**Manchester Health and Wellbeing Board**
**Report for Resolution**

**Report to:** Manchester Health and Wellbeing Board – 18 September 2013

**Subject:** Fundamental Review of Clinical Commissioning Groups Allocations Policy

**Report of:** David Regan, Director of Public Health

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## Summary

In December 2012 NHS England commissioned a review of allocations policy including the allocation of resources to Clinical Commissioning Groups (CCGs). NHS England has now published the formula recommended by the Advisory Committee for Resource Allocation (ACRA) to determine local CCG allocations. If this formula is formally adopted by NHS England it would see resources shift from 'poor' to 'good' health areas over time. Specifically it would impact negatively on the three Manchester CCGs and those CCGs covering the core cities, with the exception of Birmingham and Bristol. Any further loss of funding to Manchester would compound the significant funding reductions faced by the City Council since 2011 with more reductions likely from 2015-16.

## Recommendations

The Board is asked to:

1. To note the contents of this report

2. To support a robust response to challenge the basis of the ACRA recommendations through the following routes:

    - Planned Regional Workshops for NHS Commissioners
    - An approach to Public Health England (PHE)
    - Joint work with other affected Greater Manchester CCGs
    - Representation through Core Cities

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**Board Priority(s) Addressed:**

**All**

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**Background documents (available for public inspection):**

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Fundamental Review of Allocations Policy – Gateway Reference 00337

Fundamental Review of Allocations Policy – Annex A 2013/14 Allocations and Indicative Target Allocations Working Paper

## 1.0 Introduction

11.1.Alongside its decision in December 2012 to give all CCGs the same allocation increase for 2013/14, the NHS England board commissioned a review of allocations policy, including consultation with CCGs and others interested parties. The scope of this review is intended to include the local allocation of resources to CCGs and the budgets available for direct commissioning functions in Area Teams. This work is being led by the Allocations Steering Group whose members are drawn from the national support centre, area teams and clinical commissioning groups, as well as representatives of the independent advisory group, the Advisory Committee on Resource Allocation.

## 2.0 Background

2.1. The mandate to NHS England as part of the Health and Social Care Act (2012) defined NHS England's approach to local NHS allocations, and in particular the inclusion of a correction towards areas of greater deprivation and lower health status. The mandate states that NHS England's approach to allocations must have at its heart "equal access for equal need". Unlike the weighted capitation formula for Primary Care Trusts (PCTs) there is no mention of contributing to the reduction of health inequalities, but neither is it explicitly ruled out as a contributory factor in local allocations.

2,2. At the same time the 2012 Act creates a legal duty to reduce health inequalities and these duties must be reflected in the approach to allocations, as they must in everything that NHS England does. While inequalities duties on the NHS England Board are limited to reducing inequalities in access to and outcomes from healthcare, there is nothing to prevent NHS England from seeing its duties on inequalities as being wider, including how it interacts and supports the broader public health system. The work of the Allocations Steering Group should reflect these duties.

## 3.0 Impact on Manchester Clinical Commissioning Groups

3.1. Table 1 illustrates the impact on the three Manchester CCGs if the allocations were made based upon the current ACRA formula. Initial baselines have not been adjusted for changes in year (which could be substantial) e.g. reductions for transfer of responsibility for specialised commissioning, in order to be consistent with the basis of indicative allocations. The table shows that each of the three CCGs in Manchester would have reduced allocations if this funding methodology was applied.

**Table 1.** Impact on Manchester CCGs

| | Central Mcr £'000's | North Mcr £'000's | South Mcr £'000's | TOTAL £000's |
|---|---|---|---|---|
| **Resources** | | | | |
| Initial Baseline | 228,634 | 245,915 | 199,573 | 674,122 |
| Growth | 5,259 | 5,656 | 4,590 | 15,505 |
| Notified programme allocation | 233,893 | 251,571 | 204,163 | 689,627 |
| Indicative ACRA allocation target | 223,190 | 232,187 | 195,106 | 650,483 |

| | | | | |
|---|---|---|---|---|
| Difference | -10,703 | -19,384 | -9,057 | -39,144 |
| Difference as % of allocation | -4.58% | -7.71% | -4.44% | -5.68% |
| | | | | |
| Indicative allocation per head of population | 1,039 | 1,238 | 1,169 | 1,143 |

3.2. Table 2 compares the Manchester indicative loss against other core city CCGs or CCG groups, and shows who will benefit or lose out if the ACRA formula is implemented as it stands. Where a core city local authority area covers more than one CCG, the CCG figures have been combined.

