NHS
Devon
Clinical Commissioning Group

Financial Inequities

1. Introduction

1.1 Within Devon there has been a debate over several years about the observed inequitable distribution of CCG funding between localities (North, South, East and West Devon). Analyses of that distribution have consistently shown the allocation to the Western Locality being below its 'fair share' as determined by application of the National CCG Resource Allocation formula. It has been the long-standing intention to address this geographical financial inequity, however, because the system in aggregate is spending more than the resources allocated to it for the population across the whole of Devon, the first priority has been financial recovery – returning total spending to within the allocation. Addressing financial inequity in this context would have meant an even higher savings target for the CCG in order to generate additional money for investment in under-equity areas.

1.2 With the creation of the Devon Sustainability and Transformation Partnership (STP) for Devon, the senior leaders of all partner organisations who form the Collaborative Board have affirmed the importance of addressing financial inequity, and have stated an ambition that this should be achieved over 3 years, beginning in 2019/20.

1.3 The investment of the resources allocated to the CCG for the population Plymouth, Devon and Torbay is the responsibility of the CCG Governing Body. The Governing Body has made a decision on the policy it will adopt with regard to allocation of resources, having taken due consideration of this recommendation from the STP Collaborative Board.

1.4 The STP established an expert advisory group to consider financial inequities and health inequalities. That group completed its work on financial inequities and provided recommendations to the Devon CCG Governing Body to support it in developing its financial equity policy. Recommendations cover all the key questions about financial inequities that have been raised by partner organisations across Plymouth, Devon and Torbay.

1.5 One of the key findings of the group was that an analysis of resource distribution since 2015/16 reveals that without a policy to address financial inequities, there is a risk that some Localities may move in the wrong direction, with the above-equity localities moving further above and the below-equity localities moving further below. Even when a policy is put in place to address financial inequities, we are likely to find that there is an underlying current that, to some extent, works against

this. Therefore, the CCG should guard against constructing a policy that is too conservative or it is unlikely to achieve its objective.

1.6 In this report, the following terms are used:

National equity formula: a group of formulae for different service categories (e.g. mental health, general and acute hospital services, maternity, primary care prescribing), based on the size and characteristics of the population that is designed to measure the relative cost of providing services to meet the health demands and needs of a population (although the formulae are based primarily on demand data there is an adjustment for unmet need).

National allocations model: a comparison of the current distribution of the national NHS budget by CCG with the 'fair' distribution as determined by the national equity formula, with rules for how additional funds should be allocated to move CCG shares of the national general allocation towards the fair distribution. It should be noted that overspends in providers or commissioners are not taken into account in this model, it is based on the allocation of funds to CCGs.

Additional allocations: monies allocated to CCGs in addition to the general allocation which have a specific focus that is not based on general population demand or need.

2. Advisory group

2.1 The STP Financial Inequities and Health Inequalities Advisory Group membership was selected to include specific expertise on financial inequities and health inequalities, with coverage across sectors and across the geographies of Torbay, Plymouth and Devon as well as members independent of any geographical allegiance.

2.2 The group members are:

Member	**Role and Organisation**
Richard Crompton	Chair, UHP (Chair)
Simon Tapley	AO, CCG
John Dowell	CCG DoF and STP Lead DoF
Warwick Heale	STP Programme Director
Ben Chilcott	Deputy DoF, CCG
Simon Chant	Public Health consultant, DCC
Ruth Harrell	Director of Public Health, Plymouth CC
Richard Blackwell	Associate Director of Insight, AHSN
Rich Smith	Deputy Pro-Vice Chancellor and Professor of Health Economics, University of Exeter Medical School
Peter Aitken	Consultant Psychiatrist and Director of R&D, DPT
David Greenwell	Joint Clinical Lead GP, Southern Locality, CCG
Tobin Savage	Operations & Delivery, NHSE/I South West

3. Financial inequities and health inequalities

3.1 As well as financial inequity, the Western Locality, within which Plymouth is situated, has higher levels of deprivation and poorer health outcomes than the other three localities and this adds to the pressure to provide additional investment in that locality to help to address those issues. It should be noted that there are populations in all localities with high levels of deprivation and poor outcomes and these are equally deserving of attention, but the higher concentrations in Plymouth in particular, increase the pressure to address the geographical financial inequity. However, we should not regard the addressing of financial inequities as if it is an end in itself and there should be much greater emphasis on addressing health inequalities across all our system work.

