



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health and NHS England

Funding healthcare: Making allocations to local areas

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Department of Health and NHS England

Funding healthcare: Making allocations to local areas

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

9 September 2014

This report examines how the Department of Health and NHS England allocate funding to the local commissioners of healthcare.

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Contents

Key facts 4

Summary 5

Part One

The framework for funding healthcare 12

Part Two

Balancing fairness and financial stability 18

Part Three

Setting target funding allocations 31

Appendix One

Our audit approach 40

Appendix Two

Our evidence base 42

Appendix Three

The government's response to the
recommendations made by the
Committee of Public Accounts in 2011 46

Appendix Four

Key elements of the three funding streams,
2014-15 48

The National Audit Office study team consisted of:
Will Palmer and Dan Ward,
under the direction of Laura Brackwell,
with assistance from Algirdas Glemza,
Gemma Hartley, Emily Hopkinson,
Dimitris Korres and Tim Xu.

This report can be found on the
National Audit Office website at
www.nao.org.uk

For further information about the
National Audit Office please contact:

National Audit Office
Press Office
157–197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Tel: 020 7798 7400

Enquiries: www.nao.org.uk/contact-us

Website: www.nao.org.uk

Twitter: @NAOorguk

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.

Part One

The framework for funding healthcare

1.1 This part of the report covers the system for allocating funding for healthcare, the total funding available, the relevant objectives of the Department of Health (the Department) and NHS England, and the impact of the 2013 reforms to the health system.

The system for allocating funding

1.2 The Department is ultimately responsible for the system for allocating funding for healthcare. In 2014-15, it received £113.0 billion in funds voted by Parliament (**Figure 1**). Of this, it allocated:

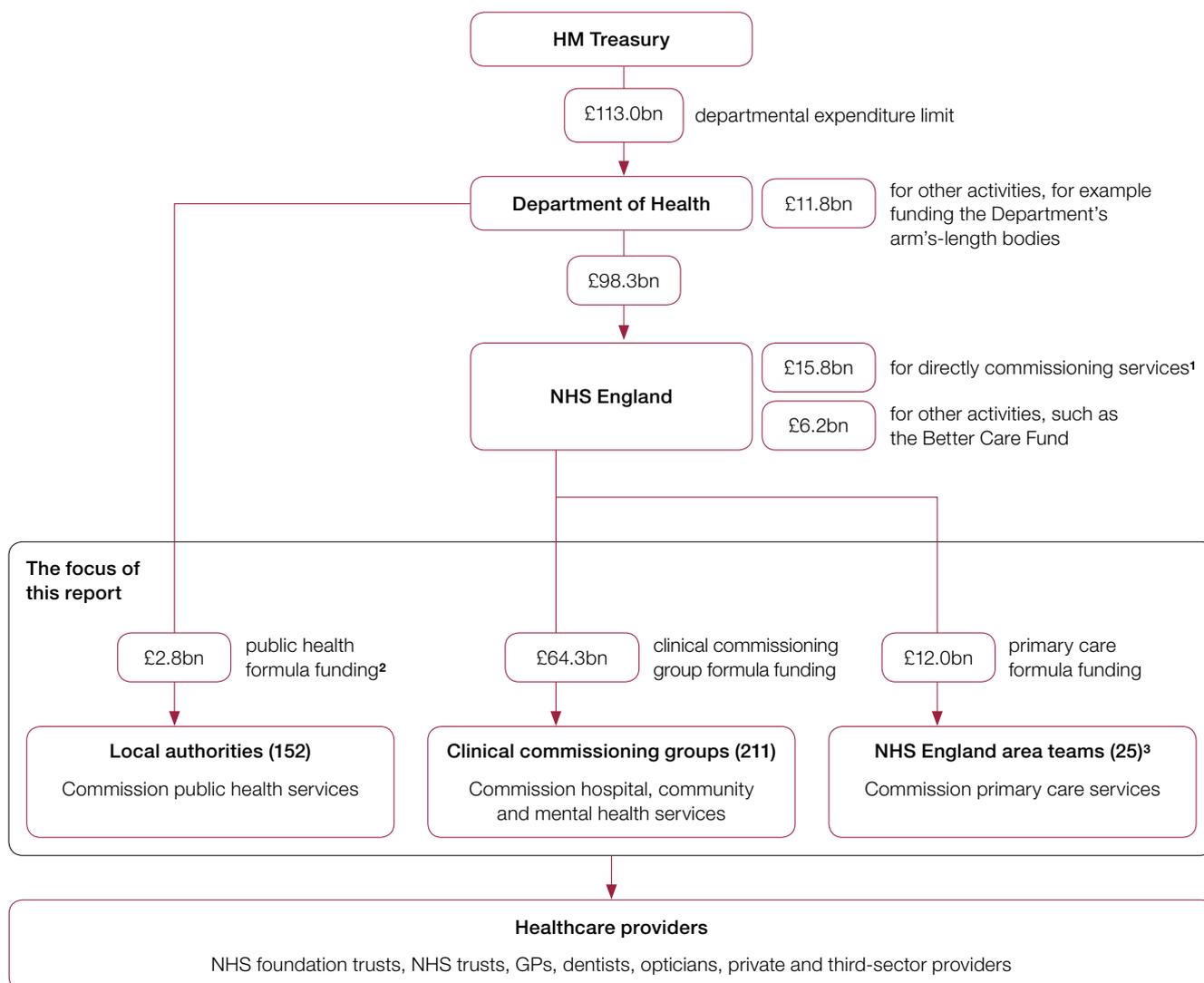
- £98.3 billion to NHS England; and
- £2.8 billion to 152 local authorities to commission public health services.

