The implications of national funding formulae for rural health and education provision

A report by the All-Party Parliamentary Group on Rural Services

March 2010

The All-Party Parliamentary Group on Rural Services

The All-Party Parliamentary Group (APPG) on Rural Services is a cross-party group formed of Members of both the House of Commons and the House of Lords. The Group exists to promote debate on the provision of rural services. Between January and February 2010, the Group undertook a short inquiry into the implications of national funding formulae for rural healthcare and education provision. This report consists of the recommendations arising from that inquiry, together with the written and oral evidence submitted.

Officers of the group

Philip Dunne MP (Chair)
Baroness Byford DBE
Lord Crathorne
Lord Dear QPM
David Drew MP
Dan Rogerson MP

Participants in the Inquiry panels

Rt Hon Sir Alan Beith MP
Baroness Byford DBE
Lord Cameron of Dillington
Lord Dear QPM
David Drew MP
Philip Dunne MP
Baroness Gibson of Market Rasen OBE
Duke of Montrose
Dan Rogerson MP
Graham Stuart MP
Roger Williams MP

Acknowledgments

The Group is very grateful to all of those organisations and individuals who presented written and oral evidence to the Inquiry. Particular thanks also go to Ruth Gripper for her assistance in drawing the evidence together to form this report.

Contacts

The Commission for Rural Communities provides the Group's secretariat, on behalf of the Sparsity Partnership for Authorities Delivering Rural Services (SPARSE). All correspondence should be addressed to CRC, 55 Whitehall, London, SW1A 2EY. The telephone number for general enquiries is 0300 068 6445. An electronic copy of the full report can be viewed and downloaded from www.rsnonline.org.uk.

Contents

Summary

The All-Party Parliamentary Group for Rural Services has now completed its inquiry into the funding formulae used to allocate resources for health and education. Our findings and recommendations (in bold) are set out below, and transcripts of the oral evidence sessions, as well as a written evidence pack, are included as appendices to this report.

We conclude that achieving equitable outcomes – the goal of any administration – costs more in rural areas, for a variety of reasons relating to remoteness and limited economies of scale. In addition, the older age profile in rural areas increases the cost of providing adequate healthcare for rural populations. Yet the current funding formula actually provides less money per pupil and patient for those who happen to live in a rural rather than an urban area.

The funding formulae used for both health and education focus on allocating resources according to need. Proxy indicators are used to predict that need, and funds allocated accordingly. Such a system sounds reasonable enough, but there are problems both with the detail (the choice of proxies) and with the system as a whole. Rather than attempting to fund according to need alone, we favour a cost-based approach which would seek simply to fund the actual cost of provision necessary to meet the need in different types of area, with top-ups open to adjustment for need and other priorities. The system as it stands, and the relative weight given to particular types of need, leaves many rural authorities under-funded. We acknowledge that this means that the Government of the day would be determining basic needs, prioritising these based on available national resource, and publishing their decisions. However, we do not consider that to be unreasonable. Indeed, in the search for transparency and the equitable distribution of national resources, it is highly desirable.

This situation is not new. Resources have been channelled to urban over rural areas by Governments past and present, and utilisation models combined with 'spend-plus' systems or blanket percentage increases have only served to prolong pre-existing funding imbalances. We wish to see an end to percentage increases and any other system which takes previous funding levels as its starting point. In its place, we envisage a clear, transparent formula whose results can be explained and justified.

The changes we are calling for will have an immediate and tangible effect on funding allocations. They may be resisted by some concerned about 'losing out,' but will provide those who have been 'losing out' for many years already with a more reasonable level of funding. The elephant in the room, according to one witness, is the economic context, which poses a significant challenge for the redistribution of resources – usually undertaken during periods of spending growth. That does not mean, however, that we should not take steps to improve a system which we know to be flawed, even if it has to be managed over several years. Change will have to be carefully and sensitively managed, but it is necessary. The argument is not simply a technical or academic one, of competing econometric measures and complex equations. Ultimately, it is about meeting the educational needs of every child, and the health needs of every individual, wherever they may live and whatever their individual circumstances.

Health findings and recommendations

The inquiry into the health funding formula focused on the Hospital and Community Services (HCHS) element, which receives 76% of health funding.

1. Additional costs of rurality

Providing healthcare to rural populations entails unavoidable additional costs due to diseconomies of scale, additional travel and travel-time related costs, and the effects of caring for an older population. Technology is sometimes cited as the solution to health provision in remote rural areas, but it does not answer every problem, nor can it be assumed that the infrastructure is in place to support it. Some services are required regardless of geography, and in remote rural areas providing such services is more expensive. England is alone among the regions of the UK in not adjusting funding allocations to compensate for those additional costs. The Arbuthnott formula used in Scotland includes specific adjustments which recognise the needs of rural areas, or of mixed rural and urban locations, when allocating funds for HCHS. Wales uses a similar model, while in Northern Ireland funding is based on the efficiency of road routes between need and supply.

There should be an evidence-based rurality adjustment included in the funding formula in England, as is already the case elsewhere in the UK, to meet the unavoidable additional costs of providing healthcare in rural areas.

2. Age-related need

The median age in rural areas is nearly six years higher than in urban areas, and rural areas have a higher proportion of people aged over 55. As a general rule, as people age so their healthcare needs, and the related costs, increase. While the funding formula does adjust for age-related need, we believe that it underestimates the extent to which age drives up costs. Furthermore, the emphasis placed on addressing additional need means that the funding formula disadvantages less deprived areas with older populations, who may be facing far greater actual costs right now. This is of particular concern for rural areas, with their older age profile and problems regarding the measurement of additional need (see point 3 below); these areas may not be receiving sufficient funding to meet their populations' basic healthcare needs. It can be argued that this is addressed by the CARAN formula's one-stage approach, stratifying by age, although this is counteracted by the subsequent health inequalities adjustment.

Age-related need should be given greater weight in the formula while an independent evaluation of the costs of serving an ageing population is carried out. There should be an annual report showing progress towards funding those costs.

3. Additional need

The funding formula adjusts for poor health needs over and above those related to age. Socio-economic deprivation is used as a proxy indicator for this additional need. However,

we are concerned that the way in which deprivation is measured is more sensitive to urban than to rural deprivation. The former tends to be more concentrated, and the latter more dispersed; rural deprivation may be due to seasonal employment or low wages rather than unemployment itself.

Further research is needed to find proxy indicators that accurately capture both rural and urban deprivation.

4. Health inequalities

On ACRA's recommendation, the formula now includes a separate element aimed at reducing avoidable health inequalities. This element does not apply to a separate budget, but is a further adjustment in the existing funding formula. Ensuring equal access for equal need and reducing avoidable health inequalities are two distinct goals, and we are convinced that it is impossible to reconcile the two in a single funding formula. There has been little research into the cost-effectiveness of previous public health interventions, and there is no guarantee that funds allocated to combat health inequalities are actually being spent to do so. Including this element in the formula prevents a clear statement of relative funding priorities, or the actual amount of funding dedicated to public health. Nor is the NHS necessarily the only relevant actor: education and social services, for example, may both have a role to play.

The healthcare budget should focus on ensuring equal access to equal need. The money used to target health inequality, which is not currently distinguished from total funding allocations, should be placed in a separate public health budget whose level of funding is clearly stated. More research is needed to ensure that that budget is spent effectively. It will also be appropriate for other departments to become involved in funding and delivery, as recognised in the recent Marmot Review of health inequalities; "National policies will not work without effective local delivery systems focused on health equity in all policies"[1].

5. Ministerial decisions

The Government established ACRA as an independent body in order to set the funding formula on an objective basis. Decisions about the formula, however, are unavoidably political, and all decisions about funding will be subject to a greater or lesser extent to ministerial influence, judgement and decision-making. The Minister sets the pace of change in policy, which has a major impact on the actual amount of funding received (as opposed to the target levels of funding determined by the formula). The Minister also sets the relative weighting of health inequalities; his decision to apply the health inequalities element to 15% of the formula had the effect of maintaining the funding status quo, leaving money in urban areas which the basic formulae for meeting current health needs would have directed to less

[1] "Fair society, healthy lives": The Marmot Review; A strategic review of health inequalities in England post-2010, UCL, 2010.

deprived and rural areas. No evidence or other justification was given for deciding on this figure. Political judgement and Ministerial decisions are inevitable, but for Parliament to fulfil its scrutiny role, the reasons for those decisions must be clearly stated and backed by sound argument.

The Government should publish a set of criteria by which ministerial decisions regarding the formula will be made, to improve transparency and to enable Parliament to exercise adequate scrutiny.

6. Acute and community services

Due to a dearth of data on community services, the funding formula is dominated by acute services. Community services, however, have a vital role to play particularly in rural areas where the nearest general hospital may be some distance, and time, away. If a patient is discharged from the acute hospital to a Community Hospital, relevant funding should also transfer to the Community Hospital, which does not happen at present. The economies of scale which can be achieved in a large general hospital cannot be achieved in small community hospitals, but the latter provide a necessary service in rural areas and their costs should be met through the funding allocation. While the lack of information relating to community services is recognised by the Department of Health and work is being done to rectify the situation, we are alarmed that there is no timetable for that work, not least given the Department's increasing priority given to care in the community. Finally, rapid structural change has adversely affected community services.

Greater effort should be made to collect sufficient, appropriate data on community services so that their needs may adequately be reflected in funding allocation, and a timeframe for that work should be made public. Structural change should be carefully managed, allowing sufficient time for the appropriate planning and management of change by all services.

7. Mental health services

The ageing population in rural areas, with the associated increased incidence of depression and dementia, will place increasing pressure on mental health services. Recruiting staff with the requisite specialist skills, and the experience to work autonomously in remote rural communities, may be costly and difficult. Social as well as geographical isolation, and the stigma attached to mental illness, pose additional challenges to mental health services in rural areas.

The forthcoming review of mental health funding allocations should look specifically at the particular costs and challenges of providing services in remote and rural areas, and consider an appropriate rurality adjustment (see also point 1 above).

8. Transport

Transport is an additional cost for both staff and patients in rural areas. Travel and travel-time related costs were mentioned (see point 1 above) as an additional cost of delivery, but their impact on patient access is also important. In many rural areas, public transport is very limited. Ensuring equal access for equal need is an explicit aim of the funding formula, and yet suitable transport, a crucial aspect of ensuring patient access, does not form part of its remit. One witness informed us that her PCT was commissioning additional transport to ensure patient access, but that they have to meet those costs themselves as transport does not feature in the funding formula. Funding for public transport comes through the Local Authority allocations of the Department for Communities and Local Government (DCLG) budget, and therefore has also to try to meet the competing needs of industry, retail and leisure services.

To ensure equal access for equal need, there should be a transport element included in the funding formula which reflects the higher costs of provision in remote and rural areas.

9. The Market Forces Factor

The Market Forces Factor adjusts funding to reflect salaries in local communities. It is designed to compensate for unavoidable geographical variations in the cost of providing services – namely, higher costs in high-wage areas. However, with staff on national pay scales, low-wage areas face similar staffing costs to high-wage areas, without the corresponding increase in their funding through the MFF. The MFF is irrelevant and inappropriate to most parts of the country other than London, and serves to disadvantage low-wage, often rural, areas which face similar levels of staffing costs but do not receive equivalent funding.

The MFF should be revised to reflect the existence of national pay scales, and its application limited to London.

Education findings and recommendations

1. Additional costs of rurality

We are concerned that the emphasis in the funding formula on adjusting for need (identified by deprivation indicators, see point 6 below) means that the aim of meeting the actual cost of service delivery is being neglected. As with healthcare, providing education in rural areas entails unavoidable additional costs. Lower demand limits economies of scale, whilst remote rural areas experience greater travel and travel-time costs. There may also be higher transactional costs as a result of greater administrative complexity. Transport, staffing and recruitment also incur additional costs (see points 3 and 4 below) in rural areas.

A rurality adjustment should be included in the formula to compensate for the additional costs of providing education in rural areas. Over the longer-term, we would like to see the funding formula move from a needs-based allocation system to one which seeks first to meet the basic costs of provision on a per capita basis. Those costs will inevitably vary between areas. Additional funding, appropriately weighted and targeted, should be allocated only once these costs have been met.

2. Sparsity

Funding for primary and diploma level schooling is already adjusted for sparsity, but no such adjustment applies at secondary level. Small secondary schools in rural areas nonetheless face similar diseconomies of scale, and the additional costs involved in ensuring student access to a broad curriculum and related facilities. The secondary curriculum is expensive to deliver: schools have to teach subjects such as science and technology in appropriate workshops or laboratories, and with appropriate class sizes. Economies of scale are limited in small rural secondary schools, pushing up cost per pupil. Concerns were also raised by witnesses about the accuracy of the sparsity measure. Any review of sparsity measures should seek to establish the cost of sparsity, looking beyond the amounts currently allocated for it by Local Authorities. Current patterns of expenditure reflect not the cost of sparsity, but the amount the Local Authority can afford to spend on it; some Local Authorities are cross-subsidising small secondary schools.

The accuracy of sparsity measurements should be examined, and the adjustment made applicable to secondary schools. Sparsity measurements should be based on the population density of school-age children, and not simply on overall population density.

3. Area Cost Adjustment

Staffing costs absorb a large proportion of any school budget. The Area Cost Adjustment is supposed to increase funding to areas where wages are high. However, teaching staff work to national pay scales, as will support staff in the near future, making consideration of the average local wage largely irrelevant. Schools in low-wage areas have to pay similar salaries to those in high-wage areas, but do not receive equivalent funding. Furthermore, staff in rural areas are often more senior, and therefore more expensive, while the cost of

temporary staff is greater due to limited choice. This means that many authorities ranked relatively low for funding actually have a relatively high rank for teachers' average salaries.

The ACA should be revised to reflect the existence of national pay scales and the additional costs of seniority and of supply staff; the adjustment for high wage areas should be applicable to London only.

4. Transport costs

Additional transport costs in rural areas are covered under the grant to Local Authorities (and therefore the DCLG), rather than the Dedicated Schools Grant (and the DCSF). The cost of school transport cannot be dissociated from the cost of that school, and yet the former comes from Local Authority funding and the latter from the DSG. It is perverse that such interrelated factors should be considered in isolation, particularly in decisions about closure where the long-term increase in travel cost can outweigh the apparent financial gain of closing a small rural school.

Funding for the extra transport costs in rural areas should form an explicit element of the DCSF funding review, which should include an analysis of the amount spent by each LA on educational transport as a percentage of its DSG and DCLG funding allocations.

5. Training and Continuing Professional Development

There is a notable lack of information regarding differences between rural and urban areas regarding access of both potential trainee teachers to ITT courses and access by schools to newly qualified teachers. Further work may be required to encourage rural schools to take up TDA support in providing Initial Teacher Training (ITT) places. Nor is information readily available regarding the availability of placements in rural areas for trainee teachers in any area. Such information is required to ensure that access to teacher training is reasonably spread throughout rural and urban areas. Once qualified, teachers need opportunities for continuing professional development (CPD). The costs of providing CPD come out of the individual schools' budget, with those in remote areas facing higher travel and travel-time costs, with no corresponding compensation in the funding allocation formula.

The TDA should undertake an evaluation of the provision of ITT in rural areas, and the availability of NQTs to rural schools. The evaluation should examine the availability of teaching placements in rural schools for those in ITT, including those training in urban areas. It should also examine the funding of graduate teacher training programs to ensure that all schools are able to benefit from them. The DCSF/DCLG funding review collaboration (see point 4 above) should consider the costs of travel for staff training as well as for pupil attendance.

6. Indicators of rural deprivation

The formula uses socio-economic deprivation (pupils on Free School Meals) as a proxy for additional need. This often results in the allocation of disproportionately more resources to urban areas, where deprivation tends to be concentrated, rather than rural areas where deprivation is more dispersed. FSM does not capture all of those who are eligible, as some groups may be reluctant to apply. Rural deprivation differs to urban deprivation in other ways too, such as lack of access to facilities, social isolation, and low pay and seasonal work rather than unemployment itself. It should no longer be necessary to use proxy indicators, as advances in management information systems now allow the capture of actual costs.

The Government should evaluate the impact of deprivation measures in rural and urban areas, and seek to improve their accuracy and sensitivity to rural deprivation. These changes should be put into place as interim measures, whilst over the longer- term there should be a move towards cost measurement using existing management information systems.

7. Additional Educational Needs (AEN) and Special Educational Needs (SEN)

AEN and SEN costs, particularly involving "high tariff" pupils such as those with Profound and Multiple Learning Difficulties (PMLD), can be difficult to predict; social deprivation and low birth weight are used as proxy indicators to allocate resources. Some of the problems of measuring deprivation have been raised above. Many rural authorities will not have specialist health facilities for low birth-weight, but will move mothers to the nearest, and usually urban, facility. Rural authorities face higher per pupil costs supporting AEN, SEN and PMLD pupils, due to increased travel costs and diseconomies of scale, while pupils may suffer isolation should they be taught in a neighbouring area with better provision. Rural authorities also face problems providing for low incidence, very high cost special needs, which can be unexpected and funding for which at present must be found from within their funding allocation. These costs can be both unpredictable and be extremely high, so that a very small number of cases can distort an LEA's budget. Transport costs can be enormous, or else residential accommodation may have to be provided. The result is that the costs of providing for the needs of high tariff pupils in rural areas often exceed the funding allocated for them through the formula.

Funding should reflect the needs of pupils educated in an authority, not only those who were born there (who may be in education in other authority areas). AEN and SEN funding should be adjusted for rurality to compensate for higher per pupil costs in rural areas, and funding for high tariff pupils should be managed centrally and disbursed to LEAs to meet actual costs as they arise.

8. Structural change

Structural change can have a significant and often unanticipated impact on rural schools. For example, if larger urban areas seek unitary status, funding provision is affected: the higher per-capita funding associated with urban pupils is no longer available to cross-subsidise relatively under-funded rural areas. Local Authority 'flattening' of the deprivation element of

funding allocations has been observed, suggesting that such cross-subsidies do exist. Rural schools also suffer from a more limited range of funding sources than schools in urban areas, such as access to City Challenge funding.

An impact assessment of any proposed structural change in the education and local government system should systematically consider the effect on rural areas.

Background evidence to the inquiry

Part 1: Service Provision in Rural Areas

This short introductory chapter provides an overview of the challenges involved in delivering public services to rural areas.

'Annex: Briefing note – How can public resources be fairly allocated between different places?' Commission for Rural Communities[2]

At the moment there is a considerable perception, backed up by some evidence, that public resource allocations *between* places are not fair. This is a view felt strongly by many of those representing and serving rural communities. This was one of the messages of research conducted for Defra in 2004. It is also the message articulated by bodies such as the County Councils Network, the Rural Services Network, Action with Communities in Rural England and others. … We also have concerns that resource allocations *within* places (e.g. local authority areas) are not always transparent or fair.

Main factors relevant to resource allocation reflecting rural circumstances, needs and costs:

It is widely accepted that there is no simple resource allocation model that will deliver exactly the right answer across a basket of services. The underlying public delivery *rationale* will also have an important bearing.

Services that cost more to deliver in rural areas are those where:

- travel involves greater mileage costs;
- travel time related costs are greater (in both cases allowing for urban congestion costs as well);
- lower demand levels lead to lower economies of scale;
- a strong focus on citizen/customer choice introduces additional diseconomies in sparsely populated areas.

Rural costs may also be higher due to greater complexity of shire administrative units and also overlapping administrative boundaries. These can give rise to higher overhead and transactional costs.

Many resource allocation systems are needs based rather than costs based. They aim to meet the needs of people and base their allocation models on weighting various population needs. Where different population groups are used within a resource allocation system it is important that the results are tested against geographic fairness. An important example is the claim of the failure within health resource allocation systems sufficiently to weight elderly population groups, as compared to deprivation based population groups.

---

2 http://www.ruralcommunities.gov.uk/files/09%20CRC%2019%20annex%201%20resource%20allocation%20statement.pdf

Needs based resource allocation systems are also less adept at looking at the (geodemographic) *cost* basis for delivering services in different places. These geodemographic factors include a set of variables relating to distance, settlement patterns and population densities.

Targeted funding often uses the Index of Multiple Deprivation (IMD) to allocate resources. This often results in the allocation of disproportionately more resources to areas of concentrated deprivation (urban) rather than meeting more dispersed deprivation (rural). This can be an unintended consequence of using the IMD.

Where resource allocation systems make assumptions about charging regimes, then this too should be considered through a geographical lens. Different geographic communities can be affected by charging regimes. For example, car parking charges within NHS hospitals.

Rural customers and citizens can have to spend more than other people on both private and public transport to access services.

'Review of Evidence on Additional Costs of Delivering Services to Rural Communities: Final Report,' Hindle, Spollen and Dixon for DEFRA, April 2004[3]

If evidence is sought by reference only to historic expenditures then only rarely have any clear cost penalties been demonstrated in rural areas – performance or effectiveness has been varied to match the funding and resources available. Few services (even so-called statutory services) are provided that cannot be varied to some degree or another in this way – for example, roads can be left un-gritted, small schools can be closed, hospitals can be 'centralised', target response times can be lengthened, visiting protocols (e.g., for district nursing) can be modified.

It is, of course, reasonable to argue that different standards are both inevitable and acceptable in the more rural areas and for a number of services such differential standards are currently formally prescribed. It is also reasonable that services should be of different styles in rural and urban areas. However, it is vital that choices such as these are informed choices and not the unpredictable, unstable and ineffective outcomes of cost pressures. It is here that this work – and the more detailed OR methods it describes – can be of most use in developing thinking around appropriate and realistic standards of service provision between urban and rural areas.

[3] http://www.defra.gov.uk/rural/documents/research/secta_rural_communities.pdf

Part 2: Health

This section distinguishes between resource allocation on the basis of need, and on the basis of the additional costs associated with providing services in rural and sparse areas. It finishes with a short comparison between the alternative UK models.

2.1 NEEDS-BASED RESOURCE ALLOCATION

2.1.1 NHA resource allocation: Background and overview of the current situation

This section describes the allocation of NHS resources. The Advisory Committee on Resource Allocation (ACRA) oversees the development of the funding formula, and makes recommendations on potential changes. ACRA completed its most recent review of the formula in December 2008. A timeline of previous reviews and formulae is also provided.

'From Feast to Famine: Reforming the NHS for an age of austerity,' Furness and Gough, Social Market Foundation, July 2009[4]

Developing the idea of equity in the NHS – allocating resources:

Since 1976 healthcare equity has been an explicit part of resource allocation in the NHS.

The NHS model of resource allocation has continued to develop, and since 2003–4 the AREA model has been in place. Utilisation is used as a proxy for need in determining the level of resource an area receives. So, areas where there are high levels of healthcare utilisation are assumed to have high levels of need.

The Department of Health explains: "A weighted capitation formula determines each PCT's target share of available resources, to enable them to commission similar levels of health services for populations in similar need, and to reduce avoidable health inequalities." This formula is based on factors such as educational attainment, birth rate, low income and morbidity in under 65-year-olds … The resource allocation formula was reviewed in late 2008, but did not change in response to criticisms about possible bias against rural areas.

'NHS Resource Allocation,' Commission for Rural Communities, February 2008[5]

The Weighted Capitation Formula

Since 2003/04 the method used to distribute resources between Primary Care Trusts has followed the recommendations of the 'Allocation of Resources to English Areas' (AREA) report published in 2002 (Sutton et al, 2002). This conceptualises 'need for health care' as

[4] http://www.smf.co.uk/assets/files/Health%20Report%20From%20Feast%20to%20Famine.pdf
[5] http://www.ruralcommunities.gov.uk/projects/nhsreview/overview

comprising two elements: 'age-related need' and 'additional need'. The latter concerns that part of a population's need for health care which is over and above that accounted for by age. This addresses, in other words, the effect of socio-economic deprivation on a population's healthcare needs.

This two-stage approach to calculating age-related and additional needs was undertaken separately for the four elements of the weighted capitation formula. These covered Hospital and Community Services (HCHS), Prescribing, Primary Care and HIV/AIDS, and each was assigned a specific set of socio-economic variables that was to be used as a measure of 'additional needs'. In addition, all but the Prescribing element of the formula are further adjusted to take account of variations in the unavoidable costs of providing health care. Market Forces Factors (MFFs) are applied to HCHS, Primary Care and HIV/AIDS, with the former also being subject to a further, very small, adjustment known as the Emergency Ambulance Cost Adjustment (EACA).

'Resource Allocation: Weighted Capitation Formula (6th Edition),' Department of Health, 2008[6]

Four elements are used to set PCTs' actual allocations:

1. weighted capitation targets – set according to the national weighted capitation formula which calculates PCTs' target shares of available resources based on PCT populations adjusted for
    a. their age distribution
    b. additional need over and above that relating to age
    c. unavoidable geographical variations in the cost of providing services (the market forces factor (MFF))

2. recurrent baselines – which represent the actual current allocation which PCTs receive

3. distances from targets (DFTs) – which are the differences between (a) and (b) above. If (a) is greater than (b), a PCT is said to be under target. If (a) is smaller than (b), a PCT is said to be over target

4. pace of change policy – which determines the level of increase which all PCTs get to deliver on national and local priorities and the level of extra resources to under target PCTs to move them closer to their weighted capitation targets. PCTs do not receive their target allocation immediately but are moved to it over a number of years. The pace of change policy is decided by Ministers for each allocations round.

---

6 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091848.pdf

Definition of 'Need':

Population is the starting point but the make-up of the population is also critical. People do not have identical needs for health care. A key difference is that need varies according to gender and age, and in particular, the very young and elderly, whose populations are not evenly distributed across the country, tend to make more use of health services than the rest of the population. The weighted capitation formula therefore takes into account the different age structures of local populations.

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

Observing need directly has not proved possible to date. Instead, statistical modelling by academics has examined the relationship across small geographical areas between the utilisation of health services, socio-economic characteristics, health status and measures of the existing supply of health services. These models have been used to decide which characteristics to include in the formula as indicators of additional need, and with what relative weights…

The new formulas capture need better than the previous formulas. However, as they are based on utilisation of health care, they capture the NHS's response to current patterns of health inequality. ACRA felt that they did not adequately address the objective of contributing to the reduction in avoidable health inequalities. ACRA therefore recommended a separate formula for health inequalities. This uses disability free life expectancy (DFLE), which is the number of years from birth a person is expected to live which are free from limiting long-term illness. It is applied by comparing every PCT's DFLE to a benchmark figure of 70 years.

It is not currently possible on a technical basis to determine the weighting for this health inequalities formula. Ministers decided to apply it to 15% of 2009-10 and 2010-11 allocations (with the exception of mental health, which already includes an adjustment for unmet need, and HIV/AIDS).

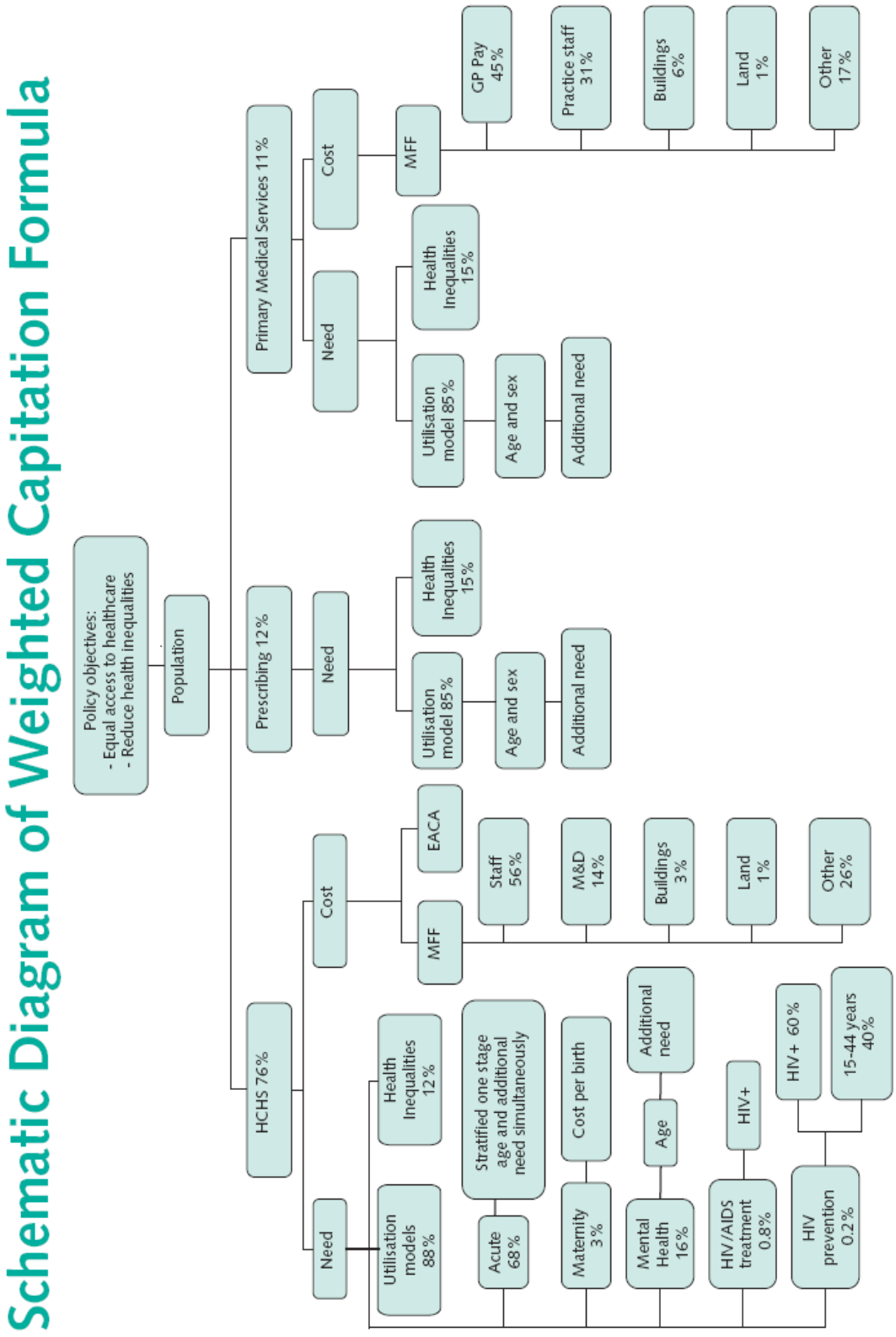


Fig.1 – The Weighted Capitation Formula

Year	Review	Variables	Objective	Method
1976	Resource Allocation Working Party (RAWP)	Condition Specific all age SMRs	Equal opportunity of access	Judgement
1982	Review of RAWP	Introduction of Market Forces Formula	Recognise geographical cost differentials.	
1986	Review of RAWP	SMR <75 plus the Jarman Index of deprivation	Resources distributed on basis of population, weighted according to need.	Utilisation: Sample hospital in-patient data
1995	York	SMR <75, standardised illness ratio, unemployment, self-carers and pensionable age living alone (-ve ethnicity)	Account for effect on utilisation of socio-economic variables and supply factors.	Utilisation: National HES
2003	Area	SIR <75 Disability Living Allowance Low Birth Weight Education Domain Comparative Mortality Figure <75 Age 75+ Living Alone Standardised Birth Ratio Income Domain -ve Ethnic Minorities -ve Employment Domain Nervous System Morbidity Index Circulatory System Morbidity Index Respiratory System Morbidity Index Musculoskeletal System Morbidity Index	As above plus additional requirement that resource allocation should contribute to the reduction of avoidable inequalities in health; 'health equity'.	Utilisation: National HES + Health Survey for England
2006	CARAN - One Stage Stratified	Age specific death rates and one or two other needs variables for 18 age bands	As above plus transparency (and favours ageing populations).	Utilisation: 2 years national HES plus outpatients
2007	CARAN - plus Health Inequalities	CARAN formula 85% & Disability-Free Life Expectancy 15%	As above. Overall allocations remain much the same as under AREA formula, as the gap for more deprived PCTs has been filled by a new 'health inequalities' element.	As above plus adjustment

Fig.2 - Timeline of resource allocation reviews[7]

[7] Taken from http://www.nhshistory.net/resourcepresentation.pdf & http://www.radstats.org.uk/no096/AsthanaGibson96.pdf

2.1.2 Analysis of current NHS resource allocation

This section provides analysis of the current system of NHS resource allocation.

'From Feast to Famine: Reforming the NHS for an age of austerity,' Furness and Gough, Social Market Foundation, July 2009[8]

The methodology adopted to allocate resources is not just a technical question, but one that reflects the central purpose of the NHS, and its approach to equity.

More affluent areas tend to have a higher proportion of older people, and may be relatively underfunded compared to areas that meet more of the criteria set out by the current formula, which places a higher emphasis on reducing health inequalities than on treating actual ill health. In reality, this might mean that rural areas are disadvantaged relative to cities because they have an older population, but suffer less from economic deprivation.

The resource allocation formula was reviewed in late 2008, but did not change in response to criticisms about possible bias against rural areas. There was an acknowledgement, however, that in defining a resource allocation formula it is impossible to reconcile need and inequalities.

It is a ministerial decision as to how much weight is given to the inequalities formula relative to the need formula in allocating resources. This was a recommendation of the advisory committee on resource allocations, "as no technical way of assessing how much weight should be given to the health inequalities formula has been found" (See section 2.2).

This shows how far decisions about equity are political rather than based on clear-cut academic formulae. It also reflects a wider tension between two definitions of equity:

- One definition sees the NHS as aiming to offer equal opportunities to be healthy.
- The other definition sees "equal opportunity to access health care for people at equal risk" as central to equity.

It is clear that these two competing definitions lead to significantly different approaches to resource allocation in healthcare.

[8] Ibid

‘Allocating resources for health and social care: the significance of rurality,’ Asthana, Gibson, Moon and Brigham, 2003[9]

Capturing need for health services in rural areas:

Age–cost curves are used in all three components of the current weighted capitation formula[10] acknowledging the rising costs of care for older age groups. If, as is accepted by the National Service Framework for Older People, older patients can and should gain from more intensive treatment, the per capita allocations for older age bands may well be conservative. This will mean that the formula discriminates against areas serving demographically older populations, and in much of England, these are rural.

There is also evidence that features of rurality directly affect utilisation rates. For example, a culture of self-reliance and a fear of stigma in rural communities have been cited as key factors in the low utilisation of health services for mental health issues.

Furthermore, there is convincing evidence that distance from services has a direct negative impact on utilisation rates (a distance-decay effect), particularly for elderly people, women and low social classes. Consequently, the employment of utilisation data to demonstrate need is intrinsically biased for rural populations.

The use of nationally standardised census-based indicators in a primarily urban country yields values which may also misrepresent need in rural areas. For example, one of the variables in the formula that allocates resources for hospital and community health services (HCHS) is the proportion of economically active people who are unemployed. This may not capture relative need in rural areas, where poverty is often the consequence of low pay, self-employment, part-time and seasonal work rather than unemployment *per se*.

Standard deprivation indices are far better at predicting variations in morbidity and mortality in urban areas than they are in rural areas. Indeed, indices such as Breadline Britain suggest, improbably, that standardised illness and mortality ratios fall slightly as the level of poverty increases in ‘rural areas’.

‘Rural health and healthcare: a North-West perspective,’ Wood, Institute for Health Research, Lancaster University, January 2004[11]

England is thus the only region of the UK not to significantly adjust healthcare resource allocation funding to compensate for costs that result from rurality.

For example, the current English formulae fail to compensate for the extra costs faced by healthcare providers in rural areas, for example, in running several hospitals, and community sites with lower bed occupancy rates. Adjustments for unavoidable variations in the cost of providing rural services take insufficient account of time, travel and transfer costs, and the

[9] Health and Social Care in the Community 11 (6), 486–493
[10] (i.e. Hospital and Community Services, Prescribing, and General Medical Infrastructure)
[11] http://www.nwpho.org.uk/reports/ruralhealth.pdf

duplication of roles. The use of census variables such as unemployment as formulae indicators of poverty may misrepresent rural disadvantage and deprivation. Funding factors that adjust for notional need are considered flawed and inappropriate, with the poorest areas receiving less than the most affluent. Services that show higher levels of need amongst older people, such as for district nursing, show inequitable distribution of funding, discriminating against areas with higher numbers of older people; often these are rural areas.

The NHS pay formula is weighted to reflect salaries within local communities, ignores the fact that staff are on national scales, and thus results in a skewed allocation for London and affluent areas.

In contrast, the Scottish *Fair Shares Model* of hospital, community and general medical services allocation weights heavily towards, and distinguishes between, rural and remote areas. In reality areas such as Cumbria, the Pennines, North Yorkshire, Northumbria, Cornwall and East Anglia offer similar issues of peripherality.

The formula used to allocate GP funding in England weights for different health measures, such as limiting long-standing illness, and better represents health need Rurality is also a significant factor in local government non-health allocations.

If PCTs target resources to areas with highest concentrations of health need, which are typically found within larger towns, they can miss out the rural poor, scattered across dispersed communities, who comprise the middle level deprivation groups in terms of both socio-economic status and social class.

For instance: Morecambe Bay PCT, with 310,000 residents, has the 5th largest resident population in the country, neighbouring Eden Valley with 69,000 residents the 3rd smallest. Covering neighbouring rural districts, how can staffing and funding levels fully compensate for such size differences? Morecambe Bay in some respects benefits from its size, in that rural residents can make use of large urban acute hospital services (IRH, 2003). However, a far smaller rural PCT may have a relatively smaller resource allocation.

‘Research into diseconomies of scale in delivering health and social care in rural areas’, Matrix Insight and the Cabinet Office Social Exclusion Task Force (SETF), July 2009[12]

In a new approach to modelling this problem, we have demonstrated that possible differences in cost between rural and urban settings do not contribute significant inequity in the current basis of funding at PCT level, when compared with the historical gap between the formula itself and the actual allocation However, we have not demonstrated that such differentials do not exist, merely that their impact on PCT allocation formulae is relatively insignificant. In particular, we have established that such differentials are *at most* one tenth of funding gaps which have historically existed within the allocation formulae following

[12] http://www.cabinetoffice.gov.uk/media/221437/rural_costs_finalv2.pdf

changes to the basis of calculating the cost of responding to excess health needs in deprived communities.

Undoubtedly, disparities do exist within the system at a local level, and we would stress the importance for PCTs to concentrate effectively in commissioning care focused on equitable outcomes. These should be based on effective needs assessment and tailored to the differing needs of local communities.

Two components of system reform have largely contributed to this position:

- the introduction of payment by results which has protected commissioning budgets for acute services from the context of delivery;
- the merging of PCTs into larger units which has ensured that even the most rural PCTs have significant urban populations.

We stress that we have not suggested that there is no cost penalty in delivering rural services; simply that any such penalty does not have any material effect on the allocation of budgets at PCT level.

'Report of the Advisory Committee on Resource Allocation,' Department of Health, December 2008[13]

Section 3: Need
Age and additional needs index

3.38 It is argued that as rural communities generally have a higher number of elderly people, the current formula may disadvantage them. The one-stage approach adopted in the review responds to criticism that the impact of age has been understated in previous work.

3.39 It is also stated that rural areas may contain hidden pockets of need or unmet need. Deriving formulas from utilisation data may bias the results against rural populations who may not use hospital services as much as urban populations due to relative distance to providers. The review attempted to include a number of rurality indicators and measures of rural deprivation in the CARAN formula, but found they were not statistically significant.

3.40 The researchers addressed the concern that the needs of rural populations are not captured appropriately in resource allocation formulas because of the sterilisation of supply factors when computing allocations. They computed needs indices with and without supply factors included, looking at the resultant difference in allocations, and seeing if it was correlated with rurality. This procedure was repeated for a number of scenarios and the results were consistent: rural areas are not disadvantaged by the sterilisation of supply factors when computing allocations.

---

13 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091483.pdf

3.41 These findings suggest that the national models proposed in the review are not biased against rural areas. ACRA, therefore, has recommended that there is no need for further adjustment for rurality.

Section 5: Market Forces Factor

5.51The MFF review demonstrated that labour costs in non-rural areas are significantly higher than in rural areas. It was also observed that hospital workers in rural areas, characterised by low turnover and low private sector wages, have higher productivity and better quality outcomes than those of densely populated urban areas.

5.52 The recommended MFF also includes a job responsibility adjustment that will help remove any bias in the calculation of SSWDs. It identified that seasonal workers did not impact on SSWDs.

5.53 ACRA, therefore, has recommended that no further adjustment is made for rurality on the basis of cost.

5.54 ACRA also considered options to update the Emergency Ambulance Cost Adjustment (EACA), which attempts to adjust for the cost differences of providing ambulance services in different areas. It was decided not to accept the updated adjustment for three reasons:

- data quality on ambulance costs is poor;
- the results of the study are counter intuitive; and
- better data will become available when ambulance services come under the tariff.

Ben Bradshaw MP – former Minister for Health Services
Primary Care Trusts: Finance
Written Questions: Commons Hansard - 12 Jan 2009: Column 177W[14]

Mr. Bradshaw: One Advisory Committee on Resource Allocation (ACRA) objective is to help to reduce avoidable health inequalities through resource allocation. To achieve this objective, a separate health inequalities formula has been developed which targets funds at the places with the worst health outcomes. This is a more transparent way of contributing towards the reduction in health inequalities through resource allocation, and highlights our commitment to tackling the issue of health inequality.

ACRA could not determine the proportion of allocations to apply the health inequalities formula to and left it to ministerial decision. Ministers decided to apply the formula to 15

[14] http://www.parliament.the-stationery-office.co.uk/pa/cm200809/cmhansrd/cm090112/text/90112w0038.htm

per cent. of the allocations, excluding the mental health component of the formula (which already includes an adjustment for unmet need) and HIV/AIDS.

This keeps the distribution of funding between the most and least deprived areas in line with the previous formula.

'Healthcare in a rural setting,' BMA Board of Science, January 2005[15]

Deprivation

It is suggested that rural areas experience particular forms of deprivation to a greater extent than urban areas. These include:

- *Household deprivation:* low incomes and lack of housing opportunities
- *Opportunity deprivation:* decline in services and employment
- *Mobility deprivation:* difficulties in obtaining access to jobs, services and facilities.

Deprivation and poverty are important determinants of health and disease, and various aspects of deprivation such as poor quality housing have been the subject of previous Board reports.

Deprivation needs to be appropriately measured if resources are to be targeted at local health inequalities. However, existing measures of deprivation are inappropriate for use in rural areas. This is partly because they may be more suitable for urban areas and partly because they do not allow for the heterogeneous nature of rural areas. Small pockets of deprivation are, therefore, missed.

'Health care equity, health equity and resource allocation: towards a normative approach to achieving the core principles of the NHS', Asthana & Gibson, Radical Statistics: Issue 96 (2008)[16]

In 1999 ACRA introduced an additional requirement; that resource allocation should 'contribute to the reduction of avoidable inequalities in health'. This interpretation of equity as an 'equal opportunity to be healthy' is otherwise known as *health equity*.

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 least advantaged groups.

Unfortunately, whilst the link between deprivation and health status is well established, it is difficult to quantify this relationship in terms of resource needs. The variety of different

[15] Ibid
[16] http://www.radstats.org.uk/no096/AsthanaGibson96.pdf

approaches used since 1976 to measure (or use a proxy for) additional need is symptomatic of this difficulty.

In general, areas with older populations tend to be more affluent whilst those with younger populations tend to be more deprived. It is thus often the case that the age-related and additional-need indices oppose each other and, when they are incorporated into the weighted capitation model, the additional needs indices usually 'win the battle' (Stone, 2007).

For instance, Central Manchester has a relatively young local demography (an age-related index of 0.91), but its Unified Weighted Population is pushed up to 1.26 by the additional needs variables, reflecting the high level of deprivation experienced in this area.

North Dorset, by contrast, has a population with significantly higher than average age-related needs (an index of 1.08), but significantly lower than average 'additional needs' which drives the final index down to 0.87.

In other words, although the population of North Dorset is significantly older than average, it received a much lower than average *per capita* funding because of the very low 'additional needs' attached to its relatively affluent population.

The overall impact of the opposing influence of the age-related and additional need indices is such that PCTs with more ageing populations would usually be better off if there were no weightings at all.

Risk of deficit has been strongly associated with resource allocation. In 2005-06, 71% of PCTs serving the most affluent and most rural populations failed to break even, compared to only 6% of those serving the most deprived and most urban populations. The fact that such a systematic relationship exists in the distribution of financial deficits strongly suggests that the current resource allocation system is not adequately capturing the health care needs of particular populations.

2.1.3 General Practice

General Medical Service (GMS) funding is one aspect of the Primary Care element of the funding formula and GP pay does include some adjustment for rurality.

'Healthcare in a rural setting,' BMA Board of Science, January 2005[17]

Remuneration

The new GMS contract specifically refers to supporting practices in rural/remote areas:

"GPs in rural and remote areas of the UK form a small but essential part of the NHS. The new contract will recognise their specific needs and help ensure they receive proper support:

(i) through the Carr-Hill allocation formula, which includes a specific adjustment for rurality. This takes account of population sparsity and dispersion, and means that rural and remote GPs will benefit in their global sum and the practice weighted population adjustment to quality payments.

(ii) through the powers for primary care organisations (PCOs) to employ staff to provide GMS and support practices. Practice-based salaried options may also be particularly useful in rural and remote areas.

(iii) through funding arrangements that will ensure support for practices in recognition of the extra burdens of being a remote and rural GP, e.g. the Out-of-Hours Development Fund.

