



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health and NHS England

Funding healthcare: Making allocations to local areas

Key facts

£79.1bn

total funding allocated to local healthcare commissioners, 2014-15

£1,371

average funding per person for locally commissioned healthcare, 2013-14

**-£137 to
+£361**

range in how far clinical commissioning group allocations are from their fair share of funding per person, 2014-15

1.2%

annual increase in funding for health after inflation in the four years to 2014-15

£64.3 billion

funding allocated to clinical commissioning groups, 2014-15

£1,076 to £1,845

estimated range in funding per person for locally commissioned healthcare, 2013-14

£0.37 billion

used to move under-target commissioners towards their fair share of funding, 2014-15

19

of the 20 clinical commissioning groups with the tightest financial positions at 31 March 2014 had received less than their fair share of funding

Summary

1 Each year the Department of Health (the Department) receives over £110 billion to fund health services in England. It passes around 90% of this money to NHS England. NHS England is the Department's largest arm's-length body and is responsible for the system of commissioning healthcare.

2 The Department is ultimately responsible for the system for allocating funding for healthcare. It and NHS England make annual allocations to local commissioners. These bodies commission healthcare from NHS bodies and other providers on behalf of their local populations. The amount of funding that individual commissioners are allocated is calculated using 'funding formulae' that apportion the total funds available. In 2014-15, £79.1 billion was allocated in this way:¹

- NHS England allocated £64.3 billion (81% of the total) to 211 clinical commissioning groups to commission hospital, community and mental health services.
- NHS England allocated £12.0 billion (15% of the total) to its 25 area teams to commission primary care.
- The Department allocated £2.8 billion (4% of the total) to 152 local authorities to commission public health services, such as smoking cessation programmes.

3 The first step in allocating funding involves the Department or NHS England calculating a 'target funding allocation' for each local commissioner. In calculating target allocations, the Department and NHS England aim to give those local areas with greater healthcare needs a larger share of the available funding. Target funding allocations are intended to represent local areas' fair share of the available funding, rather than the amount of money that might be required to meet their healthcare needs in full. In deciding actual funding allocations, the Department and NHS England seek to ensure that local health economies are not destabilised. They therefore move local commissioners gradually from their current funding levels towards their target allocations.

¹ This total does not include funding that NHS England manages centrally, including for commissioning specialised services, or the separate allocations that NHS England gives to clinical commissioning groups and area teams for their administration costs.

Our report

4 Given the amount of money involved – equivalent to nearly £1,400 per person each year – the way in which the Department and NHS England allocate funding to local commissioners is a crucial part of the way the health system works. These decisions are complex, involving mathematical formulae and elements of judgement.

5 The need for decisions to be robust is even more important at times, as now, when funding is tight. Although health has been protected compared with most other areas of government spending, funding increased by an average of just 1.2% a year in real terms in the four years to 2014-15. At the same time the demand for healthcare continues to grow. As a result, local commissioners, and in turn their providers, face challenges in remaining financially sustainable. The level of funding they receive in the first instance is one factor in sustainability, along with others such as how well organisations manage their costs, how efficient they are and whether they receive additional non-recurrent financial support during the year.

6 In 2011, we reported on the formula funding of local public services, including the Department's allocations to primary care trusts.² Since then, the government has reformed the health system through the Health and Social Care Act 2012. Most of the changes took effect in April 2013. They included new structures for the commissioning of healthcare with the abolition of primary care trusts and the creation of NHS England and clinical commissioning groups. The current arrangements for allocating funds to local commissioners are therefore relatively new.

7 This report examines how the Department and NHS England allocate funds to the local commissioners of healthcare. We set out our audit approach in Appendix One and our evidence base in Appendix Two. We analysed the arrangements against a range of criteria including policy objectives and recommendations made by the Committee of Public Accounts in 2011.^{3,4} We compared the three approaches in place now and also compared them with the approach previously used for primary care trusts. Key elements from this comparison are summarised in Appendix Four.

² Comptroller and Auditor General, *Formula funding of local public services*, Session 2010–2012, HC 1090, National Audit Office, July 2011.

³ HC Committee of Public Accounts, *Formula Funding of Local Public Services*, Fifty-fifth Report of Session 2010–2012, HC 1502, November 2011.

⁴ A summary of the government's response to the Committee's recommendations is set out in Appendix Three.

Key findings

The funding framework

8 The reforms of the health system in 2013 brought greater central control over the division of funding between primary care, hospital, community and mental health services, and public health, but removed a degree of local discretion and flexibility. The Secretary of State now decides how much of the Department's total budget should be allocated to the NHS and to public health; and NHS England decides centrally how much should be allocated to primary care and how much to hospital, community and mental health services. Previously, primary care trusts received a unified allocation. They decided locally how to split this between the different funding streams and had flexibility to shift funding in-year to respond to developments. Under the new arrangements, the commissioning bodies in each local area have different geographical boundaries and receive separate allocations to commission services for their local population (paragraphs 1.9 to 1.11).

