Response of the Association of North East Councils to the NHS England review of allocations policy, including the allocation of resources to Clinical Commissioning Groups (CCGs).

Summary

The Association of North East Councils is the representative voice for local government in the North East. It represents all 12 local authorities in the North East, throughout Northumberland, Tyne & Wear, Durham and the Tees Valley on issues of concern to them and the communities they serve. It is a cross-party organisation, with all of its members democratically elected and accountable politicians. The Association welcomes the opportunity to comment on the current review of CCG allocations. We note that the review considers the allocation of resources to CCGs and available budgets to direct commissioning functions of local area teams.
We are concerned that should the formula recommended by the Advisory Committee for Resource Allocation (ACRA) be adopted by NHS England, it would see a transfer in resource from areas with poorer health outcomes to those with better health outcomes.

Implications for North East CCGs

The allocations working paper, which sets out the indicative target allocations based on the ACRA formula, suggests that:

- The five CCGs in the Durham, Darlington and Tees area will receive £50m (3.27%) less allocation;
- The eight CCGs in the Cumbria, Northumbria and Tyne and Wear area will receive £179m (7.25%) less allocation;
- Total loss for the North East alone will amount to £166m;
- Some CCGs in the North East will be particularly hard hit, with three CCGs losing between 8% and 11%.

Every single CCG in the North East is impacted negatively. Any further loss of funding to the area as a whole will compound the significant funding reductions faced by North East local authorities since 2010/11, with further reductions anticipated in the next spending round.

Observations

Whilst we acknowledge that the figures presented to date are for discussion, we would like to submit the following observations:

NHS Mandate and the DFLE formula

The NHS mandate sets out the responsibilities of NHS England for allocation: '*The government expect the principle of ensuring equal access for equal need to be at the heart of the Board's approach to allocating budgets.'*

There are major changes proposed in the current review including: using individual based calculations of need not area level indicators, using GP registered populations not the higher ONS population estimates, and focusing almost exclusively on age and gender factors (with a correspondingly smaller focus on deprivation). Crucially, the new formula does not include the health inequalities weighting (disability-free life expectancy (DFLE) element) which was used to account for unmet need as well as ill health prevention. This seems counter to the above statement in the Mandate and to the Health and Social Care Act 2012 which created a legal duty to reduce health inequalities.

A recent article in the British Medical Journal maps the difference in funding per person between the current formula and the proposed formula by CCG area (figure 1) and NHS Local Area Teams (figure 2) depicted below. This clearly shows a movement of funding towards more affluent (and healthier) areas of England, away from poorer and 'less healthy' areas. For example, in CCGs like South Eastern Hampshire, where healthy life expectancy is 68 years for women, NHS funding will increase by £164 per person (+14%). This is at the expense of CCGs such as Sunderland, where healthy life expectancy is 58 years for women, and where NHS funding will decrease by £146 per person (-11%)

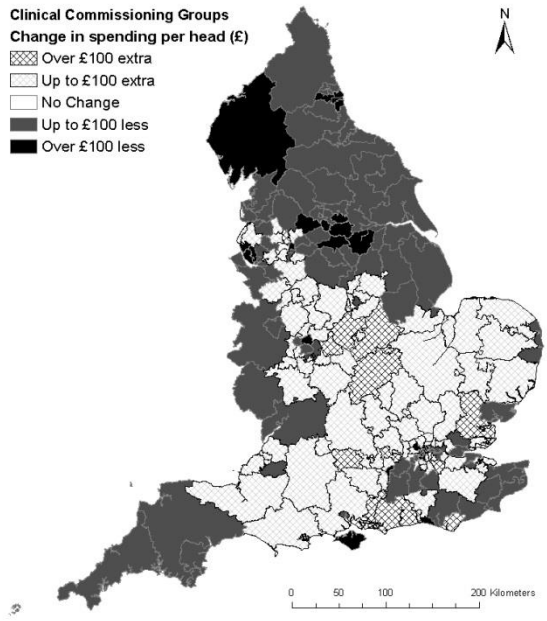

Figure 1: Change in spending (£ per head) between new and old Resource Allocation Funding formulae by CCG