**Table 2. Core Cities (LA areas) in order of % loss/gain**

| Core City | Gain/ Loss £ 000's | Gain/Loss % | Target per capita £ |
|---|---|---|---|
| Leeds | -83,784 | -8.79 | 1,059 |
| Liverpool | -50,937 | -7.25 | 1,320 |
| Sheffield | -48,644 | -7.57 | 1,125 |
| Manchester | -39,144 | -5.68 | 1,143 |
| Newcastle | -15,278 | -4.37 | 1,192 |
| Nottingham | -15,247 | -3.97 | 1,059 |
| Birmingham | +10,326 | +0.93 | 1,144 |
| Bristol | +7,260 | +1.45 | 1,061 |
| | | | |
| England Average | | | 1,137 |

## 4.0 Key observations

4.1 At this stage the figures circulated (giving a target for Manchester down £39.1m or 5.7% on 2013/14 allocation) are for discussion only. It is worth noting that they were rejected earlier this year by the Finance and Investment Board of NHS England for two obvious reasons: they move money in the 'wrong' direction and hence seem to contradict the statutory duty on NHS England to reduce health inequalities, and in addition they do not include any formula for unmet need which ACRA are still working on and which would favour areas of poor health.

4.2 The two factors outlined in point 4.1 form major issues to be discussed in the review.

4.3 As a minimum we need to confirm NHS England's views about discharging their duties on health inequalities and to confirm that CCG funding (as well as the other funding streams and wider determinants such as the economy) is an essential element in reducing geographical and socio-economic health inequalities in England.

Also it could be argued that as an interim until ACRA come up with a viable formula for unmet need, that the previous 'health inequalities formula' or something similar be re-instated (at 15% weight it added about 12% to Manchester's target).

4.4 The review terms of reference also include discussion of the risks of undifferentiated allocations such as this year's equal increase allocations. Because Manchester's population is rising much faster than the England average, equal increases to all CCGs will penalise Manchester to some extent depending on the age spread of the population increase. Further work to estimate the size of this effect will be carried out.

4.5 The previous point could also be an issue even if formula are used because for the next few years at least any significant movement towards target will only be possible if real cuts (i.e. increases less than inflation or numerical reductions) are made to some CCGs and that would be considered radical in historical terms, though it may become necessary to prevent too great an imbalance through population change.

4.6 Further Local authority funding cuts have also been proposed. Provisional figures for 2014/15 and 2015/16 were issued to local authorities as part of the technical consultation released by DCLG in July. These contained an additional reduction of Start Up Funding (government grant and local share of business rates) of 1.1% or £3.9m for 2014/15 above the existing reductions and of 14.4% or £51.7m for 2015/16. With the partial relocalisation of business rates reductions are now applied to the Start Up Funding only. The most deprived authorities will receive a much higher cut in funding as they are less able to generate council tax revenue and are more dependent on government grant funding and hence will see a bigger reduction.

Manchester intends to respond to the consultation highlighting the issues raised and the disproportionate impact that this has. If the reductions are applied in line with the respective consultations GM as a whole will see a further reduction in core local government grant funding of almost £211m across 2014/16 (or a reduction of £322m in spending power once the previously announced reductions for 2014/15 are included).

Note as part of the Spending Review £3.8bn funding for Health and Social was announced. The funding is to drive integration and transformation. In addition it is to support local authorities and the NHS to better manage the demographic pressures and funding reductions. There is an expectation the funding will be targeted to deliver the maximum impact and service transformation including an assessment of the impact on acute services. Disappointingly £1.9bn is existing funding that has already been allocated. There will be an additional £1.9bn from NHS allocations with £1bn of this being performance related.

## 5.0 Next Steps

5.1. It is worth noting that these are only indicative future allocations; nothing has been agreed and indeed NHS England have already rejected this direction of travel earlier this year. However we can not be complacent. It is important that CCGs are supported as they engage with NHS England through a series of workshops that will be held in September 2013.

5.2. In addition to supporting local CCGs it is recommended that the HWB approach PHE to challenge the way that the formula has developed and to reinforce the view

that this allocation formula contradicts NHS England's duties to reduce health inequalities.

5.3. Manchester HWB should work with other Greater Manchester HWBs where CCGs face a similar negative settlement to explore how we are liaising with NHS England, PHE and others.

5.4. The Manchester HWB should make representation through the Core City governance structure to share intelligence and discuss how we communicate with Government.