9 Since 2013 the Department has directed funding to support its policy objectives to some extent. The split of funds between primary care, hospital, community and mental health services, and public health is a matter of judgement, informed by previous spending patterns and policy priorities. In the two years to 2014-15, the Department demonstrated the importance it attaches to public health by increasing funding, which now goes to local authorities, by a total of over 10%. NHS England has increased funding to clinical commissioning groups for hospital, community and mental health services faster than to area teams for primary care, despite the long-standing aim of moving care out of hospitals. Clinical commissioning groups decide locally how much of their budget to commit to community health services; however, there are no current data on this (paragraphs 1.12 to 1.14).

10 The new funding arrangements are more transparent and continue to use expert, independent advice. In our 2011 report, we highlighted that the Department had not consulted publicly on changes to the formula it used to set target allocations. Since then, the Department and NHS England have consulted publicly on changes. NHS England also decided funding allocations at a public board meeting. The Department and NHS England are advised by the independent Advisory Committee on Resource Allocation in developing and applying the funding formulae (paragraphs 1.4 and 1.15).

Balancing fairness and financial stability

In allocating funding to the local commissioners of healthcare, the Department and NHS England aim to balance fairness (that is, allocation based on need) with the aim of not destabilising the financial position of local health economies.

11 There is wide variation in the extent to which the funding that local commissioners receive differs from their target allocations. In 2014-15, over three-quarters of local authorities, and nearly two-fifths of clinical commissioning groups, are more than 5 percentage points above or below target. Funding for clinical commissioning groups varies from £137 per person below target to £361 per person above target (paragraphs 2.3 to 2.5).

12 Decisions about how quickly to move commissioners towards their target funding allocations are not based on evidence and are therefore a matter of judgement. The Department and NHS England do not consider that there is objective evidence on which to base decisions about the most appropriate 'pace of change'. Therefore, decisions are based on judgements about the changes in funding that local health economies can tolerate without being financially destabilised and about the effects of organisations not receiving their target allocations. Our exploratory analysis suggests that local bodies may be able to tolerate changes in funding that are more significant than those currently provided for (paragraphs 2.15 to 2.17).

13 Progress in moving commissioners towards their target funding allocations is slow. It is harder to make progress towards target allocations when the financial position is tighter and there is less money available to give larger increases to those bodies that are furthest away from target. For 2014-15, the Department and NHS England used £1.61 billion of the £1.98 billion available to increase funding for all commissioners by a minimum level. The remaining £0.37 billion was used to move under-target commissioners towards their target allocations. As a result, the total amount that commissioners were below target fell by 5% from £1.97 billion to £1.87 billion. In contrast, had the Department and NHS England used all the available funding to move under-target commissioners towards target, the total amount that commissioners were below target would have fallen by 39% to £1.20 billion (paragraphs 2.6 to 2.14).

14 NHS England has taken steps to address the risk that changes in local populations may jeopardise financial stability. Changes in local populations are accounted for in calculating target funding allocations. But a slow pace of change towards target allocations limits how far actual allocations reflect the changes, and funding per person may not be stable. For example, in 2011-12 the 20 primary care trusts that had the largest increases in population all received less funding per person than they had in the previous year (by an average of 2.2%). NHS England mitigated this risk for 2014-15 by introducing a rule to increase every clinical commissioning group's allocation by at least as much as its population, unless they were already considerably over target. NHS England has not adopted this approach for its area teams, nor has the Department for local authorities (paragraphs 2.18 to 2.20).

15 There is an association between the financial position of clinical commissioning groups and whether they receive less or more than their target funding allocation. We found:

- The 20 clinical commissioning groups with the tightest financial positions received, on average, 5.0% less than their target funding allocation. Of these 20 groups, 19 received less than their target allocation.
- The 20 clinical commissioning groups with the largest surpluses received, on average, 8.8% more than their target funding allocation. Of these 20 groups, 18 received more than their target allocation.
- The 107 under-target clinical commissioning groups received a total of £1,606 million less than their target allocations and had a combined deficit of £165 million. The 104 groups that received funding above their target allocation had a combined surplus of £547 million (paragraphs 2.21 to 2.23).

16 The Department and NHS England decide current funding allocations without fully considering the combined effect on local areas. For 2014-15, NHS England considered the aggregate funding position at the level of the 25 area teams. We aggregated funding for primary care, hospital, community and mental health services, and public health at a more local level, based on clinical commissioning group geographical areas. This exploratory analysis suggests that in 2013-14, on average, local areas received £1,371 per person for locally commissioned healthcare, ranging from £1,076 in Oxfordshire to £1,845 in Knowsley. The funding received ranged from £186 per person (12.8%) below target (in Corby) to £508 per person (39.3%) above target (in West London) (paragraphs 2.25 to 2.27).