(iv) for immediate care and first responder services. Rural and remote GPs are often more involved in the provision of emergency care outside the setting of their surgery or a local community hospital. This work requires extra training. Under the new contract, these services will be commissioned and funded as an enhanced service. PCOs will normally wish to commission such services where land ambulance response times are relatively long or the practice is remote from the nearest appropriate hospital.

(v) Under the new contract, staffing of community hospitals and minor injury services will be commissioned and funded from the unified budget or its equivalent in Northern Ireland.

(vi) through twinning arrangements. The Remote and Rural Areas Resource Initiative (RARARI) in Scotland will examine how twinning arrangements could best support GPs in remote and isolated areas. Lessons learned from this will be implemented throughout the UK.

[17] http://www.bma.org.uk/healthcare_policy/healthcarerural.jsp

Carr-Hill allocation formula

This is a new resource allocation formula and will provide the basis for allocating funds for global sum resources and for quality payments. It takes account of determinants of relative practice workload and costs. The proposed formula includes the following components:

- an adjustment for the age and sex structure of the population, including patients in nursing and residential homes
- an adjustment for the additional needs of the population, relating to morbidity and mortality
- an adjustment for list turnover
- adjustments for the unavoidable costs of delivering services to the population, including a staff Market Forces Factor and rurality.

2.1.4 Health and social care for an ageing population

This section looks more closely at the implications of rural demographics, considering the costs of providing health and social care for an ageing population. Two topics likely to be of increasing importance in future – the integration of health and social care, and the advent of personalised budgets – are also touched upon at the end of the section.

'State of the Countryside 2008,' Commission for Rural Communities, 2008[18]

- The population of rural England continues to rise at a faster rate than in the country as a whole. Most of this increase is due to internal migration by people moving out of cities rather than different birth and death rates.
- People continue to leave rural areas at around age 20. This leaves a relatively small proportion of people aged 20 to about 35, but correspondingly more people aged over 60 in the age profile.
- The median age for rural residents is nearly six years older than in urban areas (44.4 in rural and 38.5 in urban).

'State of the Countryside 2008,' Commission for Rural Communities, 2008[19]

Prevalence of hypertension, stroke and cancer follow similar patterns where sparse areas show the highest rates, and towns and villages and hamlets all show higher rates than urban areas.

[18] http://www.ruralcommunities.gov.uk/projects/stateofthecountryside2008/overview
[19] Ibid

‘State of the Countryside 2008,’ Commission for Rural Communities, 2008[20]

Per capita NHS funding is 30% lower for more affluent and rural areas than for more deprived and urban areas. The formula gives greater weighting to the ‘additional needs’ relating to deprivation, than to the demographic needs relating to the age profile of different areas.

Under the current system rural areas receive a lower than average per capita funding even though they have higher than average absolute healthcare needs which leads to needs of older people in particular being ignored or unmet.[21]

‘Review of the Weighted Capitation Formula on behalf of the East of England Strategic Health Authority,’ Asthana, Flowers and Gibson, 3rd August 2007[22]

Critique of the weighted capitation system

5. Thus a number of authors contend that although demography is a far more significant determinant of morbidity and mortality than deprivation, the influence of the ‘additional needs’ indices typically outweigh that of the age-related need indices. The result is that younger deprived communities - which tend to be urban - receive significantly higher funding relative to underlying morbidity than their older affluent counterparts - a high proportion of which are rural.

6. Taken together, key elements of the current weighted capitation formula would thus appear to discriminate against less deprived communities (and particularly rural communities). This is commensurate with evidence relating to service outcomes. Thus the literature includes compelling evidence that affluent PCTs are far more likely to be in deficit than their more deprived counterparts, and that PCTs serving the most affluent, most rural populations have the greatest risk of all.

Capturing the increased costs of providing health services for older populations

10 An analysis of age-specific hospital utilisation in the East of England reveals that the Hospital and Community Services (HCHS) component of the weighted capitation formula significantly underestimates the increasing costs of providing services for older populations.

E.g. The overall HCHS cost-curve presumes that, other things being equal, individuals who are aged 85+ will cost 5.47 times as much to treat as 0-4 year olds. That portion of the overall HCHS that relates to 'acute inpatient and geriatric services' presumes a ratio of 7.44 between the costs of treating 0-4yr olds and those aged 85+. Actual hospital expenditure data for the East of England SHA reveals this age-cost ratio is more like 9.28. This discrepancy is highly significant because of the high proportion of overall expenditure accounted for by older people.

---

[20] Ibid
[21] Commission for Rural Communities (2008) *NHS Review – a rural response*, CRC, Cheltenham
[22] www.eoe.nhs.uk - 1210754845_xybJ_review_of_the_weighted_capitation_formula.pdf

12. In other words, the demographically older its population the less, in relative terms, a PCT tends spend on its oldest age groups (r=-0.72; p=0.004). These PCTs with demographically older populations are also more likely to have ended 2005-06 in deficit (r=0.44; p=0.11).

'Rural Premium: Health & Adult Social Care in Rural Areas,' CRC briefing note[23]

Sparsity adjustment in Adult Social Care

Local government spending on domiciliary services accounts for around 43% of their spending on older people's social services. The sparsity adjustment is set in proportion to 1% of this.

English rural County Councils have argued that central Government funding allocation for domiciliary social service provision appears to bear little relation to the higher care costs actually faced by rural social service departments.

'Facing facts and tomorrow's reality today: the cost of care,' Local Government Association, January 2009[24]

How social care is funded

Services such as adult social care are funded through a combination of central and local government funding.

We estimate that government is contributing 61 per cent of the cost of social care, compared to councils' estimated 39 per cent.

Our analysis shows that the proportion of projected expenditure on social care for 2008/09 that will be funded by government ranges from 18.5 per cent to 30 per cent to 71.4 per cent. Conversely, council tax will be required to fund 81.5 per cent, 70 per cent and 28.6 per cent of planned social care expenditure.

This clearly demonstrates that social care is not a service funded simply through national taxation and funding.

This is one of the factors that leads to a national variation in services and claims of an inherently unjust 'postcode lottery' that denies some people access to services that others elsewhere in the country are able to benefit from.

---

[23] www.ruralcommunities.gov.uk
[24] http://www.lga.gov.uk/lga/aio/1546471

2.1.4.1 Health and social care integration

'Allocating resources for health and social care: the significance of rurality,' Asthana, Gibson, Moon and Brigham, 2003[25]

It is doubtful that deficiencies in funding for rural health services are offset by sparsity allowances for personal social services. Social *care* – which does attract a rural premium – should not be expected to substitute for medical *cure* – which does not.

Despite the fact that sparsity measures may not capture adequately the additional costs which are incurred in rural areas, the fact that rurality *is* identified as a legitimate cause of cost variation in the provision of local government services is significant. It raises the question of why rurality is *not* considered to be a legitimate cause of cost variation in the provision of health services.

2.2 ADDITIONAL COSTS ISSUES

2.2.1 Context

This section briefly highlights the specific challenges of delivering healthcare in rural and sparsely populated areas.

'Health care in peripheral and remote rural areas,' Commission for Rural Communities factsheet, March 2008[26]

Six key issues are important when considering peripherality:

Travel

Peripherality leads to increased travel by both health professionals and patients. Nurses have reported that they see a lower number of patients in a day than their urban counterparts because of the travel distances involved. GPs found that they did more home visits in rural areas because they knew that many of their patients had no transport and could not travel to the surgery. Those on low incomes, without private transport, the elderly and disabled are especially vulnerable.

Staff recruitment and retention

In remote rural communities, because there is a need for more senior, experienced staff who can work autonomously in a range of roles, salary bills are often high. In other areas

[25] Ibid
[26] http://www.ruralcommunities.gov.uk/files/Peripherality%20Factsheet%202Tagged.pdf

where complex or specialist needs exist, for example people with dementia and mental health problems, there can be problems in recruiting specialist staff.

Access to continuing professional development

Health practitioners frequently find it difficult to access continuing professional development (CPD) education, because of the distance involved in travelling to higher education facilities, and lone workers and single handed GP services finding it difficult to obtain locum cover.

Equipment and resources

For allied health professionals it can be difficult to obtain and transport equipment for use in out-lying areas.

Delivering care at a distance

Emergency services have difficulties meeting response times in rural areas and this can have serious health consequences.

Cross border issues or the 'edge effect'

On the English/Welsh border it is often easier to access services 'cross border' than within the country of residence. A recent study in mid Wales showed that patients were accessing cancer genetic services in England rather than the specialist cancer service in Cardiff because travel across the border is easier and local GPs had far greater knowledge about the facilities across border. This 'edge effect' is an important issue for future research.

'Rural health and healthcare: a North-West perspective,' Wood, Institute for Health Research, Lancaster University, January 2004[27]

Funding rural health, social care and public sector services

Rural costs are often hidden, with rural local authorities seen to be low overall spenders, and with urban-rural unit cost comparisons difficult to calculate. As a generalisation, rural areas provide smaller service 'units', which may result in lack of choice, limited specialised services, restricted opening times, and higher unit costs.

Health Service providers face a range of rural costs, which result from the need to maintain more District General Hospitals, additional smaller community hospitals and healthcare sites, as well as from lower bed occupancy rates, higher prescribing costs, higher travel costs and long term staff pay grades. Rural PCTs need to provide community hospitals, minor injuries units and clinics, within easy reach of relatively isolated populations, and in particular, within ready access of those who are most vulnerable.

[27] Ibid

'What can rural agencies do to address the additional costs of rural services? A typology of rural services innovation,' Asthana and Halliday, 2004[28]

The challenge of rurality

Briefly, because service providers in rural areas have less chance of achieving economies of scale than their urban counterparts, they must either develop more numerous smaller units (which has significant cost implications) or sacrifice accessibility by accepting large distances between service users and service centres. The latter option routinely transfers costs to patients and carers with consequent equity issues, particularly for 'transport poor' groups such as elderly people, young people and many women.

Exploring rural service innovation

Health Action Zones were introduced in England in 1998–1999 in order to find new ways (primarily through innovative partnership working) of tackling health inequalities and modernising services (Bauld & Judge 2002). However, out of the 26 HAZs, only three are arguably 'rural', whilst the same applies to only five of the 88 Neighbourhood Renewal Areas. As a result, there is still little systematic knowledge about the extent of innovative rural practice, a paucity of evaluation of such initiatives and few opportunities to disseminate learning from one area to another.

2.2.2 Transport

This short section looks at the costs associated with accessing health services in rural areas.

'Research into diseconomies of scale in delivering health and social care in rural areas', Matrix Insight and the Cabinet Office Social Exclusion Task Force (SETF), July 2009[29]

One specific issue which can contribute very significantly to additional inequity in rural communities is the lack of availability of public transport. Under the current arrangements for providing care, both the cost and quality issues mainly impact on the patient rather than the service provider.

[28] Health and Social Care in the Community 12 (6), 457–465

[29] http://www.cabinetoffice.gov.uk/media/221437/rural_costs_finalv2.pdf

‘Healthcare in a rural setting,’ BMA Board of Science, January 2005[30]

The limitations of public transport

More than nine in 10 people living in rural areas use the car for their main food shopping trips and for travel to hospital; this compares with seven in 10 adults in urban areas.

Women are more likely than men to report difficulty in accessing a chemist, GP, post office or main food shop. This reflects the longer journey times they experience and their lower car use.

Unfortunately, the funding available for enhancing public transport services in rural areas is not fully able to meet health needs, as it is also used to increase opportunities for travel to work and training, and to retail and leisure services.

Research by Hampshire County Council has suggested that some 70,000 health related journeys are provided countywide by voluntary car schemes, and it is probable that these provide a vital service nationwide.

Public transport is not the most appropriate transport option for sick people, because of timing, discomfort and lack of skilled support.

Hampshire County Council suggest that an increase in the proportion of elderly people in the population will result in a much greater demand for such health-related transport schemes.

Branch surgeries

Branch surgeries are an essential service that provides rural patients with access to GP facilities and it is important that such services are developed.

‘Is the NHS equitable? A review of the evidence,’ Dixon, LeGrand, Henderson, Murray and Poteliakhoff, LSE Health and Social Care Discussion Paper Number 11, November 2003[31]

The evidence presented here does suggest that longer travel time, greater travel cost and lower car ownership (though not distance) appear to contribute to differential access to health services by SEGs [socio-economic groups], adjusted for need. The time trade-offs of attending for health care that different SEGs have to make may also explain some of the differences in utilisation.

---

[30] http://www.bma.org.uk/healthcare_policy/healthcarerural.jsp

[31] http://www.erpho.org.uk/Download/Public/8772/1/Is%20the%20NHS%20equitable%20A%20review%20of%20the%20evidence.pdf

2.2.3 Individual or personalised budgets

'Evaluation of the Individual Budgets Pilot Programme Summary Report,' Individual Budgets Evaluation Network, October 2008[32]

16.2 Resource allocation principles

The original policy proposals for IBs made no recommendations about how resources were to be allocated to users.

The generally more transparent allocation of resources to people with highly variable sets of needs brought equity issues underlying resource allocation into sharper focus for local authority staff.

'Research into diseconomies of scale in delivering health and social care in rural areas', Matrix Insight and the Cabinet Office Social Exclusion Task Force (SETF), July 2009[33]

Individuals who live in rural communities are likely to experience additional personal costs in accessing care services. With the advent of personalised budgets, the scale of the inequity which this causes is likely to be brought into greater focus, and more work is required to understand the potential impact this will have.

'SPARSE report summary,' Rita Hale, July 2006[34]

Domiciliary Care for Older People

Shropshire County Council purchases all of the domiciliary care from external providers.

The County Council intends to move to a simpler contracting system in 2008-09 involving a single "urban price" and a single "rural price" for domiciliary care services.

The average hourly cost of domiciliary care in what the County Council classifies as predominantly rural areas is higher than that for any other type of area

The County Council is more likely to have to enter into special arrangements to provide care in the more sparsely populated / remote areas and care costs are likely to be higher in the more sparsely populated / remote areas than in the urban areas for similar types of care.

---

[32] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089508.pdf

[33] http://www.cabinetoffice.gov.uk/media/221437/rural_costs_finalv2.pdf

[34] http://www.sparse.gov.uk/pdfs/Rita%20Hale%20Report%20Summary.pdf

I found when I analysed the domiciliary care costs for elderly people in the Study area that:

- the scale of the rural premium depends on the number of visits made to a client each week; so
- the rural premium for a client who received, say, 11 hours care on a single day per week would be £ 8.70, but the rural premium for a client who received, say, a total of 8.5 hours care spread over 11 half hour visits and 3 hour long visits in a week would be £121.80.

Put simply, I concluded that the cost of providing domiciliary care services for older people living in rural areas, who need a large number of visits by carers each week, is likely to be significantly higher than the cost of providing the same care packages for older people living in urban areas.

I concluded that the findings from this part of the study:

- demonstrate that recent advances in technology – and in local authorities' management information systems – make it possible to locate clients very precisely and identify the costs of their care; and
- support the conclusions set out earlier - i.e. that it should be possible in a larger study to identify the size of the "rural premium" by matching care costs to areas with different spatial characteristics and then identifying the differences in care costs, for otherwise comparable care packages, between urban areas and more sparsely populated / remote areas in a way that could be used in RNF calculations.

'Rural Premium: Health & Adult Social Care in Rural Areas,' CRC briefing note[35]

County Councils and Rural Premiums

Currently any extra cost associated with service provision in a rural area is borne by the service provider or the user of the service and their family. Following a call for evidence by the CRC during October 2008 a small number of County Councils report that they have introduced a 'Rural Premium formulae' to a limited number of services including Adult Social Care:

- Wiltshire County Council (CC) has introduced a rural premium basing their calculations on the population density per hectare and has identified two levels for the rural premiums: 5 per cent for the less populated areas, and 3 per cent for the slightly more populated areas. Wiltshire CC has reported that their domiciliary care contracts pay approximately £3-4 higher per hour in the more rural areas of the county in contrast to urban and semi rural areas.

[35] Ibid

- Within the Gloucestershire County Council (GCC) funding formulae for domiciliary care, a specific 16 per cent enhancement for all rural provision is paid to allow for additional travel time and travelling costs.

- Somerset County Council has split the County into nine zones, with higher hourly rates in the most rural areas. Somerset CC report that the issues which they face in their predominantly rural county 'relates to all aspects of adult social care including – limited supply of staff, cost of transport to day-services, distance from care homes, travelling distances for home care provision –all of which negatively impact on the overall cost of services in rural areas'.

- Essex CC has a policy of paying enhancements for domiciliary care across specified rural post-codes for contracted Spot Providers (buying individual services to match the needs of the service user). A premium of £2.08 to £4.16 per hour is paid in rural areas.

- Cheshire County Council's Domiciliary Care contracts pay a premium of £1.00 over the basic rate for each of the 12 areas within Cheshire defined as rural areas. Cheshire aim to compensate the service provider for the 'extra travel time and costs associated with such visits'.

- East Sussex County Council (ESCC) applied a rural premium of between 13 per cent and 18 per cent to hourly rates paid in respect of home care services in 2006/07.

2.3 ALTERNATIVE MODELS

Health is a devolved responsibility of the Scottish Parliament, Welsh Assembly and the Northern Ireland Assembly, each with distinct rural communities and identities. Scotland in particular offers an example of an alternative model of funding.

'Shaping the Future of Care Together: The Big Care debate', CRC response to DoH green paper, November 2009[36]

Scotland currently applies the Arbuthnott formula when allocating NHS funding. The Arbuthnott Formula is a population-based formula that gives extra weight to certain factors such as the number of older people in particular areas, levels of deprivation and additional costs of providing services in rural and remote areas. It is designed to provide greater resources to areas of greater need, the Arbuthnott formula introduced a number of specific adjustments to recognise the requirements of rural areas (e.g. Highlands, Borders, Dumfries and Galloway) as well as mixed rural and urban locations. Since 2000, the formula has been used to distribute funding to NHS Boards for Hospital and Community Health Services and

36 http://www.ruralcommunities.gov.uk/events/shapingthefutureofcaretogetherthebigcaredebaterespondingtothegreenpaper1

GP prescribing, which together account for around 70% of the total budget. Community Services include care of older people and health visitors.

The adjustment for community services has two components relating to travel-intensive services and clinic-based services. Travel-intensive services are based on a simulation model of the additional travel associated with the delivery of services by district nurses and health visitors in rural areas. For clinic-based services it is derived from an analysis of the costs of providing General Medical Services in remote areas.

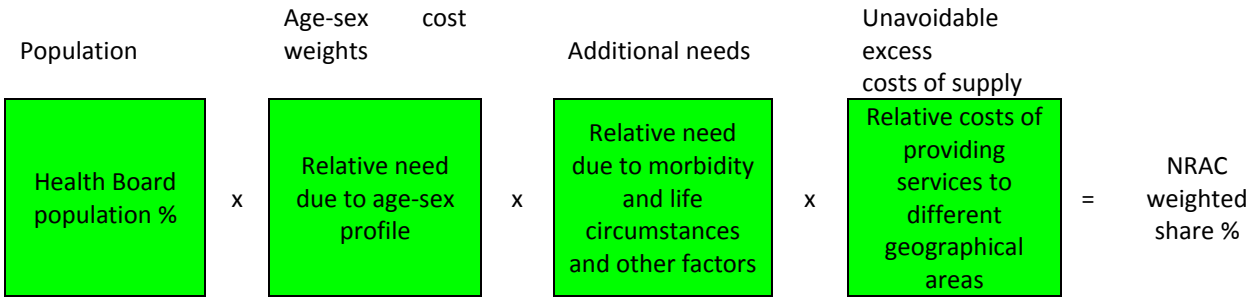
'Delivering Fairer Shares for Health in Scotland,' report of the NHSScotland Resource Allocation Committee, September 2007[37]

Since the introduction of the Arbuthnott Formula in 2000 there have been changes in the way healthcare services are delivered (more care in the community), new challenges faced by the service (ageing population) and new information about the needs of the population (2001 Census, Scottish Index of Multiple Deprivation)

The NHSScotland Resource Allocation Committee (NRAC) was set up to review how the NHS budget is shared among the territorial Health Boards and ensure that the methods used are evidence based and equitable.

This so called 'weighted capitation' construction has been maintained by NRAC as outlined in Figure 1. NRAC has improved and refined each element of this formula to bring it up to date, using the best available evidence with rigorous, objective research processes.

Fig 3. The NRAC Formula



[37] www.nrac.scot.nhs.uk/.../NRAC%20-%20Final%20Report%20-%20public%20version%20-%2027%20September%202007.doc

Recommendations

NRAC's work has involved complex analyses and resulted in over 30 detailed recommendations to improve and refine the Arbuthnott Formula.

The new formula should:

- Be built up from smaller geographical areas within Health Boards, to improve the accuracy of predicting needs and allow it to be used for planning purposes below Health Board level.
- Take better account of the higher relative needs of the elderly and the very young.
- More accurately reflect the increased need for healthcare services in areas of deprivation and poor underlying health.
- Compensate for the under use of health services for circulatory diseases in more deprived areas.
- Take better account of the unavoidable excess costs of delivering hospital and community health services in different urban-rural areas.

Purpose of the unavoidable excess costs of supply adjustment

As well as taking account of the differing health needs of each Health Board's population, the Arbuthnott Formula includes an adjustment to reflect any unavoidable excess costs incurred by Health Boards in supplying services to remote and rural areas.

There are two important points to note about this adjustment:

- The intention is that it corrects solely for the higher unit costs that a Health Board incurs in supplying services – not the needs of its population (which are accounted for in the age-sex and additional needs adjustments).
- The adjustment is aimed solely at *unavoidable* excess costs – those which arise from circumstances over which the Health Board has no control (e.g. the remoteness of its geography) – not avoidable excess costs (e.g. from inefficient services)

The Review Group stated that there was no case for a staff market forces factor (MFF) at that time, but suggested that more work might be done in the medium term on the possibility of developing a land/buildings MFF.

Current method

The Arbuthnott Formula adjustment for excess costs is applied to both hospital and community services, with different approaches for each.

The hospital services excess costs adjustment is based on the relationship between the costs of commissioning hospital services for residents of each Health Board and an indicator of remoteness. The remoteness indicator for hospital services is the number of road kilometres per 1,000 people. The resulting adjustment gives a greater weight to those Health Boards with remote and rural areas.

The expected costs are not adjusted for the fact that rural areas will tend to have a more expensive speciality mix, a lower proportion of day cases and a higher average length of stay.

The community services excess costs adjustment involves separate elements for travel intensive services (e.g. district nurses, health visitors) and clinic based services (e.g. immunisation, family planning).

The two community adjustments are combined in relation to the relative size of the spending on each of them – two thirds accounted for by travel based services and one third by clinic based services. The community services adjustment has not been updated since the Arbuthnott Formula was introduced.

One of the key weaknesses of the Arbuthnott Formula's approach to excess costs was the difficulty of breaking the formula down below Health Board level.

'Rural Premium: Health & Adult Social Care in Rural Areas,' CRC briefing note[38]

NHS Funding Formulae & Sparsity Adjustments

Funding in Northern Ireland is based on the efficiency of road routes between supply and need locations. The Welsh formula is based on the Scottish model.

The English NHS formula includes a market forces factor designed to capture the above average costs of providing health services in high cost areas like the South East of England, but applies a weighting for sparsity only to expenditure on the emergency ambulance service, which represents just fewer than 2% of the hospital and community budget.

[38] Ibid

Part 3: Education

3.1 Context

Ministers from the Department for Children, Schools and Families (DCSF) launched a review of the Dedicated Schools Grant (DSG) at the end of January 2008.The review is being overseen by the Formula Review Group (FRG), which comprises a wide range of stakeholders. For the period up to the summer of 2009, the FRG will be gathering evidence on the main issues, which it will use to develop proposals to put to Ministers in the autumn of 2009.

'Review of DSG Distribution Formula: Terms of Reference,' DCSF, January 2008[39]

Outline timetable:

Oct-Dec 09	Develop consultation proposals
Jan–Mar 10	Consultation
Apr-Jun 2010	Build up to decisions
July 2010	Ministers announce broad decisions
Oct 2010	School funding settlement for 2011-12 onwards.

3.2 Education resource allocation: the current situation

'School Funding,' House of Commons Library Standard Note SN/SP/04581, 21st May 2009[40]

Background to the reform of school funding

Under the local government finance system in operation prior to April 2006 local authorities received formula grant from central government that covered general revenue expenditure on education, social services, roads and other services. The Government calculated the notional amount it thought each local authority needed to spend on education – the Schools Formula Spending Share (SFSS) - and on other services. These totals were combined into a formula spending total. Government funding made up around three-quarters of the formula spending total nationally; local authorities made up the difference between this and their actual expenditure through Council Tax receipts. Local authorities were free to decide how much to spend on education and other services. This could be above or below formula spending totals, on any one service or overall, within certain limits. The Local Education Authority (LEA) also decided how to distribute total spending between schools and central services.

[39] http://www.teachernet.gov.uk/docbank/index.cfm?id=12419
[40] http://www.parliament.uk/commons/lib/research/briefings/snsp-04581.pdf

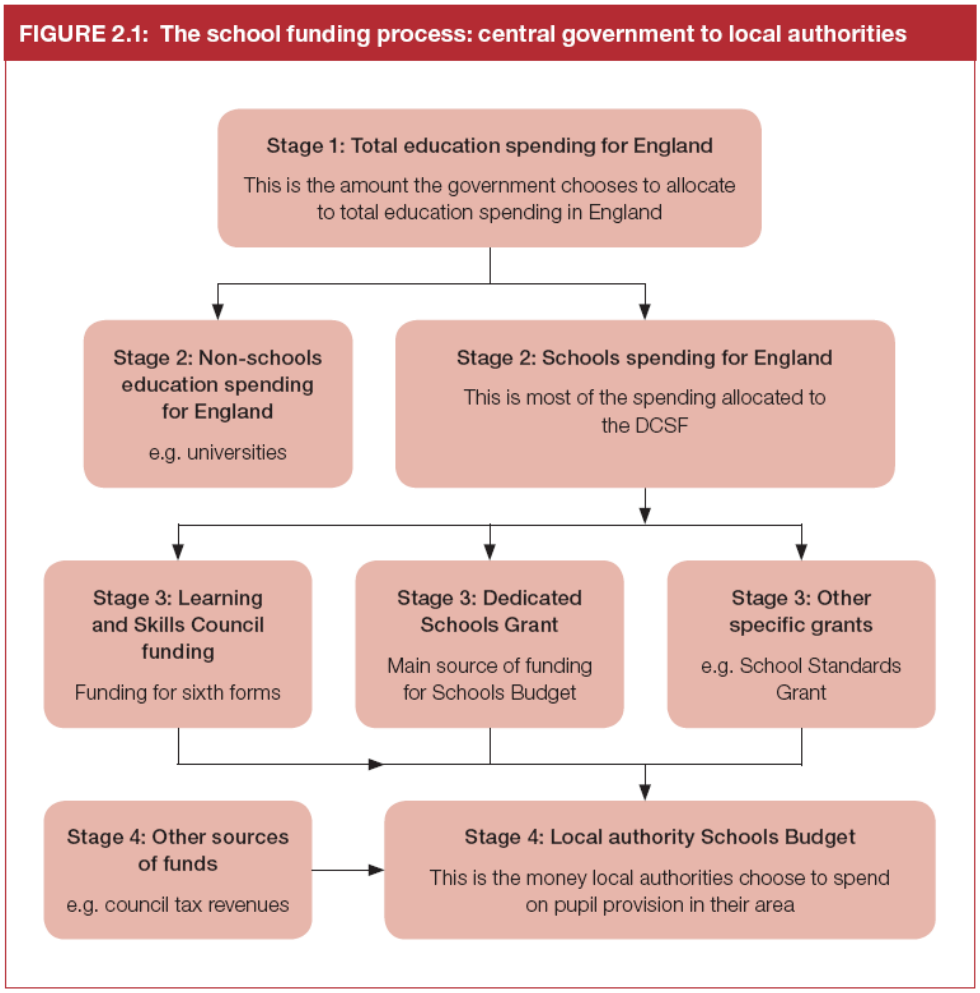
On 21 July 2005 the then Minister for Schools, Jacqui Smith, announced the Government's decisions on new school funding arrangements. These included the introduction of multi-year budgets, with the two years 2006-07 and 2007-08 as a transitional period, and the full arrangements for three-year budgets introduced from 2008-09. The Minister announced the introduction of a Dedicated Schools Grant (DSG), a ring-fenced education grant paid to local authorities by the Secretary of State, to replace the Schools Formula Spending Share (SFSS). The Minister also announced the consolidation of several sources of standards-related funding into an expanded School Development Grant, and gave additional powers to School Forums.

In Spring 2007 DfES opened a consultation on funding for schools and early years. This closed on 1 June and on 25 July 2007 Jim Knight, the Minister for Schools, set out the framework for school funding for the years 2008-11. The Minister announced that the DSG would continue to use the spend plus methodology (as in 2006-08), rather than a single formula (see below). A longer term formula review for DSG was also announced, with the 'aim of the review… to produce a single, transparent formula available for use from 2011-12.'

Allocation of the Dedicated School Grant (DSG)

The basic methodology is known as 'spend plus' as it takes the past year's level of spending/funding per pupil in each LEA and multiplies this by a fixed percentage increase across the country. This is then multiplied by pupil numbers to reach each authority's basic allocation. There are three more steps after this before the final allocation is reached – funding for specific ministerial priorities, a measure to bring funding up for authorities that 'underspent' in the past and a check to ensure that all authorities received a minimum cash increase regardless of changes in pupil numbers.

Fig 4: School funding process:[41]



[41] http://www.teachingtimes.com/userfiles/file/levelplayingfield.pdf

'School, early years and 14-16 funding arrangements 2008-11: Summary of decisions announced on 25 June 2007,' DfES, June 2007[42]

Funding for diplomas at key stage 4

- Funding for 14-16 years olds taking diplomas will be distributed to local authorities through a specific formula grant, on the basis of a formula reflecting the diploma lines being offered, take-up, the higher cost of provision in high wage areas and the additional costs in sparsely populated areas.
- How the funding is delivered to providers will be for local decision, building on existing successful partnership models.

3.2.1 Tackling deprivation

'School Funding,' House of Commons Library Standard Note SN/SP/04581, 21st May 2009[43]

Deprivation and other cost-related factors

The DSG has no explicit deprivation elements in its main formula. The 'pockets of deprivation' priority funding is outside the main formula and is worth 0.14% of DSG in 2008-09.

However, funding for Additional Educational Needs (AEN)/deprivation is based largely on the proportion of funding for these areas in the 2005-06 formula, rolled forward into the DSG. In the indicative 2008-09 allocations 12.1% of DSG is said to be allocated on AEN (including deprivation) and 10.3% on deprivation alone.

In other words while there is superficially no deprivation element in the formula, deprivation indicators used in the 2005-06 formula are effectively locked into the DSG because it uses a spend plus method. The same is true of other elements that affected per pupil funding levels such as the area cost adjustment.

'Dedicated Schools Grant: Technical Note for 2008-11 Allocations,' DCSF, November 2007[44]

Spend plus: a basic increase in DSG and funding for Ministerial priorities

Pockets of Deprivation:

- An increase of £40/40/40 m will be allocated to fund pockets of deprivation. This will be distributed using our new deprivation indicator based on Tax Credit data.

---

[42] http://www.teachernet.gov.uk/docbank/index.cfm?id=11544
[43] Ibid
[44] http://www.teachernet.gov.uk/docbank/index.cfm?id=12222

- Local authorities who receive funding under this priority will be those who:
    - are in the bottom third least deprived authorities in overall terms; and
    - have pupils from areas where 80% or more of pupils come from deprived backgrounds (subject to a de minimis limit of 10 pupils).

- Each qualifying local authority will receive £500 per qualifying pupil, adjusted for area costs.

'New Indicator for Deprivation in 2008-11 School Funding Allocations,' DCSF, November 2007[45]

Pockets of Deprivation

The new deprivation indicator is being used to fund the Pockets of Deprivation Ministerial Priority included in the 2008-11 DSG allocations. The Pockets of Deprivation Ministerial Priority targets authorities which have an overall **low** level of deprivation but have pupils which are from very deprived LSOAs. An authority level of deprivation threshold of 55% was set - this targets the bottom third **least** deprived authorities. Only authorities which have a level of deprivation at this percentage or **below** are eligible for funding via the Pockets of Deprivation Ministerial Priority.

The Ministerial Priority funds pupils who go to school in LAs which have a low level of deprivation but themselves are from LSOAs with a level of deprivation of 80% or more.
Using the National Pupil Database, all pupils are matched to the local authority which maintains the school they attend, figures for which are aggregated up to a local authority level. This results in a percentage for each authority of the proportion of pupils who live in LSOAs which are at least 80% deprived.

Pupils who live in LSOAs which are 80% or more deprived and attend schools in authorities with an overall level of deprivation of 55% or less are each allocated £500 (subject to a de minimis limit of 10 pupils).

'The new grant targeting pockets of deprivation in areas of otherwise low deprivation,' Lindsey Wharmby, f40 consultant[46]

- The old measure gave a much higher weighting to families on benefits but no weighting to low-income families; it was therefore not as good at picking up low income families, particularly rural poverty.

[45] http://www.teachernet.gov.uk/docbank/index.cfm?id=12225
[46] http://www.f40.org.uk/f40/low%20deprivation.pdf

- The old indicator was a measure of Additional Educational Need but with a crude measure of social deprivation and the new measure only tackles the social deprivation contribution (but much more accurately) but not EAL/ethnicity.

'Level playing field? The implications of school funding,' Sibieta, Chowdry and Muriel, CfBT Education Trust, June 2008[47]

How redistributive is school funding?

On average, a large amount of funding appears to be directed towards social deprivation. Our estimates suggest that pupils who are eligible for FSM [free school meals] attract over 70% more income to the school than pupils who are not eligible for FSM; this is broadly true in both primary and secondary schools. Moreover, these FSM premiums have grown over time. We also show that this extra funding comes both from local authorities' formulae and from direct payments and grants from central government, with the latter being a disproportionate source of the FSM premium.

However, our work also shows that local authorities (LAs) only allocate around 40–50% of the extra funding they receive for pupils who are FSM-eligible towards the schools these pupils attend. In other words, LAs seem to spread the funding targeted at low-income pupils more widely (i.e. 'flatten' it). This flattening makes school funding less redistributive (on the basis of social deprivation) than the government intends. We find that the FSM premium would be more than doubled in primary schools and 50% higher in secondary schools if LAs did not flatten out their resources at all.

'Review of the distribution formula for DSG: Strand 1: Additional Education Needs (AEN) Final Report,' Price Waterhouse Coopers, September 2009[48]

Studies have suggested that rural deprivation differs somewhat from urban deprivation in being characterised by a low population density/sparsity and a lack of access to facilities. As a result of this and, particularly where pupil enrolment is low, schools often cannot provide the full range of services for children with AEN, and where they can, the cost of provision is usually higher on a per pupil basis (due to diseconomies of scale). As a result, some pupils are taught in schools in neighbouring areas where provision is better matched to the needs. This in itself reinforces need, as pupils in this situation can be more isolated socially than their peers who live closer to the school.

Some of the key issues for school funding seen by stakeholders as arising from rural deprivation are as follows:

---

[47] http://www.teachingtimes.com/userfiles/file/levelplayingfield.pdf
[48] http://www.teachernet.gov.uk/_doc/13481/FRG33%20-%20DSG%20Strand%201%20and%202%20Interim%20Report%20Final.pdf

- **FSM [free school meals] does not adequately reflect rural deprivation**; focus group participants broadly agreed that FSM was not a robust indicator for reflecting rural deprivation. In rural areas, low paid workers in the farming community are often reluctant to complete forms for FSM and as an indicator it does not sufficiently illustrate deprivation levels in rural areas. Deprivation in rural areas is often less obvious in comparison to deprivation in urban inner city areas. There are pockets of social deprivation in rural communities which are characterised by families with histories of long-term unemployment and children with low aspirations for their future. There was agreement amongst focus group participants that these pockets of rural deprivation ought to be recognised in any future funding formula. This finding was reinforced by submissions to the CRC that the limited choice for pupils *'reinforces rather than challenges their existing perceptions, and can affect their motivation to work towards gaining good qualifications.'*

- The **cost of support can be more expensive in rural areas** as there can be additional transport costs involved. The qualitative research found that the cost of providing support for a pupil in a small rural school may not be shared with support for other pupils and, as such, the school has to absorb the full cost for that one pupil; in larger schools the cost burden can be shared across a larger number of pupils. This was one of the biggest contrasts in response between the focus group participants in shire and non-shire local authorities and a common theme in submissions to the CRC from members of the Rural Services Network.

- **Lack of access to facilities and technological support in rural areas**; similar to the point above, schools are unable to offer a range of after-school activities as many pupils rely on public transport travelling to and from schools making it economically unviable to offer these activities for a fewer number of pupils. In addition, in rural areas, broadband coverage and access can often be poorer; therefore schools cannot offer pupils the full range of technological support to enhance their learning.

- **Difficulties in funding short-term rural deprivation**; when there are large-scale redundancies this can have a drastic effect on the local community as there are no short-term opportunities to solve these problems (unlike in large urban areas). This can result in high levels of deprivation and social need occurring within a relatively short space of time. Participants in rural communities expressed concern that the funding formula was not flexible enough to respond to these external events.

Some of the above findings are illustrated by the following quotations from focus group participants.

"One way of ensuring that rural areas are adequately captured in the funding formula would be to include an indicator for distance travelled per pupil to school."

<u>In summary the key points from this chapter include:</u>

- Qualitative evidence indicates strong views from stakeholders that Free School Meal entitlement does not adequately reflect rural deprivation. No indicator was successful in specifically identifying rural deprivation.

- The qualitative research identified specific pupil needs associated with rural deprivation, largely concerning lack of access to specialist support and social isolation compounding other needs.

- Stakeholders also identified distinct costs including fewer economies of scale and additional transport costs. There were differences in view as to whether the costs of rural deprivation were greater than those of urban deprivation or simply different.

Whilst the costs of rural deprivation appear to be distinct from those of urban deprivation, there is no clear evidence from the data that they are greater.

3.2.2 Small schools and the sparsity factor

'FRG20: Sparsity and Small Schools,' Dedicated Schools Grant Formula Review Group, DCSF, July 2008[49]

What is a sparsity factor?

Within the Dedicated Schools Grant formula is a sparsity factor to take account of the fact that there are additional costs associated with sparsity of population for the provision of education. Within primary schools this is principally to reflect the need to maintain schools in rural communities, most of which would be small, in order to minimise the travel time required by young children.

Existing formula

The current Dedicated Schools Grant is a 'spend plus' formula using the 2005-6 baseline. Prior to this, there was an additional sum of money in the formula given to LAs to cover the additional costs of sparsity. Taking national census data (calculated from the 1991 Census) a sparsity index was developed, based on population per hectare.

The sparsity measure was used in the calculation of funding for primary schools –reflecting the strong relationship between average school size and level of sparsity within an authority, and also for the LA central funds, to reflect the strong relationship between transport costs per secondary pupil and sparsity. There was no significant relationship between the sparsity measure and secondary schools and therefore there was no additional allocation for them.

Issues with the formula

The current sparsity index relies on data from the National Census. The next update is not due until 2011 and will not be available for the distribution of DSG from 2011-12. We therefore need to consider whether the current index is still appropriate. One possible line of enquiry will be (newly available) pupil postcode data from the School Census.

[49] http://www.teachernet.gov.uk/docbank/index.cfm?id=12740

We will also need to consider whether the additional costs of small schools has changed over time and whether the sparsity unit cost needs to be changed to reflect this.

'FRG026: Sparsity and Small Schools: An Evidence Pack,' Dedicated Schools Grant Formula Review Group, DCSF, November 2008[50]

Per Pupil Budget Share vs. School Size

Small schools are associated with a larger budget share per pupil compared to larger schools. For primary schools in 2007-08, the average budget share per pupil is £4,616 in schools of 0 – 49 FTEs falling to £3,484 in schools of 50-99 FTEs. These figures compare to £3,045 per pupil taking a national average.

The Additional Funding of Small Schools

Each Local Authority will have its own method for distributing funds to its school. How much additional funding, if any, a small school is given to reflect its local needs associated with sparsity will form part of that distribution method.

We show that when you set the school size to 100 FTEs or less, most of the small schools are also rural. However, the 'extra' funding for these small schools is significantly less than the notional sparsity funding for each LA.

However, small rural schools defined as 250 FTEs or less has produced a more comparable result against the sparsity funding.

Understanding the Presence of Some Small Schools

A case study of North Yorkshire was undertaken in 2006 and showed that in addition to the high levels of sparsity, denominational schools could be a contributory factor in explaining why North Yorkshire had so many small schools. Whilst this is a case study and the conclusions cannot be assumed to hold for all LAs, it provides additional detail on the complexity of small rural schools.

Summary

A link between sparsity, super-sparsity and the proportion of pupils attending schools of certain sizes has been found for primary schools but the link for secondary schools is less evident and robust.

[50] http://www.teachernet.gov.uk/docbank/index.cfm?id=13174

'Sparsity and Small Schools: Small Secondary Schools and KS4 Curriculum,' Dedicated Schools Grant Formula Review Group paper FRG53, DCSF, July 2009[51]

Whilst larger schools typically offer a greater number of subject families, the skew of the number of subject families offered within each school size bin suggests it is not school size that affects the number of subject offered.

Given the earlier conclusions in previous papers and as the inclusion of alternatives to GCSE would reduce the number of schools offering the lower number of subject families, there is enough evidence to suggest that there is no need, from the point of view of breadth of curriculum subject families, to introduce a specific small secondary school (sparsity) factor.

'Input to DSG Formula Review,' Devon County Council, July 2009[52]

Area Costs

A considerable number of authorities with relatively low funding rank have relatively highly ranked average salaries for teachers. It is not apparent that the conditions that the area cost adjustment would be expected to fund actually apply in many authorities. We believe this data merits updating and further review to determine whether other than for London there is a need for an area cost adjustment.

The relative costs due to size of school and in particular the increased cost in running smaller primary and secondary schools.

School leaders still have to do many of the same jobs as leaders in large schools and in many cases combine this with a significant teaching load. Costs of leadership is one of the factors increasing the costs of small schools. This is particularly apparent where schools have become smaller over time. In recognition that for some small schools the head teacher's salary represents more than a third of the total school budget we have over recent years had to include a formula factor that recognises high head teacher salaries in minimum funded schools.

Small Secondary Schools are also expensive to run. Travelling distance and time for pupils may already be significant. There is currently no recognition of the high cost of operating small secondary schools and yet in order to offer the full curriculum in a rural area we believe we have to protect the funding of small schools.

We suggest that consideration be given to a small schools factor in the DSG that recognises the number (and possibly size) of schools within an authority.

- Authorities with lower average number of pupils per school are predominantly rural and only urban schools have averages over 350. Research may indicate that this

[51] http://www.teachernet.gov.uk/docbank/index.cfm?id=14396
[52] http://www.teachernet.gov.uk/docbank/index.cfm?id=12740

approach is indistinguishable from the sparsity factor. It is however unlikely that two authorities with equally sparse populations will have the same number of schools per head of population and if there is a national determination to maintain small schools those authorities with a proportionally higher number of school units will be disadvantaged because of the fixed costs of running any school.

- We will be keen for consideration to be given to a sparsity factor (or small schools factor) for the secondary sector where there currently is none. We recognise there is an impact on outcomes. Travelling costs impact widely in sparse rural settings:
    - Bought in support services that involve on site visits carry a substantial overhead in terms of travelling time.
    - Travelling costs impact on schools ability to collaborate, work in partnership and share facilities.
    - Travelling costs impact on the viability of early years provision and extended services in rural sparsely populated areas.

We wish to highlight the challenge of providing PRUs in a rural authority. To provide an example the unit cost per pupil at an Exeter City PRU £13,216 per pupil per year and the unit cost per pupil of a rural PRU Centre £15,396 per pupil per year.

'Rita Hale SPARSE report summary,' July 2006[53]

Schools

My analysis of Schools Budgets for 2005-06 showed that in aggregate, LEAs budgeted to "overspend" in relation to Schools FSS in 2005-06 by about £217 million, or 0.9% and that:

- the biggest "overspenders" in relation to Schools FSS, in percentage term, were the most rural LEAs; and
- the metropolitan districts planned to "overspend" in relation to FSS to a smaller extent in percentage terms than the rural LEAs.

I acknowledged in Section 5 of the main paper that some may argue that the issue of population sparsity is no longer important for schools because of the recent changes to schools funding – and explained why I do not share this view – i.e. that in my view these data provide a sound starting point for work on the relationship between settlement patterns and the costs of local authority and other public services.

[53] http://www.sparse.gov.uk/pdfs/Rita%20Hale%20Report%20Summary.pdf

'Arguments for a fairer funding system for education,' f40, March 2009[54]

Areas Costs and Sparsity

The additional costs are associated with staffing and size of school. The costs of resources and utilities do not vary across the country – but staffing is about 80% of direct costs in a school budget and contributes to other budgets (including catering, cleaning and support services). In terms of direct and indirect costs, staffing probably contributes to about 90% of the budget.

There are clearly higher staffing costs in London, both in teacher costs and support staff. An initial survey by the f40 Group showed that there did not seem to be significant differences in staff costs in other areas. This requires more detailed analysis.

