



BRIEFING PAPER

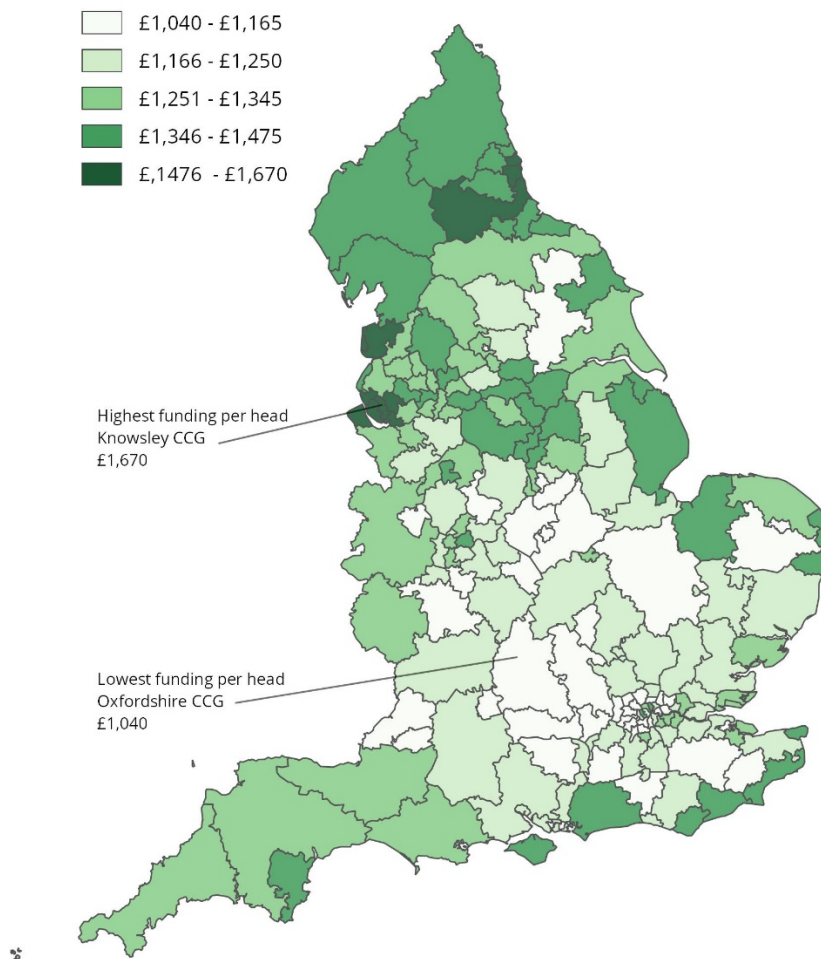
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NHS Funding Allocations: Clinical Commissioning Groups

By Shadi Danechi

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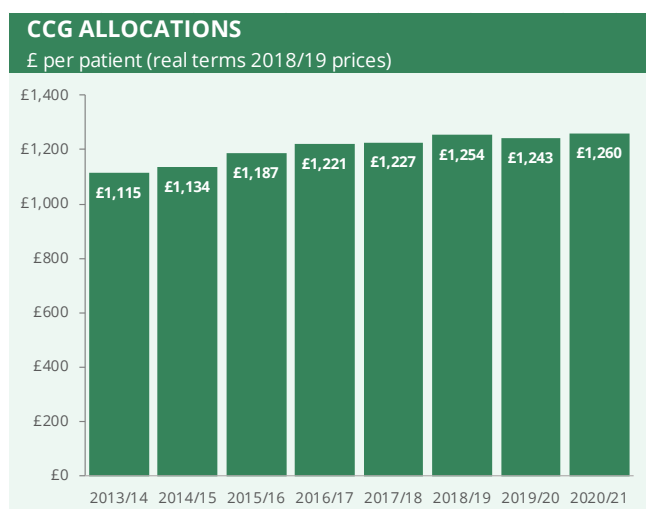
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Summary

In 2018/19 NHS England distributed a total of £74.2 billion across 195 CCGs in England. The overall funding equates to £1,254 per registered patient in England.

Funding per head increased in real terms between 2013/14 and 2018/19. The average annual increase from 2013/14 to 2018/19 was 2%.



