Equality Analysis for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams
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Equality Analysis for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams

**Author**
NHS England Strategic Finance

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**Target Audience**
CCG Clinical Leaders, CCG Chief Officers, CSO Managing Directors, NHS England Regional Directors, NHS England Area Directors, Directors of Finance

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An analysis of how the formulae used (in calculation of CCG and AT allocations for 2014-15 and 2015-16) address issues of equality.

**Cross Reference**
Technical Guide to the formulae for 2014-15 and 2015-16 revenue allocations to Clinical Commissioning Groups and Area Teams

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N/A

**Contact Details for further information**
Michael Chaplin
Analytical Services (Finance)
5E40 Quarry House
Leeds
LS2 7UE
0113 825 3680

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Prepared by: NHS England Analytical Services (Finance)
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1. Introduction

In December 2013 NHS England announced revenue allocations for 2014-15 and indicative 2015-16 revenue allocations for Clinical Commissioning Groups (CCGs) and, for primary care, NHS England Area Teams (ATs). These allocations are covered by this equality analysis.

The decisions taken by the NHS England Board were based on the Mandate to NHS England requiring a transparent allocations process based on the objective of equal access for equal need, and the Mandate also requiring NHS England to have regard to reducing inequalities in access to and outcomes from healthcare. These duties are in addition to the public sector equality duty of the Equality Act 2010.

Each CCG receives a single allocation (excluding running costs), which is not broken by function or programme. It is for each CCG to determine how best to invest their resources to meet the needs of their responsible populations, within national standards and NHS England’s strategic guidance. ATs also receive a single allocation for primary care which is not broken down by programme. CCGs have the same equality duties as NHS England.

The following sections cover: an outline of 2014-15 and 2015-16 allocations; the weighted capitation formula; and the role of local commissioning. Annex A covers the protected characteristics under the public sector equality duty.

2. CCG and Area Team allocations

The NHS England Board agreed allocations for 2014-15 and indicative allocations for 2015-16 at its meeting of 17 December 2013. The Board paper on allocations set out the principles and issues considered in setting allocations, and is published on NHS England’s website.

There are four steps in the calculation of allocations to CCGs and primary care allocations to ATs:

- determining CCGs’ and ATs’ fair (or target) shares of the total resources available based on relative need for healthcare services;
- establishing baselines (the previous year’s allocations);
- setting actual allocations through pace of change policy, which balances, within the available resources, moving those furthest below their target share towards their target share and providing stability in funding for all areas.

Recurrent programme allocations across all CCGs are £64.3bn in 2014-15 and indicative allocations are almost £65.7 bn in 2015-16. Each CCG is receiving growth of at least 2.14% in 2014-15 and 1.7% in 2015-16, with those CCGs furthest under target receiving the highest growth per capita. Programme allocations for primary care to ATs are £12.0 bn in 2014-15 and £12.2 bn in 2015-16. Each AT is receiving

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growth of at least 1.6% in 2014-15 and 1.2% in 2015-16, with those furthest under target receiving the highest growth.²

Target shares are based on the weighted capitation formula recommended by the Advisory Committee on Resource Allocation (ACRA). ACRA is an independent expert committee and its members are GPs, academics, public health experts and NHS managers. ACRA’s recommendations are based on independent academic research.

3. Weighted Capitation Formula

The national weighted capitation formula is used to calculate CCGs’ target shares of the available resources. Target shares are in proportion to each CCG’s population weighted, or indexed, by need for health care services (such as that due to the age distribution of the population). There are also weights to account for differences in unavoidable costs due to location in providing healthcare services between geographical areas across England. There is a separate weighted capitation formula for primary care target shares for ATs.

Equality is at the heart of the weighted capitation formula. The formula recommended by ACRA aims to allow local organisations to commission similar levels of health services for populations with similar levels of need (horizontal equity), and appropriately higher levels of health services for populations with higher levels of need (vertical equity).

The principle of a weighted capitation formula was established in 1976 following the Report of the Revenue Working Party (RAWP). RAWP interpreted its terms of reference as being: “to reduce progressively, and as far as feasible, the disparities between the different parts of the country in terms of the opportunity for access to health care of people at equal risk.”³

Weighted capitation formula - CCGs

The weighted capitation formula for CCGs is based on:

- the population base – a count of the population each CCG is responsible for;
- a weight, or adjustment, for the higher need for health care services due to age (areas with more elderly populations receive higher allocations, all else being equal);
- a weight, or adjustment, for additional need for health services over and above that due to age (areas with poorer health receive higher allocations, all else being equal);

• a weight, or adjustment, for unavoidable differences in the costs of providing health services due to location alone – the Market Forces Factor (areas where the cost of living, land etc are higher receive higher allocations, all else being equal).