A particular concern for many rural schools is the high cost of supply staff. There is simply not the pool of teachers available and the cost of staff travelling from the nearest urban area can be substantial. Recruitment in rural areas can be as difficult and costly as in London because there is so little choice.

'School funding formula,' Teachernet, March 2009[55]

Some authorities use factors in their funding formula to sustain the educational viability of small schools. In some cases they use the formula to provide partial or at least transitional protection to schools with falling rolls. Factors that are used include: guaranteeing the minimum number of teachers in each school including a premises sum linked to the proportionately increased fixed costs of small schools triggering lump sum figures at different pupil numbers and for significantly different amounts.

The funding formula is a mechanism for encouraging change as well as protecting the status quo. Setting a small school protection factor at too high a level may make it too easy for some schools to live with too many surplus places. Rochdale has raised the threshold at which small school protection kicks in, on the basis that one of its effects was to 'compensate' schools for operating with high levels of surplus places. The result is that fewer schools are now 'artificially' supported through the formula. This puts greater pressure on schools with falling rolls but for a deliberate reason.

[54] http://www.f40.org.uk/f40/Arguments%20for%20a%20fairer%20funding%20system%20for%20education.pdf
[55] http://www.teachernet.gov.uk/management/tsp/secondarytoolkit/action/funding/

3.2.3 Early years

'School and early years funding arrangements 2008-11': explanatory note for local authorities,' School Funding Unit DCSF, November 2007[56]

A single local formula to fund the free entitlement

The introduction of a single local formula for funding the free entitlement at local level is intended to ensure consistency and fairness in the way that all providers of free nursery education and care are funded. It does not necessarily mean that providers will all be funded at the same level, but that the same factors should be taken into account when deciding on the level of funding. The consultation document included a proposal that local authorities should have a standardised methodology for setting the per pupil unit of funding in the maintained and PVI sectors. The commitment to a single formula incorporates that proposal – as LAs will need to have a consistent way of calculating the per pupil unit of funding in order to develop the pupil-led element of a formula – but it also goes beyond that, by bringing into scope other factors which LAs currently use to determine levels of funding in the maintained sector.

3.3 Analysis of the education funding formula

'School, Early Years and 14-16 Funding Consultation: A Response from the f40 Group,' f40, May 2007[57]
(Note this document precedes the Minister's announcement but has been included because many of the concerns remain relevant)

While the consultation covers revenue spending, there is still the big issue of the 'double whammy' of relatively low capital funding for f40 authorities. We recognise the huge increase in spending overall in recent years, but contend that this is far too biased towards the better-funded authorities in main urban areas. We urge the Government to urgently establish a fair and transparent method of distributing capital allocations. Just as f40 demands greater fairness and equity in the distribution of revenue funding, we contend with equal force that the same applies in respect of capital. We would like to see firm proposals from the Government for addressing this point.

Under 5s and 14-19 funding

We would not wish to comment on many of the detailed proposals here, other than to say that is it important that these developments are fully funded. The opening of Children's Centres is already placing great pressure on authorities and schools and it is not clear to us

[56] http://www.teachernet.gov.uk/docbank/index.cfm?id=11544
[57] http://www.f40.org.uk/f40/The_review_of_funding_arrangements08-09/Final%20Version%20f40%20response%201%20May.pdf

that they are sustainable given the current funding arrangements. This is particularly true in rural areas.

Similarly, we feel that the assumption that 14-19 diplomas will be self-funding once established, is wrong, again particularly in rural areas where the transport issues are significant, and for schools where the take-up is likely to be low. We would want local authorities to take a pragmatic approach to local market needs rather than implementing expensive 'blanket' solutions.

'Level playing field? The implications of school funding,' Sibieta, Chowdry and Muriel, CfBT Education Trust, June 2008[58]

Stage 5: Deduct money from the Schools Budget for central services

Not all of the money in the Schools Budget goes directly to schools (though most does). Local authorities hold back part of the Schools Budget for 'central services' which they provide directly to pupils, such as high-cost special educational needs (SEN) provision and Pupil Referral Units. The remainder of the Schools Budget (i.e. anything not held back for central services) goes into the Individual Schools Budget (ISB). In 2006–07, local authorities spent about 12% of their Schools Budgets on central services, with some local authorities spending substantially more (over 20% of their Schools Budget) and some substantially less (less than 5% of their Schools Budget). Central government again limits local authority autonomy at this stage, by forbidding the central service budget from growing faster than the Individual Schools Budget. This restriction is known as the Central Expenditure Limit. This creates another incentive for local authorities not to reduce their expenditure on central services, lest they want to spend more in future years.

Stage 6: Distribute Individual Schools Budgets and direct payments

Individual Schools Budgets are allocated by local authorities using a local 'fair funding formula', created by the local authority itself but subject to numerous constraints. Central government imposes at least three constraints on local authorities at this stage.

1. The factors that a local authority may take into account in its 'fair funding formula' are quite tightly circumscribed. For example, until recently, local authorities had to allocate at least 75% of funding on the basis of pupil numbers; most continue to do so.
2. Schools are guaranteed (by central government) a minimum increase in their per-pupil funding (known as the Minimum Funding Guarantee or MFG), meaning that the local authority's funding formula will be overruled if it prescribes a funding increase below the minimum guarantee.
3. Several Local Authority grants (notably the School Standards Grant) must be passed directly into schools' bank accounts, in full, according to a formula determined by

[58] http://www.teachingtimes.com/userfiles/file/levelplayingfield.pdf

central government. The local authority has no say at all in how these funds are distributed.

Other important elements of the formulae used by local authorities include:

- additional pupil-led funding, e.g. additional contributions for schools with sixth forms;
- potential indicators of social deprivation, e.g. number of pupils qualifying for free school meals and number of pupils with English as an additional language;
- special educational needs (with statements) – specific provision for statemented pupils with special educational needs;
- special educational needs (without statements) – funding for pupils without statements who are still judged to have special educational needs;
- school factors, e.g. amount per square metre covered by schools;
- site factors, e.g. business rates bill.

'Arguments for a fairer funding system for education,' f40, March 2009[59]

Basic Entitlement

As pupils move through school, the curriculum becomes more complicated and expensive to deliver. Secondary schools have to deliver technology and science in appropriate workshops and laboratories and with class sizes appropriate to the safe use of these facilities. The major cost in the secondary curriculum comes when there is choice within the curriculum. Schools have to offer a reasonable choice at Key Stage 4, and choice costs.

Definitions of additional educational need and special educational need.

There are some aspects of rural communities that could be identified as an additional need. Rural communities will have more limited access to a wide range of educational support for pupils, for example, libraries, cinemas, theatres, museums and swimming pools. Choice within small rural schools (primary and secondary) is more restricted and options that require long distance travelling are not a solution. Extended school services are more difficult to access (or the transport costs and time escalate). Whilst good access to the Internet will help, not all families can afford, or choose to provide, this support for their children.

We have defined pupils with high cost, low incidence special needs as being those who require a special school or unit. At present the proxy indicators used to allocate resources are social deprivation measures and low birth weight – both of which correlate well with incidence of high cost need.

There is a slight problem with the use of low birth weight as presumably it is based on the percentage of babies born within an authority below a specified birth weight. Many rural

[59] http://www.f40.org.uk/f40/Arguments%20for%20a%20fairer%20funding%20system%20for%20education.pdf

authorities will not have specialist low birth weight provision but will move mothers with known likely problems to the nearest (urban) facility. If low birth weight is to be used it must again be based on the pupils educated within the authority and not where they were born.

Rural authorities face considerable problems in providing for all their pupils requiring special school places. Either the transport costs are enormous or residential accommodation has to be provided.

3.4 Additional cost considerations

3.4.1 Transport

'Questions submitted by Tony Norton, North Lincs to the Schools' Minister Jim Knight,' f40, June 2008[60]

Q - How do LAs rank in order of costs for transport?
Expenditure on transport is slightly different … as transport is paid for centrally by the local authority from the LEA budget whereas the other categories are paid for by the individual schools and are funded from the schools budget.

'Rita Hale SPARSE report summary,' July 2006[61]

Home-to-School Transport Costs

I concluded that it is possible to match home-to-school transport costs to individual schools – and that it should be possible for a larger study to identify the relationship between settlement patterns, school size and home-to-school transport costs in a way that could be used in RNF calculations.

'Should I Stay or Should I Go: Rural Youth Transitions,' Midgley and Bradshaw, Institute for Public Policy Research, August 2006[62]

Subsidised transport

The impacts of subsidised transport must not be underestimated with respect to the success or failings of broad post-16 participation, now and in the future.

LEAs have a statutory duty to ensure that students are not prevented from going to college because fares are too high or there are no services to take them there. It is evident that this requirement has varied interpretations.

---

[60] http://www.f40.org.uk/f40/Formula%20review.htm
[61] http://www.sparse.gov.uk/pdfs/Rita%20Hale%20Report%20Summary.pdf
[62] http://www.ippr.org.uk/ipprnorth/publicationsandreports/publication.asp?id=492

Government guidance states that sufficient transport provision must be made for students in rural areas. It also states that it is not acceptable for EMAs to be relied upon to cover all transport costs, as this erodes the incentive effect of EMAs – one-third of EMA used to pay for transport costs is deemed the accepted maximum.

Earlier transport initiatives included the piloting of an EMA specifically for transport (EMA(T)). Evaluation of the pilots found no consistent impact on education decisions, but that eligible students in rural pilot areas were more likely to be in FTE but had the lowest awareness of EMA(T)s and were least likely to apply for it, suggesting that, as public transport availability is lower in rural areas, the value of the subsidy was effectively reduced.

Another recent transport initiative aiming to maximise the participation and retention of young people in post-16 education was the Transport Development Pathfinder, with 70 local authorities involved and support amounting to £5 million during 2002-03. Evaluation of the Pathfinder revealed that there was a notable difference between the responses of rural and urban authorities. Rural authorities were concerned with meeting identified gaps in service provision by connecting remote areas to colleges, either through linking with main bus services or providing mopeds where conventional responses would not be effective.

In contrast, urban authorities concentrated on supporting students who encountered financial hardship in using transport.

3.4.2 Extended services

‘Planning and funding extended schools: a guide for schools, local authorities and their partner organisations,’ DfES, 2006[63]

None of the funding for extended schools is ring-fenced: it can all be used flexibly – for example, to appoint a manager to work across a cluster of schools to develop extended services. Most is revenue funding, but there is some capital funding for primary schools (secondary schools will benefit from the ‘Building Schools for the Future’ programme).

‘Introduction to extended services in rural settings,’ Training and Development Agency, accessed 20 December 2009[64]

Extended services can bring real opportunities for rural schools and communities. At the same time, dispersed communities and geographical isolation present a number of specific challenges.

---

63 http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DFES-0472-2006&

64 http://www.tda.gov.uk/remodelling/extendedschools/howtodeliveres/ruralaccess.aspx

Local authorities can play a vital role in encouraging and supporting the development of extended services in rural areas. Rural schools may need extra support, particularly at a strategic level, to develop key services, such as high-quality childcare, and to provide flexible transport, so that pupils, parents and members of the community can access extended services.

Oral evidence session; Health

Tuesday 9th February
Boothroyd Room, Portcullis House

Panellists:

PD: Philip Dunne MP
GS: Graham Stuart MP
LD: Lord Dear
BB: Baroness Byford
DD: David Drew MP
DR: Dan Rogerson MP
RW: Roger Williams MP
DM: Duke of Montrose

Witnesses:

PH: Dr Peter Holden, General Practitioners' Committee, BMA.
TH: Theresa Huddart, North East Commission on Rural Health.
RM: Richard Murray, Dept of Health
SA: Prof. Sheena Asthana, University of Plymouth
MSu: Prof. Matthew Sutton, University of Manchester
MSt: Prof. Mervyn Stone, ex-UCL

First session – 10:30-11:30

GS: Well its 10:30 and so I'd like to welcome you to this Meeting of the Rural Services APPG. This is our inquiry into the funding formulae of health and education in rural areas and today we are focusing on the areas of rural health. I would like to welcome Richard Murray from the Department of Health, Dr. Peter Holden from the General Practitioners Committee of the BMA, and Theresa Huddart who is from the North East Commission on Rural Health and Assistant Director of Pathway Development and Primary Care and Community Services at the NHS in County Durham. Hope I have got all those titles right as they've been provided to me here. I would like to welcome you all today.

Can I start with you Richard and ask you to give us a brief introduction. We've got about an hour for this session. Just a brief introduction to the formulae to get us started.

RM: I wish I could say that the allocation formula was simple and I that I could do a two-minute introduction to it. Unfortunately, it's not. It's quite a complex piece of analysis and statistics but I will try and take you through some of the key elements as quickly as I can.

Firstly and very importantly, ACRA is the group that works on the formula and provides recommendations to the Secretary of State which he can formally reject but in fact never has. But ACRA works within the broader objectives that the government has set and the first of the two objectives that we have been given are to achieve equal access for equal need. So wherever you are in the country you have the same chance in terms of funding from the health service. The second objective is reducing health inequalities and that was a new objective set for ACRA in the late 1990s and is the one thing that separates the English formula from the Scottish formula. In terms of the coverage of the standard (CARAN) formula, I should quickly say that it doesn't include all services. That means that particularly for example; general practice goes through the general practice contract. Pharmacies have their own contract. It's really talking about primarily hospitals services either maternity or acute services and those form the bulk of the spending in NHS.

The formula works on the basis of population, so we use the latest ONS counts on population that are common to the rest of the government. It then adjusts those basic populations for an estimate of need and the current formula (the CARAN formula) does this in one step and it is different to the one that we used until 2008/09. Need is driven by a wide number of factors; critically age but also indicators of health status, how well the local population is, and often those are determined by how poor or how deprived the population is. That forms the need element.

We then adjust the need element for an estimate of cost. It is believed that the cost of delivering services does vary across the country in a way that local services can't avoid, it's not something that reflects inefficiencies it's an unavoidable cost difference. This is the Market Forces Factor. The Market Forces Factor works largely off the private sector wage rates and reflects how much pressure the local NHS is

under from trying to pay sometimes below market rates. That forms the kind of standard needs-based adjustment on the formula.

The current formula is different to the one that preceded it. The researchers came back to the department to say that they could not deal with the two objectives within the same formula, so they thought the CARAN element did very well on equal access for equal needs but it couldn't deal with reducing health inequalities.

What ACRA did do is recommend to ministers that if they wanted to achieve something on the second objective they needed a second formula and they did also recommend what that formula should be based upon; which is disability-free life expectancy – your life expectancy being in good health. But couldn't say how much money or what proportion you should put into it other than saying that if you put in zero then obviously by definition you have not met the second objective. Ministers had to take the decision and came up with 15% and this remains the one of the things that ACRA continues to do further work on.

All of that that sets the target allocation; what we think would be a fair level of spending. But of course you can't move local spending very quickly as you'd cause disruption within local services so ministers also then set the pace of change; how quickly over time you move towards your target allocation. That is the last element of the formula and it's that which actually sets exactly how much money PCT gets.

The formula is being partly reviewed at the moment; some elements are up again and we review on a fairly regular constant basis, picking up things as the world of statistics moves on and as the population of England moves and so its refreshed on a fairly routinely basis. The current emphasis on that is particularly around some elements of mental health and how the population is measured.

GS: Thank you very much Richard. Peter, can we come to you to give us your overview and perhaps pick up on whether you think there are any shortcomings of the current allocation system.

PH: Thank you. You mentioned ACRA in my notes background, but I have yet to attend my first meeting yet but that's not a huge problem because as it's just been said as far as General Practice is concerned the funding formula is dealt with through the new contract. I am one of the two survivors from either side of that new contract and on rural practice I have been the lead for the BMA for over 20 years now including for community hospitals.

We need to understand how the funds arrived in the new contract in the first place. It was a simple mapping across of the old cost plus contract into the new contract into the various components of it and some new money put in through for the QoF (Quality and Outcomes Framework). It was an unashamed attempt to boost practice resources and to reverse 15 years' of interference in review body awards. That was why the new GP contract rewarded generously because we had a crisis in GP recruitment, crisis in GP retention and now we are going back there again. And a part of that was down to the Out of Hours and that has had an impact on funding as well, particularly in rural areas.

Within the new GP contract is the market forces factor. Roy Carr-Hill from York University produced a formula for the funding and it has been very wrongly written off, there was nothing wrong with the Carr-Hill formula. What went wrong was that at about 11.59 and about the thirtieth second, the highest people in the land decided that there was no such thing as dis-economies of scale because at the time they were having a political down on single-handed practice. If you remove dis-economies of scale from the formula, that particularly hits rural practice, that is as fundamental as removing C^2 from Einstein's theory of relativity – the formula won't work as intended. And what that resulted in was that on Wednesday the 13th of March 2004, just two weeks before the contract was supposed to go live, suddenly about 80% of practices realised the resource they were going to get wasn't even going to come up to current resource, and indeed in some practices would be sufficiently short that they would go bust. Because the GP contract was a cost plus contract, a very tightly geared one, the expenses of which over the years had been calculated by the Technical Steering Committee of the NHS Information Centre - on which I sit – the expenses were calculated from a 100% sample of Inland Revenue Tax Returns which showed all the practice expenses and thus average practice expenses could be calculated to within £50 a year under steady state circumstances. So with the Cost Plus contract mapped across, if there was a fault in the formula it was going to be devastating, and so it proved. Because of this it was necessary to introduce the notorious Correction Factor of the Minimum Practice Income Guarantee (MPIG) which has stopped the intended redistribution of monies. How can you, for example, explain two neighbouring practices serving largely the same rural or semi-rural area where one has two and a half times of funding per capita of the other? - That kind of problem.

So components of the contracts are the Market Forces Factor, diseconomies of scale, and capitation; people thought there were lots of different reasons for variations in workload – capitation, age, gender, English not a first language, deprivation - the only two that matter are gender and age, we've looked at that quite carefully. And there is a rurality factor in the contract contained within the diseconomies of scale; inevitably rural practices are smaller. So there are problems there.

The Government and all political parties wish to deal with MPIG and the Correction Factor, and so does the profession and it is interesting to hear pace of change mentioned for PCTs because obviously they need time to turn the super tanker of the NHS around. Yet ministers wish to cut MPIG within 2-3 years. That really would have driven the train off the rails. At the moment we don't know how it's going to work medium term, but 37% of us are now off MPIG but still the average practice funding is something in the order of £70 a patient per year. It varies; I did a full enquiry in Derbyshire, the fundings are enormously spread but for General Medical Services (GMS) contract practice which is 60% of them, around £70 – £80 a patient per year, for PMS (personal medical services) roughly 40% of practices, of the order of £90-£100, but there are some big outliers. And in the areas where they cannot get doctors, where the PCT runs the practices (PCTMS), you are talking funding of about £200 - £300 a head per year in the urban areas, so the rural people are having

money sucked away to fund these other places as most PCTs are now big enough that they cover both urban and rural.

So that gives you a bit of a flavour there and of course I do note that hospitals do the bulk of the spending but not bulk of the activity and there are problems in delivery of care in rural areas simply because of distance. Also as GPs we have to do a considerably broader spectrum of work in a rural area compared to an urban one, a lot of emergency work. Indeed within the draft report, part of the documentation at this table, it talks about provision within the new contract for resourcing emergency work. It's there, I negotiated it in but I know of only one place in the country where it's being commissioned.

One of the problems we have is that within PCTs sometimes managers don't accept that in a rural area it costs more to deliver than in an urban area. What is more, rural areas are perceived as being the wealthy area compared to say, for example, the place I know best – Derbyshire – in the old coalfield areas in the rural areas and the High Peaks are perceived as being wealthy. And so you get the 'no chance' response when you start talking about investment. So there are problems with perceptions at management levels, there are problems with the GP contract because it was interfered with politically at the very last minute, too late to do something about it. The idea of the new contract was to level up funding; by the concept of a rising tide coming into the harbour it would lift the boats off the bottom. Well the tide hasn't come in and it's not likely to come in for many years now.

GS: Thank you Peter. Theresa, let's move to a Primary Trust Care point of view.

TH: In the Primary Care Trust I've got a dichotomy really; myself I wear a hat where I work within the PCT, but I'm also the programme lead for the North East Commission On Rural Health for the North East cluster which covers four cluster PCTs in the region. It is recognised by the strategic health authority where there is a large area of rural population in Northumberland and Weardale/Teesdale and so there was a specific focus on PCTs to provide evidence that they are improving equitable access to health care in the North of England. And as my colleague has just alluded to, certain PCTs were not aware but certainly in the North East we are well aware of issues that the PCTs do face. We cover both urban and rural areas. There are higher costs associated with delivering and commissioning services in rural areas. You have to deliver differently. You can have economies of scale within urban areas, you've got hospitals that can deliver, but in rural areas you have to serve the population differently who may not have to access health care.

LD: So are you saying it more expensive to delivery services overall in the rural areas as opposed to urban area?

TH: It is. You have to think differently as commissioning services and delivering services within rural areas. There isn't the population, its sparse, you've got midwifes and community services staff and GPs who really work on their own and work across sparsely populated areas so there is distance involved and you usually find that car ownership in those areas is much less than in urban areas.

GS: Thank you very much for that. Can I turn to David Drew?

DD: Apologies, but I have another debate at 11:00, hence why I'm going first. Can I make a rounded question; hopefully you can pick the bones from what I am saying. Is the biggest problem in rural areas in terms of health one that you would also apply to education, that in a sense it's the transport problem, it's the access problem – it's just that it gets muddled up in the formula.

But there is also an issue to do with perceptions of fairness as against the reality of provision and we can always argue about what formula we've got but there are some dangers if we move to a new formula. This is what I am getting to – should we be measuring, in terms of formula, people's real health needs or should we be recognising that people's perception of their health needs also have a part to play? Because I suspect that in rural areas, and I don't know what statistical measure this is, that we've got a fairly articulate group of people who probably know who to ask but on the other side have got to get there on their own to where the help is provided. If you pick the bones off that, I welcome your views on my analysis.

PH: I think the truth is there is hidden deprivation; quite literally within the same wards I have people in the Times 100 top rich list and some very poor people indeed but you can't detect them. So there is hidden deprivation in rural areas. I am sick of hearing that word deprivation, what about rural deprivation. Transport access is undoubtedly an issue. It's all very well being commanded to open till 8'Oclock at night but the last bus leaves at 6:30pm, so it's not much use. The perceptions of fairness and the reality of provision is a very real question. In terms of rural health needs, the rural population is, as a generalisation, an elderly population compared to the urban one, as patients get older their needs go up.

It doesn't matter what population you look at, the elderly cost a lot more. It's one of the reasons why our funding formula is loaded in terms of age. To give you a very rough figure; an 84-year-old lady compared to a 15-year-old boy, is worth something like 12 times as much in my contract because it's a least that much more work if not more, bearing in mind the annual consultation rates of the elderly at 75 is around 8 per year. The average national consultation rate is 5 per annum. It rises by 1 per year to age 85, to somewhere around 18 consults a year. More is done out in the community so that that goes up because all the things that used to be done in the hospital we now do. So we've got problems – as more is being done in the rural area on reduced resource with an increasing elderly population.

Are they more vocal? Yes. And when it's been a bad Monday morning my argument is that they've had all weekend to think about it and vocalise it; that may sound cheap but it's a fact. But also I think the elderly do feel disenfranchised in what is increasingly a younger person's world and it's all very well saying it's on the website; some of them haven't got a computer.

TH: I just wanted to say, in Durham it's alright having technology as a solution, but some of us cannot get mobile signals, we can't even access mobile in some of the areas so there is a real need for investment. Health can't do that alone, we've got to do that in partnership so I would agree with that statement and certainly the North East

Commission has partners around the table and certainly some of the solutions do lie in technology but we need investment there as well.

RM: Could I please pick up on the cost issue, which I think has been raised a couple of times. I think we need to distinguish what kind of services we are talking about here. I can see certainly in primary care you are talking about a very small business, if you don't mind me referring to it as a business, where economies of scale are going to matter. I can again see it in community services where in fact you are reaching out to people in the local areas. But you've got to remember a lot of the costs sit in acute care in large hospitals. These are not small businesses but very very large businesses. The evidence on economies of scale is that once you reach around 200 beds which any NHS acute hospital will do, the economies of scale don't exist. So I think it's important to try and target the areas where...an analogy might be a small rural post office, or small business where the issue of small population is critical to the way you run your service. But to a large hospital where it's got to maintain a large staff then you're going to cross the level of reasonable economies of scale because they won't be safe otherwise; they wouldn't be able to maintain the level of clinical staffing that you need.

PH: Can I come back on that? There are 400 community hospitals in United Kingdom, the average size of which is about 23/24 beds. They were slagging them off 10 years ago when they suddenly realised they were the solution not the problem. That's what keeps the district general hospital bed state liquid and in fact community hospitals are run by the local primary health care team. And so I can understand the argument that's being made but nevertheless the argument that was being thrown at us in the late nineties and early noughties was that the cost per bed is enormous. Of course it is because you are running an estate for only 23 or 51 beds. Of course it is, it's part of the cost of providing services in the rural areas.

RM: And I think the area of community services is important, particularly because if you wanted to look at something that is difficult in the current formula, the data on community services is very very weak and so it tends to be dominated by what we do know which is the acute side. So I think there is a question mark over community services not because we haven't tried, there is now an attempt to try to collect better data on community services, but it's a definite weakness.

GS: There is a move to move budget from the acute to the community centres and therefore you are trying to run neighbourhood community teams; we've shut community hospitals in sparsely populated rural areas such as the one I represent and there are teams driving around the roads trying to support people with multiple problems in their homes – because that's the best place for them - and yet there seems to be nothing. We have an already, as some would suggest, a funding system that doesn't recognise rural needs and it is going to be exacerbated by that move and no effort seems to be made to allocate additional resource to help it happen.

RM: There is a lot of work going on at the moment to try to improve the data sets in community services. That is where I think we need to look to in the future to try and get the information we need to estimate whether or not there is an additional cost

in providing services in rural areas. I think you are right it doesn't exist at the moment.

GS: Shouldn't that work have been made before the policy was made to move it then, before the beds were shut, before Hornsea Hospital was to lose all its beds in my constituency? Shouldn't someone have worked out how much it would cost to deliver neighbourhood community care before they made the decision to shut the beds and move allocation to acute...

RM: At the moment if you look across the country, the areas that have lost the most beds are in London so although I know it feels very difficult in the rural areas, at the moment, what the formula has done over time is actually extract money from London and distribute it across the rest of the country. So although, yes in the future with a real drive on improving investments on community services this becomes a critical issue. I think this has already come up in mental health where we didn't change the formula from the AREA report simply because the CARAN formula was driven so much by acute services and acute services don't account for enough of mental health to actually base the formula on. So I think it is coming and the work is under way but I think at the moment that the level of evidence you need to run a statistical formula on community services isn't still there.

LD: If I may. We live in a world of formulae and tick boxes and it seems to me very often that common sense and the qualitative side goes out the window because it is easier to be quantitative. I understand why we lean that way, but it seems to me that the perfect world would have somebody making an objective decision purely and simply on the evidence from people involved and say, the allocation would be X. Because we know it can't work, we must have a framework. So I go forth on that basis. But listening to you describing the formula, there was three words I didn't hear. In fact my first question to you is whether they figure in the formula; the geography of the area; comfort, for example if there is a snowfall, people with a ten-mile journey now face a 40-mile journey, that sort of thing; the adequacy of local transport; and the adequacy of staff. There may be others that colleagues may think of, but would those three factors feature in the formula as well?

RM: Staff is in the staff Market Forces Factor because that is what it is based on. So it is an attempt to measure is the ease of recruitment, turnover rates, the competitiveness of the salary, and so yes, in the acute sector, the staff issue is picked up.

Adequacy of local transport and geography – not really. The previous-but-one Secretary of State did ask as a part of the current review that the researchers looked more closely at the rurality issue. And again remembering that we are talking about hospitals we are not talking about primary care and community services, couldn't find a link to geography and I'm afraid you might say that is because they are just using statistics

LD: Did I hear you correctly that you don't take into account the fact that there is no transport to quote an extreme case; no bus, no train.

RM: No, the formula does not pick up the adequacy of local transport. What they do, is not just saying they're not going to look, the formula does link the presence of local providers and how far it is for people to get to them. What they didn't find is actually what drives how often the people used the hospital. It doesn't show up.

LD: I remember being involved in a House of Lords debate, I suppose it was two years now, when I was amazed to find within that debate that one of the indicators of poverty was ownership of a car; if you had a two-car family you weren't in the poverty bracket. Yet in rural communities you've got to have often three motor vehicles for the father, the son, and whoever else. And frequently in council housing estates in the country you will see three or four, beaten up old, cars. But they need them because there is no bus and there is no train, yet they were not there in the poverty bracket though, yet patently they were very poor, and in an urban area they would have been in the poverty bracket right away. So it seems to me that there is a mis-match that if you don't factor in the adequacy of transport and take into account the distances that are involved, you are asking people, surely not, to walk 10 miles? That is a ludicrous way of putting it, but that is the extrapolation of what we are talking about, that they go on a bike or they walk because there isn't any other factor to get them to where they want to be.

RM: Like I said this isn't an issue that ACRA haven't considered. They have looked at the location of the provider, the hospital and the link to utilisation. What ACRA can't do is say whether or not that imposes costs on the individual either because they've got to use a taxi or they've to find another means of getting into the hospital and that is partly reflected in the acceptance that in some circumstances those costs aren't covered by NHS. So it's never going to get picked up by an NHS-based formula. It can't do it.

LD: So without wishing to flog a horse to death, we have a formula which has accepted deficiencies in it, and any formula will. Is there the ability for those administering the formula to apply some common sense to the outcome for a given area and skew the formula on a value judgment?

RM: That would need to be done by the PCT itself within the PCT area; it couldn't be done between PCTs.

LD: So if I could turn the question round. Is that value-judgement into position carried on, should it be carried on, does it work or is it not working?

TH: I can only tell you from my experience, in County Durham we have had to commission additional transport to enable our patients who are resident in rural areas to access primary care and secondary care and tertiary care. So the funding isn't there for additional transport needs and so I would guess the formula is flawed. Durham is 5% below target and so we don't have the resources but we have to make sure that we have resources to ensure equitable access. So I would say the formula would need to be reviewed.

LD: I'm getting the picture of a formula which is very complicated, and one understands why it is complicated with all of the factors in play, but at the end of the day it

doesn't work. We then have this wooden acceptance; "the formula is the formula, and that's tough". Because one cannot then step in and adjust the result by the interposition of common sense. Would that be fair?

PH: Yes it is a fair thing, because the bottom line is; you can have all the formulas in the world, all the formula does is say is how many millions each PCT gets. It is then up to the PCT how it spends the money. The current feeling from primary care is; "well it's all going to get soaked up by the secondary care deficit anyway". And if I may go back to the argument about transport and hospitals; you only get sent to hospital because you need something doing. Can I say, again, you can argue the percentages but over 80% - some will say 90% - of all patient transactions with the health service occur in primary care. That's where the bulk of the work is done. Why do you think we have to set up surgeries in the agricultural centre on a market day? Because otherwise the farmers would never get any healthcare, because they just can't get there.

So of course they don't get seen in hospitals, their problems never even get to our front doors let alone hospitals. I think we've got a real issue here, that is the failure by successive governments of different colours; the need to distance themselves at the dispatch box, from difficult rational decisions which we've got to accept in the real world. But the problem we've got is, that by doing that we've handed so much power to local discretion that even if you have loaded the budget to reflect rurality, it would still get swallowed up by teaching hospitals if you've got to pay for something because it's about shroud waving.

Now you may say that I would say that as a GP and why wouldn't I? I have seen it so many times and the best example of this of care to close to home was the High Peak and Dales Primary Care Trust which was swallowed up in the last re-organisation. The PCT was going nicely, and then finished up with £6-8 million deficit and it was solely because of the way funds flowed. The traditional pattern of stroke care in our neck of the woods was; have your stroke, two days in a district general where you had your CT scan to establish your swallow reflexes were OK, then come back to community hospital for rehabilitation. What happened? The big secondary care hospital held on to the entire tariff fee so we paid twice for the average extra 18 days that would be needed. This is what's happening in reality on the ground. In reality what happens on the ground is that the big foundation trust gets involved in churning and starts actually taking the mickey financially out of PCTs and then PCT manager is between a rock and a hard place. So you can have all the formulae in the world; but if the manager has got discretion he is going to manage a budget, which is inevitably going to be short (especially in years to come), in the best way he can. And we will lose again in rural areas. So unless there is some form of ring-fencing, and I know that word is a dirty word in Whitehall, but unless there is ring-fencing you are not going to achieve what you want to achieve.

LD: Could I wrap up with one very simple question? I accept you do need a formula to start you off to get somewhere near the truth, I repeat myself, but the lack of qualitative element in then looking at what the formula is bound to deliver seems to me to be missing, would that be a fair question? Because the obvious

supplementary to that is; do you intend to address that, and to inject an element of qualitative judgement into the formula?

RM: Where qualitative judgement comes into the formula at the moment is where the ministers set their raw objectives for ACRA to consider. After that, I'd actually put it round the other way, there is a real attempt not to get involved in qualitative judgments and I say that because I am here today but I have also sat in meetings with deprived urban areas about the fact we can't count well the numbers of homeless, the fact that they can show a churn in the population numbers which shows almost certainly I expect that we have undercounted their populations. The exercise of judgement wouldn't be limited to the issues raised in this room there would be a very long series of judgments. And in the past before there was a formula the sum-total of those judgements tended to be that the money stayed where it was and where money was, was around large teaching hospitals. So it feels bad now. Look back 30 years before the formula arrived and you will find that it was a thousand times worse, money went to where the Victorians set up charity hospitals and it was still there in the mid-1970s when the formula was developed. And that's the problem about those judgements is that there isn't just one, there are hundreds. And so by setting up ACRA as an independent group, that publishes its reports, that commissions out work to universities, it's a deliberate attempt to say that this as an objective attempt at setting the formula, it's not really supposed to be subject to ministerial movements behind the backdoor. And the scope for ministerial involvement is there but it is made very explicit and it really focuses around the pace of change. As I said, no minister has ever rejected a recommendation from ACRA.

GS: I come to Hazel.

BB: If I can put in another quick one to you and then please definitely to the others. I am quite alarmed by the fact that you said there is no real data on community hospitals and their cost and that you are reviewing it now. Are there other areas within the whole concept of health care that you don't have data on, that need reviewing?

RM: Community services probably stands out as the weakest and it's been an area that has transferred in terms of organisational structures; it was once controlled by acute trusts then transferred to PCTs and had no long-term organisational status. It's slightly difficult to define. We all talk about community hospitals in fact there is no one accepted definition of the community hospital, when is it a poly centre? When is it just a really rather small outpost of a DGH. And so it struggled on some of the basic analytical functions. I think because of the strategic goal now to move services out of the acute sector, we've long known that on GPs we have pretty good data sets, we do on pharmacies and dentists as well. It's this group in-between that has been weaker. So there are data sets it's just that they are not of the standard or the quality used to generate a formula that has to run across the entire country.

BB: How quickly will that come about? Do you have a timetable for that?

RM: Not strictly speaking my area, so I would have to come back to you on that. [*RM: ACRA is currently looking at mental health, including available datasets – 17.03.10*]

BB: If you could I would be grateful. Because a review could be 1 year, 2years, 5 years or whatever. Right, I think my colleagues have asked enough there.

Can I go back to the area of general practice as clearly that is where most of us go. Two things really, one is; Presumably there are geographical differences even within your own provision between the north for example where general level of health is not as good as perhaps that of further down in the south, presumably that is reflected in the amounts of money allocated. Does it come within the framework of yours? The second question, could I follow up on the whole question of lack of transport even to GPs' surgeries? Does that mean then that those in rural areas have to do more home visits than they would otherwise do in an urban area and with that I'd link in the out-of-hours provision? And thirdly, the recent announcement that every cancer sufferer is likely to be given a home individual person to look after them, how on earth are you going to tackle that? And eventually for the teams, whose responsibility will that be and where does that money come from?

PH: If I could add a fourth comment; the one danger relating to community hospitals is that the government has suddenly decided that PCTs must divest themselves of their "provider" arms. Many provider arms were looking to turn themselves into foundation trusts, then only last week they were told; scrap that, within a month– you must find a new home. There is serious risk to community nursing, community midwifery, community hospitals with the chaos of very fast-running decisions which inevitably are being driven by a timetable which must have a bearing towards the first Thursday in May. Coming to my point; is it geographical difference? Well market forces factor is only a small part of GP's funding formula but obviously it's in there and in fact one problem with the MFF is whilst there are 110 I think (University of Warwick) MFF regions, it can't allow for local quirks, the fact that I practice in the town where the county administration and the district council administration is located, this pushes up wages for the type of people that I need to employ, and the MFF won't reveal that. So there's the geographical north and south split. Other than that, it's pretty even sort of payment because there is already reflected relative morbidity and of course the Quality and Outcomes Framework is 40% of our resources. We will have higher prevalence of disease and therefore there is a weighting on those payments so in that sense the contract is sensitive to the north/south split.

Transport/home visits; Home visiting has fallen by the wayside in this country. Now some people say that is terrible. The reason home visits were at the level that they ever were in this country was tradition because pre-1947 it was two and sixpence for a home visit and doctors were visiting for cash reasons and not because it was clinically necessary. Go to places like Denmark and Sweden and their governments openly say; "we do not pay doctors to drive around in cars. If you are clinically in need of a home visit, of course we visit" - and that is in fact what was secured in 1996 was for the GP to determine whether, when and where a consultation if need be by home visit would take place. So we do feel that the ones we do now take longer, I can reflect that in what I'm going to say about out of hours, they take longer, they tend to be knottier and they tend to be visiting quite seriously sick

people who in the old days would be in long-stay geriatric beds who are now hopefully properly cared for at home, and in most cases they are. But there is no doubt that funding is a complex issue in both social and health there is a little bit of institutionalised neglect going on simply because there isn't the money there to provide the level of input people need.

Just repeat the cancer question please.

BB: The Prime Minister announced that every cancer sufferer would be entitled, I think, that they would be able to have a person who looks after then individually in their own home.

PH: What do you think we've been doing for the last 25 years Mr Brown?! It's part of the essential services; terminal care. We coordinate along with the district nurses and the Macmillan nurses. If you want the single guaranteed person the same way as midwifery and child birth, it's impossible to achieve. The bottom line is, we now live in a society that is not prepared to work the clock round and anyway since the Great Heck train disaster you are not allowed because since that case, tiredness is no longer an excuse for making mistakes. So it isn't realistic. Of course the general practice and the district nurses team will coordinate this, they have to, hand-in-hand with the local hospice. Often if you've got a community hospital, using that as well. I'm not saying it's perfect but also I just think that sometimes people think the health care is what you see inside the M25! It isn't.

Out of hours. Well, 40% of us are still doing out of hours. I did Saturday and last Sunday and I was clinic lead for the whole county on Sunday. It can be done to a very high standard, but you pay for what you get. Where the problems occur, and the very unfortunate thing that occurred in Cambridgeshire, was because it was down to a price. If you look at what PCTs are paying for out of hours coverage it's anything from around £5 to £25 per head per year rising exceptionally in the highlands and islands to about £50 per head per year. And you very much you get what you pay for. Once you get beyond about £18-20 a head, you've got to be asking what are the special circumstances. The services that tend to be the best run are the services that are still cooperative or are cooperatives that are morphed into Not-For-Profit organisations, so there are no shareholders to satisfy.

GS: Peter, I hate to interrupt you, it is fascinating, but I want to stay as focused as we can on the formulae

PH: The bottom line is that the formula does not reflect anything out of hours at all. The original formula of the out of hours was £6,000 per GP principal. That's what the DPRB[65] in 1997 said we were notionally paid for out of hours. So the formula doesn't reflect it. It down to PCTs to commission it and it's then down to what they are prepared to pay for it. If you look you pay for what you get.

---

[65] Doctors Pay Review Body

TH: I'd like to add that out of hours care we do have to pay for what you get and County Durham has had to invest an additional £5 million to have a one-point of access to integrated service across rural and urban areas.

GS: We will now come to Philip and then Dan.

PD: Getting back to the formula, the first basic question is that I assume the formula relies on census material as the basic data for population. The census is done every 10 years, and we've all witnessed in our constituencies considerable movements of populations between censuses. What estimates do you rely on and is that common across other departments in Government?

RM: Yes the ONS forecasts that go in between the two census points are commonly used across all Departments. They do sometimes look different if the Department issues its own allocations and of one of them did it this May and the other one did it May next year; the cycles aren't completely the same, but each one usually uses the latest ONS estimate.

PD: Does that cover age bands?

RM: Yes, that is where we get the demographic data down on age and sex.

PD: What happens when you move between? The formula allows for areas to be above or below target. What happens if an area is clearly below target, are there any adjustments made to try and bring it closer to target once that assessment's been made?

RM:

What happens is, once the formula has been set and you find out the target, you can then distribute to all PCTs in the area according to whether they're above or below target. The issue then reserved for ministers is how quickly you go from the actual amount of money that you get up to or down to your target level and it's called the pace of change. And it's a mix of a sense of how wide the distribution is and then how quickly you can move PCTs up or down to where their target is. Never have we actually taken money away from a PCT to move it down to a target. So what you are relying on is that over time as health spending grows, some of them don't get the full 5% or 6% average that everyone should get, they will be down to 4.5% or 5.5%. With the money you get over the top you add it to the ones below target. That's why Country Durham is a bit below target. Over a number of years you attempt to narrow the distribution gap down again.

PD: Has that happened in practice over the years?

RM: There was a very sharp narrowing in distribution up until 2008/09. Then it froze for a year because ACRA took time to develop a new formula. We are shrinking the distribution again now, but more in the way that it was done before the 2003-4 round. Yes, they are shrinking but not shrinking as quickly as they were before.

PD: What does that mean?

RM: Movement to target used to be a fairly slow affair and it really relies on the health service average budget going up quite a lot, because you need money to invest in the services to begin with. So the pace of change from 2009-10 is slower than it was in the previous round but in fact very similar to what it was in the years before 2003.

PD: Can you quantify what that means?

RM: It means that, I think, that no PCT will be more than 5.5% [*RM: corr. 6.2%*] below target by the end of 2010-11 and they'll have been opening around 13% [*RM: corr. 10.6%*] I think is the worst below target.

PD: So some PCTs are 13% below?

RM: When the new formula was worked out and we realised that populations have moved and things have changed. You open around I think 13% [*RM: corr. 10.6%*] below target and now the worst will be around 5.5% [*RM: corr. 6.2%*] by the end of this period.

PD: In about two years?

RM: Yes it has taken two years to do.

PD: Thank you. You said a moment ago that ministers do not get involved in making decisions. Have they also accepted the ACRA recommendations for the health inequalities aspect?

RM: Indeed, all aspects of the formula.

PD: Right, well Ben Bradshaw MP a year ago said that ACRA could not determine the proportion of allocation to apply the health inequalities formula to and left it to ministerial decision. Ministers decided to apply the formula to 15% reallocations.

RM: Yes.

PD: Does that not contradict what you've just told us?

RM: What ACRA said was, they couldn't identify the right percentage for the health inequalities adjustment, but they did say that if you didn't have a health inequalities adjustment that zero was not really acceptable. It would have meant that the second half of the objective which is to reduce avoidable health inequalities would have failed. So ACRA said that we can't tell what it should be, but there should be one if you mean to reduce health inequalities because our formula can't do it otherwise. And then passed on to the minister what the percentage should be, not really whether there should be one or not.

PD: Right, ACRA said there should be one, couldn't come up with a number. How did the ministers arrive at 15%?

RM: What was done in the end, some of the work that the researchers did around the new formula didn't indicate that the previous formula had been incorrect, we just couldn't reproduce it as data had moved on, we didn't have the same collections that we used to have due to changes in service provision etc. And so the health inequality adjustment was set to be such that on average, and I stress the word "on average" because with a lot PCTs there is a wide distribution above and below, was as generous on health inequality as the formula before. So effectively it left policy on health inequalities where it was under the previous formula.

PD: A consequence of that was the extraordinary perversity in PCT performance and financial performance and it appears as though those PCTs which received the greatest uplift on health inequalities were most likely to achieve a surplus or break even in their financial performance and those that received the least benefit from health inequalities were in deficit and the suggestion in 2005/06 is that over 70% of PCTs in the most rural areas failed to break even compared to only 6 serving the urban communities as a result of the health inequalities adjustment. Is that a fair reflection of the consequence of the health inequalities adjustment?

RM: This slightly goes back before my time so I might need to check exactly the things I am about to tell you. The Chief Economist of the Department of Health did do a review of the relationship between the formula and the appearance of deficits in the NHS and I think the conclusion came out was two-fold. One is that deficits actually began in 2004-05 which was only the second year the AREA formula had come in so it would be fairly striking if the NHS lapsed into deficit immediately that a new formula was introduced. It in fact looked like a reflection of more long standing problems. The second one was that focussing on PCT deficit is only half of the picture. Trusts were running deficits at the same time and the balance between whether a PCT ran the deficit or the trust ran the deficit was really a reflection of history rather than any exact rule; tariff was in its early days. If you include the trusts' deficits, and say "was the whole health economy in deficit?" then that relationship breaks down, not least because London was one of the biggest deficit areas across the country which is also the most urban. So that relationship between PCTs in deficit and formula only works if you restrict it to PCTs and as soon as you move to a whole health economy level as a whole, the relationship disappears.