The formula used to distribute funding means that CCGs with elderly populations, in urban areas, or in more deprived areas tend to have higher allocations than they would under a simple population-based formula.

The highest allocation per patient in 2018/19 is Knowsley CCG in Merseyside (£1,645), the lowest CCG allocation per patient is Oxfordshire CCG (£1,040). All of the 10 highest allocations per patient are CCGs in the North East and North West of England.

10 HIGHEST CCG ALLOCATIONS PER PATIENT		10 LOWEST CCG ALLOCATIONS PER PATIENT	
Knowsley	£1,670	Oxfordshire	£1,040
South Tyneside	£1,596	Berkshire West	£1,059
South Sefton	£1,580	Wandsworth	£1,069
Sunderland	£1,575	Cambridgeshire and Peterborough	£1,070
Durham Dales, Easington and Sedgefield	£1,565	Milton Keynes	£1,074
Halton CCG	£1,539	Bradford City	£1,089
Wirral	£1,536	Richmond	£1,091
Blackpool	£1,533	Buckinghamshire	£1,092
St Helens	£1,524	Newham	£1,097
Liverpool	£1,513	West Leicestershire	£1,100

For individual CCG funding in cash terms and adjusted for inflation, as well as funding per registered patient, please refer to the Excel File published alongside this briefing

1. Current Allocations¹

NHS England is responsible for determining allocations of financial resources to Clinical Commissioning Groups (CCGs). CCGs were established in 2013/14 and are responsible for around 60% of the NHS budget.

The Library Briefing paper [The structure of the NHS in England](#) provides further details on the current organization of the NHS.

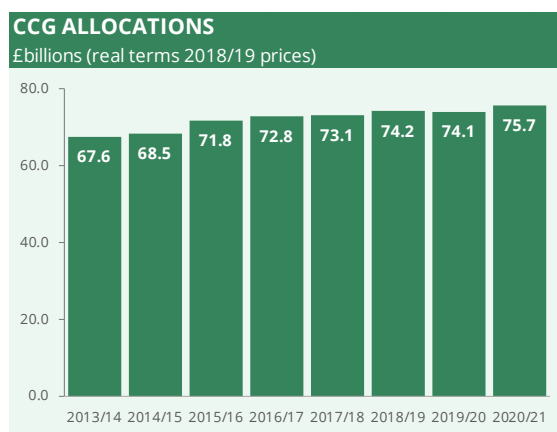
CCGs are provided with annual resource allocations to cover the costs of providing health services for the population they cover. In 2018/19 NHS England distributed a total of £74.2 billion across 195 CCGs in England.

CCGs use this funding to commission a wide range of services including mental health services, urgent and emergency care, elective hospital services, medicines and community care. NHS England also directly commissions 'specialised' services (such as treatments for rare conditions and secure mental health care), military and veteran health services and health services for people in prisons. Some public health services are also directly commissioned by NHS England.

CCGs allocations have been published covering the period from 2013/14 to 2020/21. Initial allocations were subsequently revised with the inclusion of additional funding for 2017/18 and 2018/19.² It seems likely that allocations for 2019/20 and 2020/21 may also be revised given the June 2018 announcement that funding for the NHS in England would be increased by £20.5 billion by 2023/24³.

Overall allocations have increased in real terms each year from 2013/14 to 2018/19, with real terms funding over this period increasing by an annual average of 2%.

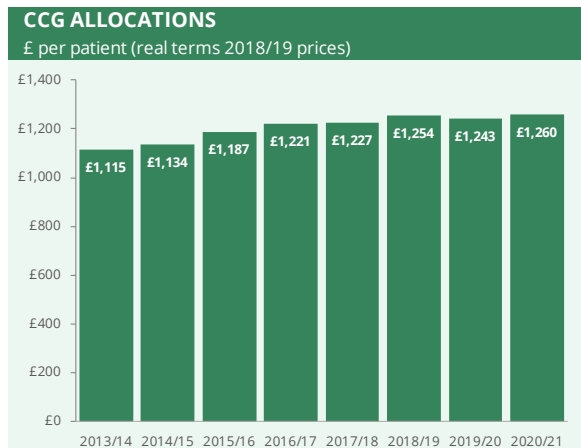
Adjustments to 2017/18 and 2018/19 figures were non-recurrent but should further funding become available in 2019/20 the trend of real terms increases may continue.