3.2 It is recognised that the contribution that the NHS can make to reduce health inequalities is relatively small and that other determinants of health, such as education, housing, employment, lifestyle and other socio-economic factors have greater significance. The advisory group is also reviewing indicators of health inequality and the interventions that the NHS and other agencies could make to address health inequalities.

3.3 Another important perspective is the inequity in resource allocation between services (e.g. mental health, acute, community, primary care). This is discussed later in this report, but the majority of this report focuses on geographical financial inequity because that is the primary issue that the CCG has committed to address.

4. Scope

4.1 The scope of costs to be considered could include:

- General community, secondary and mental health services commissioned by the CCG
- Primary care services, delegated from NHSE to CCG
- Specialised services, commissioned by NHSE
- Prison health services, commissioned by NHSE
- Health services for the armed forces, commissioned by NHSE
- Public health
- Social care (adults and children)
- Voluntary and community sector

4.2 The primary question for the system has been how we should distribute the CCG allocation most fairly. Therefore, everything covered by the CCG allocation must be included. Primary care and specialised NHS services (commissioned by

NHSE) should also be included in this work in order to give a more complete picture of local NHS provision. Funding for prison and armed forces health services are not distributed according to the general population allocation because prisons and armed forces bases are not equally distributed across CCGs. Therefore, spend on these services should be excluded.

4.3 The national equity formula only relates to NHS expenditure, therefore adding other costs (such as social care or public health) would mean that we would be comparing actual expenditure with an unrelated NHS measure of 'fair shares'. To address this we would have to attempt to develop our own combined model of health and local authority services' financial equity which would be a significant undertaking. There is an added difficulty with social care costs because these are means tested and therefore local authorities might spend proportionately more money in areas where people are less wealthy – potentially an inverse relationship with need.

4.4 However, wider expenditure on support for communities, such as social care and housing, will affect population need and demand for health services and therefore the costs of provision. This could form a second phase of analysis if there was agreement in the system that this was worthwhile.

4.5 **Recommendation 1: That the scope of the analysis is limited to the CCG allocation, primary care and NHSE-commissioned specialised services.**

5. Measurement of fair shares

5.1 The national equity formula has been developed over many years. It explains c.70% of the variation in health spend. The 'model' is built upon separate formulae for different services (e.g. hospital and community services, mental health, maternity).

5.2 The individual formulae include their own weightings for age, sex and deprivation. The data to which the formulae are applied are GP registered populations. These populations are mapped to the Devon localities.

5.3 It is accepted that any formula will be imperfect, but there is no better, validated alternative to the national equity formula. Any decision to amend the national equity formula would expose us to the risk of cherry-picking or special pleading by localities and would undermine the validity of the formula.

5.4 Recommendation 2: That the national equity formula is used for assessing financial inequities within Devon.

6. Recent changes to the national equity formula

6.1 There were significant changes to the national equity formula between the 2018/19 and 2019/20 allocations. The change with the greatest impact between localities in Devon was a change to the mental health formula. This gives a greater weight to Southern and Eastern Devon in particular and a lower weight to Western. We are still awaiting a response to requests to the national allocations team for more information in order to help us understand what has produced that change.

6.2 It is uncomfortable for everyone involved, and particularly for the Western locality, that the national measure of 'fairness' can change and have a material impact on localities' positions relative to equity. However, this discomfort should not lead us to revert to the 2018/19 formula just because it paints a picture that is more familiar. If we accept that we will use the national equity formula we should use the most up-to-date version. However, until we understand the changes to the mental health formula and the reliability of the data sources, we cannot confidently rely on its outputs.

6.3 Recommendation 3: That the latest national equity formula is used for assessing financial inequities within Devon, but that this is regarded as draft until the changes to the mental health formula are understood. This does not prevent the CCG from developing its financial inequities policy, but the locality values to which this policy are applied should be regarded as subject to change.

6.4 Recommendation 4: That an explanation for the changes in the national equity formula from 2018/19 to 2019/20 is obtained and is reported to a future Governing Body meeting, along with an assessment of any risks to reliability of the formula.

7. Disinvestment or differential investment

7.1 The national allocations model does not reduce the allocation to above-equity CCGs. Instead, lower levels of growth are given to above-equity CCGs and higher levels of growth to below-equity CCGs. In this way, CCGs are moved closer to a fair share of national funding without the destabilising effect of withdrawal of funding that could lead to severe service instability or service closures.