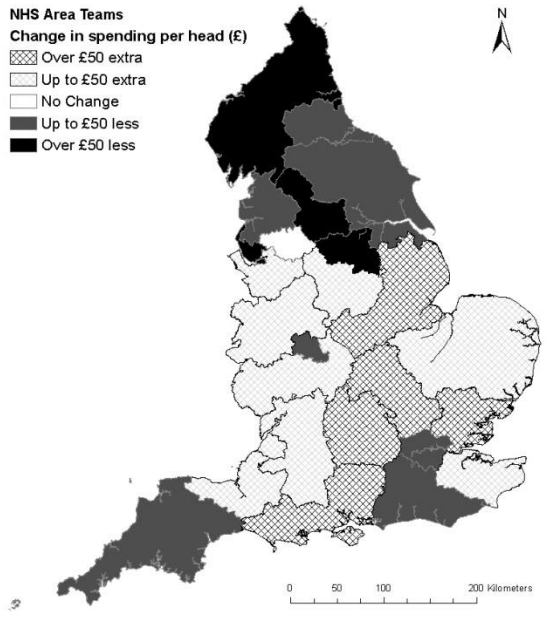

Figure 2: Change in spending (£ per head) between new and old Resource Allocation Funding formulae by NHS Area Team

Source: Bambra and Copeland, British Medical Journal, 2013, ***Grim Up North? Weighted Capitation Formula for Clinical Commissioning Groups will reduce Northern NHS budgets***

The DFLE element of the funding (which was originally 15% but already reduced at ministerial discretion to 10%) is a key contributor to reducing inequalities and we oppose its removal. We believe a key role for NHS England is to reflect on inequalities throughout the system including public health. As such, we believe that one element of the NHS cannot be examined in isolation from the other parts, and any disinvestment in one part of the system should lead to investment in another. Indeed, investment should ideally come first to compensate for the time-lag in improving health outcomes. The removal of the DFLE weight should at least be compensated for by increasing local public health budgets.

In its report *on 'Tackling inequalities in life expectancy in areas with the worst health and deprivation' (2010)*, the NAO recommend that 'greater investment in prevention is necessary if the NHS is to tackle health inequalities now and in the future'. The report found the failure to invest at greater levels in specific communities as being a factor in the slow progress being made in reducing health inequalities at a national level, which highlights the need to maintain a proportionately higher level of spend in the most deprived areas.

Total spend on health and social care

If disinvestment occurs in CCG allocations in the North East, we would ask how much is being spent in total on health and social care in the region, and where will the funding be allocated to compensate for this loss? Clearly, an adjustment would be necessary to allocations for primary care, public health, and social care. We consider there is a real need for an informed strategic discussion about the health and cost reduction benefits that could accrue from a substantial increase in the level of local public health prevention investment and activity. This is especially pertinent when account is taken of the above average health needs linked to deprivation that are prevalent in the North East, and the importance of properly resourced early intervention and preventative measures – both of which are vital to improving health outcomes.

We would seek a commitment to a Health Impact Assessment being carried out prior to any of the proposed reductions in funding to identify potential effects and implications on the wider health economy.

Pressures on one part of the system inevitably impact on others. To reiterate, we believe that one element of the NHS cannot be examined in isolation from the other parts, and disinvestment in one part of the system should lead to investment in another.

In this context, ANEC is offering to work with ACRA and NHS England to fully explore the proposals and to work with partners to consider their implications and explore options that will not be disadvantageous.

Inequity in funding

We note that the NHS Board rejected the proposals earlier this year, citing that it would necessitate a greater targeting of resources towards areas with better health outcomes.

The prospect, therefore, of deprived areas such as the North East suffering the biggest cuts from a change to CCG Allocations which shifts resources to the least deprived areas of the country is a major issue of concern for ANEC member authorities. This is at a time when there are significant pressures on resources available to public services in general, and in particular a massive reduction to core grant funding for councils nationally to fund vital public services over the next two years. The Government is proposing an extra £1 billion of cuts to the core grant funding for services – bringing the cash reduction in core funding in 2015/16 to £3.1 billion as opposed to the £2.1 billion or 10% cut announced in the Spending Review. Added to the £2.4 billion cut in 2014/15 the total cut escalates to £5.5 billion. What we are facing is a real terms 25% cut in core over the next two years. This is at a time when people are increasingly looking to councils during this period of economic difficulty, and when the effects of the welfare reforms are hitting the most deprived areas hardest. It is estimated that £940m per annum will be lost to the North East economy through the effects of the welfare reforms alone once fully implemented.

Pace of change

In terms of timescales, pace of change is paramount. We are extremely concerned that disinvestment would cause the destabilization of current service provision. A long term approach to any changes with a robust evidence base would be required, along with consideration to alternative investment in other parts of the system. Destabilization is a current and very real risk, with uncertainty over future allocations affecting business planning and future capital schemes.

Next steps

Local government is a key stakeholder and should be closely involved in discussions with NHS England and with ACRA to shape and inform decisions before they are taken regarding future funding allocations. In this regard, ANEC member authorities are keen and willing to work with all stakeholders and would welcome a period of formal consultation to further develop approaches to funding allocations.