PD: Just going back to the point that was made by Hazel about community services weak data, do you look at other aspects of government allocation such as to adult social services care and the formulae they use? Is there any comparable logic approach as to the two types of formulae?

RM: Social services formula shares many common features with the health formula. I think that is true both with the one that I use around hospitals, and also particularly around the primary health care one, because social services in some ways shares more aspects in common with primary care than it does with the acute sector. So in a sense we both look the same, yes, are they meant to be the same, no. And again it reflects the fact that the formula for practices of GPs is not the same as that of hospitals, and they both run off their own data sets. Both focussing on their very own specific kinds of services.

PD: Can I ask Peter and Theresa, are there any specific anomalies arising out of formula which you would like to draw to our attention and do you have any ideas as to how we fix them?

TH: I think it is an interesting question because that is why the Commission on Rural Health in the North of England has been established to try and look at these issues. I think one of the issues is we've got to work in partnership better together. You talked about social care, and certainly PCTs and local authorities work better together now, more so now and also the fact that practice-based commissioning plays a part in that because at Durham Dales we have a pilot of integrated care organisations and it will be interesting to see how that works; it's in its early days.

PH: Most of the points about general practice will now be on record. The big fear that we have is next year's census. General practice is I think something like 60% of that side of the budget and the funding of those services is entirely head-count driven. Officially when we did the contract there were 53, 800,000 people in England on our books, and there are no ghost patients as we have done the list-cleaning. The population derived from NHS Information Centre statistics in their reports on the quality and outcome framework, which isn't all the population its only about 97% of the population are covered by it, that the population has already risen by from 52.6 million in about 2004-5 to, I think if my memory serves me rightly 54.3 million, and this is England only figures in the last reported year which was 2008-9. I think most of us are not taking bets on the population being much under 58 million after next year's census for England, now that is going to be quite serious because that means if you have assumed the capitation at the moment is what you need to deliver the service we will be arguing then that we're 8% adrift before we even start and that is a very real worry. The Local Authorities have been on this story for several years as well. We've got a real problem in that the Poll Tax messed up the last census.

GS: The way the formula works is that there is a weighting for age and then there is the weighting in pursuit of equity and for deprivation and deprivation effectively completely trumps age so that East Riding with a population of 333,000 is weighted down in the end to nearly 300,000 and the population of Hull which is on average 10 years younger with a population of quarter of a million is weighted to a higher amount. So that the much younger population of Hull gets £1,800 per head and East Riding of Yorkshire has a funding of just over £1,200. So there is 50% more money goes to Hull than East Riding although East Riding is sparsely populated, rural and older. Is there any justification for that gross anomaly when according to everything I have seen and read, age far more than deprivation is the key to our health needs?

RM: First off, if you look at the current formula it doesn't do two steps of weighting for age and then weighting for deprivation. It is exactly the same step so if you disagree with the weighting on deprivation, let's say for poor health because the formula uses deprivation as a proxy for poor health and sometimes we use the poor health indicator itself, the poor health indicator itself would work just as well, it's just rather easier to get data on deprivation than data on health status. They need also to knock out the age weighting. The CARAN formula does the same workout simultaneously. So the part we'd have to disagree with on that basis would be the health inequalities adjustment. The second, if you like, objective of the formula is

the bit that is difficult because the first part all works on the same basis. When one half of the formula falls over...I can't really say that it's one half because I'm falling into the trap of saying there are two halves of the formula, because there isn't, the CARAN formula is one formula...

GS: But there's 50% more per head in Hull than in East Riding although the population in the East Riding is older, although the number of people over 60 is higher, the number of people over 80 is much higher and increasing all the time and in Hull they had surpluses when the East Riding had deficit and they ended up buying a yacht. The PCT in Hull must have been working out where to spend their money. What justification can there be for 50% more for an area that has got a much younger population when age is the key driver of need? That is the big simple question? I may not be getting the exact terms and where it fits in the formula, but that's the outcome, isn't it?

RM: It is, but I'm afraid the academic evidence given is that areas of very very high deprivation and very very poor health status also leads to a demand for health care. Solid as the evidence is on age, it's also pretty solid that poor health leads to a higher demand for health use.

GS: Reviewing the academic literature it appears that anything not produced by your department mostly points to the opposite direction, maybe I have been reading the wrong things but we will hear from some academics in the next session.

RM: And I would hope the academics would give the balanced view that there is a lot of evidence that poor health leads to higher demand for health care. I should also say that the deprivation element – you are right, on average it works against rural areas, but that's a pretty broad average. County Durham is a rural area that benefits and also benefits in the health inequalities adjustment, as does the whole of Northumberland. There are quite a lot of rural PCTs that do have poor health status and consequently also benefit from it and equally I should add there are an awful lot of urban PCTs who have very high health status and lose from it as well, so as its really targeting health not rurality, it's rather dangerous to keep on talking about the average.

GS: It's just trying to understand when we go through the complexities of it all, which perhaps explains why there's so little public engagement. It's having the lady who a few years ago contacted me, who works for NHS and needed a hysterectomy, scheduled for an operation at Hull Royal Infirmary but because she didn't live in Hull and she lived in the East Riding they delayed it for four months. Hull had the money but East Riding didn't so therefore the message went; you don't get the operation. How do we get past the complexity of these formulae to work out whether or not what looks like a grossly unfair allocation is grossly unfair or not?

PH: Just to come back to the inverse care rule. I accept there are a lot of people are in poor health in the inner cities. A proportion don't seek help in time. So if they don't seek help we are not incurring costs, though they may well score on all the things and load the formula up. The other thing is, it depends on what your formula looks at. People elderly and crumbling in the rural area are crumbling with things like

dementia which don't register on the scale in the same way as coronary heart disease does. Diabetes can't use that argument because it affects rural and urban but it's probably a question of what health indices are put in the formula, and I am not an expert on that. But if you want to look at edge-ism, go and look at places like Royal Shrewsbury Hospital – they run two waiting lists one for patients from Wales and one for patients from England. Now that cannot be right, we are all UK tax payers.

DR: My apologies for being late but I was discussing planning and regulations, so you've probably covered a lot of the issues but do please just tell me if so. You referred to market forces factor there, and coming from Cornwall that's an issue raised again and again because there are many things which it doesn't really matter where you are, they cost the same to provide. Now as I understand it, in this review that is being addressed. Are you able to sum up on market forces and where we are exactly?

RM: The changes to the Market Forces Factor did a number of things; I will try and focus on the ones that I think particularly affect areas outside of London. There was adjustment made for job responsibility reflecting the fact that the job titles might be the same for example in a rural area as it is in London but as we said before because of the often wider responsibilities in the rural [*RM: corr. ~~rural~~ urban*] areas, a more heavily loaded post, that will balance the market forces factor out of some of the urban areas and I think we see some of the benefits of that in Cornwall.

The other one that really matters is for areas which are somewhere within the commuting zone of a large urban area which is that the market forces factor used to have a lot of cliff edges. As you move from one roughly "local authority" area it would drop very quickly in steps; clearly people were commuting in and I think many of the areas surrounding London and the home counties and other urban areas were competing for the same staff as providers at the centre of towns so a smoothing change was made to the market forces factor such that it reduces all the cliff edges. The primary loser on that, in fact the only loser on that is inner London, everywhere else it ripples out across the country. Again around Birmingham and Liverpool you would expect to see much of the same effect with the areas effectively that you could possibly commute to or from will have their market factor forces raised and those are the biggest changes.

DR: You also referred to interactions with local authorities, I won't go into that other than there may be unfortunately coinciding factors between the two which means that funding is even worse. The issue also of historic debt problems, particularly now we've had PCT mergers and some which were ok coming together with some which weren't, has led to a historic problem being carried forward. That is exacerbated sometimes where you've got acute trusts and deals being done in some cases with PCTs to support sorting out the debt in the acute trust on a phased basis. The problem with that is if that isn't recognised, the work going on now, people who are in health need now are still paying for problems that went before, even when a lot of those problems were caused by the formula in the past. The issue there is that this move towards targets is being held back by this historic debt effectively, and the servicing of that. And while I know that the department has been very firm about

writing off debts, is there recognition in the formula that they are fighting hard to stand still let alone move towards the target.

RM: There isn't recognition in the formula but I don't know beyond the formula what else there might be either for the SHA or for the PCTs that are affected to manage that. I think on the wider issue we'd have to come back to you on what is the policy on inherited debt.

DM: You raised the question of the future census coming up, and you've made your estimates on that. I don't know whether the census will bring out statistics on deprivation but will certainly bring up statistics presumably on a larger ageing population. Do you have any guesstimates of where that is going to take us?

PH: We are seeing it in general practice. We can see it because each quarter they recalculate payments according to who is on the list and we all know what is happening with over 85s which are the real workload for the NHS; it's just mushrooming. I can't remember figures off the top of my head beyond the fact that it's something that policy makers have just got to get their heads around; they can't walk away from this much longer because the number of people who used to get a telegram from the Queen in my practice you could count on one hand its now so common that I've stopped looking at them and commenting; it's huge. It really is, and so the elephant in the room is the ageing population, a bigger population full stop, and the economy.

GS: Well on that suitably non-upbeat note we will bring this session to a close. Thank you to all of you very much for coming and for giving evidence to us today and we will move swiftly to bringing our next witness forward.

Second session – 10:30-11:30

GS: Can I welcome Prof Prof. Sheena Asthana, Professor of Health Policy, University of Plymouth and Prof. Matthew Sutton, Professor of Health Economics, University of Manchester and Prof Mervyn Stone, Emeritus Professor, University College of London.

As we know we are discussing the formula and it is a great privilege to have three such distinguished students of this astonishingly complex and difficult issue. If you are all happy I would ask you to make brief introductory remarks any key messages you would like to give to this All Party Group. In a sense we are addressing that there will be a general election coming up and whoever wins the election there will be new ministers starting and a new look government and so we need to be clear about what messages we send the incoming government in terms of what needs to change. Perhaps I will start with you Prof Sutton.

MSu: Thank you very much. I only caught the last half an hour of the previous session but I think you've already picked up what was going to be my main comment which was that we all need to remember how multi-variable this exercise is and so you will know that the formula accounts for population, for age, for additional needs, for the market forces factor and that when we look at the figures on allocations what we are really looking at is ministerial decisions on the difference between what an area is allocated and what its target allocation is. So whilst a lot of the figures discussed may look like they are driven only by age or driven only by deprivation you need to remember that they are driven by loads of other things some of them being analysis and some of them being ministerial decisions.

You've already talked about the lack of community services data – that was one of the things I was going to emphasise; that we do need more data on community services. That seems to be coming through in mental health but I'm not sure there is progress in other areas. The only other thing I thought in terms of reading the evidence which has been assembled for this session was, I think there is more that could be gained by comparison of the formula used in England and the formula used in Scotland. The formula used in Scotland has a very explicit cost adjustment for rurality and I can go into that as I was involved in that work, but I think there is a very clear distinction in the Scottish formula probably reflecting its geography between increased volume of services and increased cost of services and a separate analysis of those two issues in the Scottish formula.

GS: Is the bigger issue rurality and the additional cost issue which we've talked about or is it age? Because rural areas tend to have an older population. What is the bigger distortion, is it the failure to take into account the bigger cost of services in the rural areas or is it the fact that age is not given the allocation it properly deserves according to the burden of disease?

MSu: I don't believe there is a problem with the way age is treated in the formula. I am clear on that. I think there is a risk that we are distracted by variables that are correlated with rurality. I think there is much more to be learned by looking

explicitly at rurality - the role of rurality in the formula; does it increase or decrease the volume of services, and does it increase or decrease the cost of providing that given volume of services.

MSt: It is interesting to hear about the Scottish Arbuthnot formula but I think the log jam that we have here in England needs to be broken: the ice needs to be broken. The basic fact, that affects the clash between looking at the outcomes and all of this very technical discussion about an apparently scientific formula, is that the formula is rubbish! I set out a case for that in the booklet Failing to Figure, if you would care to read it. It's not too difficult: there are 19 pages in it about the formula which are addressed to laymen. I would like to be here as a representative of the Royal Statistical Society, but I can't do that because I am no longer at the centre of the Royal Statistical Society, I no longer have many contacts, but I do have general support from all the statisticians I talk to.

So it's clear there is a clash between our professions which should have been engaged right from the start of this problem. Because what we are dealing with here is not a specialized econometric problem that only econometricians can solve, but a general problem of mathematical statistics which should have brought in thinking statisticians at an early stage. I am not putting myself forward as the thinking statistician here. I can refer, however, to the world's top statistician who wrote to me in 2006 to say "I have read your submission [to the Health Committee] with interest. You make a strong, overwhelming I think, case that the present allocations are irrationally based". Now you may question who this individual is, but I am prepared to reveal who he is to any bona fide inquiry. There are other comments of this sort. But that is just an aside to the professional problem that we have here: that a profession that should have been involved has not been involved.

On the issue of these formulae I take it, Mr Chairman, that you were talking about the CARAN formula when you said that age wasn't appropriately treated in that formula. In the move from AREA to CARAN, we've actually had a transition between two classes of fundamentalists. I was reminded yesterday of Peter Brook's new play 'Eleven and Twelve' where two groups disagreed on whether a sufic prayer should be repeated 11 or 12 times, and this led to almost warfare and other consequences. I regard this dispute between AREA and CARAN as a similar controversy – worthless. Worthless to engage in it at great length instead of looking at other approaches. Prof. Asthana does like ,I think, the CARAN formula because its output, I would say fortuitously, has outputs that (just looking at the basic formula - just the needs formula dispensing with health inequalities) are generally consistent with what she, a very dedicated researcher, has found to be what is suggested by an approach to direct measurement of care. Which is what we have to go to, and the case for that is what has been put to you today.

I don't want to say too much more, in fact I've probably said all that I want to say. I do believe that there is no case, at the moment, for deviating very much (certainly not in the direction in which it presently deviates) from 'equality' in a sense that every person in the country (in populations of 300,000 so you don't need anecdotes) gets allocated by the formula a sum which is constant. So everybody gets the same amount of money wherever they live and however old they are. And then you have

the health inequality thing on the side, to achieve those generally broader purposes. I think that's all I have to say.

SA: I pick up on your question about age, I think that really belies another thing. CARAN did, I think, address the problem that the AREA formula had, where with AREA you had additional needs effectively cancelling out the effect of age, so with the problem you had in East Riding you captured that exactly. CARAN by using a one-stage stratified model basically addressed that issue and CARAN suggested that there would have been a significant redistribution of resources toward communities such as yours towards older less deprived more rural communities. So if you actually look at the needs-element of CARAN it does involve a fundamental redistribution of resources. My question on what is the big issue to take into the next government is; On what basis the decision was made to ignore that academic evidence and to, instead, ensure the current allocation is exactly the same as the AREA allocation. So in other words the value judgement has been made to maintain the status quo despite the fact that the review that the Department of Health itself carried out found that that status quo was deeply problematic in terms of achieving the objectives of equal access for equal means.

GS: How radical is CARAN?

SA: A paper has been distributed which if you look at rurality for example, and remember this isn't including health inequalities adjustments. If you remove health inequalities adjustments and just look at equal needs for equal care, 10 of the most rural PCTs would have gained about £92 per person. That is really quite significant, it's a gain of about 7%.

GS: So in Hull and East Riding, then East Riding would move from £1200 to just under £1300 and Hull would still be getting £1800 with a population nearly 9 years younger?

SA: No, according to CARAN, if you didn't have such an enormous health inequalities weighting, if you just look at equal access to equal needs alone, your most deprived areas would have lost out, and overall fall of about 9%. But this would have been impossible to implement because what CARAN would have resulted in is a fundamental re-distribution of resources which would have caused such turbulence obviously you can't do that. The problem I have is, and I have written a book about health inequalities and I might come out with the case for rural areas but I have my politically correct hat on as well. My problem is where this figure of 15% was plucked out. And if you did the analysis what this what this figure effectively does and in fact there is a quote from Ben Bradshaw himself – being absolutely honest about this - Ministers decided to apply this formula at 15%, quote; "this keeps the distribution of funding between the most and the least deprived areas in line with the previous formula". There was an absolutely explicit decision to maintain the status quo. Now my problem really is; why conduct a review if you are then going to ignore its findings?

GS: How long standing is this current bias? I don't know for instance in my East Riding and Hull comparison what the situation was say 15, 25 years ago, is it long standing or a New Labour creation?

MSu: Could you clarify what you mean by bias then?

GS: Following on from Prof. Asthana who has suggested that she felt that CARAN, rather fortuitously or not if we go with Prof. Stone, better reflects needs according to Prof. Asthana's work looking at what the burden of disease is, if that is the right expression, I know being with academics I sometimes get my terms wrong. When Ben Bradshaw decided to apply the 15% to keep things pretty much the way they were, how long have things been "like this", whatever that means.

MSu: The formula has been changing regularly since 1976 each time that the research is conducted it tends to be more comprehensive, it includes a wider range of activities, differences in the costs of different procedures or different interventions are better costed, population are better counted. So...

GS: Prof. Stone seems to be suggesting that all formulae he has seen so far are rubbish and we might as well split the money evenly between the population apart from some fairly small adjustments at the edges. He says that would be fairer than what we've got now. Has the difference between the lowest per capita allocation in the country and the highest per capita allocation in the country, varied enormously over the years?

MSu: Over time each of the adjustments has become more sensitive. So the sizes of the age adjustments have been getting larger over time, the variations between areas in the market forces factor were increasing over time until the last two years and the size of the adjustment for the variations and additional needs, deprivation and morbidity, they were getting wider over time until this most recent review when they have become narrower over time.

SA: I think it's quite interesting that the chief economist report on deficits was raised by the Department of Health representative. It suggested that the introduction of the AREA formula wasn't sharp enough to bring a sharp enough change to be brought up around deficits. One interpretation of that could be you have had systematic underfunding in your older rural areas for some time. I think there is evidence of that.

GS: How long has this been the case?

SA: I know because when I was writing about this stuff probably in the early-mid 1990s there were certain concerns about underfunding in rural areas for various reasons and again it's because at the time needs indicators were more sensitive to urban needs than to rural need and a whole range of things like that. I think what AREA did do was widen the gap between your most deprived community and your least deprived community and of course as rurality is associated with that, there was a definite kind of widening of that gap during that period, wasn't there?

MSu: The area formula was introduced quite slowly actually and so my understanding of that issue of deficits is it was too soon, but it wasn't until about 2005-06 that AREA really started to have an impact on allocations. One of the things we need to be clear about is the adoption of the formula and how long it takes for that formula to start to really influence allocations and that is this pace of change policy

SA: But what I am suggesting is that systematic underfunding had been going on for quite some time, because there definitely is an association between the level of funding and the risk of deficits – very strong association. Unless that's completely coincidental?

MSu: You talked about some of that evidence earlier about whether the deficits were in the acute sector or in the PCTs. The evidence is not that strong in that case.

GS: Prof. Asthana does seem to emphasise that funding for older rural populations does seem to be inappropriate as compared to younger urban populations. I am trying to find out if that is the case.

DR: To be quite specific, there are a number of indices that tend to favour urban areas over rural, and you make that point as an aside in your references to work done in the 1990s. Representing an area that is rural and is also one of the lowest income areas in the country, we get convergence funding from the European Union because we are that much poorer than the average let alone the rest of the country. What sort of indices are you talking about that automatically favour urban over rural?

SA: I was actually referring to the past, If you look at the formula in the 1990s they used a number of indicators which I think potentially worked differently in difference geographical areas, I wouldn't argue that was the case anymore.

DR: My point about that is, because of the DoH won't writes off debt for areas', PCTs and acute trusts which have debt that has accumulated over previous era, they have carried those forward over to now and so those inequalities are being worsened by that. So if you could just take a moment to highlight what those areas were which favoured urban over rural areas, because we're still trying to fix that now.

SA: I actually think that is a distraction. If you really look, for me really it's strongly about age. It comes to this concept about poor health status which again was raised before. There is a difference between health inequality and having a low life expectancy, high rates of premature illness in a particular community, and need for health care. Any such community, if that population doesn't move out, which it probably will as it gets older and more affluent, will have an enormous need for health care in 30 years time but at the moment poor health status doesn't actually mean high rates of crude illness and there is such a muddle going on here. So that is one key issue I really wanted to get out there, that deprivation doesn't necessarily correlate with high rates of crude illness. Sometimes you can get very affluent areas, but because they are so ancient they are simply really rather ill so there isn't a strong association between poor health status, which we keep on focusing on and the need for healthcare. In the rural literature we spend quite a lot of time looking at problems of how to measure pockets of deprivation, how to get appropriate

indicators, the ways in which some indicators work differently in different areas, and that's a really important issue but for me its peanuts compared to this big issue of age.

I think that we distract ourselves sometimes; that the rural community distracts itself by focussing on transport etc. Transport is of course important, but I think that additional needs adjustments are fairly small scale compare to the absolutely central issue we've got now which is the balance between health equity and healthcare equity. The fact is that this has been going on for a long time, we've now exposed that, it's become transparent, but the good thing about the CARAN formula is that we can now at least say "well that's how much this formula says areas ought to be getting for people with equal need for equal healthcare, this is how much they're not getting because of the size of the health inequalities adjustment". But that's what we should be focussing on. That's the big issue here.

DR: I'd simply say that certainly in some rural areas it's not just pockets of deprivation, it's not just the little estate on the edge of the village, it's whole towns. So I just wondered....what you're talking about today is particularly housing conditions etc. which have influence the formula historically but you don't think are important going forward? So if new communities have come into an area, that might not be reflected until after they've left?

SA: There are many rural areas.....things like employment...I mean we know that in rural areas there is underemployment and seasonal employment, and self-employment, there's a whole range of issues which aren't necessarily captured in the statistics....benefits data etc....car ownership is a classic one and we've mentioned that as well....I do think that the set of indicators that are currently used are better....I mean, Mervyn would argue that this is all completely moot anyway; a witch's cauldron of regression analysis which yields meaningless things, Matt would probably say exactly the opposite, and I'll sit somewhere in the middle.

MSt: I think the die was cast in the wrong direction for the whole methodology by the introduction of utilisation-based approaches by York in 1994. I got entangled with this farrago in 2002 because I picked up a public health report from Hillingdon which was tremendously interesting in that it pretended to be able to move resources from one electoral ward to another on the basis of four deprivation measures of the kind which Prof. Asthana was just referring to. I was questioning this on the basis of local knowledge; my wife was a councillor in Hillingdon, so I knew something about the area. A Director of Public Health was saying she was looking for national guidance on this. So I thought "At the national level are they using formulae?". Within a week or so, I looked at the sources and found that they were, and it was horrifying. And from then on for the last 8 years I've been pursuing this mission to persuade the English to rethink this and not get involved in obscurantist discussions about this or that aspect of the formula.

A revolution is needed to break outside this mould that has been set by the Department of Health policy makers. To my mind if you read to the end of Failing to Figure you'll find out why it's been said that there are defects in the contractual machinery of departments. That's where I would put the revolution. As far as the

resolution of this thing is concerned, I think it needs to go further than Prof Asthana has done (she's at the halfway house to what I would call 'direct measurement') and go the whole way and get to know what's happening on the ground. Just as some of the witnesses have said, specifically the spokesman for GPs; we need to find out what's happening in reality.

BB: Can I come back to the formula? Which I think all 3 of you have suggested and indeed the early comments we heard have said it's not perfect or it's not working and needs reviewing. But then a comment was passed that we can't really have major upset, and if a change was passed there'd be a major upset, so I'd like to pass that thought to you. And in fact any change which we make takes so long, so it's rather like a ship on the ocean; if you want to put the brakes on it doesn't turn around very quickly. So could I have your views as to what changes you would like to see happening to enable us to have better healthcare, particularly regarding the ageing population. I think it's one of the biggest challenges we face, there are certainly going to be more of us. So really it's a question of the formula, AND the review, AND if we changed it what would you change it into and how quickly can that happen?

MSu: Prof Stone has been pushing us hard for a number of years, and I actually think that's very good even though it's the first time that he and I have met. I don't think he's reassured by the fact that there are a lot of people involved in this exercise. There was a lot of scrutiny involved in this exercise, and there are a lot of people committed to it. But that is the thing which is key for me. In terms of what I'd like to see developed into the formula, I actually think we're quite innovative in terms of the research teams which designed the formula. I think that the advisory committee received a lot of very varied advice, and actually perhaps the way in which we developed the formula was a little bit too quickly for policy-making, so there must be limitations put on it in terms of being too innovative.

My only concern about this current push that we should go to direct measurement is that I don't think it's feasible. And it's not that I don't think it's feasible because I don't think we can get the data. But if we look at how hospitals are paid, for example. Hospitals were paid of buckets of activity, where we had to have 550 different categories to be able to get at what the resource needs were. That wasn't sufficiently refined so there are now over 1000 categories for HRG4, and that's just once a patient has got through the door. That's how we need to classify them to be able to accurately measure how much of the resource they're going to use on this particular visit. So if you imagine that we want to do the whole population. And we want to do their entire healthcare needs over the period of a year, we are talking about a very very major exercise. So direct measurement sounds very attractive, but if you're worried about this being an industry already, it could become a very large industry indeed.

BB: And do the other members of the panel have a comment on that?

MSt: I'd like to comment on that directly, because I think it betrays the lack of imagination, if I may say so, on the idea of sampling. The statistician, Prof Keene, I quoted earlier is very keen on using efficient sampling as a way of dealing with

problems of huge amounts of data, records that are incomplete, and so on. I would recommend a direct informed approach by those with medical knowledge, to patients selected at random in stratified sampling preferably, of GP registered patients. That would be the first thing I would look at, with an analysis of what call the patients made on NHS services in the previous year. And the advantage of that type of approach is that it is self-correcting as far as biases are concerned. Admittedly it might be a difficult exercise, but if you narrow it down to samples you can actually do it with limited use of resources.

SA: As a matter of fact, I've just completed a two-year project which just did that very same thing, Mervyn. We've aligned direct estimates with case mix, clinical estimates of need, and we've done indicative budgets for mental health for practice-based commissioning. The department of health has paid for it and we've just completed the project. But I think there are alternatives, the results were credible, and they are being used, but I have a suspicion they're tacking a health inequalities adjustment onto them because the distribution wasn't quite as they would have liked it. But in other words it is possible to do that, I think it's challenging.

It's very difficult to argue your own approach, but I'd like to see slightly greater debate I think perhaps amongst not just the academics involved in this but the department as well. Matt's right, things do move on quite quickly, and I think there is a philosophical debate to be had here about whether utilisation is an appropriate basis on which to measure need. It's quite a fundamental point about whether there are credible alternatives etc. I'd like an awful lot more honesty about what's just happened with this current adjustment, and an explicit debate about how we cost up what is the most appropriate way of addressing health inequalities? As it's obviously an important policy goal. Is the 12.4% of NHS spending used in this area an effective use of money? Is it going to address health inequalities or should we be directing it somewhere else? If not, should there be greater redistribution to address the underfunding of elderly areas? These are fundamental areas but we need to be raising them and having the debate about them. Unfortunately the debate about these important issues has been clouded by a misunderstanding of what health status means, a misunderstanding of the goals of health equity and healthcare equity, and this tendency to believe that because an area's deprived then that's synonymous with healthcare need when it isn't! We need to be more honest and more robust about that. And that's what I would like to see; a little bit more debate.

BB: And how long will it take to turn the ship around?

MSu: I think Sheena's work is exactly an example of the innovation which I do think is there and I do think we innovate, we do produce new methods. Sheena and I could have a debate about whether her approach is sensitive enough. As I say, we can quickly establish 1000 different categories of need, but my understanding is that you'll probably have less than 10 categories of need in your model. So I agree that we need to have this debate. I am a little bit worried about how hungry we are going to be for data. And Professor Stone's point about being able to do this by sampling people. Yes we could, but then we could only allocate resources to a sample of people, because you would need to have that information on everybody to be able to allocate resource to those individuals.

MSt: All you need is an estimate for populations of 300k. You should be able to get reliable enough estimates in order to allocate to populations of 300k something that's probably better than the present stuff.

SA: And the point is that you don't need to have estimates for every single HRG, the primary resource allocation makes allocations to populations....you can do it in a couple of different ways....I think the point is that there are alternatives. There is a debate to be had about whether they are credible or not, but there are alternatives. But at the moment I don't think that there is an appetite for those alternatives. If you look at ACRA it's very strongly wedded to a utilisation regression-based approach. Most of the people who sit on ACRA are linked to each other in some way that do that type of research. It's quite a closed little field out there, and I think it's quite difficult to actually make people reflect.

MSt: How can we look at ACRA when the windows are blackened out?

GS: OK, let's bring Philip in here.

PD: I find this very very interesting, and I'm not an academic I have to admit, and I was rather alarmed, having read Prof Stone's report before this meeting, as to whether or not we'd be able to understand what the professor was saying. But you have spoken with layman's simplicity, for which I am grateful. Can I just take this back to the point that was made by Mr Murray from the DoH about the difference....your work, Professor Asthana, about PCTs....and when I put to him that the disparity in funding has become apparent at a PCT level, he more or less dismissed the claim by saying that when you marry up the bulk of the spending in the acutes, actually the disparity disappears. Are you able to respond to that? And tell us whether you think he's talking sense or not?

SA: I was quite interested in his comment about the health communities, because I do remember when I gave evidence at the health select committee on deficits, there was a very interesting map that had been published in the evidence in black and white demonstrating that there is no relationship between geography and deficits. And looking at it I thought, "that's interesting, let's reproduce it in colour", so we did and it's stark: north/south. There is a stark difference; the south, including London, are more likely to be in deficit than the north; the north, and the north-east in particular, tends to get more per head. There was an association, and we could debate this for years, but at the level of health communities, and I would argue that at the large regional level there was most definitely a relationship between deficits. So there's this business of PCTs and trusts cancelling each other out, but I didn't fully understand that argument, because there was most clearly geography going on there.

PD: You've given us some nice colour maps which are very clear, but they are related to the PCTs and certainly from experience in my area which is Shropshire, we had a deficit in the acute trust which was more or less matched by the surplus of the PCT over a period of time, so I did buy the argument locally, but the deficit was being shunted from one side of the health economy to the other, and that certainly is

what's happening now, with the PCT moving into deficit and the Trust moving into surplus. Where do we get an overall picture? You say that the department is putting out monotone maps, has anyone else done some work?

SA: I don't know of any work, and the point is that you can't really look at those any more anyway because they've been dealt with as an indicator of organisational stress, so we no longer have that indicator.

PD: But the per capita information which you've provided for PCTs, does that exist across the whole of the health economy? For example trusts?

MSu: The allocation is just for the PCTs, it's for the PCTs to decide how to spend that money.

SA: But I think what you can do is you can plausibly speculate and say that if a PCT has less money than you would expect it would require for its healthcare needs and the healthcare needs of its population and yet there is going to be demand on your trust for a certain volume of activity that you would presumably predict that there would be a risk of a deficit situation. Because there is a mismatch of funding.

GS: Talking about the qualitative issues. How does this, that's if you are right professor, how does the underfunding of some rural, older areas display itself? Is it qualitative, is it quantitative? If it's sadly out of synch with what's needed, how does that show?

SA: I've been arguing for quite a long time that the only way we can actually finally nail this, because there is no agreement, I have my view on this, Matt will have a different view on this, is to actually start to do vignette work or proper work on inequalities of access and utilisation according to use . There is surprisingly little research in the field. There are meta-narrative out there, there are sacred cows. We've talked about the inverse care law, and again I've done some work to do a systematic review of work on this and found that actually quite a lot of the research on inverse care would suggest that deprived communities use healthcare services to a lesser extent than you would expect them to. It's subject to statistical artefact; they're using the wrong denominator, you know there're real problems with the data; the evidence is very very problematic.

So I think that one way of understanding what's going on is to actually do some decent research to look at whether there are inequalities, using proper denominators etc. The other thing I think that may be happening, and this is another concern that I have, is that if I'm right, and I'll accept that deprivation will add additional costs in different ways: you've got co-morbidities which some, but not all, we're trying to adjust for, but you may have problems with being able to release people from hospital earlier because they don't have the support systems at home; There are a lot of very legitimate reasons why deprived areas might require more resources than might be implied by morbidity alone. And I'll accept that, but what concerns me is the size of the difference in funding that's now been carried for the last few years is such that I wonder if places which are receiving low levels of funding are now really struggling to the bone. There's really very little capacity in the

system to cut any more. Whereas you've probably got inefficiencies going on in very very well funded areas.

So that's the kind of qualitative difference that may be going on. A friend of mine works in a high-dependency alcohol unit in a deprived urban community and there's three of them working there and the other day they had not one client; and that is not an efficient use of resources, it's mad. So I think we need to start tying up these allocations, not just with equity, with access but also with some sort of efficiency measures as well, because I'm not convinced that at the moment we have an even map across the country in terms of direct efficiency, and what worries me is that in 2011, when we're operating under far harsher financial conditions, that there's just not going to be any flexibility in these relatively underfunded areas to cope with that. There's a cushion in your well-funded areas, which happen to be urban.

MSt: Prof Asthana has raised the question of deficit, which should be regarded as a symptom of an underlying problem. Since one of the earlier speakers mentioned the Chief Economist's defence of his analysis of deficit problems, may I draw attention to the bit I've put in to the booklet dealing with that? - which basically says it was rubbish to try to use his methodology to prove that it was a problem of management. I do think that PCT managers have been slighted by these allegations, which I would have thought would have been cause for litigation if the Chief Economist had named the individuals, if only on the basis of his improper analysis and his attribution of the deficits to mismanagement rather than to what Sheena is suggesting, namely that it is a symptom of an underlying problem which needs to be addressed.

PD: Earlier in your remarks, you said that should we introduce the CARAN-based approach overnight it would leave to such enormous problems for currently better-funded trusts. We talked earlier about the pace of change for getting trusts which are under-target up towards target. If we were to address the differential provided by health inequalities by reducing that element, have you got a proposition for how you would make that change and how fast could that go? On a reasonable basis to start bringing better equity...

SA: It's really very difficult. The problem you've got at the moment is that it's easier to redistribute when you've got a situation of overall growth in resources, but it's extremely difficult to do that when you've got either a decline or no growth at all. So I think it's a really impossible question. I can fully understand that it would cause enormous turbulence and difficulty to the system to actually follow through the recommendations of CARAN itself.

What I find intriguing, is that we're willing to slap on distances from targets when it appears that deprived communities are underfunded. We seem to be unwilling to do that when less deprived communities appear to be underfunded. And I don't think that we're consistent about this. And I don't have a particular axe to grind in terms of the nature of the communities, I would just like to see some consistency and some honesty about this. And I don't feel that the current adjustment is honest.

The first step that you can have though is the distance from target. You can accept the fact that you can't actually attain that target under the current financial climate. But what you can do is you can start providing an honest account to PCTs to suggest "look, you're probably not getting the resources that you require to equitably fund your healthcare needs, but you need to know that you're going to be working under harsh conditions, but we'll protect you perhaps, under the next funding round, we won't just have equal misery for all". And this is my real concern, and what we need to be aware of in 2011. If you assume that there is some credibility to the arguments that I am making re. CARAN, and we go for equal cuts across all PCTs, some are going to be able to deal with that better than others. And I'd like to see some active steps taken to ensure that there is an understanding that these PCTs, many of which happen to be rural and less-deprived PCTs, may be less able to cope with that harsh financial climate.

MSu: The brake I think on it is the decision which has always been there. Which is that no PCT will receive a cut in funding. And it's actually a cut in the level of funding, so populations may move away from areas but it's not the per capita figure which is protected it's the overall budget. And we shouldn't underestimate the scale of the task that's here. There's Richmond and Twickenham which is 31.5% above its target, there's Bath and NE Somerset which is sitting 24.5% above its target.

SA: That is its whole target as opposed to its CARAN target.

MSu: So there are some PCTs which are very very far away, and when you have very small amounts of increments to deal with, and no-one is going to lose money, you're talking about a very long process.

PD: Is that information publicly available, and do we have that map? Could we get that from you because it would be quite useful.

MSu: Yes.

SA: That is the target including the health inequalities adjustment, but you've got to question whether that is an appropriate target? We focus a lot on distance from target, but it's a meaningless concept if the target is wrong.

PD: And that's Prof Stone's argument, but in terms of what we're trying to achieve out of this report, it would be helpful that we produce a list of the CARAN proposal, the current proposal with health inequalities adjustment ,and then if we can compare that with what happened before this formula came in to see how individual areas have changed or not changed.

MS: Just to clarify; When you're making a comparison with what happened when the formula was changed, at the time that CARAN was adopted, there were a lot of other changes brought in at the same time. So the MFF was also changed and that had a substantially narrower distribution than it had had before. You also have the number of age bands being changed, so previously there had been 7 age bands in the formula, and there are now 18 age bands. Now that's the sort of thing which can result in a substantial redistribution of money towards the areas which have older

populations so there is quite a detailed exercise to be done to not end up with quite misleading statistics.

LD: As an alumni of UCL myself, I think Prof Stone is here a credit to that organisation. I feel that I can ask this question because I sit on the crossbenches of the Lords and therefore not politically minded here, and the question to each of you is a very simple one: Do you believe, for one reason or another, that the current formula is politically skewed or biased?

MSt: Well, we've had a quotation given to us about what Minister Bradshaw said. It seemed to me to be so.

LD: But looking at results? We are where we are, and the formula by almost common consent doesn't work fairly...

MSt: We know that there have been political influences. Even someone who isn't on the political spectrum is aware that these things have to be political. But it's more a question of the quality of the political decisions being made.

LD: They don't have to be political. The formula should start off by getting an objective result, and that principle should flow throughout.

MSt: "Political" with a small p! I think the political decision is made within the hierarchy of departments, in the way that they let contracts go out that are not open to analysis or dispute at a stage when it's too late. These disputes that we're having now should have been resolved right at the beginning. They should have been taking place in 1994. When experts disagree, we shouldn't plump for one set of experts, which is a political choice decided by the minister and his senior civil servants. You should admit that you have a problem and say "Go back and do it again, we'll open the doors when you put the white smoke up the chimney".

LD: The question is a very basic one; The formula should work with absolute fairness and equity should flow, the results therefore should be unchallengeable. I think that we have a formula which is flawed. I mean I can't put words into your mouth, and indeed I have not made my own mind up, but I do need to ask the question, which is; we are where we are with a flawed formula, do you believe the results give an unfair advantage one way or another?

SA: I can try to answer that. If we answer that, that's saying what is the difference? Who are the winners and losers? If you had followed through the implications of the CARAN formula? I think that it is undoubtedly the case that Labour strongholds would have lost and that Conservative areas would have won. I am sure that that is by accident rather than by design.

MSu: I mean, the Minister explicitly set the objectives for the formula, and Ministers control the pace of change following. Mervyn has said that he thinks different views were stifled or that particular people were chosen in 1994. But debate has raged about this since the 1970s and there has been lively debate about it. Clearly I am by implication slighted by that and I'm trying not to be offended by it, but I genuinely

don't think that there is political interference in how the research teams do their work whilst the objective of the formula and the extent to which it's implemented and the health inequalities adjustment, the scale of which was very clearly stated by the advisory committee to be a ministerial decision, I think that those three things very clearly are political. What is political is the decision to have a formula in the first place.

SA: The big political issue at the moment is the health inequalities adjustment. I think that the way in which the formula has evolved in the past has reflected difficulties of data and approach and a whole range of things and also it fulfilled expectations in terms of the understanding that deprived communities were the neediest. That understanding has been challenged, and I think fairly effectively challenged. What happened with CARAN is that this problem has become explicitly transparent, is that rather than acknowledging that CARAN perhaps revealed some inequity, there's been an ad hoc fudge. And that is my central problem with the current allocation; it's the political decision which lies behind ensuring the status quo, rejecting the findings of its own review.

GS: You said that you were sure it was by accident rather than by design. If the funding formula had come out and it had gone the other way and it had taken money away from Conservative areas and rewarded Labour areas, I cannot believe that we would have had the solution which we have. Because it's too consistent across education and various other areas; Deprivation is the universal catch-all which can be used as a model defence for straightforward political gerrymandering.

DR And not just Conservative areas, I feel I have to point out!

GS: And as you say, it's rough and ready and generalist, and sometimes it impacts on Labour areas, but fundamentally it entirely aligns with a political agenda. But is it possible for anyone to say that that's true without seeing the secret e-mails or reading the hearts of ministers? But you seem to specifically extricate them from that allegation by saying that it's by accident rather than design? Though I wonder if you are being diplomatic! One final point, to you professor Sutton. I don't know if you directly addressed the issue of whether deprivation in whatever form (I know terminology and where it fits in the formula is easy to confuse) is over-allocated in the current allocation of funding.

Because Prof Asthana was saying that the fact that you're going to have poor mortality in the long term doesn't affect your needs right now....if you're 23/24 and you don't have much else wrong, the likelihood is that you don't have much health need right now. And therefore it's not appropriate to be allocating money for health to that person for community hospital services when you've got a 90 year old however wealthy somewhere else who's not getting that money. Is there any truth in that?

MSu: I've been reviewing the papers on this recently, as I'm sure you can understand. So age is an individual variable. We can see that at an individual level it has a profound effect on the costs to the NHS. Deprivation we have traditionally measured at an area level. So essentially you're measuring those two factors at different levels and

then you're putting populations together and grouping them up into PCTs. The variation in age between PCTs is not as large as the variation in deprivation between PCTs. So it is consistent to say that, and the formula documents show this, that age is a stronger determinant that area deprivation whilst across PCTs you will still have the situation that deprivation will be allocated more resource than differences in age.

GS: But is it right? I want to know whether I should go back to my constituents and apologise for saying that they are being grossly and unfairly treated by 50% more money going to Hull than to them when they're older. If Professor Sutton was given sole charge of the allocation of funding do you imagine that you would come out with something pretty close to what we've got now? Would you look my elderly constituents in the eye and tell them that they're being fairly treated compared to people in Hull. Despite all of the complexities of the formula, that is the essential question that I'm interested in.

SA: Did you know that he IS responsible for the current allocation model, he headed up the AREA team, hence the sensitivities around this end of the table; We're being really critical of each others' work.

MS: Regardless of that, I would answer your question with a yes. I do think it's fair.

MSt: Can I just go back to the explanation that was given for this assumption? He pointed to the fact that when you measure the deprivation index, it has about twice the variation across PCTs that for the age profile index. That's a factual observation to do with the construction of those indices. To use the word 'determinant' though is to say that because something is twice as big as another then in some way it is the determinant of something. I think the implication is that he was suggesting it was the determinant of health costs and healthcare need.

MSu: I was defining my terms extremely carefully. I agree that we have to construct the statistic in some way to give it some meaning, but if you look at the proportion of the population who are income deprived and the variation across PCTs, and the proportion of the population who are 75 years and older across PCTs, then you'll find that the variation in income deprivation is much wider than the variation in the proportion of the population over 75. You apply the weightings to those factors....

MSt: ...then we come back to using the formula approach to justify the idea that these things do determine, which is a very weak justification.

MSu: No, I was saying why it was consistent to say that age was more important at an individual level, whereas we can measure deprivation at an area level if you put the two things together and you have mixed populations across PCTs, then there is much more concentration of deprivation in the PCTs than there is concentration of elderly people in the PCTs.

PD: Is there evidence to suggest that being more deprived leads to greater health need than being more elderly.

MSu: Yes.

SA: But here and now?

MSu: At an individual level, no that would not be the case. Saying "elderly" that sounds to me like an individual effect.

PD: But if 25% of my population is over 65, and I've got relatively low deprivation indices, or if those figures were reversed, is there any assessment...

MSu: Those figures can be produced from the exposition books, which is how the formula was published, if you want to run those kinds of profiles you can do.

SA: Or you can look at direct indicators; you can do synthetic estimates or you can use QUAF data. It's interesting to look at somewhere like central Manchester, where the population over 65 is something like 13%, it's a really young population compared to somewhere like East Dorset where you've got 28% over 65 plus a large percentage of really elderly people, and if you look at things like crude rates of coronary heart disease, cancer, diabetes, as you'd expect they are significantly higher in East Dorset. And that is totally what you would expect to happen, most lay people on the street would know that. So it is irrelevant that Central Manchester has really higher standardised mortality rates, it's got a much worse situation in terms of disability-free life-expectancy, and all the other indicators of health inequality. In crude plain terms it is not yet sick because it is an incredibly young population. And we can show that.

DR: So what you're saying is then that in public health terms in health prevention work, it has a real need, but in terms of acute care it's pretty low down, so are you saying that we ought to perhaps make more of a divide between those two areas of health funding?

SA: I think that we should be asked about the divide. I am concerned about Health Inequalities, but I'm not utterly convinced that pouring NHS resources into health inequalities is particularly the answer. When you pour quite a lot of this health intervention in, you can actually increase health inequalities, because the middle classes are more likely to take up smoking cessation programmes and things like that, so there is an irony to it. But what I'm concerned about is that we have absolute clarity about the relative roles of the NHS in providing curative services, in ensuring equal access to equal care, and that we know what the NHS should and can be doing effectively in its public health remit.

At the moment there is no clarity about the relative roles. We slapped a figure on with a public health remit because it just happened to suit the previous allocation and that's very very clear. And I'm not convinced that that's either an effective or equitable use of funding, and the other thing that really is important to point out is that the size of the health inequality weighting actually changes what you get for your healthcare needs. It's not a zero-sum game, this is not an addition, as you change the size of the weighting, everything else changes as well.