7.2 The Devon system is running a substantial deficit and performance against many statutory indicators is below target in all localities. Over-equity localities are suffering from the effects of financial insufficiency even if this is less than the insufficiency in under-equity localities. All localities will have to make significant savings to meet their financial targets. In this context, a policy of disinvestment to address financial inequity would be even more risky than in a financially-balanced system.

7.3 As context, the Devon NHS system will receive c.£60m of growth funding per annum so it is unlikely that we would ever find ourselves in the situation where the financial inequities were so extreme that we would have to adopt a disinvestment policy.

7.4 Recommendation 5: That movement towards financial equity is made by differential investment rather than a reduction in funding for any locality.

8. Adjustments for additional allocations

8.1 The CCG receives additional funding for the following items and these relate to particular localities rather than being incorporated in the CCG's general allocation:

- Local Improvement Finance Trust LIFT
- Small hospitals/unavoidable remoteness

8.2 These items recognise unavoidable differences in cost that do not relate to the size or characteristics of the population and which should therefore be treated separately from the calculation of fair shares. The cost associated with these items is within the total current spend of each locality so in the comparison between fair shares and current spend an adjustment for these items is required.

8.3 Recommendation 6: The additional allocations for LIFT and small hospitals/remoteness are not related to population need and should be treated separately in the comparison of fair shares and current spend.

8.4 While accepting that these items represent unavoidable costs unrelated to population need, we may nevertheless separately consider whether the value attributed to these items is correct. This is a particular question in relation to the size and remoteness allocation for NDHT. The allocation is £3.9m, but the CCG and NDHT are currently assessing whether the unavoidable excess cost of services in NDHT is greater than this. If the conclusion is that the national value is too low, the CCG will have to agree whether to recognise the national value or the locally-agreed value in the local comparison of current spend with fair shares.

8.5 The advisory group considered the argument that we are accepting national formulae and values in our equity calculations in all other cases and if we recognise a higher value we will be depriving other localities of their share of the additional funding that we attribute to Northern. On the other hand, if we know the national value to be too low but use it anyway, the Northern locality will be unable to afford services to meet the needs of the population in an equivalent way to other localities.

8.6 The group noted that the financial inequities discussion should not be extended to attempt to resolve all financial issues within Devon. It was agreed that the unavoidable cost of small scale, remote services in NDHT should be agreed between the CCG and NDHT and that, irrespective of the conclusion that is reached on that point, the national valuation should be used in the inequities model in order to maintain the integrity of that model.

Recommendation 7: The value of the NDHT size/remoteness adjustment in the local fair shares calculation should be set at the national value.

9. Other potential adjustments

9.1 There may be local factors that drive unavoidable cost that is unrelated to population need and which are not included in the national set of additional allocations. We could agree to take these into account or limit our adjustments to the nationally-recognised additional allocations. To justify taking account of additional factors, they would have to conform to the principle that they represent material, unavoidable differences in cost that are unrelated to population need. They would also need to be unrelated to unavoidable differences in cost that relate to previous years' investment decisions (e.g. failure to invest in infrastructure that now leads to greater cost could have been avoided in previous years).

9.2 An example that meets these requirements is the potential diseconomies of small-scale tertiary services at UHP as a parallel case to the NDHT remoteness/size adjustment. A report commissioned by UHP from Carnall Farrar in 2017 identified some internal productivity opportunities in tertiary services, but a £2m shortfall related to sub-scale services which would require a system solution.

9.3 The case for taking account of the NDHT adjustment is more straightforward because there is a separate source of funding that does not reduce the funding for the other localities in Devon. Recognising the diseconomies of scale of UHP tertiary services would mean a top-slice from the CCG allocation in the equity calculation, leaving a lower sum on which to calculate fair shares for all localities.

9.4 However, if we do not take these unavoidable excess costs into account the Western locality (via UHP) will bear these costs and potentially be unable to afford services to meet the needs of the population in an equivalent way to other localities. The tertiary services at UHP are provided to patients in all localities so arguably all localities should accept a top-slice for the unavoidable excess costs of maintaining local provision.

9.5 As within *Section 8*, the group noted that the financial inequities discussion should not be extended to resolve all financial issues within Devon. It was also noted that extending the list of 'special cases' beyond the additional national allocations could

form the thin end of a large wedge which would invite adjustments for each locality that would soon undermine the integrity of the national model.