1.3 NHS England is the Department's largest arm's-length body and is responsible for the system for commissioning healthcare. In 2014-15, it allocated:

- £64.3 billion to 211 clinical commissioning groups to commission hospital, community and mental health services; and
- £12.0 billion to its 25 area teams to commission primary care.

1.4 The Department and NHS England use 'funding formulae' to allocate the total money available under each funding stream between the local commissioners of healthcare. These bodies commission services on behalf of their local populations from NHS and other providers. As was the case when we reported in 2011, the Department and NHS England are advised by the independent Advisory Committee on Resource Allocation and its Technical Advisory Group in developing and applying the funding formulae.

Figure 1
Funding streams in the health system, 2014-15



Notes

- 1 The £15.8 billion for direct commissioning covers 'specialised services' (such as child heart surgery), healthcare for those in prison or custody and in the armed forces, and NHS England's public health responsibilities, such as immunisation. These services are generally commissioned through the area teams but at a national rather than local level.
- 2 The £2.8 billion of public health formula funding is distributed on behalf of the Department by Public Health England.
- 3 NHS England has 27 area teams but the 3 teams in London receive a single allocation for primary care, meaning there are 25 allocations in total.
- 4 Figures may not sum due to rounding.

Source: National Audit Office

Total funding

1.5 There was sustained and significant growth in the funding available for health services in England in the early part of the last decade, but the increase has slowed in recent years (**Figure 2**). In the four years to 2007-08, the Department's budget for healthcare grew by 5.9% a year on average in real terms. In the four years to 2014-15, funding increased by 1.2% a year in real terms.