And there are quite a lot of PCTs that are actually getting less money than CARAN itself said they should in order to equitably fund their healthcare needs. In other words they're getting LESS than CARAN said. Now that really raises alarm bells, and I think there's something really fundamental going on here. For me the NHS is a universal service and it doesn't matter if you're rich or poor, affluent, old or young, you have a right to that service, and I really believe fundamentally in that tenet, in that principle, and it strikes me that if we start to shift resources to areas which have lower healthcare needs but are more deprived (and it's a lot of money, maybe £10bn, and we don't know exactly what we're spending it on), then we're chucking that principle of universalism. We're somehow implying that less deprived people are less deserving of this service and that for me is transferring the NHS from a universal service to a residual service for the poor, and that's what you should be seriously worried about, it's critical.

GS: I feel that after that rather passionate defence, we should allow Professor Sutton to reply, so we'll allow the professor for the status quo to have the final word.

MSu: It was just to say that in terms of this compartmentalising of the two aspects of the formula that the NHS can work on health inequalities not just through health interventions, and I don't think we should misunderstand that that was what was going on there. The NHS reduces health inequality through the provision of health care. So the evidence now suggests that the supply of GPs we put into an area, the more we spend on all aspects of cancer treatment, the more we spend on all aspects of coronary heart disease, we improve health in those areas.

So we shouldn't think that this is a lost cause and all we can do is public health interventions, and there's not enough evidence for those public health interventions. The allocation of NHS resources to areas has an impact on that area's health. So we should compare that 15% (£10bn) with the cost of a leafleting campaign, the 15% is there because we are saying that the core NHS resource should be directed towards reducing health inequalities.

SA: CARAN includes an adjustment for unmet need.

MSu: No it doesn't.

SA: It does, certainly around the ethnicity variable it does.

MSu: It doesn't.

SA: We'll have to argue about this later.

MS: We will.

GS: I think it's absolutely appropriate that we should end on a point of argument, because I think that this issue will rage on. But I'd like to thank you all for coming and giving evidence today. I think what we can all agree on is that this areas needs greater attention, needs greater understanding in this place, it needs greater debate amongst the public. Because for too long, an issue of such importance to the public

in terms of both their perception and the reality of their lives, there hasn't been sufficient attention and understanding, and I thank you all for giving evidence to us today.

All: Thank you.

PD: Could I also thank the professors for providing us with some written material, I hope you're happy for us to publish this as part of the report?

All: Yes.

Written evidence; Health

Professor Sheena Asthana (University of Plymouth) and Dr Alex Gibson (RAE Consulting)

Funding Implications for Rural PCTs of the new NHS Resource Allocation Methodology
Report to the All Party Parliamentary Group on Rural Services, February, 2010.

Introduction

1. In December 2008, the Advisory Committee on Resource Allocation (ACRA) published a series of recommendations to Ministers on changes to the weighted capitation formula which is used to inform Primary Care Trusts (PCTs) revenue allocations. Recommendations for the new acute formula were informed by research conducted by a team from Brunel University.

2. Their report, *Combining Age Related and Additional Needs* (CARAN)[66] responded to a number of concerns about the Allocation of Resources to English Areas (AREA) formula (which distributed NHS funding to PCTs from 2003/4 to 2008/9). Despite this, overall allocations to PCTs remain much the same. This is because the introduction of a new 'health inequalities element' effectively maintains the *status quo*.

3. Few would deny that tackling health inequalities is a key policy objective, on grounds of both social justice and the need to deliver longer term cost savings to the NHS. However, it is legitimate to ask whether the new health inequalities element of the weighted capitation formula serves the interests of either equity or efficiency:

    a. First, the weighting given to health inequalities is based on political judgment rather than a robust assessment of the costs of effectively tackling inequalities in health.
    b. Second, while it is difficult to establish precisely what percentage of the NHS budget has been directed towards public health/preventive activities in the past, data suggest that there is a significant gulf between previous expenditure and the new health inequalities budget (which accounts for around 13% or £10bn of PCT revenue).
    c. Third, it is important to note that, due to the nature of the weighted capitation mechanism, the inclusion of the Health Inequalities element means that most PCTs in less deprived and rural areas receive less than

[66] Morris, S., et al. (2007) Combining Age Related and Additional Needs (CARAN) Report; 2007 review of the needs formulae for hospital services and prescribing activity in England. DH, RARP 30. http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_4108515

CARAN itself suggests they need to equitably resource the health care needs of their populations.

4. There are no guarantees that PCTs that are receiving large health inequalities allocations are directing these funds towards preventive and public health activities rather than using them to maintain existing acute services. Such use of NHS funding would both weaken policy drivers to improve efficiency *and* reinforce inequity, with less deprived and rural populations receiving relatively less funding for their health care needs than their more deprived urban counterparts. As generous health inequalities budgets provide a potential mechanism for trusts to cushion the effects of future spending cuts, this element may also produce an uneven playing field with respect to the ability of PCTs to operate under harsher financial conditions.

The CARAN Formula

1. The CARAN report responds to a number of key concerns about the AREA formula. Of these, the use of a "two-stage approach" to incorporate age-related and 'additional needs' indices into the weighted capitation model had been a particular focus of critique. Because the geographical pattern of social deprivation is negatively correlated with that of age, more affluent areas having older demographic profiles, the age- and additional needs indices tended to oppose each other. More often than not, the additional needs element outweighed the influence of the age element in the AREA model, so that the positive effect on funding of a relatively old population was cancelled out by the negative effect of affluence. This occurred to such an extent that PCTs with more ageing populations would usually have been better off if there had been no weightings at all[67].

2. In the new CARAN formula, age and additional need are calculated in a one-stage model, stratified by age. Resulting allocations suggest that the AREA formula did indeed overestimate the health care needs of younger deprived and urban areas and underestimate the needs of demographically older and rural areas.

The distribution of resources for health care needs: AREA vs. CARAN

1. On the basis of the 2009-10 Exposition Book[68] it is possible apply the new *CARAN* methodology and determine PCT-level allocations according to healthcare needs only, i.e. excluding the Health Inequalities element of the formula. These allocations can then be compared with 2009-10 Baseline Allocations which represent each PCTs previous allocation (i.e. the *AREA*-based 2008/9 allocation) adjusted for population and other inter-year changes.

---

[67] Stone, M. (2007). Supplementary evidence (Def07A). In House of Commons Health Committee, *NHS Deficits: First Report of Session 2006-07 Volume II.* London: The Stationery Office Limited, Ev 168-70; Asthana, S., Gibson, A. (2008). Health care equity, health equity and resource allocation: towards a normative approach to achieving the core principles of the NHS *Radical Statistics* 96:6-26.

[68] DH (2008) *Exposition book 2009-10 and 2010-11*. http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_091850.

2. As anticipated by those who argued that the *AREA* approach privileged additional needs relative to age-related needs, applying the new *CARAN* methodology results in a very significant redistribution of resources. Thus 0 below compares PCT-level AREA-based baseline allocations with CARAN 'need-based' allocations. At one extreme, City and Hackney would see a 17.7% reduction in its allocation; at the other, Leicestershire County and Rutland PCT would see an increase of 11.1%.

The pattern according to deprivation

3. In general terms, as illustrated by 0 below the application of *CARAN* alone (i.e. without any additional Health Inequalities element) would result in a significant shift of resources away from PCTs serving more deprived populations and towards those serving more affluent populations. The scale of this redistribution is such that across the four least deprived deciles there would be a 4.2% increase relative to the previous year's AREA-based allocation (£56.94 per capita), whilst across the four most deprived PCTs there would be an overall fall of 5.5% in the allocation (£89.98 per capita).

Fig.1: AREA-based Baseline versus CARAN 'Needs Only' Per Capita Allocations

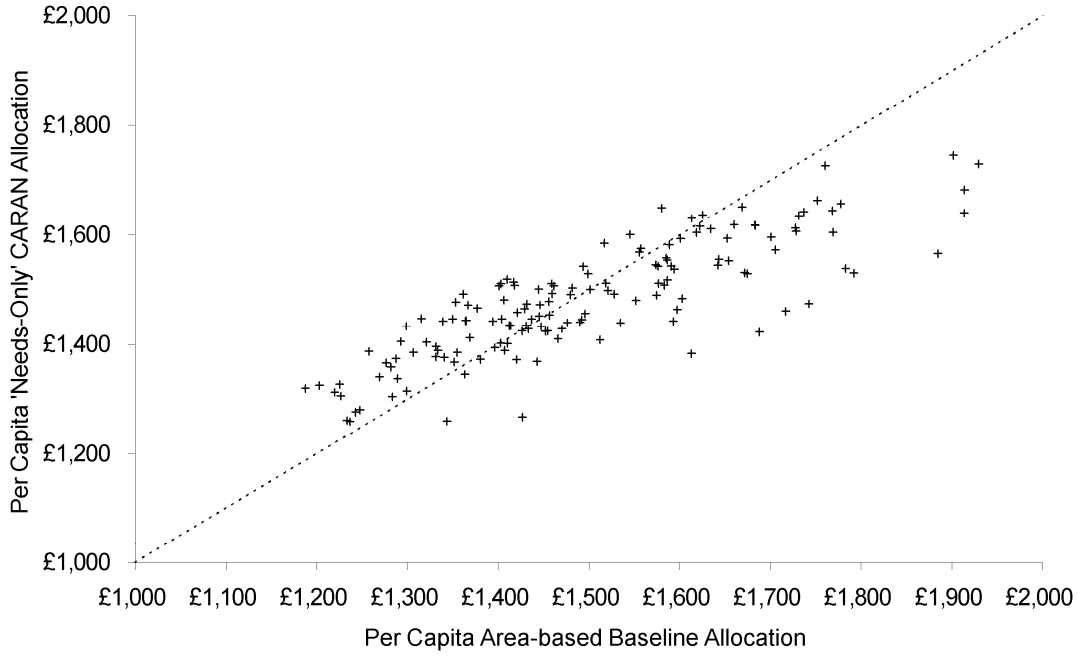
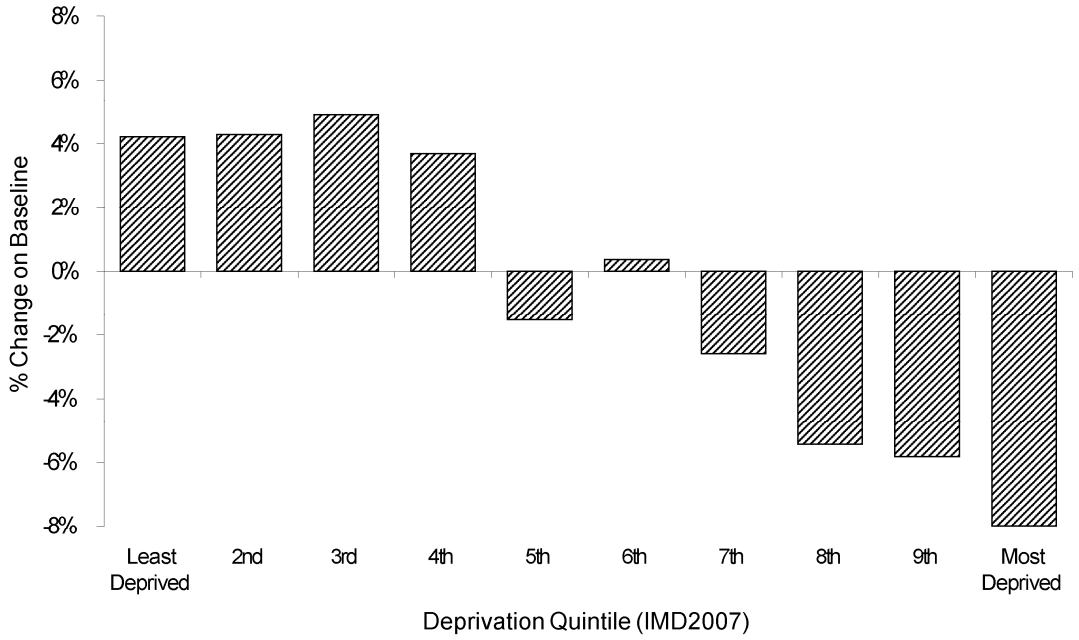


Fig. 2: 'Needs Only' CARAN Allocations relative to AREA-based Baseline Allocations; by IMD2007 Deprivation Decile

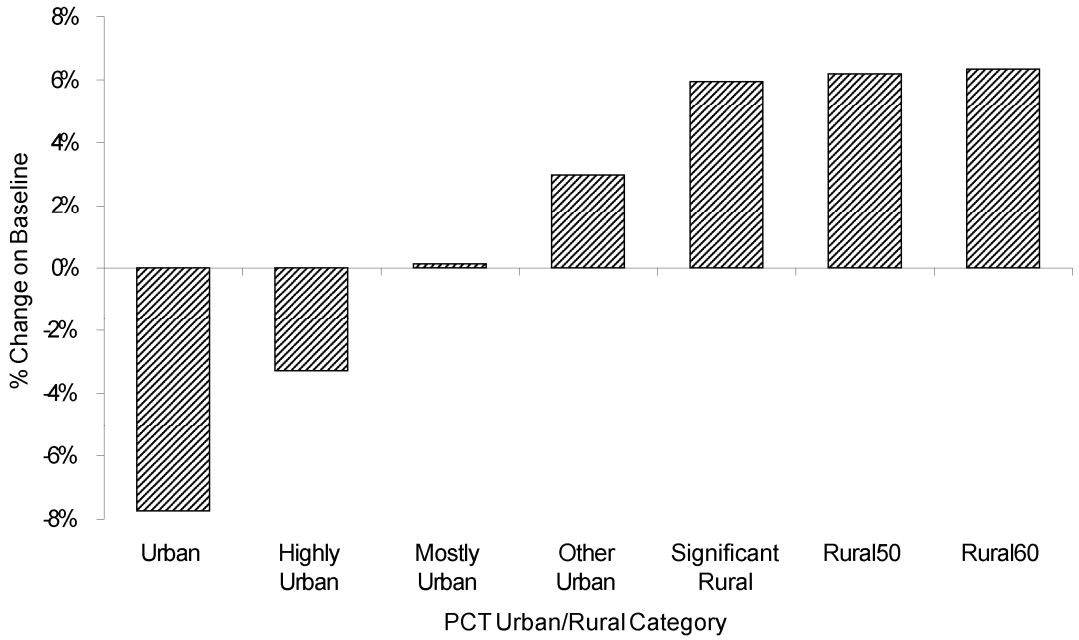


The pattern according to rurality

1. A similar redistribution of resource is evident when viewed in terms of rurality, as illustrated in 0 below which divides PCTs according to the proportion of their population living in urban areas[69]. In this case, the 7.7% reduction in allocation for the 36 PCTs which have all of their population living in urban areas (pop.=9,367,786) represents a loss of £1.19 billion (at £120.08 per person), whilst the 6.3% increase in the allocation for the 10 PCTs with more than 60% of their population living in rural areas (pop.= 5,127,306) represents a gain of £442 million, or £86.28 per person. It needs to be emphasised that this redistribution follows the introduction of a more reliable methodology for assessing the healthcare resource needs of populations. It establishes, in other words, an allocation which more adequately supports the goal of providing equal opportunity of access to health care for people at equal risk.

[69] See http://www.apho.org.uk/resource/item.aspx?RID=53312. ***Urban*** = 100% urban (n=36); ***Highly Urban*** > 95% urban (n=33); ***Mostly Urban*** > 75% urban (n=31); ***Other Urban*** > 60% (n=19); ***Significant Rural*** < 60% urban but < 50% rural (n=13); ***Rural50*** >50% but <60% rural (n=10); ***Rural60*** >60% rural.

Fig. 3: 'Needs Only' CARAN Allocations relative to AREA-based Baseline Allocations; by Urban/Rural Category



2. The implication, of course, is that the AREA-based formula has significantly underfunded Rural PCTs year-on-year since its introduction in 2003-04. This is precisely what we argued in front of the Health Select Committee in 2006[70]. Given that our case was later dismissed by the Chief Economist at the Department of Health[71] on the grounds that the introduction of a new formula based on the AREA report "does not provide a sharp enough change to budgets to make a significant contribution to explaining the emergence of deficits in 2004/5"[72], one conclusion must be that this systematic under-funding is a long-standing feature of NHS allocations.

3. The resulting geography of implied PCT-level redistribution is shown in figure 4 below, emphasising the degree to which rural areas have been historically under-funded relative to needs. This does not, of course, mean that the 2009/10 allocation has resulted in such a shift in resource, for this settlement included for the first time an explicit Health Inequalities funding stream. This, as discussed below, has a marked impact on the final allocation.

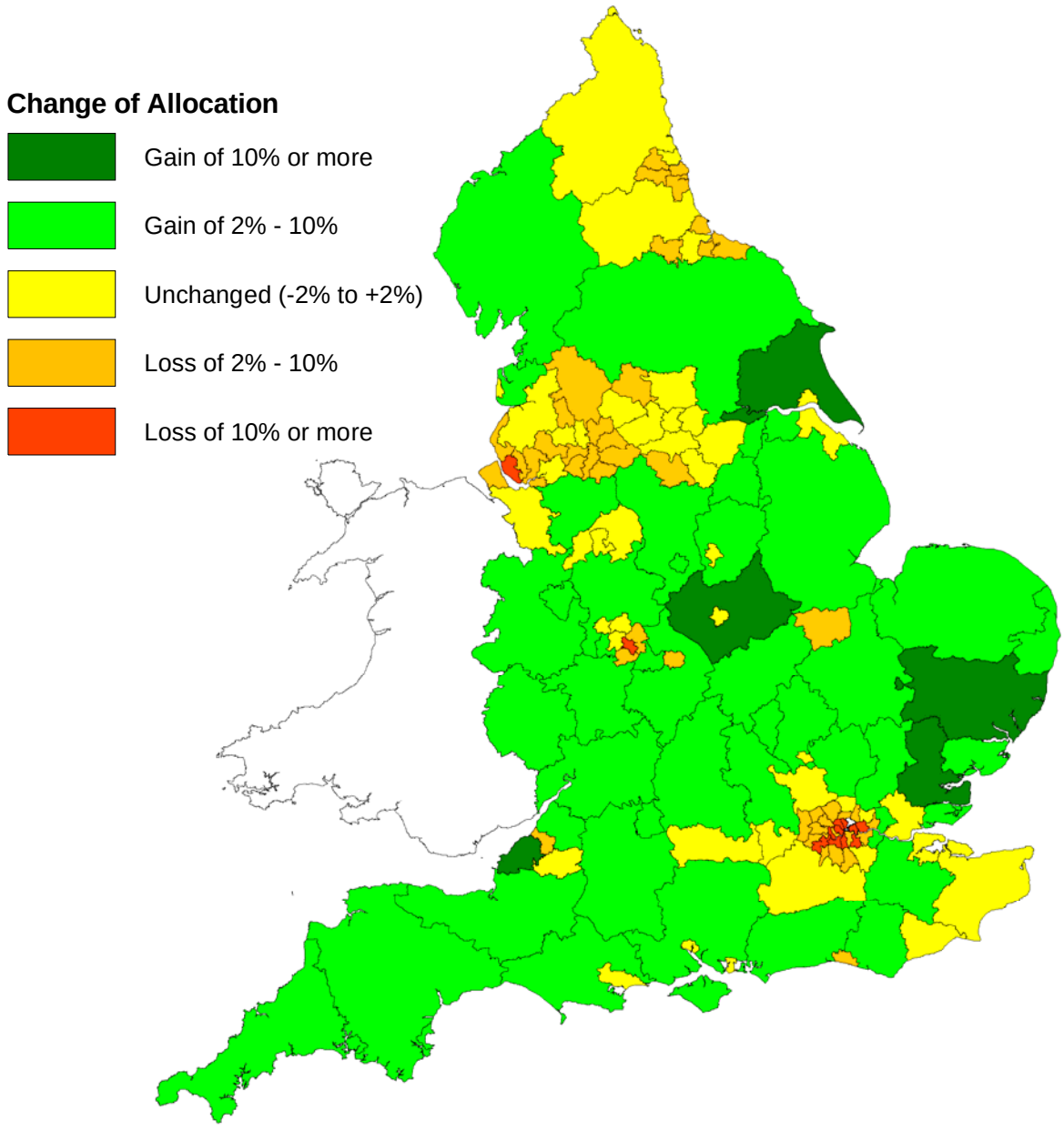
---

[70] Asthana, S. and Gibson, A., (2006) The relationship between the funding formula, the allocation of funds to trusts and the size of their deficits or surpluses, in *House of Commons Health Committee, NHS Deficits, Sixth Report of Session 2005-06, Volume II. Written Evidence, HC1204-II*. London: The Stationery Office; and Asthana, S. (2006) Oral Evidence, in *House of Commons Health Committee, NHS Deficits, First Report of Session 2006-07, Volume II. Oral and Written Evidence, HC73-II*. London: The Stationery Office.

[71] Department of Health (2007) *Explaining NHS deficits, 2003/04-2005/06*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065958

[72] *Ibid*., pp.3-4.

Fig. 4: PCT-level Geography of Gain/Loss on the Implementation of 'Needs Only' CARAN Allocations relative to the AREA-based Baseline Allocations



The new health inequalities element

1. On the basis of the new CARAN model, PCTs serving rural populations would thus be expected to have significantly benefited from a redistribution of NHS revenue, urban deprived areas losing out. In fact, overall allocations remain much the same as in the AREA formula. This is due to the inclusion of a new health inequalities element in the weighted capitation formula.

2. The decision to introduce a separate health inequalities formula reflects the correct observation that, while the traditional utilisation-based approach may support the first objective of resource allocation - equal opportunity of access to health care for people at equal risk - it is poorly equipped to support the second objective - the reduction in avoidable health inequalities. The passive modelling of influences on utilisation reinforces the historic curative focus of the NHS (and, most particularly, its orientation towards hospital services) and fails to capture need for preventive and public health activities. There are also concerns that 'unmet need' (i.e. socio-economic differences in the receipt of treatment relative to need) contributes to health inequalities. Thus, the decision to separate the formulae for each objective of resource allocation is a sensible one.

3. The *weighting* given to the health inequalities element is, however, more difficult to justify. ACRA concluded that, due to a lack of evidence, there is currently no technical way of assessing this. Instead, the recommendation was made that "the weight to be given to the health inequalities formula should be a ministerial decision" [73]. It is difficult to conclude that the resulting decision was based on anything other than a reluctance to realise the significant redistribution of resources implied by the new formula. According to Ben Bradshaw, then Minister for Health Services, "Ministers decided to apply the formula to 15 per cent. of the allocations, excluding the mental health component of the formula (which already includes an adjustment for unmet need) and HIV/AIDS. *This keeps the distribution of funding between the most and least deprived areas in line with the previous formula* (our emphasis)".

4. Although Ministers decided that Health Inequalities should constitute 15 per cent of the allocation, in practice, a weighting of 15% is applied to the Prescribing and PMS components, and a weighting of 12.4% to a weighted sum of the constituent parts of the HCHS component (i.e. 'Acute Need' (67.56%), Maternity Need' (2.934%), Mental Health Need' (16.059%), HIV/AIDS treatment and care (0.841%), and 'HIV prevention' (0.206%)). Given that the HCHS, Prescribing and PMS components are weighted 76.3%, 12.4% and 11.3% respectively, the effective overall weight given to Health Inequalities in the final allocation is 12.98%. This amounts to £9.848 billion of the total 2009/10 settlement of £75.858 billion.

5. Across all three components that make up the unified allocation the same measure of Health Inequalities is used, namely disability free life expectancy less than 70 (*DFLE from 70*). This is the number of years from birth a person is expected to live free from any limiting long-term illness, subtracted from a benchmark figure of 70 years. Thus an area with an average Disability Free Life Expectancy of 60 years would have a '*DFLE from 70*' value of 10, whilst another with an average Disability Free Life Expectancy of 65 years would have a '*DFLE from 70*' value of 5. It is worth noting

---

[73] DH (2008) *Report of the Advisory Committee on Resource Allocation* , p. 28. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091484

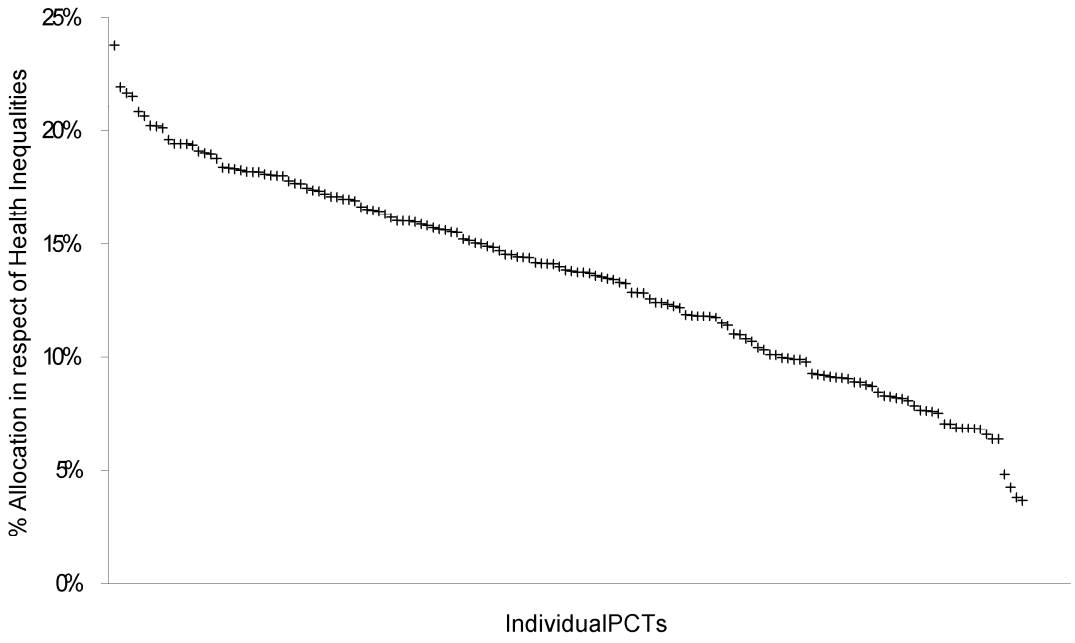
that this methodology (which is an interim measure)[74] has the effect of transforming a 14.3% decrease in Disability Free Life Expectancy into a 100% increase in the need for Health Inequalities funding.

The health inequalities element as a proportion of overall PCT allocations

1. Whilst the overall Health Inequalities element amounts to 12.98% of the total allocation, the proportion of PCT-level allocations that derive from the Heath Inequalities element varies enormously. This reflects the fact that '*DFLE from 70*' values vary from less than 2 years (Surrey, Kensington and Chelsea, Richmond and Twickenham, and Buckinghamshire PCTs) to more than 14 years (for Liverpool, Knowsley and City and Hackney PCTs).

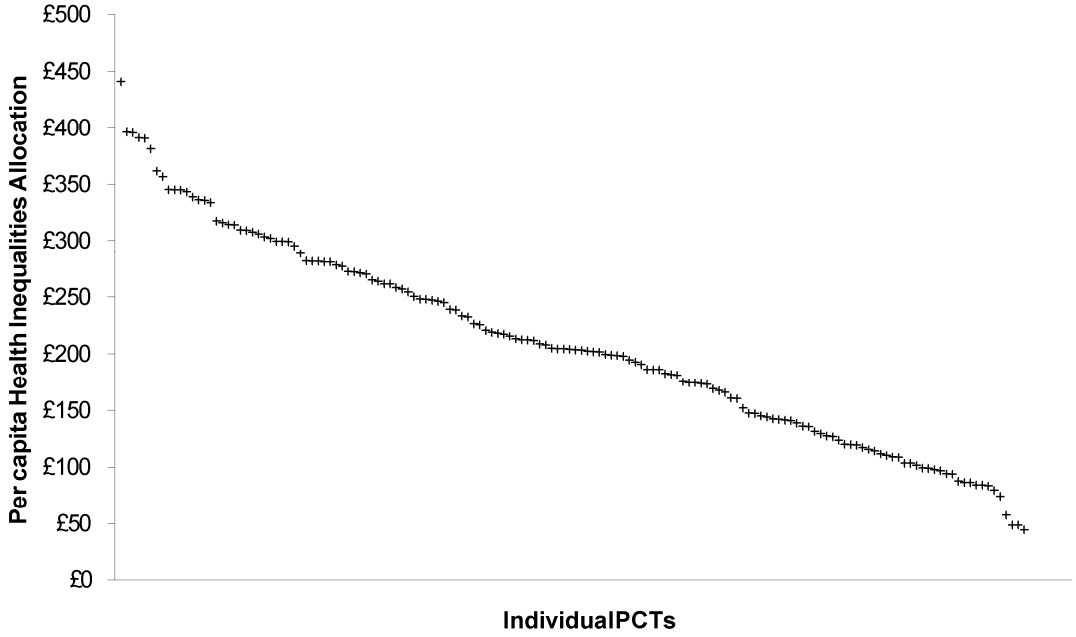
2. Thus 23.5% of City and Hackney's final allocation derives from the Health Inequalities element, compared to just 3.7% of Surrey's final allocation. 0 below illustrates how the Health Inequalities proportion varies across all 152 PCTs, whilst 0 below expresses this variation in per capita terms (excluding the effect of the Market Forces Factor). In these terms, the Health Inequalities element ranges from £441 per person in City and Hackney to just £44.27 per person in Surrey. 0 below, meanwhile, illustrates the resulting geography of per capita Health Inequalities allocations according to the current formula.

Fig. 5: Health Inequalities as a proportion of Overall Allocation; PCTs (n = 152)



[74] DH (2008) *Report of the Advisory Committee on Resource Allocation* , p. 29. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091484

Fig. 6: Health Inequalities per capita Allocations; PCTs (n = 152)



An economically robust adjustment?

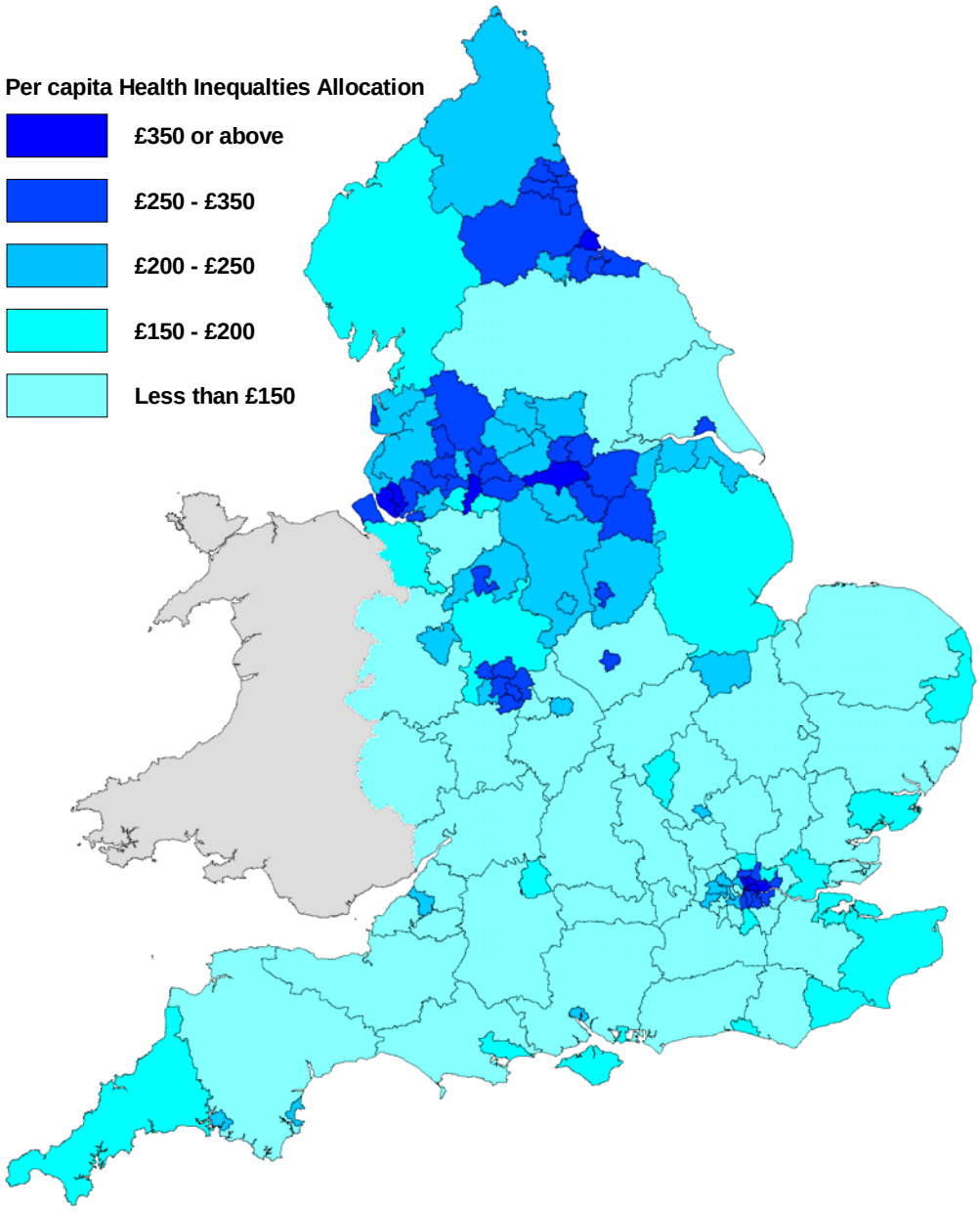
1. If NHS resource allocation is to contribute to the reduction of *avoidable health inequalities* (i.e. those that are amenable to intervention) then, ideally, the formula for health inequalities should reflect the costs of policies and interventions that effectively address the causes of health inequalities. The current health inequalities adjustment simply does not meet this requirement, in part because the existing evidence base on health inequalities interventions is currently not fit for the purpose of resource allocation. There is not only a general lack of information as to the ways in which different socio-economic groups respond to similar interventions. Relatively little information is available on *costs* and *cost-effectiveness*[75].

2. A second reason for targeting additional resources at deprived areas through the health inequalities element is to address 'unmet need'. However, it is important to note that CARAN itself includes an unmet need adjustment in the way in which it interprets the ethnicity parameter in its regression analysis. Little is known, moreover, about the costs or cost effectiveness of initiatives designed to address unmet need (such as the use of targeted health checks in deprived neighbourhoods).

---

[75] Asthana, S., Halliday, J. (2006) *What Works in Tackling Health Inequalities? Pathways, Policies and Practice through the Lifecourse*. Bristol: Policy Press; Rush, B., Shiell, L., Hawe, P. (2004). A census of economic evaluations in health promotion. *Health Education Research Theory and Practice* 19(6): 707-19; Drummond, M., Weatherly, H., Klaxton, K. et al (undated). *Assessing the challenges of applying standard methods of economic evaluation to public health programmes*. Public Health Research Consortium; Bambra, C., Gibson, M., Petticrew, M. (undated). *Tackling the wider social determinants of health and health inequalities: Evidence from systematic reviews*. Public Health Research Consortium

Fig. 7: Per capita Health Inequalities



1. If it is currently difficult to develop an economically robust approach to setting a health inequalities adjustment, we can at least compare previous expenditure on public health with the new health inequalities allocation.

2. According to National Programme Budget data, the total expenditure in 2008/09 on 'Healthy Individuals' (i.e. people who have 'no current problems but who are involved in programs for prevention of illness and promotion of good health')[76] amounted to £1.83 billion. By comparison, the Health Inequalities element directs the distribution of £9.848 billion in 2009/10.

3. This suggests that the allocation of 15% (or 13% of total NHS revenue) represents a significant injection of funding to health inequalities. Yet, there appears to have been an historic failure on the part of PCTs to direct funds towards health inequalities. According to evidence presented to the Health Select Committee's recent inquiry on Health Inequalities[77], additional funds allocated as part of the Choosing Health White Paper were spent on other priorities, and not on public health (paras 99-100).

4. While this may partly reflect the failure to ring-fence public health monies, it also stems from the lack of evidence on the costs and cost-effectiveness of interventions that address health inequalities. Until PCTs know how best to spend their health inequalities allocations, there is no guarantee that they will not divert this funding to maintain existing priorities or address pressures on acute services.

5. Against this background, we do not consider it likely that PCT spending on programs for 'the prevention of illness and promotion of good health' can expand five-fold over the course of a year – even, for that matter, over the medium term. Nor is it likely, to take the other justification for a Health Inequalities budget, that meeting any potential unmet need amongst those with the poorest health status could contribute meaningfully to closing the gap between what is allocated to meet the Health Inequalities agenda and what is actually spent.

6. It is inevitable, in other words, that a large portion of the sum directed on the basis of reducing 'avoidable health inequalities' will, in fact, be used to support the provision of health care. Given the size of the Health Inequalities budget this, in turn, means that the resources *available* to PCTs to treat the health care needs of their populations will diverge significantly from the resources *needed* to treat those health care needs.

The effect of the Health Inequalities Funding Stream on PCT Allocations

1. The great advantage of the new formula is that it explicitly distinguishes between healthcare resource needs and the additional health inequalities element. The former, which can be readily isolated within the 2009/10 Exposition, thus constitutes the current 'gold-standard' measure of healthcare needs at PCT level.

---

[76] DH (2007) *Programme Budgeting guidance manual* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073055

[77] House of Commons Health Committee (2009). *Health Inequalities. Third Report of Session 2008-2009. Volume 1. HC 286-I*. London: The Stationery Office.

2. The question, then, is to what extent the application of a Health Inequalities funding stream distorts the allocation of resources at PCT level relative to the level of healthcare needs. It is important here to note that this is a zero-sum game in that the Health Inequalities element does not represent an additional funding stream from which all authorities benefit to differing degrees. The nature of the weighted capitation mechanism means that weighted populations change in response to the inclusion of the Health Inequalities element, meaning that PCT allocations can fall very substantially.

3. This impact of the inclusion of the Health Inequalities element can be quantified by comparing what PCTs would have received if there were no Health Inequalities funding stream with what they actually receive. In fact, the impact of the Health Inequalities element can be very significant, with the extremes marked by the £232.82 (13.9%) increase in the overall per capita allocation for City and Hackney PCT and the £130.22 (9.68%) decrease for Surrey PCT.

4. The marked difference that the inclusion of the health inequalities element makes can also be demonstrated by considering the per capita funding ratio between City & Hackney and Surrey PCTs with and without the inclusion of the Health Inequalities element. When based on the CARAN formula alone, i.e. when calculated to ensure "equal opportunity of access to health care for people at equal risk", City & Hackney PCT receives 24% more per person than Surrey PCT. But once the Health Inequalities element is included that differential rises to 57%.

5. It is worth emphasising precisely what this loss to Surrey PCT represents. It is calculated relative to what the CARAN formula has determined it requires to equitably resource the health care needs of its population. Surrey PCT sees its allocation fall substantially below what it requires in order to offer "equal opportunity of access to health care for people at equal risk". The inclusion of the Health Inequalities element results, in other words, in an inequitable allocation relative to the actual need for healthcare.

6. City & Hackney and Surrey PCTs mark the two extremes of a spectrum of gains and losses on the inclusion of a nominal 15% Health Inequalities funding stream into the 2009/10 settlement, as illustrated by Figure 8 below. The resulting geography of gain/loss, meanwhile, is shown by Figure 9 below.

Fig. 8: Per capita change in PCT-level allocations on the inclusion of the Health Inequalities element

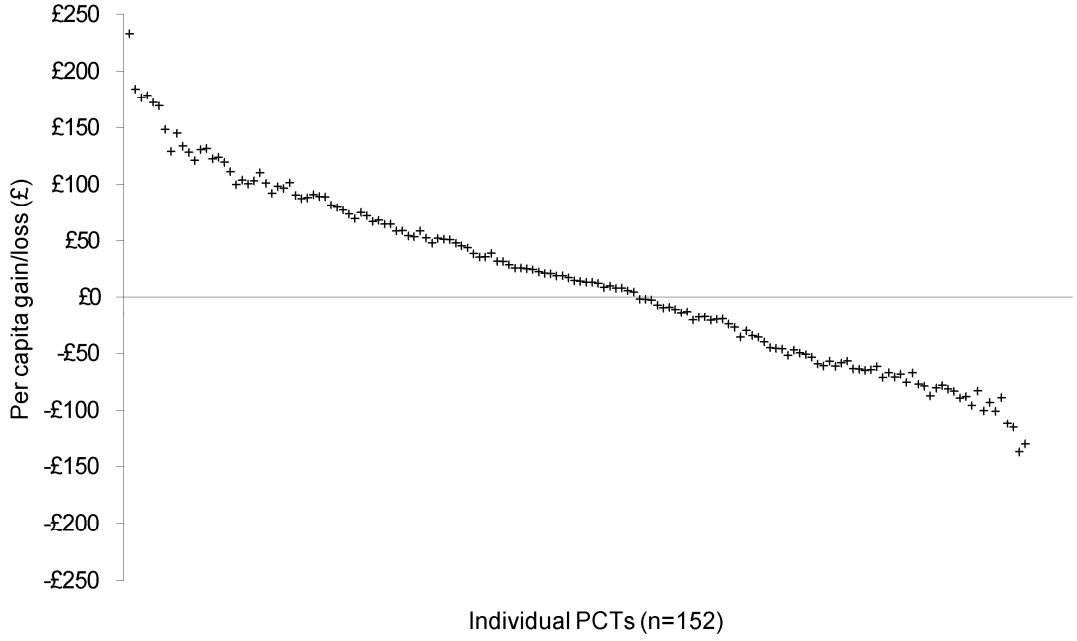
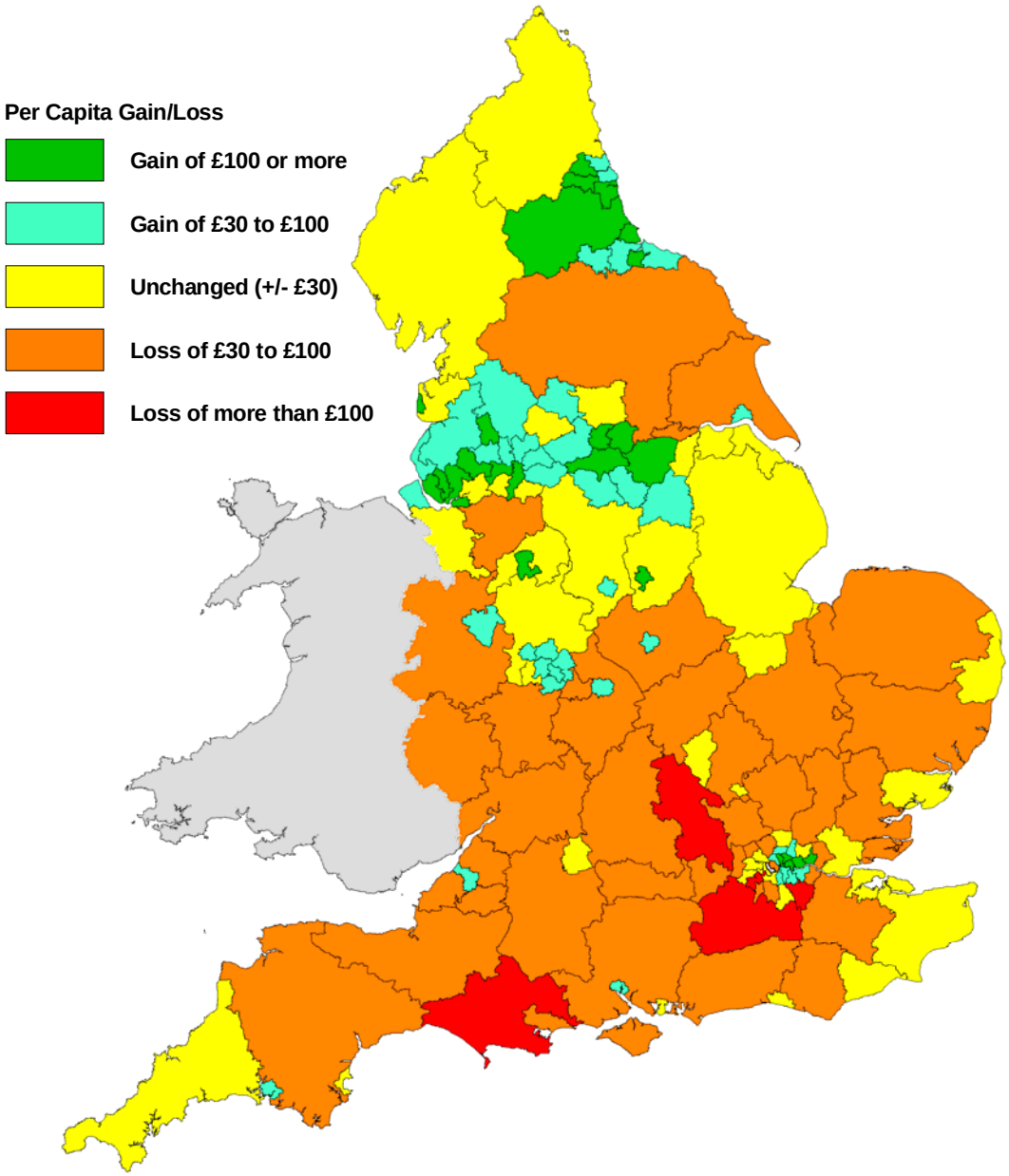


Fig. 9: Per capita change in PCT-level allocations on the inclusion of the Health Inequalities element

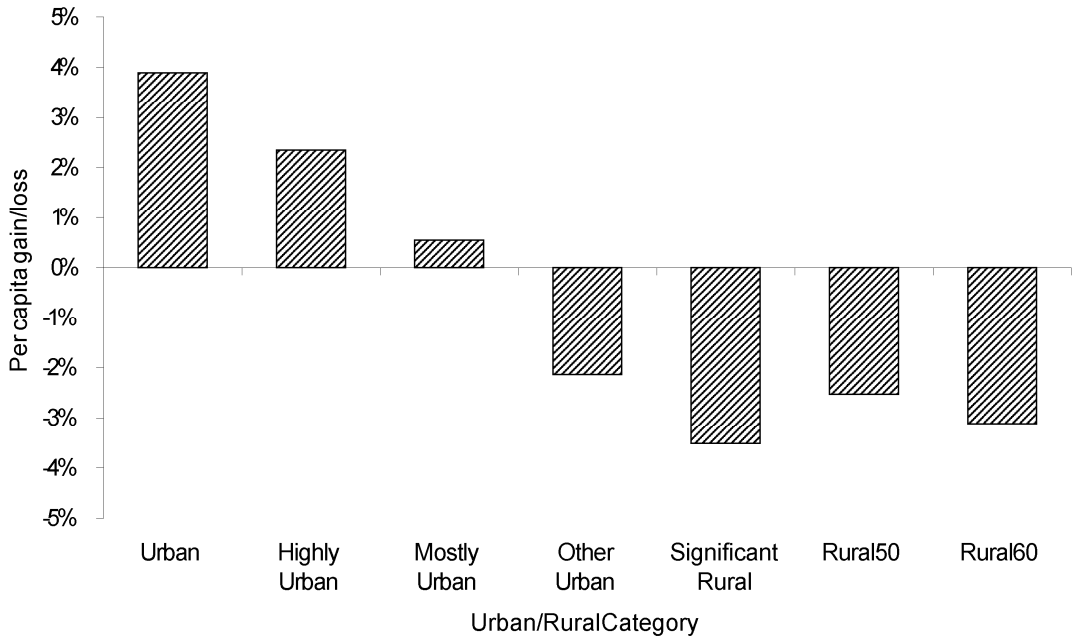


1. What this map shows, therefore, is the extent to which actual per capita allocations diverge from what the CARAN formula calculates to be an equitable distribution of resource relative to need. Allocations clearly fall short across a large swath of rural England, whereas they exceed healthcare resource needs in many urban and metropolitan areas.