9.6 Furthermore, if there is a sound case for recognising the unavoidable costs of small scale tertiary services at UHP this should be a contractual negotiation between UHP and NHSE commissioners who have responsibility for ensuring access for the population of the Peninsula to specialised services. At some point the specialised services budget is likely to be devolved to CCGs and any additional funding for sub-scale services would then become a local decision.

9.7 Recommendation 8: That no adjustments to the model should be made beyond the additional national allocations.

10. Distance from target

10.1 It is accepted that the national equity formula is imperfect and therefore it should not be used as if it explains 100% of the variation in demand for healthcare resources and is not intended to be used to determine a level of relative investment with absolute precision. Therefore, there is a tolerance around the calculated fair share within which there is no attempt to move a CCG's allocation any closer to equity. The population of Devon CCG's smallest locality is similar to that of the smallest CCG nationally so the national tolerance should be appropriate to use within Devon.

10.2 For 2019/20 the national tolerance is 2.5% below and 5% above fair shares. If this was solely a statistical exercise one would expect the tolerance to be equal above and below, but these tolerances may have a pragmatic or political dimension rather than being purely statistical. We do not understand the reasons for these tolerances nor the statistical modelling that may support them. If we are to be consistent with the national model (as we have recommended in preceding sections) we should maintain that consistency in terms of distance from target.

10.3 However, the locality that has poorest outcomes is most below equity and to bring it just to 2.5% below the modelled equity position while those outcomes remain poor may be regarded as unacceptable.

10.4 We should also bear in mind that the underlying drivers of spend have led to increasing inequity (as noted in *Paragraph 1.4*) so if the CCG policy is intended to deliver no worse than 2.5% below equity and those other drivers continue to push localities away from equity the CCG will probably fall short of achieving its policy intention. The CCG will therefore need to aim higher to achieve what it intends and will probably have to continue to invest differentially in the longer term to offset the effect of those underlying drivers against equity.

10.5 Recommendation 9: When considering financial equity, the CCG should adopt the national tolerances of -2.5% and +5% around each locality's fair

share of the CCG's allocation. This means that if outcome measures were similar, the CCG would be satisfied with this level of funding variation between localities.

10.6 Recommendation 10: Where there are poor outcomes, additional investment is needed and therefore we should not be content with areas with the poorest outcomes being funded at the lower end of tolerance. The CCG should aim to bring the locality with the poorest outcomes from -2.5% to 0% below target, specifically to address those unequal outcomes.

10.7 Recommendation 11: The position of each locality compared to financial equity should be reviewed each year alongside outcomes and further differential investments made to offset any drift away from equity that may occur for other reasons.

11. Financial inequity between services

11.1 The question about fair shares of health spend is generally focused on distribution between localities and this has been the primary focus of the work of the advisory group. However, the group also considered how fairly money is distributed across services (for example, primary care, mental health, acute physical health). This is included in the accompanying presentation.

11.2 Using the national equity formula to make decisions about relative investment in services goes beyond how it is used nationally. There will be relationships between services that may lead to the national model working better if used as an integrated whole rather being divided into separate service-specific formulae. The service-specific formulae could be used as one indication of service inequity if they were used with sufficient caution. There will be other sources of information that indicate whether the relative investment between services should be addressed.

11.3 Recommendation 12: The analysis of service inequity requires additional data sources and further work.

12. Should conditions be attached to the additional investment in under-equity localities?

12.1 Differential growth in funding between localities brings with it the risk that the adverse impact on populations in localities with lower growth will not be offset by the benefits derived from the additional investments in localities with higher growth. One potential mitigation would be to set conditions on the use of the additional growth.

12.2 Given the system commitment to address health inequalities as well as financial inequities, the CCG could make the additional growth for under-equity localities

conditional on it being directed to those interventions that will have greatest impact on improving outcomes for disadvantaged populations (as long as these are not outside the scope of the CCG allocation). This could include investment in improving access to services in order to improve outcomes.

12.3 Furthermore, given that there are populations in all localities with high levels of deprivation and poor outcomes, the CCG could set similar conditions for all localities.

12.4 The analysis of inequity in demand by service (see *Section 12*) could be used along with other data to direct the additional growth towards those services that the national equity formula indicates are particularly under-resourced in the under-equity localities. We should also bear in mind that achieving reductions in health inequalities is dependent upon services commissioned by agencies beyond the NHS.