¹ The allocations referred to in this paper are recurrent resource allocations – ie those used to fund the day to day running of services

² See NHS England [December 2016 - Non recurrent adjustments for 2017/18 and 2018/19 allocations](#) and [February 2018 - revised 2018/19 allocations](#)

³ [Prime Minister sets out 5-year NHS funding plan, 18 June 2018](#)



In 2018/19, £1,254 was allocated per registered patient in England.

Funding per registered patient increased in real between 2013/14 and 2018/19 with an average annual increase of 2%.

Full details of allocations from 2013/14 to 2020/21 can be found in the accompanying excel file on the [web landing page](#) for this Briefing paper.

1.1 Geographical differences in funding

The starting point for determining the target allocation for each CCG is the population of the CCG area. If all CCG populations had equal need, and costs didn't vary across the country, funding could simply be allocated on a per person basis.

In reality, health needs vary according to the age, health status and deprivation levels of the local population. Cost also vary across different geographical areas: e.g. staff, land and building costs are higher in London. Funding allocations are weighted to take these factors into account.

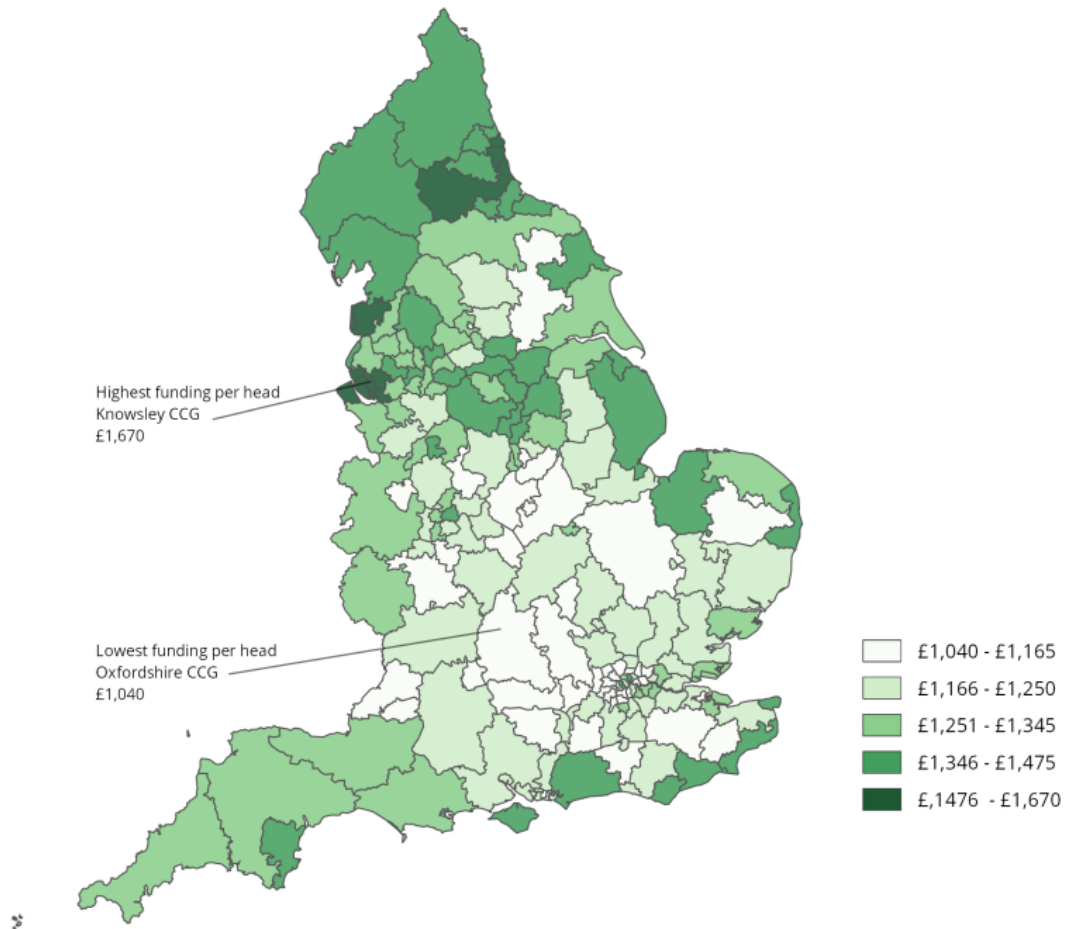
The effect of the weighting means that, in general, CCGs with more elderly populations, those in urban areas or those in more deprived areas will have higher target allocations than they would under a simple population-based formula. The map overleaf shows the distribution of CCG allocations per registered patient in 2018/19.