2. This general relationship with rurality is illustrated in Figure 10 below, although it should be emphasised that it is not rurality *per se* which drives whether or not a PCT gains or loses on the inclusion of the Health Inequalities element in the formula but rather its 'Disability Free Life Expectancy from 70' (DFLE from 70) score. This

measure, as illustrated in Figure 11 below, is closely correlated with the Department for Communities and Local Government's 2007 Index of Multiple Deprivation (IMD2007) scores[78]. The large variation in 'DFLE from 70' scores (which, as also shown in Figure 11, is far greater in the underlying variation of DFLE scores) results in the strong systematic relationship between deprivation and PCT-level per capita gains/losses shown in Figure 12 below.

Fig. 10: Per capita change in allocations on the inclusion of the Health Inequalities element; by Urban/Rural Category



[78] Department for Communities and Local Government (nd) *Indices of Deprivation 2007*. http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/

Fig. 11: The Relationship between a) 'Disability Free Life Expectancy from 70' and b) Disability Free Life Expectancy with the 2007 Index of Multiple Deprivation

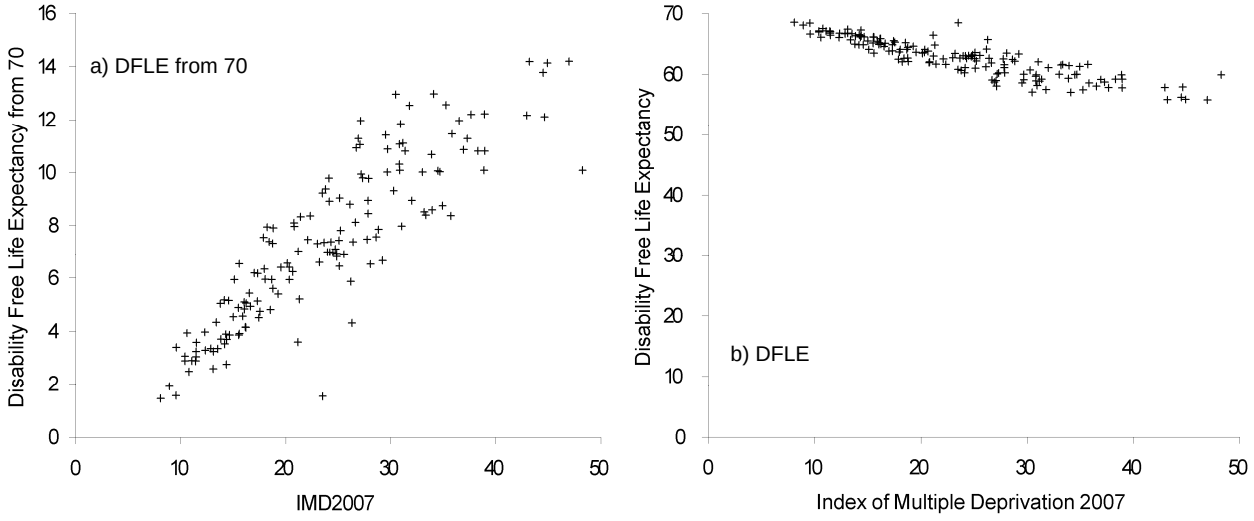
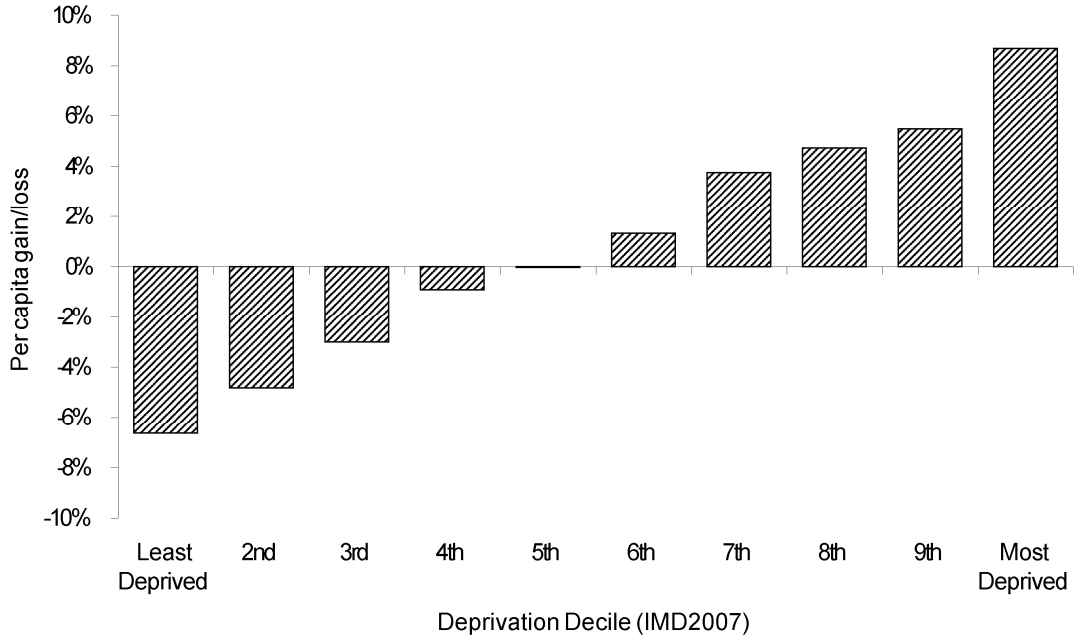
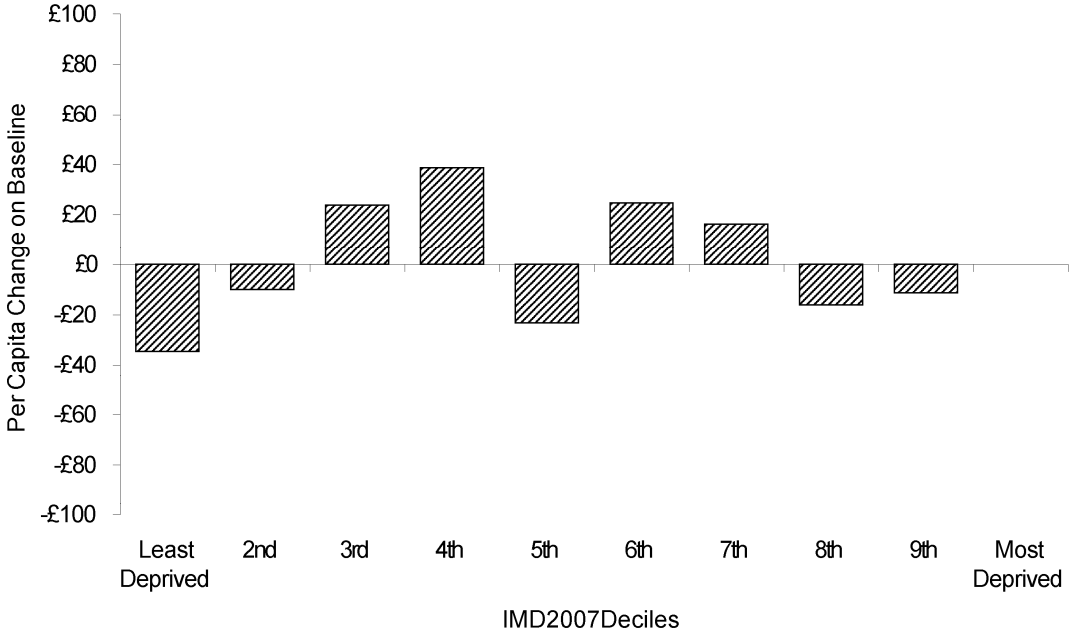


Fig. 12: Per capita change in allocations on the inclusion of the Health Inequalities element; by IMD2007 Deprivation Decile



1. What, then, does the incorporation of the Health Inequalities element within the 2009/10 weighted capitation formula mean for PCT funding levels? Remarkably (or perhaps not given Ministerial intention) the net effect is to effectively maintain the *status quo*, most notably, as illustrated in Figure 13 below, with respect to the most deprived decile which sees an imperceptible overall reduction of just £0.03 per person.

Fig. 13: Change relative to AREA-based Baseline Allocations; by IMD2007 Deprivation Decile



Conclusions

1. The key conclusions we draw from this analysis may be summarised as follows:

- That although criticism may still be leveled at the CARAN formula because it is based on an analysis of utilization data (which may have been influenced by previous rounds of resource allocation), it nevertheless offers the current 'gold-standard' measure of how need for healthcare resource varies at PCT level.

- Comparison of CARAN-based 'need for healthcare' allocations with AREA-based 'baseline' allocations demonstrates that the AREA methodology systematically underfunded rural areas relative to needs.

- Although the identification of a separate funding stream to address the important and long-standing goal of reducing avoidable health inequalities is to be welcomed, both in itself and as a means of clarifying funding mechanisms, the size of the Health Inequalities budget cannot be justified with reference to any current or plausible future expenditure on public health programmes or illness prevention.

- Incorporating a 15% Health Inequalities element into the weighted capitation methodology results in a very significant redistribution of resource and results in demonstrable inequity relative to needs. Thus all bar five of the 33 PCTs with more than 50% of their population living in rural areas end up receiving less resource than the CARAN formula calculates as being necessary to ensure 'equal access for equal need'. Conversely, all bar five of the 36 PCTs with serve an entirely urban population end up receiving more than the CARAN formula calculates as being necessary to meet the healthcare needs of their populations.

- The final 2009/10 settlement – based on a methodology which seeks to simultaneously address ACRA's two objectives of a) ensuring equal opportunity of access to health care for people at equal risk and b) contributing to the reduction in avoidable health inequalities – results in a final distribution which is, as intended, remarkably similar to the previous, AREA-based, distribution of resource. Yet, the comparison of CARAN and AREA shows that the latter is a poor benchmark.

Discussion

1. Tackling health inequalities has – quite rightly - become a central policy objective. Thus, the introduction of a significant health inequalities element to the NHS funding formula might appear – at first sight - to be unproblematic. However, it is important to remember that, in addition to contributing to the reduction of avoidable inequalities in health (i.e. promoting *health equity*), a central objective of the NHS is to promote equal opportunity of access to *health care* for equal needs *(health care equity*). There has been little explicit debate about the tensions that arise between these principles or to the fact that, in practice, these goals can be difficult to reconcile.

2. Since the introduction of the AREA formula, there has been a progressive shift in resources towards PCTs serving more deprived populations. This has resulted in very large differences in funding. The fact that the highest per capita allocations have been made to areas that have the 'worst health' in standardised terms but that, due to the relative youth of their populations, do not necessarily have the highest crude burdens of illness (and thus the highest needs for curative care) suggests that the health equity principle has been strongly shaping NHS allocations for several years. Specifically labelling a proportion of this funding in 2009-10 as a 'health inequalities element' is thus a positive step towards transparency.

3. However, it does not automatically follow that the health inequalities element has a strong underlying logic or supports equity and efficiency objectives (all standard requirements for resource allocation formulae). Where evidence suggests that the NHS can play a role in reducing avoidable health inequalities, it is important that any funding that is used to this end is targeted at effective preventive activities and that there is an explicit link between allocations and the costs of such activities. There is little to suggest that the current health inequalities adjustment meets these requirements.

4. In reality, however, many of the determinants of health inequalities lie outside the remit of the NHS. Thus, if there is a serious intention to address health inequalities, questions arise as to whether the 'top slicing' of this element of NHS funding would be better spent on services (e.g. early years, education, youth, employment, housing, financial and social services) that might address the causal pathways that give rise to health inequalities in the first place.

5. This question is, of course, academic. It is unlikely that PCTs that are receiving large health inequalities allocations could afford to divert a significant proportion of this budget to non NHS services without undermining curative service provision.

6. More fundamentally, we would suggest that the fact that PCTs serving older, affluent and rural populations have had to 'make do' with lower levels of resource than implied by the CARAN formula sets a dangerous precedent. The NHS is a *universal* service – not a residual service for the poor. By implicitly redefining the basic principle of what a 'fair' funding formula is seeking to achieve, the current approach to health resource allocation risks abandoning that principle.

Professor Mervyn Stone

'Failing to figure; Whitehall's costly neglect of statistical reasoning'
Civitas: Institute for the Study of Civil Society
London, 2009
ISBN: 978-1-906837-07-5

Prof. Mervyn Stone referred the Group to his report 'Failing to figure; Whitehall's costly neglect of statistical reasoning', copies of which were provided at the evidence session. Copies may be obtained online at http://www.civitas.org.uk/pdf/FailingToFigure.pdf:

Oral evidence session; Education

Tuesday 23rd February
Committee Room 17, House of Commons

Panellists:

PD: Philip Dunne MP
GS: Graham Stuart MP
LC: Lord Cameron
BB: Baroness Byford
BG: Baroness Gibson
DR: Dan Rogerson MP
AB: Rt Hon Sir Alan Beith MP
DM: Duke of Montrose

Witnesses:

SK: Stephen Kingdom, DCSF.
RH: Rita Hale.
JC: Jeremy Coninx, TDA.
SF: Susan Fielden, ADCS
DF: David Fitzsimmons, Devon Hands Up Campaign
MBr: Mick Brookes
MB: Mervyn Benford, NASS
LW: Lindsey Wharmby, F40
FL: Francis Loftus, F40

First session – 10:30-11:30

PD: Welcome to this inquiry into funding for rural services and in particular, the formula which Government and different departments use to arrive at their funding allocations. We looked at Health just before the recent recess and today, we're looking at Education. We've got a two-hour session which we've broken into two one-hour sessions and I have to apologise to colleagues that at the beginning of the second session, I have to drop out for ten minutes to attend to something else and then I shall come back. So I'll invite someone to take the Chair at that point.

But we will be joined, I hope, by other Parliamentary colleagues at some point who have a habit of dipping in and out, as I've just confessed I will be doing, so please don't take that as anything other than evidence of the fact that we have to juggle many different challenges while we're here. Don't take it personally!

So this morning, if you could kindly…and indeed, here is one of our most loyal stalwarts from the House of Commons, welcome to you. What I'd like to do is invite our four guest speakers to speak for a few minutes about aspects that they wish to bring to our attention about how the formula works, or the consequences of the formula on areas where they are interested. And then we'll open it for questions in the style of a Select Committee, if we may, so if the colleagues sitting around this table could think of some penetrating questions to put to our guests, that would be very helpful.

I have no particular order in which to encourage you to speak, other than I'm going to ask Stephen Kingdom to start, as he's the representative of the Ministry, to put in the defence first.

SK: Thank you.

PD: Could you just tell us your role, so that colleagues are aware of that?

SK: Yes, I'm a Deputy Director within the DCSF. My remit is school funding and wider local authority funding for children's services and technology in schools.

This is a very, I think, very well-timed hearing in the sense that we are currently developing proposals for consultation on the funding formula for schools, or for local authorities to fund schools. We've had a period now since 2006/7 where the real focus on school funding has actually been on stability and predictability and, as such, has built on a base of what was being spent in 2005/6 and incrementally added to that, with additional funding for specific priorities, including additional funding in the last round for pockets of deprivation to pick up deprived areas in generally un-deprived authorities, which I think some rural areas benefited from. But broadly, we've had a system where the current or the 2005/6 spending pattern has been, to some degree, fossilised within a period of significant, continued significant growth in school funding.

When the current three-year period was put in place, when consultation on that was undertaken, the general feedback from consultation was, it was right to continue

with that focus on stability for this three-year period but after that, we would be getting too far away from that 2005/6 base and it was time that we needed to do a fundamental review of what the underlying formula was. And we've been carrying out that review, gathering evidence, having independent research involving groups of stakeholders, some of whom are represented here….other people giving evidence today, since early 2008. That public evidence gathering ended in the summer of last year. We've been developing proposals since then and we expect Ministers to go out to consultation on the options in the very near future. So in that sense, I think this is good timing in sort of looking at the issues as they affect rural areas. I'm afraid that means I won't be able to give definitive answers as to where the formula is going because we haven't yet completed that consideration of the consultation, and obviously will be subject to the outcomes of that consultation.

PD: Do you anticipate publishing something ahead of the General Election?

SK: Yes, I do, at this point, yes.

Chair: Ok. Could you just explain a little about the results of your consultation and some of the concerns that have been raised?

SK: Yeah, I mean, I think there's general agreement about what the sort of constituent parts of a formula for….as I said, it's more a formula for funding local authorities than for schools, but some of the elements are what are appropriate for a national to local distribution when you don't get to local authorities' school distribution, you might have different emphases.

But the key accepted components for the formula are an amount for basic entitlement, the amount of the core funding for pupils, and then top-ups to that for pupils who have additional educational needs and special educational needs. That includes funding to tackle the needs of deprived pupils but it's not exclusively about deprived pupils. Top-ups for recognising the different costs of providing education in different areas, so they fall into two main categories. Those are areas where wage costs and other costs, costs of employing staff, are higher and areas where, because of rurality, because of sparsity in costs of providing the services are higher because you are forced into having smaller and less economical units. It's important to say, we don't have…we don't propose a formula which funds small schools for the sake of funding small schools. It's extra funding where small schools are needed because it's not viable to provide larger schools. Sorry, there's one element on the additional education needs; I should've said that includes a separate block for very high cost pupils' complex special educational needs, pupils and pupil referral units.

So there's a sort of five block model, and I think it's generally accepted by stakeholders that that's the sort of pattern we would expect and the formula.

So the key sets of issues then really become: what is the weighting between those blocks, how much money goes through each block and then how, within each block, you decide what goes with what local authorities, effectively, what proxies do you use, what indicators do you use to address needs and to address costs? I think two of the main ones I'd highlight in that; first is on the basic entitlement – whether you

take a judgmental view on how much resource should go in the basic entitlement, looking at balancing that against the needs in the other categories, or whether you try a more bottom-up technical arrangement which, in the jargon, is called activity-led funding where you attempt to say, well, if you have class sizes of thirty, if you have this level of support staff, if you have this level of management overhead, that's what it builds up to as an average cost per pupil. And that's a balance between whether you want to get that prescriptive into that kind of detail and appear to tell the system how to do it, or whether it's more straightforward and clear in that way, and say well, we'll make a judgmental view on the balance between the blocks. So that's probably one of the…that's the sort of main issue on the basic entitlement.

In terms of additional educational needs, what are the best proxies to identify which pupils have additional educational needs? And I think it's probably fair to say the biggest debate on that is whether more proxies are the best for identifying deprivation. One of the most frequently talked about and used in discussions about how deprived pupils are doing is free school meals, whether pupils are eligible or claiming free school meals. That has many advantages – it's transparent, it's clear, we have the data at pupil level from the annual school census, so it's very clear to see how the money can follow the pupils and it's very clear like that. It has, on the other hand, disadvantages. It's very binary, in the sense that you either are eligible or you aren't eligible, so it doesn't allow a sort of gradation between different levels of deprivation. There are different levels of take-up and claiming of free school meals around the country. There are issues about whether certain authorities or certain types of authorities' pupils are more or less likely to claim or to indicate their eligibility so that they'll be…they'll come through on the data. So there are pros and cons to free school meals, I think. The clarity in following the pupil clearly is probably best, but then there are technical difficulties.

Other measures – you move into areas like tax credit data. We've looked at using the data about out of work tax credits which, theoretically, ought to match free school meals eligibility, but in reality, the evidence shows it doesn't. Again there, you can't get down too precisely, because of data protection issues and so on, you can't get down to precisely following individual pupils, but as you can get down to sort of post code level, you can follow the characteristics and can get quite close to following individual pupils.

And the next question is, do you stop…..the next set of questions, is out of work tax credits the right level, or should you be bringing in deprived pupils from working but low paid families rather than just out of work? And then there are other indices which are out there, such as EDAC and Mosaic, which attempt to take a view of deprivation in areas, actually heavily based on the same kind of underlying indicators.

So the debate there is, what is the best indicator? What addresses, what identifies needs best? As I said, deprivation is not the whole of the additional educational needs spectrum, and there are other needs and other indicators we can use. It's important, in looking at indicators, to avoid adverse incentives or to be seen to….be seen to punish success. One quite attractive indicator is prior attainment, because

clearly, if the child has poor prior attainment, they've got greater needs and we have looked at, and one of the issues the group looked at, is where one of the indicators we might use is prior attainment to age eleven for the secondary education element, but are you then at risk of being seen to penalise an authority where its primary schools over-perform? So there's a series of issues around those.

In terms of high-cost pupils, a very similar set of issues about how do you get a good proxy for where high-cost pupils will be. This is really quite difficult, particularly where you've got small authorities because some of these pupils who are very high-cost, they're very small numbers and actually, they're…where they come, where they need services, there's actually…is actually quite random. So some of it, on that basis, you do on a straight pupil basis because there's no other indicator, but we've also looked at whether there are any health indicators that can be used. Previously, we've used indicators like low birth weight but there are concerns about that because of different effects in different ethnic groups. So we've looked at a range of proxy indicators and will be consulting on a range of those to look at the best indicators.

In terms of sparsity, two elements to the work on the sparsity really, I think – one has been identifying what is the additional cost, what do we see from actual evidence of expenditure of the additional costs of small schools, and secondly, how do we identify which areas are sparse and therefore have need of the small schools. The previous formula which underlies the current system relied on national census data. Because we now have much better pupil-led data through the annual school census, we are confident – I think I can say this before the consultation – we're confident we will be consulting and expect to move measures that will use pupil-led data from the school census, so that'll be more responsive. Because actually, by the time we're introducing this new formula in 2011, we wouldn't yet have the 2011 census data so we would be using very out of date data in that sense.

So the positive side on sparsity and indeed, many other parts of the formulas, will be much more pupil-led and much less reliant on national ten-yearly census. In fact, my hope is we won't have any key components that rely on the ten-yearly census but will be much more contemporaneous data in that sense. So that starts us at how you identify which areas are sparse, and I think one of the issues the Formula Review Group looked at was what level of sparsity is when the real cost cuts in, and I think options we will look at is whether you have a fairly wide definition of sparsity which covers more of the country, and whether you have a narrow definition which puts more money into…potentially puts more money into a smaller number of authorities but which are more sparse, and those are the issues on which we're likely to consult.

AB: Could I ask for a clarification on that? You said authorities with sparsity – is the formula still one which judges an authority as a whole?

SK: No, no, it will look at either…it will look at Super Output Areas, probably medium Super Output Areas as its unit, I suspect, on that.

AB: Thinking about the situation like Northumberland where you have a small, very densely populated area and an absolutely vast very sparsely populated area, and in

further relation to sparsity, just to clarify what the formula means, does it…is it capable of measuring the cost of extreme sparsity, which are the costs of transport when you're not transporting five children from one village to a school, but you're picking up five children who live three or four or five or ten miles apart from each other, in order to get them to a school and the problem which grows more acute at secondary level when I think the factor drops out, doesn't it?

SK: Yes. I mean, one very important thing to say is that the Dedicated Schools Grant, which is the formula we're talking about here, doesn't cover school transport. School transport…when the funding for schools was taken out of the core local authority funding system and made a ring-fenced grant to the Dedicated Schools Grant, school transport didn't make that move so that's still funded within the local Government finance system rather than a Dedicated Schools Grant. So in that sense, the review isn't looking at that issue about school transport. There's a related issue. I mean…and in solely terms of what we feel is the additional cost of small schools, the evidence we've looked at suggests that it's Primary where that focus is because it isn't looking at transport. There's a separate issue about funding for diplomas where that funding does currently have a significant sparsity element and there, where you may be including transport within the school day if a young person is having trouble with provision in a different area, that would be within the diploma grant but the home to school transport at start and end of the school day is not within the domain of this review.

AB: So I know I was going to say there's no allowance in any formula for the extra transport cost, which must be the biggest cost of rural schools…..

SK: It is taken into account in the formula which CLG use for the distribution of the formula grant.

AB: Right. But not in as sophisticated a way as you're describing?

SK: Well, we are…I haven't got the details to hand, I'm afraid, but we will look to make…if there are key things that come out of the work from this, we'll look to feed those in to how CLG operate their formula, so particularly things like, as I said, about being able to use more up to date data, we'll look at the prospect for moving that across rather than being reliant on census data.

PD: I'll try and find it during the meeting because I've got the document here.

DM: And one of the costs in very sparse areas is the cost of moving teachers around, because they very often are shared between schools. So it's not just a pupil cost.

SK: Yes, and that cost would be covered by DSG in that sense, yes.

PD: Thank you. I'm sure we'll have other questions for you, but I think, looking at the time…you've got the most wonderful 'Get Out of Jail' card, which you confessed at the outset, but I'm pleased that we've got time in this session to feed into the work that you're doing, that's very helpful. I'm going to ask now Rita Hale to speak to us. Could you just explain your credentials?

RH: Prior to my retirement, I spent more than forty years working in or on Local Government finance, specialising in the operation of grant distribution arrangements, primarily in England but also in Scotland and Wales.

PD: Thank you.

RH: So…do you want me to say anything else?

PD: Yes, I'd like you to tell us what your findings are.

AB: I think we all know you to be the person…you're obviously the only one that understands the formula system outside the department!

RH: Thank you! One of the things that's struck me over the years I've been working on Local Government finance is that successive Governments have tended to duck the issues relating to the costs associated with rurality and focus far more on issues of deprivation, which often are easier to understand, although they're difficult to solve. Easier to understand and easier to think of proxies which may reflect deprivation, so to me, that's one of the things I've learned over the years.

One of the other things I've learned in the most recent studies I've completed, either before or just after I retired, is that advances in technology and improved management information systems within local authorities, make it possible now to identify the higher costs associated with rurality so that one can drill down into local authorities' management information to pull out - what are the differences in costs between schools; what's driving the cost of home to school transport in different parts of individual local authority areas; what's driving the cost of social care provision. One can actually identify the costs, often on a case by case basis, and map them to the locality so that you can actually see where the costs are higher and what the physical characteristics of the area are.

So all those years when we've had either token recognition of sparsity in various funding formulae, or no recognition at all, I think we're now in a better position to identify the costs and then start to have discussions with Government about how one reflects those costs in funding formulae.

PD: And you presumably have been feeding these thoughts into the consultation?

RH: Over many years, yes.

PD: But the current consultation?

RH: No, I haven't. I haven't done any work on the current consultation at all.

PD: Right. Do you have current data that the Department might find helpful in grappling with the issues that Stephen's just identified?

RH: The last detailed work I did was in 2006/7 and when I was doing that, I was looking both at national level in terms of how do schools' budgets match what were in the Formula Spending Shares, as they were then, because that was the last year when we had straight formulae for funding schools and school budgets. And one was able to pull out from that, the statement of the obvious, small schools were more expensive than larger schools particularly in primary, small schools were more expensive to run than larger schools. Identify the location of the small schools so that you can match them to the physical characteristics of the area, and then when one was looking in individual authorities, try to identify the effect of rurality on costs.

The result of the case studies I've carried out as part of that last major piece of work was that you could identify the costs of rurality. The different types of rurality appear to explain something between thirty and forty per cent of the variation in unit costs in primary schools. So it was quite an important factor but also, the fact that you can identify it now, I thought was helpful. And I suppose that's one thing I would like to make clear, that you can match schools to locations. I know it's a statement of the obvious but you can actually do it now using data sets, and you can prove where the higher costs fall and then start to have the argument then about the appropriate level of the rurality adjustments.

GS: Do you believe, then, that the Government will use those tools and it's just been the lack of the tools before that's led to the distortion? There were no other causes of their….

RH: You are better judges of that than I am, but my feeling is that it has always been more attractive for successive Governments to focus more on deprivation than rurality. I think it's something that has been more…of more interest in the media, because deprivation is a big issue. Rurality sounds a little bit duller. So I wouldn't put money on it, but I don't think there's any reason why they couldn't.

GS: And has the attraction of deprivation over rurality increased between Governments, or has it been roughly the same?

RH: In my experience, all Governments have been concerned about deprivation in all of the years that I have worked on grant distribution systems. Some give it slightly more emphasis than others, but all of them, in my experience, have been more interested in deprivation than in matters of rurality.

AB: Could I just take the opportunity to throw up points, and then to Mr Kingdom, a question I put to him, and it relates to school transport and I know you're familiar....Is the formula by which that money reaches local authorities, the General formula, cruder than the formula which is in operation for school funding, or is it capable at present, the way it looks at present, of recognising the transport needs that arise from sparsity?

RH: The Department hasn't yet developed its new formula for funding schools, which will be more sensitive than the one that operated in 2005/6, so I would not say that the home to school transport formula is cruder than the schools' one. What I fear is

that in the future, it may be cruder than the formula on which the Department's now working. And I think the present formula doesn't properly look at home to school transport costs, trying to tease out what is driving those costs.

AB: So perhaps the discussion that Mr Kingdom mentioned a moment ago between Departments really ought to be encouraged, because it really does affect the work the other's doing in a field so closely related?

RH: Yes.

PD: You referred to the data sets that exist to be able to identify cost of provision in different localities. What are they?

RH: The data sets which enable one to really drill down tend to be local authority management information systems, so what I think Government would need to do would be to commission research which was based on a representative cross-section of local authorities of all different types, providing whatever the service was, and then make sure that they drill down into the management information systems in a consistent way between authorities, to tease out the information. And use the results of that analysis, then, to feed into developing an England-wide formula. I don't think it would be realistic to develop a formula based on the analysis of the management information data for every one of the four hundred and fifty six local authorities in England. That would be fun, but perhaps a bit over the top.

DR: If local…sorry, if the formula and formulae in the past have concentrated more on deprivation, why is it that rural areas which are also deprived, not just in terms of, you know, it's more commonly talked about, pockets of deprivation – for example, my own area of Cornwall which is in receipt of European Union funding now, even after some of the states have joined the EU – so it's identified in many ways, but why do you think it is that that hasn't been picked up....and that the formula still gives some school children considerably less than the average and much less than in other parts of, for example, inner London.

RH: One of the big reasons is the operation of the area cost adjustment because although I recognise that Cornwall has very significant levels of deprivation – seasonal employment, low incomes, high concentration of older people, all of those things which contribute to making it a deprived area – it doesn't face the same cost pressures as some other parts of the country, or that is what Government would argue. And therefore, one of the reasons why you're seeing lower funding is because of the supposed lower employment costs.

DR: So just to follow up – so in other words, in our Health discussion, we're going to talk about the market forces factor and that's exactly the….

RH: Yes, it's exactly the same thing.

BG: Do you think that successive Governments, as you said, have concentrated on deprivation because it's easier and that rural deprivation is very often hidden?

RH: Yes.

BG: Ok, thank you!

PD: Do you have any suggestions for how we'd reveal the extent of rural deprivation and how that can be taken into account?

RH: I suspect that more work needs to be done on income levels and the effect of seasonality, and work in rural areas is one aspect. I don't know how you address issues of isolation, but I can see that isolation must be another factor in deprivation, which is quite different from the sort of deprivation where I live. I live in Islington. But I think what would be most helpful to rural local authorities is if you were able to focus on properly reflecting the effect of rurality on the cost of service provision, because in my experience, that is the biggest single factor. Some work I did on refuse collection costs which, is not the most glamorous thing in the world, but one can actually identify the cost on a round by round basis in many local authorities, and one can see rural premia there, within an authority, of seventy to ninety per cent. So these costs are not affected by changes in policy because they're within the same local authority area, and one can see that as one moves from the most rural part of an authority, there's this huge rural premium on the cost of providing a service. So that really is what I would concentrate on.

AB: Isn't that probably increased by the creation of unitary authorities which now, for all services, combine urban and rural areas?

RH: Yes.

AB: So Northumberland and Durham, for example – that's an example of very scattered rural areas over concentrated urban areas.

RH: The one plus point I would say from that, of course, is that the unitary authorities may well be developing really good management information systems so they'll be able to help you answer the questions about what is the rural premium.

PD: Some authorities, of course, have evolved different patterns of schools in order to cope with some of the cost pressures that they have, so that there…in my area, for example, Herefordshire which is where I happen to live rather than represent, has moved to a model of relatively large primary schools in the towns and most of their small village schools have been closed already. So their pattern is rather…although they share many of the characteristics of the population of the adjacent Shropshire or the Welsh counties across the boundary, their school pattern is very different.

RH: But will they not face much higher home to school transport costs, then?

PD: They will.

RH: Than local authorities with a pattern of smaller schools?

PD: They will, and they offset that against the savings they make from operating fewer premises.

RH: Yes.

PD: I think we should…thank you very much for your time. I think we should move on and ask Jeremy Coninx to address us.

JC: I'm afraid after that you may find what I have to say very dull! I'm Jeremy Coninx, Director of Funding and Market Management at the Training and Development Agency for Schools where I've been in a similar capacity for a region of ten years.

Although I'm sure what the Agency does is for the benefit of schools, it provides very little funding to schools directly in their capacity as schools. In many respects, the nature of its work is much closer to, perhaps, for example, the Higher Education Funding Council for England where principally, we're funding the supply of training places, much of which are provided through University providers. So we're not…our role, we're principally funding training providers to supply training opportunities for the school's workforce and in that capacity, our major program which continues to be teacher training, which around eighty per cent of agencies' funding, through its funding programs, goes on supplying teacher training places and ensuring a supply of newly qualified teachers available to be employed by schools in England. So that is where its principal focus lies, so it's providing a benefit to schools but it's not wrapped up in with the formulae that have been discussed so far today.

Within that process of allocating places and resources, it's constrained in a number of different ways. The first one is that it's constrained in the amount of training it can make available, both for available funding budgets and also by the requirements and the demand from schools to really provide teachers, not the training. So it works to a set of recruitment targets which are reviewed and set out yearly or, in some cases, on a two or three-yearly cycle, and where it works towards ensuring that recruitment to initial teacher training meets those targets. So that's one constraint.

Within the medium of this discussion, it sort of has three main priorities. The first one, which is set down by statute to have regard to, is quality, quality of training. In terms of allocating places and funding for its formulae, it must have regard quality as the paramount consideration. It has to get an appropriate balance and have regard to quality. What that means is, in general, that higher quality providers which have been rated by small set inspection principally will, over a period of time, grown their share of the total market and those who continue at mainly lower quality will have seen their shares reduce or, in some cases, they will have been removed from the training market. But that's the key factor it has regard to in the allocation process.

Two other factors of particular…it's also…well, let me say, it's about access. One of the key drivers for the agency is to increase access to initial teacher training and the reason for that is first of all, to ensure a better throughput of newly qualified teachers, those that successfully complete initial teacher training courses in terms of widening the point at which they're exiting courses, and therefore available for

employment by schools, recognising some of the limits on mobility, both for people taking the initial teacher training course and then going on to teach, particularly when we have more mature career-changers in the system. We've also tried to increase access to potential training teachers, by bringing initial teacher training closer to where they live.

So in that context, in terms of the number of providers over this period of time, since 1994, it's increased from around ninety teacher training providers to two hundred and thirty distributed throughout England, to help increase the access. So in terms of where the agency's priority has been, it's been about quality and about increasing access, both for the potential of agencies to take that step forward and to train, to help us to meet our recruitment targets, but also to increase the throughput of those successfully completed courses to become then what's become newly qualified teachers in schools.

PD: Do you have a facility in every local education authority?

JC: Probably not every single local education authority, but a great number of them. I don't have the precise figure but most local authorities would have a training provider or would have the opportunity to develop training provision at a point in the past.

PD: One of the challenges in some of the more sparsely populated areas obviously, is attracting teachers, particularly attracting head teachers when there may be only one other teaching professional in the school. Do you get demand for…do you get involved in trying to help supply teachers to these schools in any way…?

JC: No, not…

PD: Or is that after they've left your care?

JC: I mean, of course, we have an interest but it goes a little bit beyond the means we have available. We can try and ensure as far as possible that there's good distribution of those coming from courses, but we can't make that next step and sort of ensure that schools have exactly the right workforce at exactly the right time. It just goes a little bit beyond our remit.

DR: Do you have any involvement in NPQH or is that…?

JC: No.

GS: In a place like Australia, where they're trying to get doctors into rural areas, they changed the training program to ensure that doctors went and did some of their training in rural areas. What… are urban schools more likely to be having teachers in placements than rural schools? Is that an issue?

JC: No, I mean, not necessarily actually. In fact, some urban schools can be some of the more difficult schools to secure placement experiences. I mean, in many respects, although there's two hundred and thirty training providers, there are many

thousands of schools involved in providing placement experiences, as of course it's a requirement of initial teacher training courses that fifty or more per cent of their time is spent in schools. And of course, we've had the massive expansion of the employment-based initial training programs since 2001, where these are spread far and wide involving local schools employing trainee teachers throughout rural areas as much as urban areas. It's about…

GS: But you have evidence to back that up, have you?

JC: We…I haven't got it here, but we can….

GS: You have looked at it specifically and so therefore, a rural school is no less likely than an urban school to be involved in these programs?

JC: Let me say…go back to…I can't say for certain that that balance is there, but I can't think of any reason in terms of natural constraint why they couldn't be involved. That doesn't mean they are, but there's no natural constraint I can think of, which is why they couldn't access….

GS: If you're able to write to us with the information on that, I think it'd be very useful. I mean, you may not be able to. I would have thought that it's more likely the training centres typically would be in urban centres, and therefore proximity would suggest that students would be more likely to go to schools nearby. The further you go, the more, you know, the more rural and distant and unknown the place, the less likely someone is to go there, but that may be belied by the evidence…..

JC: I mean, part of our engagement has been to take the teacher training out to those areas, that was its development, to make access available in a far wider range of areas, going beyond the immediate large urban areas, that was part of…but yes, we can find information on distribution.

BG: I'm a little disturbed to hear you're not in every educational authority and the reason for this is, you don't seem to know where you are not, if you see what I mean. So no-one can chase those educational authorities to suggest that they perhaps work a little harder in relation to their teacher training, and it follows on from my colleague's question here – I would have assumed that it's more likely that there is deprivation in this area, in rural areas, than in urban areas and I just wonder, at the moment, there isn't an overall picture of the country, from what you're telling us, as to what's happening about the training. I'm not saying that the agency should chase, but if we said to the Government, can you chase, they wouldn't be able to either because they wouldn't have the data.

JC: I'm just trying to think how…I mean, I mean it possibly goes beyond our direct remit which of course is to maximise access for training teachers to training, for a variety of courses…

BG: Is it not that when some education authorities are not working with you, then you're not actually able to maximise, are you?

JC: No, I mean, what I'm saying is, they're not working with us but in terms of potential trainee teachers within those areas, those potential trainee teachers within those areas may have very good access to training provision within the immediate locality. For example, when I was talking about urban areas, we wouldn't necessarily have a training provider located in every single local authority, because that wouldn't be our original intention. Our original intention was to ensure within that general area there was an adequate range of provision which was potentially accessible to those who wanted to train to teach, and had met the requirements and had the necessary qualifications and so on, and who would be able to apply. But it's never been a model where we've been trying to say, there's got to be a provider in every local authority. But in all the major local authorities, there will be.

DM: Do you have any responsibility or opportunity to state what levels of training teachers should have, or what levels of re-training should be undergone? You know, people with ten years' experience, do they come back for re-training?

JC: Well, the agency does have…in terms of the, certainly the requirements for entry into teacher training and the standards of the qualified teachers, the agency has a very big impact. Those standards set by the Secretary of State but the agency has a legal responsibility in establishment of standards with different levels of teachers, etc. and has been rolling in those areas and actually, those standards are being used at this moment.

LC: One of the issues that is put to me by rural schools is the difficulty of accessing CPD, Continuing Professional Development training, which is linked to the difficulty of actually getting cover, replacement teachers, which may or may not include having to provide housing and so on. And I was just wondering whether you have any statistics of the provenance of the people that might be coming to you for Continued Professional Development training, and whether you'd be able to back what I've just said up, with statistics?

JC: Probably not. I mean, in terms of funding responsibilities, most CPD is funded through the school's formula, that is where the majority of money for CPD goes for their formula, will go to schools. They are responsible for determining their budgets and determining priorities including expenditure on CPD within that. The agency has responsibility for some relatively, within a total amount of money, some very limited CPD programs. One of them is a Post Grad Professional Development program which is for award-bearing courses for certain teachers, and that's a limited amount of money which has been in existence for very many years. More recently, it's in the process of piloting and establishing a Master teacher and learning program. But most of the resource would go through the school grant to schools to make those decisions, about where their priorities lay in terms of CPD. The agency, in a broader sense, is seeking to broaden the range of advice it gives to schools on how it might deploy that resource, but it's not actually the funder of much of that training.

PD: Thank you, Jeremy. I'm conscious that we've only got a quarter of an hour left in this session, and we need to hear some of the impacts of this current formula on the schools' departments at the local authority level, so could Susan Fielden from Somerset give us a few words?

SF: Thank you, I'm Susan Fielden and I'm the Children's Services Finance Manager in Somerset County Council, and I've been part of the formula review group that Stephen was referring to earlier.

One of the things I'm particularly interested in is the connection between the way that resources are allocated and the policy, and that's something that we strive to achieve in our local formula in Somerset. We operate an activity-led formula and have done for many years, and it enables us to do a reasonableness check and to be able to describe in words what we have achieved through a lot of complicated calculations. And so, for example, we've welcomed the development to look at pupil population data rather than general population data in relation to sparsity, but the key is what you do with the data. How sparse does an area have to be in terms of pupils in order to need a small school, and then how much extra does a small school cost?

We have ten or so schools in Somerset with fewer than thirty pupils, and the costs in those schools are very much higher, and we're even looking at reducing the funding next year for those schools down to only enough for one class which is, as you can imagine, not going down terribly well. But the trick is, not just how you collect the data and how accurately it reflects the need, but what calculations you do with it and whether, when you get to the end, you can explain that as a mechanism of funding that does connect back to your policy. So what is it that we are trying to achieve in terms of educational provision in a rural area? Is it lots of small schools, or is it lots of transport? Is it children travelling for over an hour on a bus each way, or is it provision in a local small school in possibly multi-age classes with not much of a range of teachers to bring additional specialisms? And I think that's certainly one of the aspects that we try and look at in our local formula.

I think the other aspect of matching resources to policy relates to how easy it is for a local authority to change its pattern of distribution. You've mentioned closing a lot of small schools, and essentially centralising provision in more urban areas in bigger schools. In doing that, you make the saving in the ring-fenced schools' budget and the extra cost of transport falls on the local authority, so you can't offset one against the other. If you are trying to encourage amalgamation of small schools, you can get some very positive responses from schools and the local communities up to the point where they realise that the specific grants that the DCSF provide over and above the main formula have a lump sum element, and if they were one school rather than two, they would lose a substantial amount of funding. So the ability to change the pattern of provision has got all sorts of hiccups all the way through that, whilst I do understand that the Department won't wish to develop a formula that funds actual provision, it needs to be slightly more possible to flex your provision to match the funding that's available.

One of the other points that Stephen was making was about the different strands of the formula. They all need to be roughly right in order to get the overall balance. When we've looked at how we fund deprivation in Somerset, the notional amount that we get for deprivation when compared to how much we then allocate out to schools, there's a gap of about thirteen million, so we're not passing on to our

schools as much as theoretically we are receiving. But if you looked at…if we used our formula for funding schools, and if all of our primary schools were fourteen class primary schools and if all of our secondary schools were twelve hundred place secondary schools, we'd save thirteen million. And we also spend ten or so million more on high-cost pupils than the formula does, so it's a balancing act and you need all of the bits in it to all add up to describe something that does match the policy.