12.5 However, the system also has an intention to devolve responsibility to localities and this would suggest that additional investment should be without conditions as long as it is directed by the Local Care Partnership Board (or equivalent). Localities will be in a better position to understand where there is greatest local need. Where some of the required interventions are outside the scope of the NHS budget, other agencies within the locality should be encouraged to invest to deliver those interventions.

12.6 Recommendation 13: The CCG should provide advice to localities about how any differential growth should be invested and should include an expectation that attention is given to interventions that will reduce health inequalities, but this should not be a requirement.

12.7 Recommendation 14: Any locality benefitting from differential growth should report to the CCG on how that additional money has been invested.

12.8 Recommendation 15: The CCG should communicate an expectation to all localities that they should focus on addressing unequal outcomes within their locality.

13. Impact of historic underinvestment in under-equity localities

13.1 If there has been historic underinvestment in some localities it is possible that the population will currently suffer from poorer health as a result and therefore such localities will need a greater share of resources now and in future in order to provide additional services to mitigate that effect.

13.2 However, given the financial deficit in all localities, allocating even more growth to under-equity localities for these theoretical reasons would leave over-equity localities with even lower growth which might not be manageable.

13.3 Where outcomes are poorest and there has been historic underinvestment, that would be addressed via *Recommendation 10*.

13.4 Recommendation 16: There should be no additional allocation to compensate for historic under-equity investment. However, where there are poor outcomes, *Recommendation 10* addresses this.

14. Should the CCG invest to address inequity solely in the distribution of its allocation or inequity in the distribution of wider NHS allocations?

14.1 The national pace of change policy is applied to the whole place-based budget, including the CCG allocation and NHSE's allocations for specialised services and primary care medical services. This is based on the theory that a CCG area may be able to better cope with being below target if some of the other services are funded above target.

14.2 However, while it may be important for the CCG to understand any inequity in the distribution of NHSE's allocations as this is part of the picture of total locality NHS resource consumption, it could be argued that any inequities in NHSE resource distribution should be addressed by NHSE as they are responsible for ensuring access to specialised services for the whole population. There is a risk that if the CCG uses its allocation to address any inequity in specialised service resource use it will distort the CCG's equitable commissioning of non-specialised services.

14.3 In addition, there are some outstanding questions about the analysis of NHSE Specialised Commissioning expenditure by locality that should be addressed.

14.4 Recommendation 17: The CCG should understand total NHS resource inequity, but should only differentially invest its allocation to address inequities in the distribution of its own allocation.

14.5 Recommendation 18: There should be further analysis of the distribution of NHSE specialised commissioning expenditure compared to equity, but because of *Recommendation 17* that should not delay the CCG in developing its financial inequity policy.

15. Pace of change Policy

15.1 The STP Collaborative Board has recommended that Year 1 of the movement to equity is 2019/20 and that there should be a 3-year pace of change. This is

consistent with the national pace of change. This is a policy decision that depends upon the CCG's financial and non-financial objectives and the Advisory Group therefore had no direct recommendation to make on this matter.

15.2 Pace of change policy seeks to strike a balance between achieving the objective of improving the equity in distribution of resources, without creating undue instability or uncertainty. It is also important to recognise that the formula driven target is an indication of the expected consumption of resources by a population, and not an absolute "right" answer. In this context, a margin of error is appropriate.

15.3 Taken together, Recommendations 9, 10 and 11 from the Advisory group would support a pace of change policy that protects £5m of growth investment to be differentially invested in the Western Locality in 2020/21, with further differential growth investment in 2021/22 and 2022/23, subject to further analysis and understanding of impact on health inequalities and overall movement towards financial equity.

16. Consideration at Governing Body

16.1 This report was considered by the CCG Governing Body in October 2019. All but one of the recommendations were approved.

16.2 The GB response to recommendations 10, 13, 14 and 15 was as follows it was agreed that the CCG will consider a further move to the calculated equity figure (rather than just to 2.5% below) where an under-equity locality has particular poor outcomes. The list of outcomes, the timescale for a further move to equity and the question of conditions being set on that additional investment would be discussed at a future Governing Body meeting when the equity model has been updated for the 2020/21 plan. At that point, recommendations 10, 13, 14 and 15 will be reconsidered.