The highest CCG allocation per patient in 2018/19 is NHS Knowsley (£1,645), the lowest CCG allocation per patient is NHS Oxfordshire (£1,040).

The tables beneath the map show the CCGs with the ten highest and lowest allocations per registered patient in 2018/19. All of the 10 highest allocations per patient are CCGs in the North East and North West of England

A detailed explanation the CCG funding allocation process is provided in Section 2 of this briefing.

CCG FUNDING PER REGISTERED PATIENT 2018/19



10 HIGHEST CCG ALLOCATIONS PER PATIENT		10 LOWEST CCG ALLOCATIONS PER PATIENT	
Knowsley	£1,670	Oxfordshire	£1,040
South Tyneside	£1,596	Berkshire West	£1,059
South Sefton	£1,580	Wandsworth	£1,069
Sunderland	£1,575	Cambridgeshire and Peterborough	£1,070
Durham Dales, Easington and Sedgfield	£1,565	Milton Keynes	£1,074
Halton CCG	£1,539	Bradford City	£1,089
Wirral	£1,536	Richmond	£1,091
Blackpool	£1,533	Buckinghamshire	£1,092
St Helens	£1,524	Newham	£1,097
Liverpool	£1,513	West Leicestershire	£1,100

2. CCG Funding Allocation Process

Funding or allocation formulas are a tool for distributing central funding for local health services. They are based on the principle that resources should be distributed in a way that **eventually** secures 'equal opportunity of access for people with equal need across the country'.

2.1 Weighted Capitation Formulas

CCG allocations are based on the weighted capitation formulas 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;
- deprivation levels;
- 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 areas or those in more deprived areas will have higher target allocations than they would under a simple population-based formula.

Health resources have been distributed using a weighted capitation formula since 1977/78. Given the changing nature of society it would be intransigent to retain the same funding formula each year. Consequently, revisions to the funding formula are made to reflect such factors as changing population structures, increased understanding/estimation of health needs, and so on.

These alterations in the weighting of allocations—in particular, age and deprivation measures—have coincided with an ongoing wider political debate surrounding funding formulas and which indicators are the stronger determinants of ‘need’. Because the distribution of areas with older and/or more deprived populations across the country is not even, the weight given to each indicator alters the allocation of resources nationally. The 2008 paper [Health care equity, health equity and resource allocation: towards a normative approach to achieving the core principles of the NHS](#), explains the tension between effectively meeting existing demand and reducing health inequality:

In order to promote "equal opportunity of access for equal needs", the distribution of funding should reflect the existing burden of disease. In order to promote an "equal opportunity to be healthy", funding needs to be targeted so as to reduce the health gap between the most advantaged and the least advantaged groups. This implies that resources should not necessarily be directed at populations with the highest absolute burden of ill-health, but at those which have the worst health in terms of age-standardised measures.⁴

Since the first funding allocations were made, any suggested revisions to the allocation formula need to be tempered by the observation that the previous formula dictated a given level of funding in a given area. If a revised formula results in substantial differences in funding, it may not always be practical to immediately implement the ideal “fair share” according to a revised formula. For example, when the funding formula for 2016/17 to 2020/21 was introduced if CCGs were given their actual target allocations according to the new formula, some CCGs would have benefitted from funding increases of around +10% while others could have lost out by a funding reduction of -30%. To avoid wide swings in year on year allocations, a political decision is taken by the Department of Health and Social Care to constrain change in allocations where CCGs are determined to be under or over target.

Distance from Target (DFT)

CCGs move towards their target allocation over time. Each year all CCGs receive an increase in funding, however, the percentage increase varies depending on their Distance from Target (DFT). CCGs that are above target generally receive less than the national average funding increase while those below target will receive more. The intention being to move towards the target allocation.