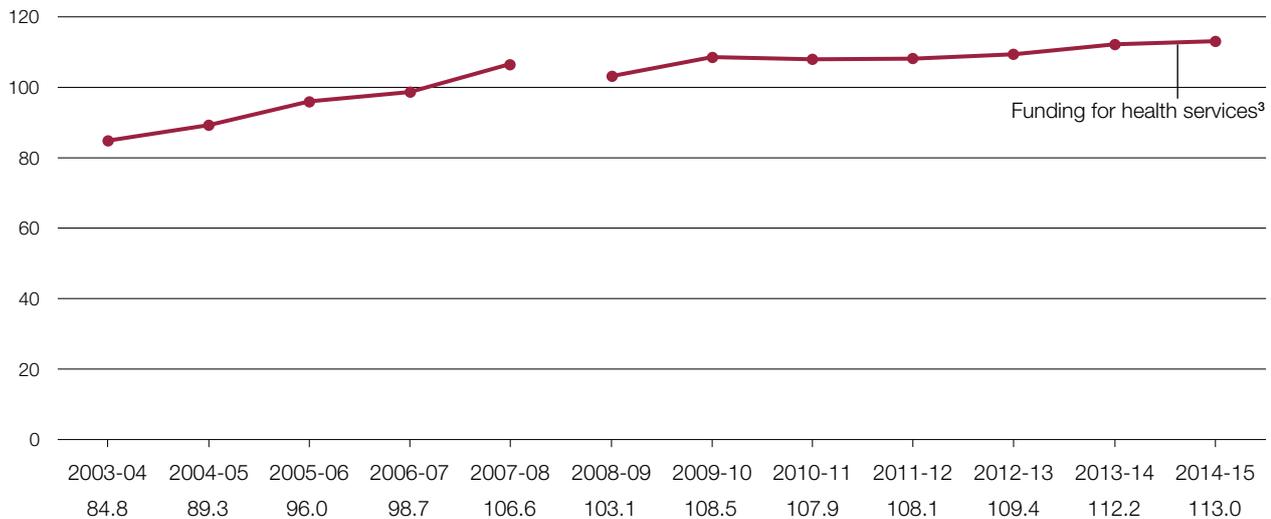
1.6 Therefore, while health has been protected compared with most other areas of government spending, the financial position is increasingly tight. At the same time, the demand for healthcare continues to grow, partly because of the ageing population and developments in drugs and medical technology. This puts NHS commissioners and providers under increasing financial pressure.

Figure 2

Funding for health services, 2003-04 to 2014-15¹

The increase in funding available for health services in England has slowed in recent years

£ billion (2014-15 prices)²



Notes

- 1 Figures from 2003-04 to 2007-08 are not fully comparable with figures from 2008-09 onwards, due to changes in the Department's responsibilities.
- 2 We have adjusted figures to 2014-15 prices using HM Treasury's gross domestic product (GDP) deflators.
- 3 'Funding for health services' is the total departmental expenditure limit for the Department of Health.

Source: HM Treasury, Public Expenditure Statistical Analyses 2009; Department of Health Resource Accounts 2013-14; and HM Treasury June 2014 GDP deflators

Objectives for allocating funding

1.7 In 2014-15, the Department and NHS England allocated £79.1 billion to local commissioners using funding formulae. The Department has long-standing, transparent objectives for allocating funding. These objectives have been re-stated recently. The Health and Social Care Act 2012 gave both the Department and NHS England a legal duty to have regard to the need to reduce health inequalities between people. The Department's annual mandate to NHS England has confirmed the objective of equal access for equal need. The Department has also set NHS England the objective of ensuring that changes in funding allocations do not destabilise local health economies.

1.8 These are high-level objectives, which are not precise or time-bound. This means that, while they provide a useful broad enduring framework, they are less helpful for informing specific judgements about allocations in practice, such as the balance between responding to needs and providing funding stability.

Impact of the 2013 reforms to the health system

1.9 The reforms to the health system in April 2013 provided greater central control over the division of funding between: primary care; hospital, community and mental health services; and public health, by removing a degree of local discretion. Funding is now split between these three funding streams centrally:

- The Secretary of State for Health, advised by the Department, decides how much of the Department's total budget should be allocated to the NHS and how much to public health.
- NHS England decides how much of its total budget should be allocated to primary care, hospital, community and mental health services, and the other health services that it commissions directly. This arrangement is intended to prevent any perception of political interference in the way that money is distributed.