The weighted capitation formula has separate components for general and acute, mental health, maternity and prescribing. This is because need varies differently across the country for each of these services.

The largest components of the CCG formula are general and acute and mental health services. The person based approach was used in the academic research developing the models for these components, using data at the individual level (anonymised) to provide more accurate estimates which take account of the different needs of different individuals and population groups. Previous formulae typically estimated need for small areas, which may have not fully captured differences in need within small areas. The prescribing formula used data available at GP practice level.

People do not have identical needs for health care services. A key difference is that need varies according to age and gender, and in particular the very young and elderly, whose populations are not evenly distributed across the country, have a higher need for health services than the rest of the population. The weighted capitation formula therefore takes into account the relative need per head of different age-gender groups and the different age-sex structures of local populations.

Even when differences due to age are accounted for, populations with the same age profiles display different levels of need. An additional adjustment to reflect the relative need for health services over and above that due to age is therefore necessary.

In the general and acute and mental health models, age-gender related need and additional need over and above that due to age-gender are estimated as a single set of weights rather than two separate sets of weights. This is because additional need varies by age-gender group and differentially across the country by age-gender group. The prescribing formula estimated need related to age-gender separately to additional need due to data availability.

Additional need for general and acute and mental health was estimated using morbidity data, based on the diagnoses for hospital admissions and outpatients appointments for each patient.

Observing need per head directly has not proved possible to date. Instead statistical modelling by academic researchers has examined the relationship between the utilisation of health services on the one hand, and the characteristics of individuals (including diagnoses data) and the area where they live on the other hand. These models have been used to decide which factors to include in the formula to predict future need per head.

The models also include ‘supply’ variables to take account of the greater availability of health care services generally leading to higher use. While the supply variables are included in the models, they are set to the national average when calculating
weighted populations. This means areas are not penalised in the formula for lower utilisation due to relatively lower capacity.

The models typically assess need as it is currently met by NHS services and therefore may not capture unmet need or inappropriately met need – the fact that some of the most deprived communities do not access health care in the most optimal way, resulting in poorer health outcomes. There is therefore an adjustment for unmet/inappropriately met need in the weighted capitation formula. This is based on a measure of population health (the standardised mortality ratio for those under 75 years of age (SMR<75)). The adjustment is applied to the population of each small area and then aggregated to CCG level. Applying the measure at the small area level takes into account unmet need/health inequalities within as well as between CCGs.

ACRA’s recommendations are largely based on independent academic research. However, due to the lack of robust quantitative evidence which is comprehensive and consistent between services and across the country, ACRA’s recommended measure to be used for the unmet need adjustment was largely based on judgement.

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 SMR<75 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 all age groups. The use of the SMR<75 was an interim recommendation and ACRA wishes to undertake further work in the area of unmet need.

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%.

**Weighted capitation formula – primary care**

The weighted capitation formula for primary care allocations to ATs follows the same principles as that for CCG allocations. There has not previously been a primary care formula covering primary medical care, dentistry and pharmaceutical services, and ACRA viewed the primary care formula recommended as the best available presently but requiring further work for future allocation rounds.

The primary medical component includes a weight for need related to age and sex group and additional need based on standardised mortality rates and the standardised proportion of the practices’ patients with a limiting long term illness.

The dental services formula is based on national average NHS costs by age, sex and index of multiple deprivation (IMD) of patients’ place of residence. The prescribing formula, which is part of the CCG allocations formula, is used for pharmaceutical services. This allocates resources for the cost of providing community pharmacy services in line with the cost of the drugs dispensed.
The NHS England Board decided that an unmet need adjustment should be applied using SMR<75, and accounting for 15% of the overall primary care weighted populations.

**Monitoring and review**

The weighted capitation formulae are regularly reviewed and updated to take account of changing patterns of need. The equality analysis will be reviewed as part of the review of the formulae.

Further information on the weighted capitation formula is available in the technical guide to CCG and AT allocations available on NHS England’s website.

**4. Local commissioning**

As noted above, each CCG and, for primary care, each AT receives a single allocation, not broken down by programme or service. The deployment of their resources through the commissioning of health care services for their local populations is a matter for CCGs and ATs.

The weighted capitation formula supports equal opportunity of access for equal need. Achieving equal access also depends on local commissioning decisions and local practice.