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

⁴ Asthana S and Gibson A, [Health care equity, health equity and resource allocation: towards a normative approach to achieving the core principles of the NHS](#), University of Plymouth, 2008

target year on year. The rules associated with the current formula are intended to guarantee that:

- No CCG is more than 5% below target.
- All CCGs receive a minimum per capita growth that is equivalent to real terms cash growth at the average population growth (in 2016/17 this equated to 0.91%).
- All CCGs receive a minimum cash growth equal to real terms growth plus specific non-routine policy pressures (predominantly relating to pensions and 7 day services); unless the CCG is more than 10% above target, when its cash growth is limited to the specific policy pressures.

The following two tables give examples of large distances from target according to the 2016/17 – 2020/21 CCG allocations. Note, these tables are for illustrative purposes and do not reflect subsequent revised allocations.

NHS Corby was under target by -7.9% in 2016/17 (and remained under target in subsequent years) so the annual increase in their allocations was above the national average.

NHS CORBY CCG				
	DFT	Allocation £millions	% change in allocation	
			CCG	England
2015/16		85.2		
2016/17	-7.9%	93.2	9.4%	3.7%
2017/18	-3.4%	96.2	3.2%	2.1%
2018/19	-3.2%	99.7	3.6%	2.2%
2019/20	-2.4%	103.4	3.7%	2.2%
2020/21	-1.7%	108.8	5.2%	3.9%

NHS WEST LONDON CCG				
	DFT	Allocation £millions	% change in allocation	
			CCG	England
2015/16		348.7		
2016/17	+34.2%	353.5	1.4%	3.7%
2017/18	+31.4%	354.1	0.2%	2.1%
2018/19	+29.3%	354.3	0.1%	2.2%
2019/20	+27.0%	354.4	0.0%	2.2%
2020/21	+24.7%	359.5	1.5%	3.9%

NHS West London CCG was over target by +34% in 2018/19 (and over target in subsequent years). Hence, their annual increase in allocation is below the national average.

2.2 The current weights and adjustments

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

Three further adjustments are applied for unavoidable costs due to location:

- The market forces factor
- The emergency ambulance cost adjustment (EACA)
- The sparsity adjustment

The SMR<75 weighted population, combined with the unavoidable cost adjustments, gives the relative overall weighted population for each CCG.

Unmet need adjustment: SMR<75

The unmet need adjustment in the pre-2016 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.

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. This adjustment is for higher, unavoidable input costs alone, not due to higher costs due to higher need.

There are four components to the MFF, unavoidable differences in cost across the country due to each of: medical and dental staff; other staff; land; and buildings.

The 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 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.

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.

The current EACA is based on modelling 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.

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 has 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:

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- 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 consolidation of services to fewer sites is feasible.
- 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 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 (e.g. differential staff and premises costs across the country).

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. The cost curve gives the estimated higher costs above national average costs for each of the hospitals with activity levels which correspond to population catchment areas of under 200,000 people. The sparsity adjustment therefore reflects the expected cost premium based on national scale/cost relationships rather than the actual cost position of the individual site, which may be affected by a number of factors unrelated to its scale.

3. The history of allocation formulas in the NHS

Allocation formulas can be used to make a 'fair' allocation of resources to areas based on various measures of need and current usage. They can also be used, as [The King's Fund](#) argued in April 2013, as a policy tool "to support the NHS in delivering its mandate and changes to the wider system".⁵ The rest of this section sets out the ways in which funding formulas have been used since 1971.

Since 1971 allocations of health funding to regional service providers have been made using three broad criteria: the size, age, gender of each population and, from the 1990s the level of deprivation. The principles behind the allocation of resources in the NHS in England have changed periodically and the weight given to each of the three criteria has been altered.

The 'Crossman formula': 1971/72 to 1976/77

Prior to the mid-1970s regional funding for hospital and community health services (HCHS) was allocated on the basis of the number of NHS staff and beds in each area which was increased incrementally each year. Because hospitals inherited by the NHS in 1948 were unevenly distributed—with more of them located towards the south of England—funding remained very uneven under this system. The formula was widely criticised for this reason. After the *1973 NHS Reorganisation Act*, the "Crossman" formula (named for Richard Crossman MP) was used. It was designed to reverse regional inequalities within ten years by allocating more resources to areas with greatest need. This funding formula introduced 'target allocations' for each area which were based on population size, weighted by age and gender, and the utilisation of available hospital beds. The formula thus introduced the principle of 'weighted capitation'.

