the highest SMR<75s. Small areas in the former are now given a much higher weight per head and small areas in the latter are given a relatively lower weight per head than previously.

Figure 2: Change in target allocation by IMD decile



Detailed analysis of the allocations changes from 2019 onwards has not been released. However, a technical guide to the 2018/19 allocations can be viewed [here](#).