AB: Something about relative funding, I think my colleague, David Heath, has confirmed to me several times that Somerset views in the way Northumberland does, the surprising disparity between its funding per pupil and that of authorities like, say, Westminster where there may some factors, teacher cost factors or even first language issues which are relevant, but the disparity seems very great. Have you developed an understanding of why, in the formula, this is?

SF: I think part of it is the considerable emphasis on deprivation that Rita was mentioning. We've probably got the wrong sort of deprivation - it's in the wrong places, it's not grouped enough together, it's not measurable in the right way – and whilst many of our teachers may be towards the end of their teaching career and at the higher end of the salary spectrum, that doesn't count against extra costs in London. It's not recognised in the same way, and I think that one of the aspects that Stephen mentioned about free school meal eligibility, the annual census that records pupil data from schools allegedly collects data on free school meal eligibility but the child has to be taking up the meal in order to count. If the child is not taking up the meal because they're not very nice, then you're missing data about eligibility. We have one of our schools where there is only one child who has come forward as eligible for free school meals, and they can't find a supplier that will provide one meal a day without paying ten to fifteen pounds taxi every day for one meal, which has to be a sandwich because by the time you've driven it that far, it's…you know! So that's deprivation in the wrong sort of sizes. Scattered all over the place and not really very measurable.

LC: Can you remember what the disparity between Somerset and urban authorities is?

SF: Our difference between Somerset and our average funding and the average across the country, is something in the region of two hundred pounds per pupil, which would translate to twenty or so million pounds, which would go very nicely in Somerset for schools.

PD: The league table, I think, extends from…is it City of Westminster has the highest funding?

SK: City of London.

PD: City of London, I'm sorry.

SK: But that is slightly an anomaly.

PD: It is, but that's close to seven thousand pounds and at the bottom end, it's close to three and a half thousand pounds, which I think is about twice, from top to bottom,

something of that order. I believe I have the distinction of having, in Shropshire, the lowest funded school in the country. That's not in my constituency, and that's obviously a choice between the local education authority grant and the choice within the county. Graham, I'm just going to have to apologise, I've got to step out in a few moments. I think this is extremely interesting and I'd very much welcome the opportunity for Stephen, if he's got the time, to listen to the next session because I hope he will get something out of it as well. I can't continue to stay. Dan Rogerson's kindly going to take over the Chair while I step out.

GS: Susan, well this is fortuitous timing – here we are, we're going to be able to report in, got the Department looking anew, we've got a General Election coming up, we'll have a new Government of some description and it's a great time to get some change in a system which apparently, successive Governments – it's not all New Labour's fault – have tended to minimise the importance of rurality and exaggerate, perhaps, deprivation in the funding formula.

So we've identified the problem. What do you most…what can we most press the Government, whichever Government it is, to do that will most likely lead to a change? Because our difficulty is as MPs and mostly not too hot on the complexities of the formula, we bounce off the geniuses in the Department who are masters of it and then their political masters pull at whatever prejudices make the final decision, and it seems like successive Governments have been prejudiced against rural areas. How do we break that?

SF: I think there are two things for me. One is, as I mentioned, the sort of reasonableness check. By using an activity-led formula in our schools in Somerset, we can explain what we've done in words, in words that relate to school activities so that if we've got reduced funding, then we can have a sensible conversation with our school representatives about which aspect of the formula we reduce. Is it about assuming we have larger class sizes? Is it about reducing activities in relation to teacher development, or whatever, so we can pick aspects of the formula and that influences where the targeting goes. And we have that conversation based on a shared understanding of policies and priorities, and linked to the Children's Trust. So I think part of it is about not getting bogged down in the complexities of the formula, but seeking to understand when that emerges with an answer, how does that reflect back to? What would that actually fund in reality in a local authority? And ask for a description in words, not numbers.

I think the other bigger challenge, though, to be honest, is redistribution, so if you were looking…and I would love to see better funding for rural areas, but unless there's growth funding, it's got to come from somebody else and that would probably be areas of greater deprivation, and that's going to be a really difficult thing to expect to happen. And so the management of the change is, I think, a bigger issue than getting the data right.

GS: I would tend to agree with you. There's a person I always quote – I think there was a civil servant in the Treasury who said, 'When we make a change, you never make the people you make happy as happy as you make the people unhappy, unhappy.' So those in the East Riding who finally get the fairer funding, they'll just grunt and go,

'About time,' whereas those, if some urban area loses its money, it'll be screaming and blockading Downing Street and any Government will back off! So I think you're right, but nonetheless, the first thing to do, if there was a new Government and there was a new Secretary of State, the first thing to do, you might say, 'Well, if you care about rural funding, come and talk to me about what we should do.' You've got to win the argument and at least, if we decide on the destination, they will then have to live with the political realities of getting there.

SF: Yes.

GS: And the floors and ceilings, and all the rest of the things….

SF: Yes, let's get it right first and then….

GS: And slow change. But if you don't get the destination in mind so it's…and notwithstanding the difficulties of the second part, persuading the Government that what we've got is incorrect and that there is a…and then getting a consensus on what it should look like. It still seems distant to me. Have you got any…how would you do that?

SF: One of the reasons that I have made the effort to come along to the Formula Review Group is that it feels to me that it's perfectly possible for rural local authorities scattered far away from London to not be able to join in the debate about the way that the formula works. And I wonder how strong the voice is from representatives from rural areas, and the debates…

GS: So the F40 group hasn't been effective enough, then?

SF: Oh no, no, I wouldn't….no, the F40 group is very loud! (laughter) I can hear them muttering behind me!

DR: One of the…and I'm sorry, I missed the very beginning of this session, so this may be the first question that was put to you and if it is, that'll be a quick answer, but one of the questions we had on Health is, from one of the experts who came to us – do we actually need a formula at all? Could we just have funding that goes per pupil to local authorities? What would be the effect of doing that, given that what Graham was saying, if you went to that model, you wouldn't have to do it overnight but you could get there, but that could be the direction of travel? What would be the response? Because the alternative is, in a lot of these things, to get a formula to be more accurate, it has to be more and more complicated and there are always downsides to every complication you add as well. So I just wondered, you know…..

RH: A huge loss of resource to London and the barricades that your colleague was describing outside No.10, I think.

AB: From London, you mean?

RH: Yes. The simpler you make the formula, almost inevitably it will shift money out of urban into rural areas.

DR: But particularly London?

RH: Because of all of the adjustments on things like higher London costs, I would expect it…

SF: And deprivation.

RH: And deprivation, I would expect London to be the main loser which has much greater access to the media than Somerset.

AB: It would go down very well in my part of the world!

SF: Yes, it would.

DR: I suppose one thing that interests me is the fact that you mentioned, Rita, earlier on about, why Cornwall loses out because of the low cost of living and all of those sorts of issues – so therefore, not having spoken in detail to David Heath about it…your distance from the average is about two hundred pounds per pupil?

SF: Yes.

DR: In Cornwall, it's three hundred pounds per pupil, yet everything that I know about the way the South-West works, despite the pockets of deprivation and undoubtedly there are very deprived areas in Somerset, that Cornwall tends to be worse off because of peripherality but we're further from the average, and so – what is that in the form of? I mean, is that because…I wouldn't imagine the cost of living being different that much between Somerset and Cornwall, so what in the formula is making one hundred pounds' difference?

SF: I think the pockets of deprivation aspect has probably had an impact. It's possible that Cornwall has been too deprived, it seems, and because of the cut-off in current formulas in terms of levels of deprivation, I think…I seem to remember Devon being only just the other side, I think we're one side and Devon's the other side, and Cornwall's probably the wrong side of that line. And that made a significant difference in Somerset, that had pockets of deprivation…

DR: We're at our limit now before we move and change the next set of witnesses. Is there anything just lastly that we haven't covered that you'd like to mention very briefly?

All: No.

DR: Well, thank you very much indeed for coming and talking to us, we really appreciate that and we'll have a short break now while we change seats. Thank you very much indeed.

Second Session – 11:30-12:30

DR: Right, we seem to have assembled so rather than wait a further couple of minutes, we can make a start. Perhaps if we could just run through everybody we've got on the panel so I know who everybody is.

DF: David Fitzsimmons, Principal of Holsworthy Community College and Chair of the Devon Association of Secondary Heads.

DR: A next door neighbour, nice to see you!

DF: Nice to see you too.

MB: Mervyn Benford, the Information Officer of the National Association for Small Schools.

MBr: Mick Brookes, General Secretary of the National Association of Head Teachers.

LW: Lindsey Wharmby from the noisy F40 group and the Financial Consultant for the F40 group.

FL: I'm Francis Loftus from the F40 group, and have recently just retired as a nineteen-year serving Secondary Head in North Yorkshire and before that, I was four years at Berwick as Deputy Head.

DR: Thank you very much, everybody. If we start off, then, with David who's first on our list. Would you like to just respond maybe a little to what we've heard in the general discussion at the previous session, and pick up the final issues before we open it up to questions?

DF: Thank you. I think probably I would say in Devon, we are frustrated that the consultation is not out on the formula funding review because we knew when the three-year settlement came in 2008 to 2010, we predicted we would have schools in a severe situation at the end of that three-year funding period, so we've been waiting for a while to actually try and make our points in the formal consultation. We were told it would be before the end of 2009, then 4th January, mid-January, so we are frustrated that we've not got the opportunity to put that out because we know, if there's another three-year financial settlement in 2011 to 2014, we're going to have real problems.

A child in Devon this financial year receives £378 less than the average spend per pupil. In the next financial year we're going into, it's £393 per pupil. My school is a seven hundred pupil school. For me, that's £275,000 a year in each financial year that I don't get - to provide a quality education service. Last year, there were significant numbers of redundancies in Devon. We're trying to cut our cloth accordingly, but the County Council did not have the money centrally to fund the redundancies required to bring all schools back into budget, so the pressure's acute. Holsworthy Community College is at the centre of a learning community where I

have fourteen feeder primary schools. Now only two of those schools have more than a hundred pupils and ten of those schools actually receive, through the funding formula, we have in our schools' forum a subsidy of £180,000, as Susan Fielden was saying from Somerset. And that money's there to fund the cost of the head teacher, the cost of the school secretary, the cost of the site manager, etc. But that's a subsidy that takes money away from other areas of Devon.

The Devon Association of Secondary Heads – we have thirty seven members, we have thirty seven secondary schools of various sizes. The largest, Exmouth, is two thousand two hundred, the smallest – Dartmouth Community College –about three hundred and fifty. But we're probably, the secondary schools….the thirty seven secondary schools are only ten per cent of the total number of schools in Devon. We have three hundred and sixty four schools. Through the Schools Forum, we are already trying to plan for, if nothing changes, we know we need to rationalise our school provision and we're going through the painful thing at the moment where we are trying to talk about, do we need so many schools based on a Victorian model and a geography that's a Victorian model. And that's painful because those communities, they see their primary school…if their primary school goes, they see it as the death of their community and it puts the education sector under pressure. We're not sure that the education budget should be being used to try and sustain small rural communities.

Things we would like to say when the formula consultation comes out is that we would like to see a more up to date measure of deprivation used. At the moment, Devon is perceived to be in the bottom third, if you look at local authorities, in terms of deprivation. If you used a more up to date measure, we would move into the middle third and that would enable us then to receive additional deprivation funding. As Mr Kingdom was saying, if you go for something like the tax credit system rather than free school meals, that would see Devon benefit.

We would also like to propose that there should be consideration of the area cost adjustment. We can see the need for certain areas to receive additional funding compared to Devon, but we think too many authorities receive the area cost adjustment. Eighty per cent of a school's costs are set nationally. There are national pay scales for teachers, and with single status legislation or job evaluation, support staff are also being paid theoretically on national pay scales, and with the School Support Staff Negotiating Board working at the moment, we will have national pay scales for school support staff, we assume. If you have national pay scales for support staff and teachers, we would argue, why do you need such a huge discrepancy between the highest funded authority, City of London, on a per pupil basis and Shropshire at the lowest. We think that gap is too wide. We would like to see that gap narrowed.

We're also concerned that there is recognition in the formula for sparsity for primary school age children but not for secondary school age children, and we would like to see a recognition of that fact in the formula review. For example, next September, I've been told that I have a hundred and twenty nine pupils joining my year seven next September. I will have to run three thirty-two's and a thirty three. Mixed ability in year seven – what I would want to do in year eight, then, is set those children to

cater for their needs, but I don't think I'm going to have the money to do that, unless there's some additional funding.

We would like to see some recognition, as again Mrs Fielden from Somerset said, additional recognition for the increasing number of what I would call high-tariff pupils, increasing numbers of children on the autistic spectrum disorder, children's life expectancy's now much greater and children with profound and multiple learning difficulties, it's a significant cost. Mrs Fielden from Somerset said ten million spent over and above the Dedicated Schools Grant in Somerset. We reckon in Devon, we spend about six million over and above what we get. So we would like to see some kind of system that recognises that need and there's also a frustration in Devon that we think children have got a statement of educational need – actually, it's money out of the Dedicated Schools Grant that's funding their needs, when actually, we think at times, those needs are medical needs and should be funded possibly through the Primary Care Trust.

We would like to see an activity-led funding formula that isn't based on a historical model of Spend Plus. Devon spends very little because we get very little. We'd actually see a formula that actually recognises what is required to actually fund the education, and in trying to press for a review of the formula, we've been told, 'Well, in Devon, we've looked at your school budget balances and some of your schools don't have six figure deficits, they've got surpluses.' When you look into that, it's largely to do with the cost of staffing. A teacher at the top of the scale, UPS3, will probably cost the school – not what the teacher gets in their pocket – but will cost the school £45,000. If you're able to employ a teacher in the early stages of their career, the cost to the school will be £30,000. And so some schools have been fortunate in that they've got a staffing profile where they're not paying UPS3 in significant amounts, and they can get a lot more teaching for the same money that's coming in.

As I said earlier, we are seriously looking, as an education forum, of putting forward proposals which are not popular, about how we try to federate schools, but it's a slow process. If the formula doesn't change, we won't be able to put things in place for September 2011 to say, ok, we need to have fewer schools, we need to have fewer head teachers. We can't move that quickly, so although we're trying to move to that case and if a head teacher resigns from a school, it may be that the Governing body is asked to consider not appointing a head teacher and looking for opportunities to federate.

Equally, we're concerned in planning for the next financial year, recent news that Exeter has been granted unitary authority status, and if you take out five large secondary schools out of the thirty seven that we've got there, we're very concerned that the thirty two secondary schools left – and the primary schools aren't in rural Devon – our costs are going to increase significantly, and we won't have the economy of scale we've got if Exeter's allowed to go to unitary authority status.

My school has the highest percentage of pupils that are transported to school by public transport – that's seventy five per cent. Out of entitlement and because

we're a comprehensive school, we actually use some of our specialist status money to fund transport on a Monday to Thursday evening, so for those pupils who normally would have to catch the school bus at a quarter to four, or they want to stay and complete their GCSE course work, we actually fund transport which costs us about £12,000 a year to enable those pupils to stay, get on with their course work, catch up on whatever it is, take part in extra-curricular activities and then we get them home. But that cost falls on school finances.

The Fair Funding Campaign – we really hope that we will be able to see a change in the formula that sees Devon and other authorities such as Somerset and Shropshire, see the gap narrow. We're not expecting to get £393 per pupil extra in 2011, but we would like to see the gap narrow somewhat.

I think rural isolation is an issue. Mr Coninx from the TDA was talking about putting on training. The Specialist Schools and Academies Trust seems to think that if training happens in the south-west, it has to be in Bristol. And it's even worse for schools in Cornwall, but the amount of time my staff have to spend travelling to events – the Examination Boards I think are the worst – you can't deliver a GCSE syllabus and mark the course work unless you've been to one of their Exam Board courses. Sometimes, the nearest course for us is in…we've had Birmingham for Design Technology, Portsmouth…and that's a significant amount of money out of my training budget that actually goes on travel, not on paying for the cost of the courses.

One of the problems we face – I advertised for a Head of Maths last year. I had one applicant. That's because I'm unable to actually offer the Teaching and Learning responsibility allowances at a higher level, so we tend not to attract significant applications for posts. We do get, referring to the earlier discussion, we do get very good initial teacher trainees from Exeter universities and University College Plymouth, but I would love to have some Graduate teacher…people on Graduate teacher training programs, but I can't afford to pay their salaries in training, much as I would like to have them. So I think probably, I'll stop there.

DR: Thank you very much indeed, that's a very thorough introduction. I mean that as a…it was very, very helpful to get the picture of what you're facing. Do colleagues have any questions?

GS: Right, I wonder with such a large panel, Chairman, whether we go right across the panel!

DR: Next on the list, we've got Mick Brookes, let's have your perspective.

MBr: Thanks very much. I'm speaking not only as General Secretary of the NAHT so I've got sort of an overview, but also as Head of a small primary school in Fenton, Lincolnshire for seven years and a Deputy in Lincolnshire as well. So I understand first-hand what it's like to run a small school.

Our view is that actually, a debate between primary and secondary funding is a sterile one, and also a dangerous one. And many of our colleagues in primary

schools would love to have the levels of funding that they currently see in secondary schools. We do not think, as an association, that money should be drawn from one area and put to another. What we need to do is see how funding levels can be readjusted and I think, to be slightly provocative, I think we've missed the boat here a bit because this should've happened seven years ago. And it would be much easier, wouldn't it, to redistribute money on the back of rising school budgets, and we know that the amount of…well, the increase is likely to be 0.7 per cent in 2010 and Lord knows what it's going to be in 2011.

So with that as a background, we also believe that the rural school, and particularly the small rural primary school, is the glue of the local community and unfortunately, it's becoming unstuck and…for instance, I was at a meeting the other day. The Head of a small school was coming there. She was late. She said, 'I couldn't get here because I had to go and get the leaves out of the gutter because there's just nobody else there to do it.' And these are the sort of stories that are legion. When I'm talking with my colleagues in Cornwall, and I say, 'Well, look, all of these things that you're having to do, running around, health and safety, HR and all of these things, plus a very large teaching workload, plus having far less support than any others…those are things you shouldn't have to do. Therefore, we have to look at ways of clustering schools together – and there we do agree – clustering schools together to share that support but the Head should not have to do it.' Their response was laughter because they're just so used to, you know, being the person that clears out the drains etc. etc.

So, we have a difficulty here, I think, of there certainly needing to be greater funding but greater working together and cohesion in small schools. And we do think that there could be, I think, greater innovation and looking at the way in which small schools could be used. I know Mervyn, on my right here, has referenced some small schools where they really are the hub of the local community and for instance, there is a post office on the site. And of course, in primary schools, surplus places aren't exactly that. They're actually surplus spaces, so when spaces become clear, there could be an opportunity, for instance, for a library in a small rural school.

So we think, absolutely, we do not want to see the closure of small schools. We do want to see ways in which funding of those schools can be altered to make sure that children in small schools with special educational needs have the support that they need, and I know we've heard previously about the CPD, professional development for teachers, and the way that formula works because it is on numbers per head, therefore the smaller amounts mean you don't have the economies of scale. And then, you do need to be adjustments. But I'm just really very worried that we're several years too late in this, and we should've taken those decisions a while back. But we are where we are and this, I think, is a very strong argument for protecting funding in education per se.

PD: Thank you and my apologies for missing David, I think I missed that contribution. Can I just ask you, in relation to what we heard from the Department about how the formula is going, if we move towards a stronger element of capitation payment, for small schools where the…like we heard in Somerset, there are many under thirty

children, how would you address the problem that arises if capitation is the primary determinant? In that there won't be enough funding to keep those schools going?

MBr: Yes. If this is about per pupil funding, and of course, most of it is because actually most funding systems still have seventy five to eighty per cent which are based on pupil factors. There's some additional funding but that's the base amount, additional funding put on top of that – the largest slice of that, of course, is for deprivation. But deprivation actually tends to be something which goes to city and urban communities, and I know there is separate funding, a small amount for pockets of deprivation. But it's looking at those things on top of the pupil premium which I think would make a difference.

PD: Do you have any suggestions for how educational authorities should argue to the Department that there needs to be an amount per school? You're getting to the problem that was identified about…in Somerset, where if you have a system, a formula which rewards a particular pattern of provision, then how do you change that if circumstances should change? And I think the anxiety of most of the members of this group is that we have a pattern of small village schools which don't meet many of the tests which a central department might set in terms of the number of pupils to be optimal. They're sub-optimal in size, but the local community decides they're appropriate to maintain a presence for all sorts of other social reasons, as well as educational reasons and often the attainment is as good, if not better, from some of these smaller schools. So how do we grapple with coming up with a formula which doesn't penalise those areas that have got that pattern, and encourage them all into a larger school pattern of provision?

MBr: And of course small schools have a block grant, which is a tapered block grant according to the number of pupils so that helps to address some of the economies of scale, dis-economies of scale there are in small schools. But it brings me back to my first point. If you're going to change the formula with the same quantum of money, there are going to be winners and losers and I think the scenario described earlier is the one that's going to be there. So we actually have to go outside that. We actually have to have a purist view of what's right for children in schools, and that's where we need to lead.

PD: Anybody got any particular questions?

MBr: Could I just add to that, because I think the other thing about city and urban areas is that they do have greater access to other funds. What you see on the funding formula is…I won't see it's the tip of the iceberg, but it's certainly the bottom of the iceberg. There's an awful lot more of funding to be accessed by city and urban areas on top of the funding they already have, so I think that's something to bear in mind.

PD: Outside of Government, you're thinking?

MBr: Such as City Challenge, for instance.

PD: Ok, thank you very much, Mick. Mervyn Benford.

MB: Yes, I represent a small association, voluntary association, which was set up specifically to help schools that were facing closure when the first big rush of surplus places came under the Government of James Callaghan with Baroness Williams then as Secretary of State for Education, and local authorities facing whatever the demands of the Department of the day were, started to close small schools in rather large numbers and that's why we were formed. But we have dedicated ourselves, not only to helping such schools and campaigning with them, if necessary, to try to persuade the local Councils to keep them open, we have also pursued the evidence for the quality of small schools and we, I suppose…I prepared a paper which I'm not sure if you have a copy of? Sorry, I didn't want to go through it, but our principal argument is that if you start looking at economics in a different way than conventionally looked at, you begin to see that there is a cost benefit factor working to the benefit of the finance of the country. And that tax payers are not only getting some of the best results on the teaching and learning that's going on in even the smallest schools, but they're also getting a good economic model which we now argue needs to be looked at as possibly a model for town and city and inner cities. Because principally – and this is what the Scottish Government clearly was impressed by last year – principally, not only did its smallest schools get its best results and its children have a twenty five per cent higher chance of reaching higher education in the smaller schools, and those schools will be in pretty remote highland and island places, they won't be sort of havens of privilege, but also, children from disadvantaged and impoverished families with using standard socio-economic indicators that the Government data included, actually made progress.

And it's very sad, of course, to see in the Independent today but you know, two hundred and fifty million pounds spent on most deprived pupils fails to improve results. Well, if they're in small schools, it does. It does improve results, and the question of how we spend the money is important, as is the mechanism by which we use it and we believe that if we start looking at small schools in terms of the benefits they bring, we will start to discover other factors. For example, the DCSF told us last July – and I state it in the paper – that no more than 5.4 per cent of teachers, which is the biggest expense in most small school budgets, worked in schools of a hundred or less pupils on roll, which OFSTED and we call small schools. 5.4 per cent of teachers…some of those are going to be needed wherever the children go. We're not draining resources from the urban centres or the urban poor in the way that is often levelled at us when we're campaigning, defending the small school model. The benefits of small school education show no better than in a school in the Scilly Islands, when they federated the schools, which made particular geographical sense, federated into an all-age primary school, secondary school, and two little island schools. I've been an OFSTED inspector, and was OFSTED inspector at the time for six years, and when that federation took place, both the larger schools were actually causing OFSTED problems, but the two little island schools with just four or five pupils were getting their second glowing OFSTED reports. And I can tell you, as an OFSTED inspector, that if there is any factor that is disadvantaging small children such as not enough peer group or whatever the arguments that are levelled in closure documents, there is no real evidence to sustain that. It would emerge in OFSTED figures, it would emerge in OFSTED reports and the same quality of report comes from Scottish inspectors, and from Estyn in Wales. Estyn in Wales have said

that small schools are as successful as any others, that's just three years ago and nothing has changed.

And we have to start looking at the benefit from money that we fund. In the end, funding mechanisms are about educational results and what parents and tax payers demand, and that quality is emerging. It isn't costing these inordinate sums that sometimes are said in documents that justify closures or rationalisations or amalgamations, but whenever we do get into a situation where we are campaigning - as in Shropshire, Herefordshire, the Isle of Wight, you name it – inevitably we find that there are money issues...and sometimes, we very much sympathise and with legitimate concern for those local authorities at the level of funding they're getting for things like deprivation and sparsity, and so to some extent, we can understand why the rationalisation pressures are being engendered. But we believe that we need to start looking at a rural educational model, which is successful across the board.

The Commission for Rural Communities has looked at the results of rural schools in primary and secondary across the board, and in successive state of the countryside reports has actually said that just living in a rural area guarantees a better result. Now I think that's a bit over the top, but nevertheless, we have some very small secondary schools that many local authority officers will tell you are below viable thresholds which are getting glowing results. There's a set of results here which would impress Mick, I know, from a school in Herefordshire – a secondary school which has three hundred and fifty pupils. The Cumbrian Rural Academy has secondary schools with under two hundred pupils in one or two of the smaller schools. And they are at the top of Cumbria's secondary school results. If we start focusing on why we fund services like education, then we need to look at the quality of those results and they do argue that there's some other factor at work, and the factor at work which we believe is the most important one is the close relationship between parents and teachers. And there's no doubt that if you get that right at the start, when the small children are coming to their first school and they know that the parents, Mum and Dad are on the one hand and the teacher and the Head on the other taking them all in the same direction, that is enormously effective in generating the kind of results that the Scottish data shows, that the Welsh data shows, that in fact research across the decades has shown. That if we get that right, that model, we could use that in our tough, difficult inner city areas. I've done fourteen years' work recently, on and off, in Sweden and Swedish education is quite a subject at the moment nationally, but the great strength of Swedish education is the early years' provision in small units, even in urban areas, which are close to the homes where the children come from, where there's just eighty or ninety children, forty families, fifty families that everybody knows each other, and that factor is driving the success of small primary and small secondary schools in this country.

This school whose results I have here – the Head teacher knows every one of those three hundred and fifty pupils, the secondary pupils, and he has a discussion with them about their careers and their futures and their work, every year with them. That human scale factor is what is currently being funded by no less than four major foundations – Paul Hamlyn, Gulbenkian Arts Foundation and Esmée Fairburn, Human Scale Education, a partner organisation with us – they're funding that to the

tune of four million pounds to create small scale in existing large schools. Just down the road in Richmond, there's an argument developing called PAUSE – Parents Against Unwanted School Expansion. The issue of size of school is becoming quite critical. There's a lot of evidence that parents are not so happy as schools get bigger. So why don't we just generate funding that enables the small schools that we have to survive, and then develop that model, in all ways it can be developed, in order to create a success that would be a national success? And that's really the position we stand by.

PD: Thank you. Do you have any specific suggestions when it comes to the narrower issue of allocating the money that we have, as to how we should go about it to benefit the small schools that you've been struggling to save?

MB: Well, certainly, we need to build in those block factors that are ring-fence factors which enable what we call diseconomies of scale, which we believe are economic virtues, to enable those to work so that schools are not starved of resources to the extent that we now find for example governors in Lincolnshire closing their schools because they can't meet their budget. We've heard how budget factors can vary from school to school according to the age and experience of staff. These so-called factors need to be protected, and we don't believe that it's going to cost very much when you think that no more than 5.4 per cent of the national budget is being spent on small school teachers. And so we believe that we need to look seriously at a model of investment which values small schools for the quality they represent, and enables local authorities to develop all the kinds of community links, and small schools with community links has been one of the factors that we always acknowledge, even in closure proposals. And the parent partnership links - in a small school, in a small village with four pupils, you don't need Sure Start. I mean, you know the families have got babies. You could talk to them about what's in their lunch box if you're worried about diet, or what's important in Maths homework. I mean, the relationship factor is so powerful in education. Fifty years ago, I started learning to teach in King Arthur's College, Winchester – fifty years ago, and I've seen it all come round and round again in a kind of cyclical debate, whatever it is, streaming, you name it, or choice – whatever the arguments are, it goes round and round and round and this urban/rural funding one has been there all the time. We need a model of education which recognises what works, and then funds it.

PD: You're straying towards the political choices that any new Government's going to have to take, or any Government's going to have to take, and we're really here to focus on funding. I don't mean to, in any way, belittle the contribution that you're making because I think you're absolutely right but you are preaching to the converted! Everybody sitting round this table believes passionately in what you've said. Has anybody got any specific questions on that? If not, I think we'll move on.

DM: The only question might be is that does the pupil teacher ratio come into the factor? You were saying that a small versus the big school, but…

MB: I could cause some upset amongst my professional colleagues, but as an OFSTED inspector, we used to watch lessons and the quality of the lesson and we put how many children were in it. And I used to ask regularly, Chris Woodhead and other

people, do the computers throw up, after six years, several million of these lesson grades, any correlation between the quality of the grade awarded for the teaching and the numbers of pupils in that lesson…those lessons? And the OFSTED computers have not yet managed to do that. There has been a lot of research. Way back in the seventies, NFER did some research which also was relatively inconclusive. We have plenty of small schools where the classes are up in the twenties anyway because they've got a roll of eighty or ninety, or getting on for a hundred or so. So I think it's an open question, that, but what isn't an open question - and Estyn in its report to Wales in 2006 actually reported this – namely, not only did small schools do as well as others, but the quality of the relationship between parents and teachers was very high and was contributing. That's the factor which we think is driving it.

But you asked for the mechanism, sorry. I meant to say that when we were discussing reorganisation in Northumberland, the chief inspector told us that that year, they actually had less grant for sparsity than Birmingham. So we would say that there must be something wrong with a system which notes that, and therefore, that's one suggestion – can we look at a better mechanism for sparsity and deprivation.

PD: Thank you.

GS: A quick question, if I may. Just on...you said five per cent of teachers are teaching in small schools. I mean, and then you quite rightly passionately have given the case for small schools, but they cost more, don't they? So if you want to take the five per cent model and apply it everywhere, you're talking a massive increase in expenditure on an already massively increased expenditure at a time when, as Mick rightly says, we're looking at anything but a massive increase in expenditure. So…

MB: If you're throwing reality at me, I can't deny that but what I can say is that small schools…when the Scottish Government looked at the cost of education, and it has been mentioned earlier by Mick, when they looked at the cost of education, the total cost of education, they found that children were getting more spent on them in Aberdeen and Glasgow and Dundee and urban areas which were mainly large urban schools, than in their mixed rural and urban areas like Morayshire, Angus and Dumfries. And so in fact, we believe that for the debates about closure to be premised on just those narrow unit cost figures using only the school's devolved budget, is unfair because in fact, in any county, whatever county it is…the amount of spending on children's education is likely to be much higher than in those individual devolved budgets.

GS: One more, if I may. The biggest problem we've got, and I've had this ever since I was elected, talking to everyone, Jim Knight was the Schools' Minister and he represents an area similar and so sympathetic – he was sympathetic – but, you know, he said at the time, 'Well, one of our problems, of course, is that the East Riding and Dorset, despite having low funding, actually manage to do quite a good job.' And despite politicians always saying they like to reward success and punish failure, they actually…the reality is, we all do the exact opposite. All Governments have and we tend to reward failure and punish success. And we're struggling to see

how we get out of that because rural areas, as you said, rural areas deliver generally a better education despite getting lower resource. Any thoughts to throw into that?!

MB: I mean, our argument is that the fact that most works with young children, particularly in primary education, most of our members are primary schools, is that close relationship with home. If we could generate that in any school, then we'd get quality of results. But what we're concerned about is that at the moment, the pressure to build academies, the pressure to build larger schools, the pressure to have one Head as a shared executive over several schools is actually being converted by local authorities into pressure to close more village schools. And if that trend continues, we represent now no more than ten per cent of the total stock of schools, primary schools, and that ten per cent will disappear if the present trends continue. And if funding is the argument for these rationalisations and reorganisations, then there's a problem with funding because it's denying the best results.

PD: Thank you, Mervyn. I think we're going to have to move on to the F40 group now, so if Lindsey Wharmby and Francis Loftus could….

LW: Listen, if you plot spending per pupil against outcome, it's always going to be a negative correlation. The more you spend on youngsters, the poorer their results are and that's because our whole funding premise is based on, we fund according to need. And if you take a simple analogy, if you look at the amount I have spent per child on my two children on their eyesight, I'd have to say that the one with really bad eyesight had the most spent on her. The one with perfect eyesight had very little spent on her – in fact, nothing spent on her eyesight, now I come to think about it, but there we are. So we fund according to need. So we're not arguing that we shouldn't. We're arguing precisely that, that you should fund youngsters according to their needs and therefore, if you have an authority with a very, very high number of youngsters with special needs, with extra needs, support needs, you're going to spend more funding per pupil in that authority and we're not going to argue with that.

What we're arguing about is that we're missing out – it's what we said earlier on – we're missing out on a particular need which is to do with rurality, and that is different from some of the deprivation, educational deprivation, that you get in inner cities. The educational deprivation that you get in rural areas is different and is, if you like, in the sort of modern terminology these days, 'less sexy' than your urban deprivation and therefore it has been missed. And that what we haven't done is really looked at the additional costs of running small schools, and I'm in favour of small schools in rural authorities – actually, I'm in favour of small schools, but that's an irrelevance. I'm recognising that there'll have to be small schools in rural areas simply because I believe in education and not in bussing children, and children spending hours and hours on transport is never an answer.

So, we're going to be running small schools and their unit costs are higher and sadly, we can't afford small schools across the country but we're going to have to accept that we've got to have them in rural areas, and we want them.

And we've got to look at the real additional costs, and what you can't do is simply go to an authority like Somerset or Cornwall or any of the others, and say, 'How much subsidy do you give to your small primary schools? Ah, that's the cost of rural sparsity,' because it isn't. It's what that authority can manage to afford to pay. So it's very, very bad to make the assumption that if you look at present patterns of expenditure, you're looking at patterns of cost. You're not. You're looking at what the authority can afford to give, so if Somerset, or North Yorkshire, for example, which I happen to know better, right? It doesn't apparently spend all of its sparsity subsidy on subsidising its small primary schools. Actually, because it subsidises its small secondary schools as well, and that isn't there in the formula. So what they're giving to their small primary schools is what they think they can afford, and not necessarily what the school needs.

So we have got to have a much better look at what it really costs to provide a good education and I know that the results are very good from rural areas, but you're not comparing like with like. A small rural school may have a small number of youngsters in it who need support. A small urban school could have a hundred per cent of youngsters in it who need extra support, so you're not comparing like with like. So never do that, because it's really dubious.

So, we need more support on the real costs, and the final thing to remember is that all the time we're talking about how to get the money out to the local authority. And we're not talking about how the local authority will use its formula to fund its individual schools, because there will be very, very different patterns across the country. There is a big difference between Tower Hamlets and Cornwall. There is actually big differences between, you know, Northumberland and Shropshire in terms of the distribution of urban areas and so on, so each authority has to find its own solutions. That's why we have a local authority system in education and one size doesn't fit all. But do remember that what we're talking about in the formula distribution to the DSG is simply getting the lump, the money to the authority and in it, you have got to recognise the extra costs that will be inevitable in rural areas. And that's what, I think, we've missed out on in the present formula.

PD: And do you have some suggestions as to how we do that? I think you're right, you've identified the nub of the problem and what we're trying to come up with are some recommendations we can encourage Mr Kingdom and his colleagues to take account of.

LW: Yes. Well, I think we have to look harder at the costs of sparsity. I mean, we know where it is. We've got much better data now and I think there are two issues on the DSG, on the consultation that I hope will come out shortly. The one is that where we have better data and we can see that it's better data, that we should use it and clearly, data that is based on the number of children in the schools in the authority is far better than simply some kind of census, ten year out of date census, which counts all the old people in as well as all the young. You want the sparsity of children in maintained schools. So that's the first thing, so we've got better data, that's really good.

But then you're going to be making choices and they are political, with a small and big 'P', on what you do with that distribution. And, you know, I think we're going to have to be honest like Mick says. We're talking now about a redistribution of…because we're not going to have a vast amount more in the Education budget, so we've got to look really hard. But if you decide that something is unfair, accepting politically that losers always shout louder than winners, isn't an excuse for not doing something. You've got show a bit of leadership occasionally and say, 'This may not be popular, but this is better and this is fairer, and we've got to do it.'

So we've got data, and then we've got decisions and I think we've got…the data I worry about is the data on the costs of sparsity, because I think that they've underestimated the costs in schools because they've just looked at what the authorities can spend, and they've underestimated all those little super sparsity issues. If you have youngsters with additional needs in a small school, you're only going to have one or two. It costs you more to look after those than if you've got five or six in the class.

PD: I think the children with special educational needs are a sort of separate category…

LW: They are.

PD: And I think you said that earlier. I think that's sort of broadly accepted that that's countered by the individual having met the threshold.

LW: No, I agree with you. I should have said additional needs. But there are all sorts of other little issues that are very difficult to quantify that are there. Somebody mentioned supply, right. If you are in, as I ran, schools in large cities, right, you may only need one specialist history supply teacher in a term but you've got a pretty good pool in Leeds to pick from. But if you're in the North Yorkshire Dales you've only got people living in the village and unless you're going to pay somebody from Newcastle to come out and, you know, travel. And you just can't. So there are those kinds of costs which are hidden. Every support, every time you have a choice in the education system, whether it be in the curriculum or in giving support to a youngster or use of EWO's it costs you more in rural areas because those become super-sparsity issues.

MBr: Could I build on something that Liz has said because I think the formula for special needs is very important because the high cost, low occurrence children, very high cost special needs, they are estimated in the formula by a combination of deprivation and low birth weight. Where does that occur most frequently? It's in deprived areas in cities. Therefore rural areas miss out yet again. And I think the other – picking up one of David's points – if we were going to look at the sparsity factor then I think we should look at the way in which small schools, the small schools subsidy works rather than transport and other things like that. And I think that would begin to answer some of those issues that I think are very dear to David's heart. And I think that would be a very good place to look in terms of turning a formula around to make sure that those small schools are properly supported but not at the cost of the other schools in an authority. Those authorities with small schools do, per se, have the lowest levels of funding, as you know.

PD: Before I bring in others, are you suggesting that we should look at a completely inverse way of allocating special educational needs payments so that there is a central pot and authorities who have – if we work based on annual censuses of school children we can determine each year which children in each school have this, have extra requirement and they can, the local education authority could bid to the central pot for that requirement, rather than have it allocated at the beginning of the year.

MBr: I don't think it's necessarily – sorry, Lindsey – I don't think it's necessarily either or, it's the balance. And so there does need to be some centrally held money so that those children who suddenly appear in a school with 50 other children actually create havoc, not of their own volition of course, but actually covering them. So there's money there but we don't want to see a lot of money left in the local authority either. So it's getting that balance right.

LW: But if you're talking about the youngsters with very high cost needs, which is an area I've done a lot of work on, one of the problems we have is that the present, well one of the suggestions in the DSG work was that there are better proxy indicators than the ones we use at the moment. But there comes a point at which a proxy indicator simply doesn't work so that, for example, if you look at the distribution of visual impairment across the country, it's irrespective of deprivation and it's fairly uniform. But if you look at those, the tragedies of the youngster with very, very severe, multiple disabilities it isn't correlated with anything because they are those tragic, random events. And therefore, because they're random, it can be very unfair if they land. You know, I always say that if you take a youngster who may cost £300-400,000 per year and that is not unknown, they land up in Rutland and you've wiped out a couple of Rutland's schools almost. So there is that problem of the very, very high cost.

PD: And at the moment those incidents have to be absorbed out of the overall pot. There is nowhere to go.

LW: No. The authority has to cope with things.

FL: One of the suggestions you've been looking for – practical suggestions – one of the suggestions we've discussed in the F40 is that that funding for those youngsters are actually regionally based on government office areas and the LEA that faces, the local authority that faces youngsters like that, which aren't very common, then get that direct in and it doesn't drain their budget. So if a youngster appears in Arkengarthdale in North Yorkshire, for example, and North Yorkshire have to find £400,000 from the Children's Trust and if they route it through the Children's Trust then the PCT – somebody mentioned the PCT earlier on – the PCT can be involved in that because there is shared funding there. And it's those practical answers that we need to search for, particularly in rural areas. Sorry. Not my turn.

PD: That's very helpful.

GS: Yeah, particularly the practical point about looking at it regionally is an important one, though I think the optimism about Children's Trust sharing the budget is running far ahead of the reality. Can I ask – if we win the argument politically, particularly given where we're at and going forward, it's going to be so hard – we need moving cases, we need opinion columns to be written in newspapers just saying how evident this imbalance and unfairness is, evidence of that. Because I know you looked frustrated when I mentioned earlier about Jim talking to me about the results but if you, if it doesn't look bad, if in fact the overall result generally speaking is better than in most urban areas, where's the beef? Where's the drive for change? We need, particularly – we might have been able to do it seven years ago but there wasn't the political will – now even if there is the political will, even if a change of government inclined that way if that were to happen.

The truth is, we may not be able to do it unless we can make a really powerful political case and it won't be about technically measuring a few costs here and there and showing that they're not being covered. You're going to have to do a lot better than that in the environment we're moving to, to win the argument and get government to change and take the pain which it will doubtless face from those who are losers.

LW: But the DCSF themselves produced the data last year or the year before – I can't remember now – in which they looked at the success of youngsters coming from socially deprived backgrounds and said that those from, on free school meals, if you like, a simple measure – those in urban areas, in other words in areas of high density of deprivation did better than those who were isolated in more rural authorities. And that's the biggest and most telling one. Because there you're comparing like with like. There you were saying: Here are a group of youngsters who we know that there are educational disadvantages associated with social deprivation and you're comparing, you know, as it were, similar disadvantage. But you're quite right, the moment you start looking at the average results in the East Riding, they are better than the average out in Hull. But you're not comparing like with like and you can't do that. Even though most of our media do.

MB: And the smaller ones are under threat, as I said earlier, because of funding factors in local authorities so they've disappeared. That's the issue, not that whether they happen to get the results or not but if they're not there they can't get those results.

AB: Looking again at the transport issue, is there a correlation between those authorities which don't find their rurality or sparsity sufficiently recognised immediately in the schools funding and those who are affected by general local government formulae in the ability to fund transport in rural areas? And secondly, is there a distorting effect around the cost of transport? Does the separation of transport into a different funding stream actually make it easier to ignore transport costs when considering whether a school should be closed?

LW: I'm not an expert on transport costs but I expect that that is very true, the fact that the home to school transport comes out of a different budget makes it easy to leave on one side and I mean there are all sorts of issues that are going to be around once under-5's, the entitlement to under-5 provision and so on and so forth, and

transport issues come in as well. And post-16, local authorities are responsible for all post-16 as well and that's going to become an issue. So I think it is a problem. It's interesting that in the grant that's used to fund the diplomas in 14-19, which is done because, it's done on a grant because the take-up is patchy across the country as it's developing, that grant does have a sparsity factor in the secondary schools, even though there's no sparsity factor in the original ESSF block in the secondary schools. It is there in the grant because they have recognised that transport does become an issue then.

AB: And is there a correlation in the authorities who …

LW: I don't know.

AB: My impression is that there is.

LW: Yes, but I don't know.

FL: The answer to your question is one of natural justice. If we talk, as a country, about fair funding the gap between the best and the worst is huge. I run a school of 700 and I did the same calculation as you, to do that. We've already decided, or they have already decided in North Yorkshire that youngsters will not be given their entitlement to 13 diploma lines because it cannot be delivered because there is not the funding to ensure that there is. But how can you run 13 diploma lines in Upper Wensleydale in a school of 390 which has to exist because the next nearest school – look at Berwick, when I was at Berwick. The next school was the Duchess's, 30 miles away.

AB: No schools in the other direction because they're in Scotland.

FL: None at all because they're in Scotland and that was it. So that's that. The other is that cost pressures on pre-school and the early years which we haven't talked about very much, but the early years funding is a nightmare in an authority like ours in North Yorkshire because, to offer the flexibility around it, is very expensive because you can only use the village primary school and therefore the costs are higher than a private provider. And trying to square that circle in the Schools Forum is taking hours and hours and hours. So there's a justice issue here and how that works I don't know, but to do that.

GS: Just wanting to bring those out. Without those examples, one after another, being able to pick up and show how deprived children – the deprivation formula that's about tackling deprivation is in fact letting down a lot of deprived kids. And unless you've got those kind of arguments and you can fill them out then you're not going to carry people, because you're going to have to make that argument against people who are going to say we're taking money away from a deprived area, possibly in Hull, and they're going to say give it to leafy and successful East Riding. And the fact that it's not so leafy and not so successful is a hard point to make if you haven't really done your …

FL: To be fair, F40 has never said that. What F40 wanted to do was to raise the bar, close the gap and we got into trouble for using that phrase because apparently the minister had said it but we weren't allowed to use it. But that's the problem. We know in F40 that if we do take it, and it's not just in F40 – to be fair to F40 – it's not just rurality. There's something going on in Solihull because Solihull is right down at the bottom. Solihull is a member. So there's something fundamentally wrong if somewhere like Solihull is in the F40. So you know, it might be a bigger issue.