The RAWP formula: 1977/78 to 1988/89

By 1975 concerns about the sensitivity of the Crossman formula to levels of need led to a review being launched. The Resource Allocation Working Party (RAWP) established the principle that "there would eventually be equal opportunity of access to health care for people at equal risk". The RAWP formula subsequently introduced standardised mortality ratios (SMRs) as a proxy measure for morbidity to identify health needs over and above those which were age-related. The use of SMRs meant that the allocations were responsive to differences in death rates between regions; the result was a transfer of resources

⁵ The King's Fund, [Improving the allocation of health resources in England: Deciding who gets what](#), April 2013, p1

from Regional Health Authorities in the South East to those in the North.

The RoR formula: 1990/91 to 1995/96

The RAWP formula received criticism for its use of SMRs which were seen as an inadequate proxy for non age-related need. The review into RAWP (known as RoR) used 1981 Census data to assess how hospital utilisation related to local socioeconomic and demographic variables. RoR recommended in 1988 that the measures of deprivation it had developed should be used alongside SMR among under 75s in order to measure need.

Although the RoR review process changed the way reviews of health allocations were performed—having established that need could be determined empirically rather than by informed judgment—its recommended formula was rejected by the Department of Health. SMR continued to be used on its own as a measure of need albeit with less weight given to it.⁶

The York formula: 1996/97 to 2002/03 and the AREA formula: 2003/4 to 2007/08

Two further reviews resulting in the York formula (1996/97 to 2002/03) and the AREA formula (2003/03 to 2007/08) followed. The 'York' approach used a statistical method (known as regression analysis) for quantifying the relationships between variables to determine which of them best predict health utilisation. These were then used to create an allocation formula to better address need.

The later 'AREA' approach had the additional goal of reducing health inequalities by using indices of multiple deprivation to calculate need. This method involved quantifying the relationship between socioeconomic factors and the healthcare need that was currently being met. It also involved calculating 'unmet' need, which was done using a complex process which is described in the [formula handbook](#).⁷

From 1999/2000 the hospital and community health services (HCHS) component of NHS funding was merged with prescribing and primary medical service funding. This meant that the 28 Strategic Health Authorities, which replaced the 14 Regional Health Authorities abolished in 2002,⁸ received a 'unified' allocation of funding.

⁶ Rather than a constant weight being applied, the square-root of the SMR was used; in short, this means the importance of the SMR diminishes as it increases in value.

⁷ Department of Health, [Resource allocation: weighted capitation formula](#), 6th Ed., 2008, p18

⁸ Initially, around 100 Health Authorities took over the responsibilities of Regional Health Authorities but these were quickly amalgamated into 28 Strategic Health Authorities.

Current Age Related and Additional Needs (CARAN) formula: 2009/10 to 2014/15

The CARAN formula was based on a review that ran from 2005 to 2008. The most significant change, in terms of its impact on allocations, was in the way health inequalities were measured. It was determined that it was not technically possible to fully achieve both objectives of equal access for equal need and a reduction in health inequalities within a single needs-based weighting. Therefore, the review recommended a separate component be added to address the objective of reducing avoidable health inequalities: an estimate of disability-free life expectancy (DFLE). However, the weighting of this component (ie how much money should be allocated to reducing health inequalities) within the overall additional need adjustment was left for Ministers to decide. This weight was set at 15 per cent, meaning that 15 per cent of PCTs' allocations were top-sliced and distributed according to the health inequalities component. It has been suggested that the decision to set the weighting at this level was a calculated effort to dampen the impact of the new formula, which would otherwise have resulted in some transfer of resources from urban to rural areas, thus preserving the previous *status quo*.⁹

Another significant but more technical change involved the way in which acute and maternity needs were modelled within the HCHS component of the formula. Specifically, maternity need is now calculated separately from acute need.

In addition, acute need, which had previously been measured using indices of age-related need and additional need³⁰ has been replaced by a one-stage approach that allows for the relationship between age-related need and additional need to vary between age bands.