CCGs and ATs have duties to have regard to the need to reduce inequalities in access to health services and outcomes for patients. All NHS organisations have a statutory duty to meet the general and specific duties of the Equality Act 2010 and the public sector equality duty. The public sector equality duty requires public bodies to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics under the Public Sector Equality Duty are:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion and belief;
- sex;
- sexual orientation;
- carers ‘by association’ with some of the protected characteristics e.g. disability and age.
Annex A: Protected Groups

The academic research considered a wide range of need characteristics for inclusion in the models. The sub-set of variables included in the preferred models were selected on the basis of statistical criteria relating to statistical significance of each characteristic and the statistical goodness of fit of the overall model. The modelling was necessarily limited to considering those characteristics for which consistent data are available for each individual or small area.

Age

The weighted capitation formulae specifically takes into account the different needs for health care services by age group, which are especially higher for older age groups and significantly greater for the oldest age groups.

For example, the general and acute formula gives a weight per head 12 times higher for those aged 65-70 compared with those aged 20-25, and 32 times higher for those aged 85 and over compared with those aged 20-25.

The mental health component has separate formulae for working age and older adults, as their needs are different. Dementia is more prevalent amongst the older age groups, while acute need is more prevalent among the working age group. The different needs of different age groups are also taken into account in each of the working age and older age group models.

Sex

The weighted capitation formula directly takes account of the different needs of males and females in each age-group. For example, the need for general and acute services for women in their 30s is higher than that for men, while the need for general and acute services for men aged 85 and over is higher than for women.

The mental health component has separate formulae for men and women of working age as their needs were found to be different.

Race

The general and acute and mental health formula both include ethnicity. The general and acute research did not have data on ethnicity for each individual. Instead the proportion of people by ethnic group in each individual’s place of residence was used from the Census (place of residence was defined by Lower Level Super Output Area – LSOA\(^4\)). A number of variables for ethnicity were considered and the proportion of people from black and minority ethnic groups was found to be statistically significant.

The modelling for the mental health formula had data available on ethnicity for users of mental health services. The modelling tested 16 ethnicity variables, of which 3 or 4 were found to be statistically significant, the number varying between the working

\(^4\) LSOAs are designed by ONS to have similar population sizes (average of 1500) and as far as practical similar socio-economic characteristics.
age and older adults models. Those of Caribbean ethnic origin were found to have higher need, and also for men, those of African ethnic origin.

Disability
The aim of the formula is to equalise allocations relative to health needs across CCGs and across ATs for primary care, and therefore directly reflect need due to disability. For example, the general and acute and mental health models are largely based on past patterns of morbidity at the individual level as measured by diagnostic data for hospital admissions and outpatient appointments. The prescribing formula also includes morbidity measures and the primary care formula includes the proportion of patients with a limiting long term illness.

There is also a separate unmet need/health inequalities adjustment based on the SMR<75 for small areas (Middle Level Super Output Areas - MSOAs\(^5\)). This is because the models typically assess need as it is currently met by NHS services and therefore may not capture unmet need or inappropriately met need – the fact that some of the most deprived communities do not access health care in the most optimal way, resulting in poorer health outcomes.

Gender reassignment (including transgender), sexual orientation and religion or belief
These groups' treatment needs, as for all population groups, will be included in the diagnostic information for general and acute inpatient and outpatient services and mental health services. Beyond this, there is a lack of data on the groups' needs suitable for consideration for use in an allocations formula and so there is no specific adjustment in the formulae. As for other groups, local commissioners and providers are subject to the public sector equality duty.

Pregnancy and maternity
There is a separate maternity formula within the HCHS component to take into account the specific health care needs related to pregnancy and maternity.

Carers
There is no specific adjustment in the formulae for carers. As for other groups, local commissioners and providers are subject to the public sector equality duty.

Other identified groups
All groups’ treatment needs will be included in the diagnostic information for general and acute inpatient and outpatient services and mental health services. This includes those from different socio-economic groups.

\(^5\) MSOAs are designed by ONS to have similar population sizes, with an average population size of around 7,000.
Areas with greater socio-economic disadvantage typically have poorer health after accounting for age and higher health care needs. This is reflected in the formulae: the general and acute and mental health formulae include morbidity data. The prescribing formula also includes morbidity data and the proportion of prescriptions dispensed which are exempt from patient charges.

As noted above, there is also a separate unmet need/health inequalities adjustment based on the SMR<75 for small areas (MSOAs). There is this adjustment because the models typically assess need as it is currently met by NHS services and therefore may not capture unmet need or inappropriately met need – the fact that some of the most deprived communities do not access health care in the most optimal way, resulting in poorer health outcomes.