PD: Well, thank you very much. I think we've probably exhausted our allotted time and I'm very grateful to everyone for coming today. We are intending to produce some recommendations to give to each of the different parties ahead of the General Election and we would encourage you to – if you've got any more material which it occurs to you would be useful for our report, please bring it to us if you're happy for us to include it and we'd be delighted to do so. I'm not quite clear in my own mind how we're going to arrive at recommendations out of these sessions but I think we've spent more time focusing on the problem than the solution, which is perhaps where Stephen Kingdom and his colleagues come in. We'll leave it to his department to come up with a solution but we'll give you some ideas. Thank you all very much indeed for coming and thank you to the Commission for supporting the effort today.

Written Evidence; Education

Devon Associations of Primary & Secondary Headteachers

Written evidence to the APPG on Rural Services
Tuesday 23rd February 2010

Devon associations are grateful for the invitation to give oral evidence to the group. The changes we would like to see made to the current formula appear on page 3.

Context

One representative has been invited by the APPG and the Devon Association of Primary Heads (DAPH) has requested that the Chair of DASH represent their views.

On a per pupil basis Devon is the 148th worst funded out of 151 English Local Authorities. We strongly believe that the gap between the City of London per pupil funding at the top of the "league table" and those at the bottom has become morally indefensible, if not obscene. Devon's performance in measures such as 5+A*-C including English and Maths is slightly above the national average. Devon constantly overcomes its lack of resources to meet challenging benchmark targets, but the pupils, who are going to lose out with reduced funding are those who do not reach the national benchmark – nearly 50% at the end of KS 4, for example. At a time of reduced employment opportunities for today's school leavers, this surely cannot be right.

This iniquitous position for Devon's school children has led to a campaign for Fairer Funding for Devon's school children and the launch of an on-line petition to Number 10 Downing Street. The model for the campaign has been offered to other f40 members. Currently the No.10 on-line petition has the third highest number of signatures in the Education sub-category, with the petition open until October 2010. *(See links below)*

http://www.fairfundingfordevonschools.org.uk
http://petitions.number10.gov.uk/handsup4schools/

Support for the campaign has been unanimous from both the Devon Association of Primary Heads (DAPH). Devon Association of Secondary Heads (DASH), Devon Association of Governors (DAG) and Special Schools Heads' Association for Devon (SHAD) supported too by the political members of the County Council and Officers. Peter Younger-Ross, MP, recently held an end of session debate on the perilous state of funding of the County's schools.

We are disappointed that Devon has not had opportunity to contribute to the proposed consultation on review of the funding formula variously promised before end of 2009 and then by 4th January, mid-January, end of January and now according to Stephen Kingdom in the oral evidence session before this, before the General Election. Devon has been waiting for the opportunity to respond as we knew the 3 year funding settlement for 2008-10 would create difficulties for Devon's schools. We know that if nothing changes for 2011-14, if there

is another 3 year funding settlement, we face inadequate resources to provide basic education. We would prefer to be able to give a considered response and not have to rush one off in the summer holidays!

We have been running a "fair funding for Devon school children" campaign since the autumn term 2009. In this current financial year a child in Devon is funded at £378 less than the average amount per pupil. In the next financial year the figure will be £393. For a comprehensive of 1,000 pupils this equates to £393,000 per annum. Given that a teacher at the top of the pay scale costs the budget roughly £45,000, one can see how many additional teachers this would add to a school's staffing, with consequent smaller group sizes, let alone additional teaching assistants and administrative support.

Devon has 364 schools, 37 of which are secondary schools. (There will only be 32 left in rural Devon, should Exeter be allowed to pursue unitary status.) In 2009-10 20% of Devon's secondary schools made staff redundant and the rest had to reduce staffing through "natural wastage".

Devon's school budget balances have been scrutinised, particularly since Peter Younger-Ross' debate, but false conclusions drawn. It is not that some have surpluses, because they can manage their allocation correctly, and some have six figure deficits, because they are financially inept. Some schools are fortunate to have additional lettings income, for example, particularly in urban environments. However, the main reason is that some schools have a very experienced, but costly staff. The figure of £45,000 has already been mentioned above. An inexperienced teacher in the first few years of teaching will cost a school budget only about £30,000 i.e. £90,000 will fund only two teachers in one school, but three in another. Formulae do not take account of this.

The pay rates for teachers are set nationally. Single status legislation (job evaluation) has also resulted in greater similarity of pay for support staff and we await the outcomes of the new School Support Staff Negotiating Body (SSSNB). Given that 80% of a school's budget is spent on staffing, we have to ask why an Area Cost Adjustment is necessary outside of London. These staffing costs were predicted to create pressure on schools' budgets in Devon: staffing costs are recurring, national pay deals for teachers agreed at 2.3% have been greater than the minimum funding guarantee of 2.1% and the effects of the implementation of single status legislation have also been increasing pressure on expenditure at a rate higher then income, as support staff have been mostly upgraded in small rural schools and placed on the bottom of an incremental range leading to increased recurring costs over several years. The librarian in my school, for example, is paid the same as the librarian in the largest school in Devon, with 2,200 pupils: same job title, but hugely differing incomes.

I speak as Principal of Holsworthy Community College, a 700 pupil comprehensive in NW Devon with 14 feeder primary schools. There are 700 pupils o roll and about the same total in the feeder primary schools. 10 of the latter receive £180,000 per annum subsidy allocated as a result of Devon's Education Forum formula distribution. Every £1,000,000 million in the DSG in Devon equates to about £10 per pupil via the AWPU (Age Weighted Pupil Unit) i.e. small school protection as a result of Devon's own formula deprives learners in other schools of about £20 per pupil funding. This is the funding implication of resourcing small primary schools in just one learning community (family of schools) in Devon. Were the new formula

to fund small schools in the same way, this would alleviate pressure on other schools, which currently are penalised.

What changes would Devon like to see as a result of the formula funding review?

The ending of the Area Cost Adjustment outside of London, because schools increasingly pay the same for posts as a result of national pay scales.

A sparsity factor for secondary age pupils and not just primary age pupils. Sparsity should be calculated on the population density of pupils in mainstream education and not general population density.

A more up to date method of calculating deprivation that recognises rural deprivation, as well as urban deprivation. FSM is not a robust enough method to allocate funding. As Mr Kingdom has pointed out Tax Credits may well be a fairer way of calculating this. For Devon, we are currently in the bottom third of deprivation funding allocation, whereas more up to date methods of calculating deprivation used by the DCSF would place Devon in the middle third.

An activity led funding formula based on real costs today and not historical spend. Devon spends less, because it receives less. Our own Schools' Forum activity led funding calculation sees schools funded at about 75% of the actual need calculated.

Regional funding of what we might term "high tariff" pupils e.g. pupils with Profound and Multiple Learning Difficulties (PMLD) and the increasing number of pupils on the Autistic spectrum. We heard in the first oral evidence session how Somerset spends £10 million in addition over DSG – for Devon we calculate this as £6 million.

Devon is not being tardy or burying its head in the sand. The Devon Education Forum has a consultation document out for discussion on the educational viability of the current model of provision of schools. We are being pro-active, but the discussion is inevitably a heated and emotional one, as the rural school's budget is seen as essential to the livelihood of the local community.

In the last financial year Devon was unable to fund the required number of redundancies to balance school deficit budgets, as there was insufficient county funding centrally.

We feel inadequate funding is causing us as educationalists to have to look at rationalising the provision of schools in Devon. This is very emotional for small rural communities and we question whether education funding should be the saviour of rural communities, instead of a rural support grant.

Should funding remain inadequate to fund the current provision of schools we will be forced to move to a different model, but this cannot be achieved overnight. School re-organisation will not be achieved for September 2011, for example.

Much has been made of the issue of transport in the first session. 85% of pupils travel to Holsworthy Community College by school bus – the highest percentage in Devon. The

College has to fund additional out of school hours transport four nights a week in term time to enable pupils with no other means of transport home other than the end of school bus, to access extra-curricular activities. This year this additional transport will cost the school about £20,000 funded out of specialist status monies. Urban schools do not face this pressure.

Reference was made in the earlier session to CPD. It is infuriating that the exam boards and organisations such as the SSAT seem to think that training for the South West is fine, as long as it is held no further south than Bristol. Finance for INSET (Standards Fund) is related heavily to pupil numbers. Isolated small rural schools face a “double whammy” of a smaller than average training budget and higher than average costs of accessing the training e.g. mandatory examination board training for GCSE has seen my staff having to go to Portsmouth and Birmingham, as the NEAREST venues offered for training.

Having Initial Teacher Trainees in school has not been an issue for us, but not having sufficient money to fund Graduate Teacher Trainees on the GTT Programme has been frustrating. Recruitment is difficult, as small rural schools are unable to match the TLR allowances offered by financially better off schools.

We are grateful for the opportunity to present our case and should any further clarification be required, please contact us.

National Association for Small Schools

Submission to All-Party Inquiry on Rural Funding by Rural Service Parliamentary Group Tuesday 23rd February 2010

Secretary: Barbara Taylor
Chairman: Bill Goodhand
Information Officer: Mervyn Benford

1. The general tone of debate about rural education and finance is negative. It is as if we have constantly to apologise for the cost. There has rarely been any attempt at cost-benefit analysis. It is time this was done The Aberdeen University study of 1983 for the former DOE did examine the economics of the impact of closure and found several real factors such decisions produced that were disadvantaging and recommended they should be set against the then gathering pace of rural rationalisation. Studies from America and evidence persuading the Scottish Government in 2009 to pass a Bill seriously protecting small rural schools shows there are long-term economic factors that argue cost benefit through reduced costs of educational failure and enhanced learning that leads to better jobs and higher tax revenues.

   Furthermore the negative cost arguments are rarely examined for their credibility, their flaws rarely identified. The Scottish Bill reflected evidence that when total spending on education was calculated it was found that more was spent on urban pupils in wholly urban authorities where schools were invariably large. Focussing too exclusively on pupil unit costs against devolved school budgets ignores massive spending on other children such as the £40m project announced by Birmingham in 2009 for 50 schools with classroom discipline problems to try to reach parents, *something small schools do almost exclusively richly, and almost for free*……..as inspection evidence across the UK well affirms.

   Conventional cost analysis tends to minimise real costs of proposals designed to reduce rural spending, while justifying long-term dividend payments to private companies involved in largely urban BSF projects. Transport now is rarely addressed in closure and reorganisation proposals in anything but a rudimentary way when commercial estimates show that *school bus costs start at £1000 to £1500 per pupil, per year, per five-mile journey and rising*. For-ever decisions like closures, federations and amalgamations add future costs that are inadequately assessed…….if at all. They significantly pre-empt the future of rural communities long-term. A French study showed that when 22 of 50 rural schools were closed, *ten years later transport costs were almost as high as keeping all 50 open and as 50 they obtained better results*!

   Scottish wisdom has recognised fundamental flaws in conventional economic analysis. A Scottish bus and driver now costs more than heating, lighting, cleaning and maintaining the school proposed to close. Two major studies, by Price/Waterhouse/Cooper for the former DfES in 2003 and by Newcastle University for the Design Council in 2005 both showed conclusively that provided adequate

working space, ventilation, sound-proofing and sanitation were provided you could, in the words of the 2005 report, "*change a school from a Ford to a Ferrari with little impact on long-term performance.*" Such studies clearly do not influence BSF thinking, claiming long-term to raise standards, and under which bigger and bigger organisation is unpicking the rich educational fabric of the rural UK, including ours. Funding needs to acknowledge proper priorities. PWC are respected enough by the Department to be involved in this present future funding investigation. Was the buildings research not interesting?

The DCSF told us last July what we have long known in fact, namely that a very small percentage, currently 5.4%, of all primary teachers work in schools with fewer than 100 pupils, invariably but not exclusively rural. Schools under 50, the prime targets for closure or federation, will employ an even smaller percentage. Some of these will be needed wherever the children attend. There is and never has been the alleged massive draining of resources by small rural schools from the rest and we should not be apologising for it. *Small is not always beautiful but it IS effective*. The evidence exists.

2. The Scottish evidence conclusively demonstrated, as invariably shown in national and international research, that children from impoverished and disadvantaged backgrounds do well in small schools. It is the same close and effective parent-teacher partnership factor. Society today is very worried about family and neighbourhood breakdown, young offenders, truancy, educational failure and disaffection. It is worried about quality of teaching. Sue Palmer's book "*Toxic Childhood"* exposes the dismal picture that earlier persuaded three former Secretaries of State, now peeresses, to initiate an investigation into the nature of childhood today. Small schools in rural communities have long provided the answer and *NASS argues for small schools in our towns and cities*. Ofsted's 1999 comparative study reported quality of teaching better in small schools and proportionately more good teachers.

   The Commission for Rural Communities annual *"State of the Countryside*" reports show that living in a rural area brings better results despite minimal levels of choice. There is quality in the educational model, one seriously tied to smaller, more manageable size. Provision of resources needs to recognise the virtues of what is being done. Small schools are argued to be havens of social privilege and so better outcomes are to be expected. This may be true in commuter counties adjacent to large Metropolitan areas but it is not true across rural UK as a whole, nor even rural England, as income levels clearly show. Grant allocations to such low-income LEAs has been seriously awry threatening the rich fabric of rural England, something DEFRA predicts will be wanted by more and more people in coming decades. Yet, within this somewhat perverse assumption of rural privilege, funding has strongly favoured urban Authorities.

   The attached charts show that in sparsely populated regions of England and Scotland levels of disadvantage are now almost as high as in the inner city but with outcomes far better. This again influenced Scottish thinking. *Long-term small schools are profitable to the Exchequer*. Professionally they also well address *hoary,*

unresolved educational chestnuts like mixed age and ability, summer-born syndrome as well as social attitudes and behaviour. *We need funding mechanisms that recognize, serve and protect these very significant and desirable virtues*. The TES has just covered three pages with praise for Finnish education. It has rightly identified two contributing factors but omitted to mention that average primary school size in Finland is 50 and that reading together at home is a distinctive cultural strength.

3. Ofsted in 1999 and the new Cambridge Review of Professor Robin Alexander in 2009 *both argue a place for small schools in national provision as a whole*. Both do so on the basis of their academic attainments and the strength and quality of their relationships with parents and their local communities, the majority rural. It is a model rooted in people, and people factors are the ones consistently confirmed in research as enriching educational outcomes. Estyn also noted the significance of small school relationships with parents in its 2006 report to the Assembly which confirmed small schools did as well as any others academically. The community relationship between schools and villages has long been attested and usually, albeit grudgingly, admitted as a factor in LEA closure proposals. Some very rich practice has occurred and currently one of our member schools with 48 pupils aged 4-8 is part of the DCSF Innovations Unit advancing primary practice in community link terms and principally through ICT.

4. Currently we have parents' cars and school buses, just taking and collecting children to school. Other community members face their own transport challenges. Post-buses and District Council dial-a-bus schemes exist but randomly and far from universally. Intermittent, often infrequent public transport in rural areas mainly serves elderly passengers travelling free at Council expense. An integrated, sophisticated neighbourhood community transport system that served all interests, including the school's, trips to the surgery to collect prescriptions, to the local park-and ride and even the occasional village outing, would have real merit and make better sense. A few schools exist with post offices or shops integrated independently into the premises. One set of governors wanted to see banking facilities opened.

   Rural schools are expected somehow to provide the new obligatory extended services yet their need for every kind of imaginable public service is far less than in urban communities- for example victim support. It would be far better to view local schools as community agencies for the kinds of service they are more likely locally to need- for example, space for medical clinics for local needs which doubles as sickbed space for children. In its 2003 Select Committee Report on Rural Education *DEFRA argued for more departmental joined-up thinking in the provision of rural services*. It remains a cry little addressed The school is potentially a major multi-agency service for rural communities and Cambridgeshire pioneered the model decades ago but few were interested or even noticed. With the new open from 8 to 6 requirement the opportunity is there. The Welsh Language Society wants an entirely different model of rural provision and related funding, based on recognising needs and with communities managing themselves, including providing education space, which would probably have resolved surplus space more effectively had we had such a

system when we were building all those schools destined to become such an empty embarrassment.

5. Surplus space was never a rural problem according to the original fully national report of the Audit Commission. The bulk of spare space has been urban. Successive governments have encouraged addressing the problem but needed to keep reminding Councils, with threats of penalties within funding and now inducements to build new and bigger schools. Consistently Councils have preferred to close rural provision arguing their levels of surplus space are a financial barrier justifying rural reorganisation. Government eventually extended the permitted level of rural surplus space and introduced a presumption against closure. Two Ministers told NASS in writing that surplus space was not a reason to close village schools as there were alternatives and yet surplus space is argued as a financial problem for rural education even now- even while birth rate has been rising for several years and the problem if it exists at all in rural areas to any degree is passing into the secondary stage. Yet many LEAs continue to cite it generally as a priority "problem" in decisions relating to future planning that involve rationalising rural education provision.

6. Principles of public service provision in rural areas may be without the remit of this Inquiry but it would seem sensible to be aware of what the agreed funding arrangements are providing and why. Whatever our respective concerns for fairness of funding and recognition of need there is surely time for discussion about the principles of provision and known best practice before we settle on the mechanisms of fund allocation. Within the latter we see ring-fencing as particularly significant despite heavy pleadings for the priority of local circumstance.

   In the name of devolution Wales spends up to £200 a year less on its children than we spend on ours. In England before ring-fencing LEA spending varied dramatically as different local priorities influenced decisions sometimes more than pupil and community need. Shirley, now Baroness Williams, had to ring-fence urgently needed mathematics in-service training moneys to ensure it was spent on precisely that. Ring-fencing is essential if small schools are to be funded with the respect their quality and long-term economic worth deserve. Local variations in current staffing formula patterns already create some difficult circumstances and any notion to fair entitlement for children falls as a result.

7. In considering funding mechanisms some reference to and deference to overriding national principle and priority seem wise. Recognition of national realties such as sparsity needs urgent attention. How else could Northumberland's Chief Inspector tell NASS when we were discussing LEA school reorganisation that that year his Authority received less grant for sparsity than Birmingham. Surely it requires better understanding of sparsity before we determine how such money will be allocated? There is much rural sparsity but some rural communities have good populations….of older people. It is children who are in short supply. Sparsity of children should govern educational funding more than numbers of old people, who of course have their needs that sustain the aforementioned principle of policy integration.

We largely endorse what has been argued about new forms of analysis of need and the fairness and accuracy factors governing that. We do so on the basis that there is a model of excellence in rural education that needs proper protection if it is ever to be used to improve the educational well-being and prospects of our many urban children enduring difficult circumstances. We argue that funding rural education is about funding one of the most effective models of education yet developed and needs to be adequate to enable it to survive as it best functions, which is not through wholesale bigger and bigger organisation flowing from tacit acceptance of rural provision costing more.

An All-Party Inquiry into the real economics of rural education would be most welcome since it would almost certainly expose the need in our towns and cities of the urban village concept Dr. Wetz of Bristol University is advocating for secondary education and which NASS has argued for primary for over ten years based on village school virtue. Rural education well addresses the more significant aspects of the learning process, and in key respects perhaps better.

Addenda

1. We also have other tables from the Executive which show that University entrance levels and performance are enhanced by coming from rural areas. Pupils from remote rural areas are 25% more likely to go on to full time higher education than their urban counterparts (From Scotland August 2006).

   S2W-7136 - Rhona Brankin (Midlothian) (Lab) (Date Lodged 22 March 2004) :
   To ask the Scottish Executive what proportion of pupils attending rural schools go on to higher education compared to the proportion of those attending urban schools.

   Answered by Peter Peacock (22 April 2004):
   The percentages of school leavers (2002-03) entering Higher Education from publicly funded schools are as follows:

   Full-Time Higher Education:

Scotland	31		
Large Urban Areas	28	Other Urban Areas	31
Accessible Small Towns	34	Remote Small Towns	33
Accessible Rural	34	Remote Rural	37

   Definitions

Large Urban Areas	Settlements of over 125,000 people.
Other Urban Areas	Settlements of 10,000 to 125,000 people.
Accessible Small Towns	Settlements of between 3,000 and 10,000 people and within 30 minutes drive of a settlement of 10,000 or more.
Remote Small Towns	Settlements of between 3,000 and 10,000 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.

Accessible Rural Settlements of less than 3,000 people and within 30 minutes drive of a settlement of 10,000 or more
Remote Rural Settlements of less than 3,000 people and with a drive time of over 30 minutes to a settlement of 10,000 or more

2. Scottish Executive have analysed exam results against clothing grant and free school meal uptake. Remote rural schools did exceptionally well in this study. Pupils qualifying for school meals in a remote rural location show a 30% advantage in academic achievement over their urban counterparts when compared to all children in Scotland who so qualify. If you are of low income and want your children to succeed academically - get out of town!

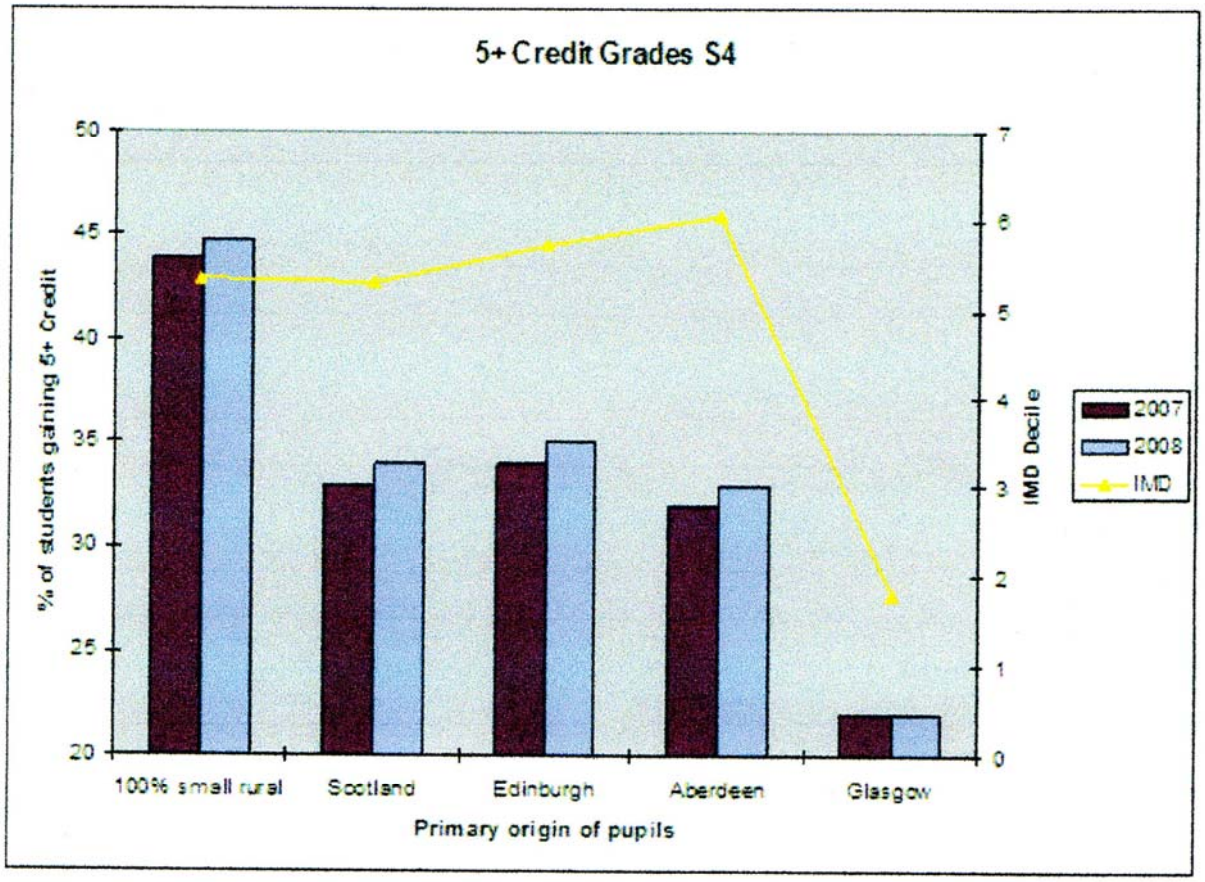
   They gave exam results achieved up until the age 16 a tariff score with standard grades at level 1 carrying the highest points score. This was totalled for every pupil in Scotland and then analysed out for ethnicity, site of education and financial status (using uptake of free school meals).

   Results as follows Date of data March 2006

All pupils	152000	average tariff	180	free school meals	110
Urban	104000	average tariff	176	free school meals	109
Remote Rural	6000	average tariff	193	free school meals	142

   Apart from those from remote rural areas scoring 7% better as a whole than the average and 10% better than urban it can be seen that qualification for free meals leads to a fall in tariff of around 39% on average but in remote rural areas this is reduced to only 26%. This represents a considerable narrowing in the educational handicap of impecuniousness of parents.

   Schools in rural areas within 30 mins. of large urban settlements did not show the same advantage. When you look at these lowland areas many of the "rural" schools in the catchment areas have rolls well in excess of 100 pupils. It is those in the remote areas that have the preponderance of small schools. Interestingly, the best chance your child has in Scotland of getting a high tariff score is to be Chinese (215) I personally believe this is because they tend to operate as very small communities within very large ones and gain many of the similar benefits.



The Scottish Government have sent me their spreadsheet on the attainment for pupils from every secondary school in Scotland. They have Highers and leaver destination as well as S4 results. I have used my totally inadequate Excel skills (with Justin's help) to pull out some data into a new database. Below is one small part of this.....

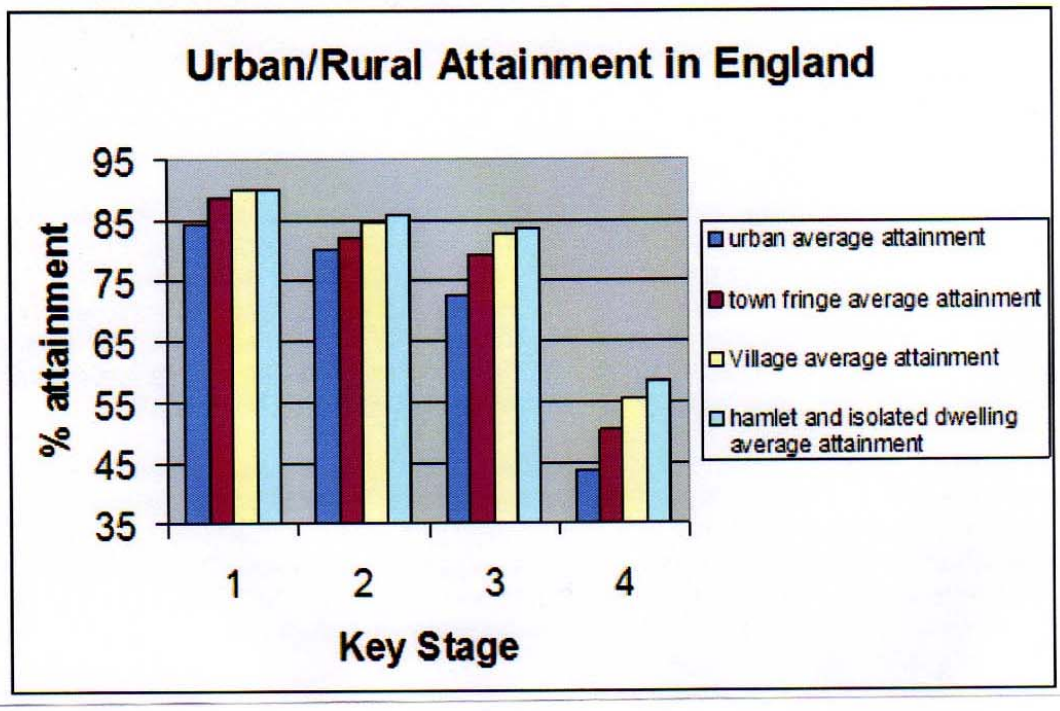
It is said (mainly by Jim Anderson and Judith Gillespie) that small rural schools lead to cognitive and social problems in their students. During the transition to secondary they suffer an even greater setback, having difficulty settling in to secondary.

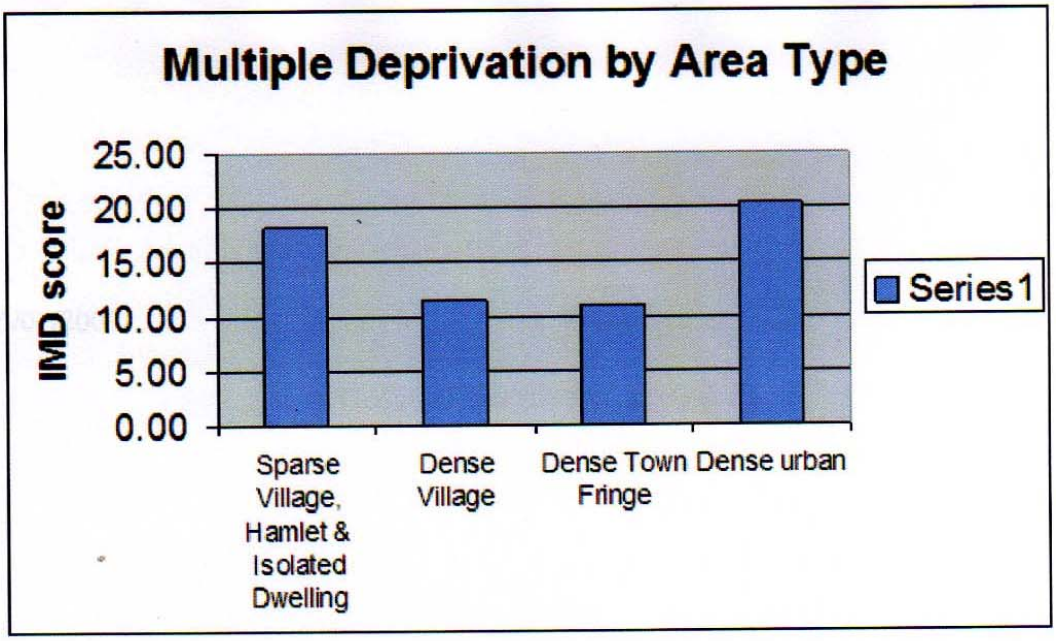
If there was any evidence that this theory was true it would be shown up in secondaries which took 100% of their intakes from rural schools with <100 pupils. There are 25 such schools but three are so small that they do not have students in every year of the analysis. So below is the results from 22 such secondaries, 95 feeder primaries with a total roll of 3408 kids. Average size of feeder primary is 36 pupils.

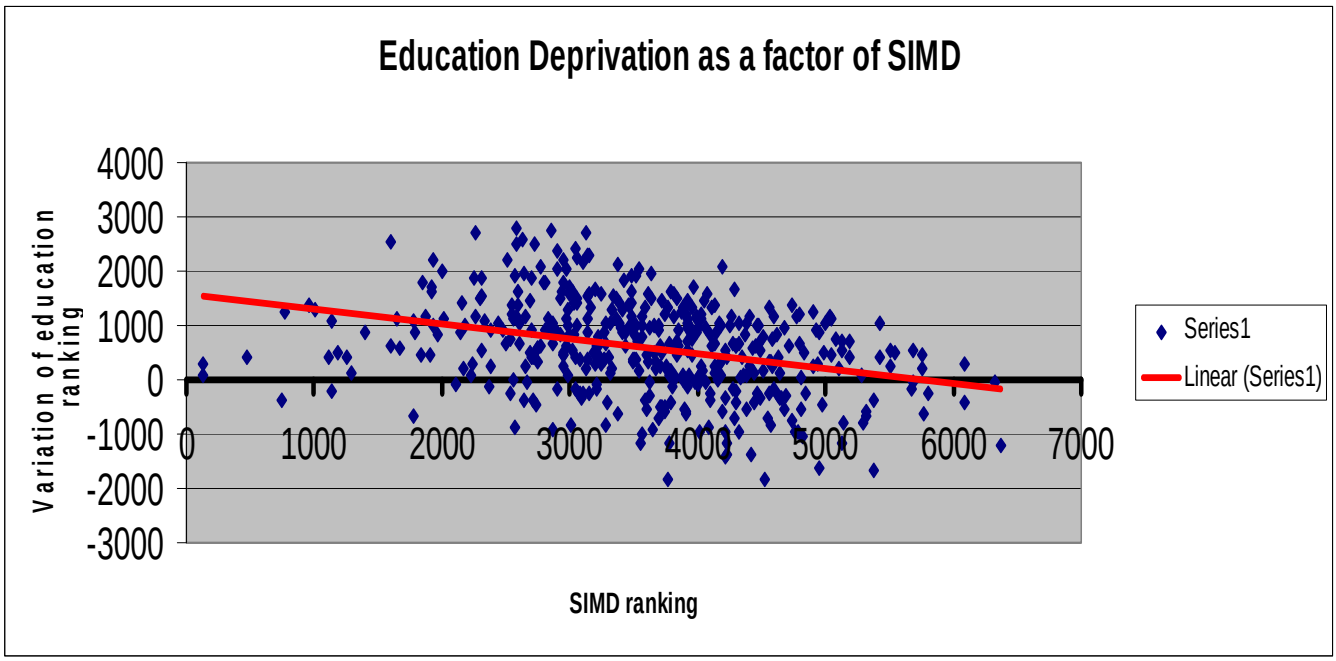
I have ranked the schools by the Index of Multiple Deprivation (IMD) for the datazone in which the feeder primary is located. I have compensated for the size of schools in each datazone. The deprivation score for these schools is almost exactly the same as the national average and they are classed as more deprived than the cities of Edinburgh or Aberdeen.

The first graph is based on the individual results of over 2 million children. For the first three key stages the various subject attainments are averaged and key stage 4 is the percentage of pupils gaining 5 GCSEs at C or above including English and Maths. The hamlet and isolated dwelling category is the results for around 16000 pupils per key stage and is where the vast majority of small rural schools are located. (there are around 20000 pupils per key stage in England in rural schools of fewer than 100 pupils).

The second graph is the Index of Multiple Deprivation by area type. These are figures produced by Government and take into account average income, unemployment, lack of accessible services, crime etc in Super Output Areas (SOAs) which are cells of around 1500 people. I have totalised the scores for every cell in each category and divided by the number of cells. It is often said that the educational benefit in small rural schools is down to socio-economic advantage .....







SIMD ranking 1 is the most deprived datazone in Scotland.
SIMD ranking 6505 is the most privileged datazone in Scotland.
Each datazone is around 750 people which is a common catchment size for small rural schools.

Any plot above zero on the x axis means the education in any given datazone is outperforming where overall deprivation would indicate it should be. You will note that only a tiny handful of remote rural areas have education levels more than 1000 ranking points worse than their SIMD score. Compare that to the number that are 1000 ranking points better than the SIMD score.

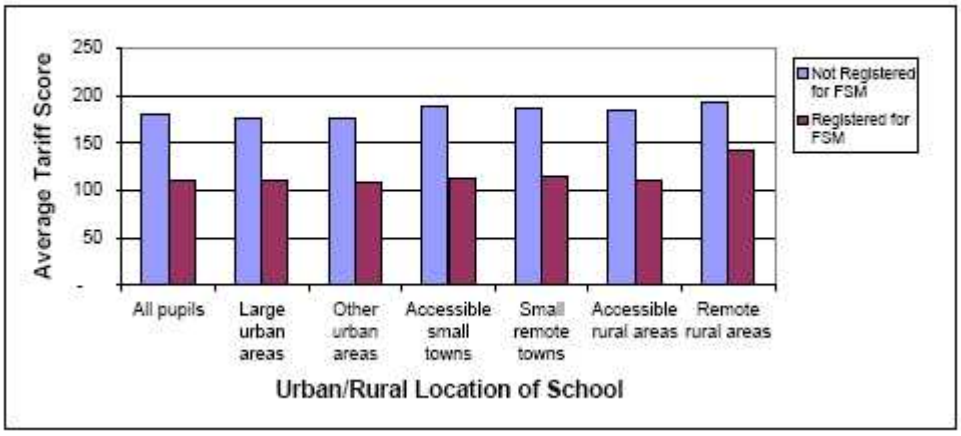
Remember this is not a sample analysis – this is every remote rural community in Scotland plotted here.

Table 7: Three year average tariff score of S4 pupils, by urban/rural location of school and registration for free school meals: 2002/03-2004/05

Urban/Rural location of school	Not registered for free school meals		Registered for free school meals	
	Number of pupils	Average tariff score	Number of pupils	Average tariff score
All pupils	152,871	180	27,410	110
Large urban areas	50,312	176	13,971	110
Other urban areas	53,590	176	8,347	108
Accessible small towns	20,478	188	2,012	113
Small remote towns	9,095	186	865	115
Accessible rural areas	13,654	183	1,727	111
Remote rural areas	5,742	193	488	142

Note: In this table, number of pupils refers to the total number of S4 pupils from the last three years, average tariff score refers to the average score of all of these pupils

Chart 11: Three year average tariff score of S4 pupils, by urban/rural location of school and registration for free school meals: 2002/03-2004/05



Training & Development Agency for Schools

Submission to Rural Services APPG Inquiry into the education funding formula
Jeremy Coninx, Director of Funding and Market Management, TDA

TDA GRANT FUNDING RESPONSIBILITIES FOR INITIAL TEACHER TRAINING

The Training and Development Agency for Schools (TDA), formerly the Teacher Training Agency, was established in 1994 and took on full responsibility for grant funding initial teacher training (ITT) in England from 2005/06. The following year it took on responsibility for grant funding award bearing postgraduate continuing professional development programmes for serving teachers in schools.

The TDA's responsibilities, both funding and otherwise, have broadened and changed since then. However, ITT continues to be the single largest grant funding programme taking up 84 per cent (£572 million) of total TDA programme expenditure in 2008-09

Structure of ITT in England

Background

The TDA has three important, linked roles for ITT. It determines:

- how many ITT places each ITT provider will be allocated;
- how much funding they will receive for those ITT places;
- who may be accredited as an ITT provider and, therefore, eligible to receive places and funding.

The TDA allocated 38,512 ITT places for new trainee teachers for academic year 2009/10, plus funding for those ITT places, to 230 separately accredited ITT providers spread throughout England. There are four main forms of ITT provision:

- higher education institution (HEI)[79] delivered postgraduate ITT (23,305 postgraduate ITT places - 61 per cent of total ITT places – were allocated to 73 HEIs);
- HEI delivered undergraduate ITT (7,489 undergraduate ITT places - 20 per cent of total ITT places – were allocated to 46 HEIs);
- school delivered employment based ITT (5,840 ITT places were allocated - 15 per cent of total ITT places – to 100 employment based[80] ITT providers);
- school delivered postgraduate ITT places (1,875 postgraduate ITT places - five per cent of total ITT places – were allocated to 58 SCITT[81] ITT providers).

[79] Principally universities but also including other higher education institutions and one further education college
[80] Principally consortia of schools and/or local authorities and/or higher education institutions
[81] Principally consortia of schools and/or local authorities

HEI ITT provision

Typically HEI ITT providers are long established, large scale providers delivering large volume ITT to cohorts of undergraduate and postgraduate higher education students from their main campus base. 80 per cent of total ITT places were allocated to 73 HEIs at an average of 400 ITT places each.

Postgraduate ITT traditionally takes the form of one year full-time postgraduate ITT courses starting in September and leading, upon successful completion, to trainee teachers being awarded qualified teacher status (QTS) and the award of a postgraduate certificate in education (PGCE). Since 2000/01 more flexible delivery forms of postgraduate ITT have been developed and introduced by HEI ITT providers.

HEI delivered undergraduate ITT continues to be important, although reducing, route for producing newly qualified teachers particularly newly qualified primary teachers. But between 1994/95 and 2004/05 undergraduate ITT, as a proportion of total HEI ITT provision has reduced from 38 to 24 per cent. Undergraduate ITT usually takes the form of a three year or four year first degree courses leading upon successful completion to trainee teachers being awarded a first degree (a prerequisite for qualified teacher status) and the award of QTS.

SCITT provision

SCITT provision was first introduced in 2003/04 and in 2009/10 there were 58 SCITT providers allocated five per cent of total ITT places allocated at an average of 33 postgraduate ITT places each. Typically SCITT providers are small providers of ITT filling geographic gaps in the ITT market that are not met by HEI ITT providers. Although typically small, the largest SCITT providers are bigger than the smallest HEI ITT providers.
In most key respects SCITT provision is not too different to HEI postgraduate ITT provision. Trainee teachers must meet all of the same entry requirements and must meet all of the same standards for the award of QTS. Most SCITT providers also deliver a university validated PGCE to their trainee teachers. The key difference is, of course, in the learning experience in that the trainee teacher is part of a small cohort of trainee teachers based in a school for the whole of their ITT course. However, although based in a school, the trainee teacher continues to be treated as being a higher education student in the same way as they would as if they were with a HEI ITT provider – they pay tuition fees for their ITT course and are able to access the same package of financial support, tuition fee and maintenance loans and grants, as other higher education students.

Employment based ITT provision

The biggest change in ITT in recent years has been the growth and roll out of ITT provision since 2001/02. Employment based ITT provision shares many of the same characteristics as SCITT ITT provision but goes one step further in that trainee teachers are employed by schools as unqualified teachers whilst they train and are salaried employees. Trainee teacher on employment based ITT route do not pay tuition fees for their ITT course and are not deemed to be higher education students. For 2009/10 there are 100 employment based ITT providers each allocated an average of 50 ITT places.

Nearly all employment based ITT is postgraduate (with the exception of the small registered teacher programme). The largest programme is the graduate teacher programme.
Employment based ITT providers take a number of forms but are principally consortia of schools and/or local authorities and/or an HEI or SCITT ITT provider partner.

Change since 1994/95

The biggest change between 1994/95 and 2009/10 has been the growth in the numbers of ITT providers (113 per cent increase) and the number of ITT places allocated (30 per cent increase). The number of TDA accredited:

- HEI ITT providers, mainly as a result of amalgamations, closures and withdrawals, has reduced from 81 to 73;
- SCITT providers has increased from 13 to 58;
- Employment based ITT providers have increased from nil to 100.

The average size of ITT providers has reduced from 315 to 193 meaning that ITT is being delivered in smaller volumes by a greater number of ITT providers. Most of this change has been a result of growth in school delivered (SCITT and employment base ITT) rather than reduction in HEI ITT delivered ITT. HEI ITT providers were allocated more ITT places in 2009/10 than they were in 1994/95.

The second important change is the changes that have been made to the requirements for ITT courses and the standards for the award of QTS. To meet those standards, all trainee teachers must now have significant experience of teaching in two different school settings. Although campus based, even trainee teachers on ITT courses delivered by higher education students will typically spend more than half of their time based in schools receiving practical experience. Although on paper ITT is delivered by 230 ITT providers in practice ITT is co-delivered by 230 ITT providers plus many thousands of schools throughout England.

Access to ITT

An important issue for the TDA has been to improve access to ITT. That access issue takes two forms. The first is access by potential trainee teachers to ITT courses. The second is access by schools to newly qualified teachers. There were good strong reasons for doing this. The first was to increase contestability for ITT places from potential applicants (both quality and quantity) for ITT places particularly in secondary priority subjects. The second was to increase the throughput and supply of newly qualified teachers from ITT courses to schools in areas less adequately supplied by the main ITT routes.

The only constraints on this expansion to now has been the availability of funding of places to allocate or reallocate from existing ITT providers, limits on the suitability or willingness of potential ITT providers to offer ITT of the right quality of ITT provision. The TDA has now placed a cap on further expansion for a number of reasons. The first is that there is less clear evidence of unmet need justifying further expansion. The second is that the cost of starting up new ITT providers and bringing that provision up to the requisite quality is high. The third is that ITT volumes are reducing and there is less flexibility or scope to build new provider capacity. The fourth is that the TDA is identifying further options for increasing access other than through the development of new ITT providers.

Funding for ITT

The TDA grant funds ITT providers using a set of funding prices for different categories of trainee teachers. In other words one ITT provider receives exactly the same amount of funding for the same category of trainee teacher as another.

The sole variation to this arrangement is that the TDA pays a higher amount of funding for a trainee teacher trained within Inner London (plus eight per cent) or Outer London (plus five per cent) that it does for an equivalent trainee teacher trained outside of London. This change was introduced from 2003/04 and replicates the funding arrangements operated by the Higher Education Funding Council for England which had, and continues to have, an identical premium rate. It followed a separate study which showed that the costs of delivering ITT in London were significant greater (largely driven by far, higher staff costs) than the comparative cost of delivering the same ITT outside of London.

As well as reviewing ITT funding prices annually, the TDA has reviewed its funding arrangements more systematically on a number of occasions. The first was in 1996 when it first established its current grant funding arrangements and the last most recently in 2004 (the ITT unit of resource review). The ITT unit of resource review identified that, across the board, there was a significant gap for all ITT providers between the amount of resource they receive per trainee teacher (TDA grant funding and tuition fee income) and the cost of training that trainee teacher. The TDA took steps over time to increase its grant funding prices to close that gap.

Neither as part of its regular annual reviews or as part of its more formal period reviews of its ITT grant funding arrangements has population sparsity emerged as a key cost issue or constraint or inhibiting factor preventing delivery of ITT across all parts of England.

An electronic version of this report can be found online at www.rsnonline.org.uk

The All-Party Parliamentary Group on Rural Services

March 26th 2010