2014/15 Changes

Following a fundamental review, NHS England announced on 17 December 2013 the funding formula for 2014-15. This was the first time that the final decision on funding allocations had been made independently of the Department of Health.

At the meeting, the Board decided to reject proposals for a faster move towards CCGs' allocation targets (which would have resulted in some CCGs which were above target receiving a reduction in funding). Instead, all CCGs would receive at least flat real terms growth for 2014-15 to 2015-16. In addition, £180 million would be made available in 2014-15 to provide above inflation increases for the CCGs which are furthest from their target allocations.¹⁰ NHS England explained that 10 per cent of

⁹ Department of Health, [Resource allocation: weighted capitation formula](#), 6th Ed., 2008, p18

¹⁰ *Health Service Journal*, [Live feed: 3.20pm](#), 17 December 2013, [See also](#)

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the total funding for CCGs would now be based on deprivation levels to reflect unmet need, which it said would enable “CCGs to tackle the impact of health inequalities.”¹¹

2016/17 changes

The formula used from 2016/17 onwards refined the unmet needs adjustment and Emergency Ambulance Cost Adjustment and also introduced a sparsity adjustment (see Section 2). The changes to the formula are relatively small overall but tend to move money in the direction of CCGs in areas with a combination of greater age and deprivation. NHS England produced the tables shown below to illustrate the profile of target allocations with respect to age and deprivation.

AGE AND DEPRIVATION DISTRIBUTION												
2015-16 Target Model												
		Youngest								Oldest		
		A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	All
Least deprived	D1		1,084	1,097	1,169	1,120	1,086	1,117	1,156	1,158		1,124
	D2			1,170	1,127	1,140	1,117	1,142	1,182	1,196	1,244	1,152
	D3		1,121		1,139	1,256		1,204	1,164	1,202	1,303	1,215
	D4	1,026	1,125	1,137			1,192	1,289	1,200	1,224	1,302	1,195
	D5		1,121		1,168	1,218	1,264	1,276	1,262	1,286	1,267	1,244
	D6	1,110	1,158	1,161	1,168	1,301	1,262	1,327	1,292	1,282	1,258	1,236
	D7	1,153	1,160	1,163	1,136	1,193	1,354	1,346	1,380		1,303	1,212
	D8	1,149	1,167	1,191	1,295	1,351	1,291		1,445		1,330	1,262
	D9	1,183	1,147	1,336	1,462	1,249	1,381	1,397	1,456	1,397		1,290
Most deprived	D10	1,152	1,200	1,351	1,252	1,374			1,463			1,275
	All	1,152	1,159	1,263	1,187	1,226	1,246	1,235	1,246	1,236	1,295	1,222

AGE AND DEPRIVATION DISTRIBUTION												
2016-17 Target Model												
		Youngest								Oldest		
		A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	All
Least deprived	D1		1,059	1,059	1,126	1,144	1,111	1,148	1,119	1,198		1,135
	D2			1,157	1,142	1,171	1,101	1,138	1,200	1,197	1,220	1,156
	D3		1,062		1,135	1,237		1,220	1,164	1,203	1,291	1,209
	D4	1,005	1,126	1,118			1,208	1,251	1,211	1,217	1,299	1,194
	D5		1,109		1,168	1,227	1,277	1,267	1,278	1,298	1,290	1,250
	D6	1,061	1,094	1,169	1,173	1,283	1,216	1,312	1,299	1,315	1,281	1,230
	D7	1,143	1,141	1,166	1,184	1,179	1,339	1,351	1,366		1,308	1,207
	D8	1,150	1,168	1,173	1,286	1,356	1,303		1,486		1,348	1,265
	D9	1,164	1,115	1,332	1,426	1,253	1,354	1,400	1,452	1,401		1,275
Most deprived	D10	1,151	1,243	1,343	1,284	1,371			1,527			1,285
	All	1,139	1,158	1,254	1,189	1,234	1,239	1,235	1,254	1,247	1,295	1,222

Indicates a decrease of over £5 per head
 Indicates an increase of over £5 per head

Notes:

The published target distribution has been normalised using 2016-17 populations to facilitate comparison

Source: NHS England Board Paper in the distribution of CCG allocations 2016/17 to 2020/21

¹¹ NHS England, [NHS England publishes CCG funding allocations for next two years following adoption of new formula](#), 18 December 2013

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