Setting target funding allocations based on need

In calculating target funding allocations, the Department and NHS England aim to give those local areas with greater healthcare needs a larger share of the available funding.

17 NHS England's use of GP lists to estimate clinical commissioning group and area team populations makes target funding allocations more responsive to changing needs, although there is limited assurance around the reliability of these data. Compared with Office for National Statistics projections, GP list data are updated more frequently and allow need to be assessed better. However, there are known concerns about the accuracy of GP list data, including the tendency for lists to be inflated. NHS England has published guidance for tackling list inflation but centrally has limited ongoing assurance that area teams are following the guidance. The Department's allocations to local authorities for public health continue to be based on Office for National Statistics projections (paragraphs 3.4 to 3.8).

18 Weighting for relative need for healthcare can change target funding allocations significantly but progress in improving measures of need has been mixed. NHS England's approach to assessing need in calculating allocations for clinical commissioning groups is better than the previous approach at predicting relative need because it uses more detailed data. In contrast, its approach for area teams for 2014-15 was heavily based on the primary care component of the previous primary care trust formula, and is regarded as an interim solution. For 2014-15, the adjustments for relative need ranged from a 27.9% increase to a 25.0% decrease in the target allocations for clinical commissioning groups, compared with the position had funding been distributed based on population size alone (paragraphs 3.9 to 3.16).

19 NHS England makes a smaller adjustment to funding allocations to support the government's objective to reduce health inequalities, but the evidence for basing this adjustment on life expectancy is unclear. Target allocations for clinical commissioning groups and area teams include an adjustment that moves money towards areas with lower life expectancies. However, the evidence is unclear on the extent to which increasing funding can help to reduce health inequalities. The Advisory Committee on Resource Allocation plans to do more work on this area. For 2014-15, the adjustments for health inequalities ranged from a 7.3% increase to a 4.1% decrease in the target allocations for clinical commissioning groups. Broadly, the adjustment moves money towards parts of London and the north-west of England (paragraphs 3.17 to 3.25).

Conclusion

20 The Department and NHS England's approach to allocating funding for healthcare is generally sound. There have been some improvements since 2011, including greater transparency, and decisions continue to be informed by independent, expert advice. However, the evidence supporting some aspects of funding allocations, such as financial stability, is limited and these factors have a significant impact on the amount of money each local area receives.

21 The low real-terms growth in total funding for the health system in recent years has made it difficult for the Department and NHS England to allocate funding in a way that achieves the twin aims of fairness and financial stability. The concern of the Department and NHS England not to destabilise local health economies has resulted in them making very slow progress in moving local areas towards their target allocations, which are intended to represent fair funding.

Recommendations

22 Our recommendations are designed to support an objective approach to balancing fairness and financial stability and to strengthen the evidence base for funding decisions:

- a** **The Department and NHS England should develop an evidence base to inform their decisions about how quickly to move commissioners towards their fair share of funding.** This ‘pace of change’ has a significant impact on the funding for each local area and there is a clear relationship between distance from target allocation and financial position. In making decisions about pace of change, the Department and NHS England should take account of: previous changes in local spending patterns, evidence on the effect of distance from target and the views of local commissioners.
- b** **The Department and NHS England should gain appropriate assurance over the quality of all data used to set target funding allocations.** A priority for NHS England should be GP list data as they are central to calculating allocations for clinical commissioning groups. There are benefits to using GP lists but there are known concerns over the reliability of these data.
- c** **The Department and NHS England should use emerging data to develop their evidence base on how best to use funding allocations to reduce health inequalities.** Currently the evidence is unclear about the best way for allocations to support this objective.
- d** **The Department and NHS England should set out how the funding framework supports their key policy objectives.** While there is now greater central control over the distribution of funding between primary care, hospital, community and mental health services, and public health, at local level funding is now more fragmented than under primary care trusts, meaning there is less flexibility to move resources between settings. In particular, NHS England should further explore how funding can support the provision of more care outside hospitals.
- e** **The Department and NHS England should consider the combined effect of their different allocations as part of the process of making funding decisions.** In particular, they should work with the Department for Communities and Local Government to take account of funding for social care, given the impact it may have on the need for healthcare. They should also publish data on aggregate local funding to help local commissioners plan services and understand better the financial position of local health economies.
- f** **NHS England, working with the Advisory Committee on Resource Allocation, should develop the approach for allocating funding to its area teams for primary care.** NHS England has refined the approach for funding clinical commissioning groups for hospital, community and mental health services, but has made less progress on primary care.