1.10 Before the reforms, the system for allocating funding was less fragmented. The 151 primary care trusts received one unified allocation from the Department. They decided locally how to split this between the three funding streams. As a result, the split varied between local areas. In addition, primary care trusts had flexibility to shift funding in-year between funding streams to reflect developments or changing priorities.

1.11 The reduced local discretion will have an uneven impact, depending on the starting position of local areas. It is likely to reduce geographical variation in the split of funding. For example, our exploratory analysis suggests that in 2012-13 there was a 10 percentage point range in the proportion of funding allocated to hospital, community and mental health services. Under the new arrangements, this range will narrow over time to 7 percentage points.

Allocating funding to support policy objectives

1.12 Given the amount of money involved, the split of resources between the three funding streams is a crucial part of the way the health system works. Decisions on allocating funding are a matter of judgement, informed by previous spending patterns and policy priorities. The Department has started work to develop an analytical framework for assessing the benefits of re-allocating resources within and between sectors.

1.13 In practice, the degree of flexibility that the Department and NHS England have in making funding decisions is constrained by a number of factors, such as financial controls imposed by HM Treasury in agreeing NHS England's budget. Also, to protect financial sustainability, the Department and NHS England consider the cost pressures in different sectors and reflect these in the way they share funding between primary care, hospital, community and mental health services, and public health.

1.14 Against this background, we examined the extent to which recent funding decisions have supported two of the Department's key policy objectives:

- **Protecting spending on public health** – In 2010, the Department committed to protect funding for public health services. In the two years to 2014-15, it increased allocations to local authorities for public health by a total of over 10%. It did not routinely collect data on this area before 2012-13, so we could not analyse the trend in public health spending over a longer period.
- **Supporting the provision of care outside hospital** – NHS England does not decide how much funding is allocated to each of hospital care, community health services and mental health services, because it provides a combined allocation to each clinical commissioning group. Decisions about the distribution of funding between these three settings therefore rest with clinical commissioning groups. There are currently no data on how much of each clinical commissioning group's budget was allocated to community services. From 2003-04 to 2012-13 primary care trusts increased the proportion of total spending committed to community services (from 6.8% to 10.7%) by more than for core hospital services (from 45.6% to 48.3%).⁵

NHS England does decide how money should be divided between area teams for primary care and clinical commissioning groups for hospital, community and mental health services. For 2014-15 it increased funding for primary care by less than for hospital, community and mental health services (2.1% compared with 2.5%). Under primary care trusts, which received a combined allocation for all care, the proportion of total spending committed to primary care fell from 29.1% to 23.4% between 2003-04 and 2012-13.

The 2013 Spending Review announced the creation of the Better Care Fund to increase integration between health and social care with the aim, for example, of reducing emergency hospital admissions. In 2015-16, the Fund will comprise at least £3.8 billion of pooled local budgets shared between the NHS and local authorities.

5 Data from NHS (England) Summarised Accounts. Core hospital services defined as general and acute services and A&E.

Transparency

1.15 Transparency has improved under the new funding arrangements. In our 2011 report we highlighted that, in contrast to other funding formulae, the Department had not consulted publicly on changes to its formula. Since then, the Department and NHS England have consulted on changes made as part of the reforms to the health system. Both organisations also continue to publish key documents and data, and NHS England decided funding allocations at a public board meeting.

Predictability

1.16 The Department and NHS England have sought to give commissioners more notice of their funding allocations to help them plan. For example, NHS England's most recent allocations to clinical commissioning groups and its area teams covered two years, and it is considering giving allocations that cover between three and five years in future.

1.17 Allocations were subject to considerable change during the course of 2013-14 following the reforms to the health system. For example, NHS England adjusted clinical commissioning group allocations during the year by up to 9%. This was to correct for inaccuracies in the data provided by primary care trusts, which underpinned the allocations for 2013-14.

Part Two

Balancing fairness and financial stability

2.1 In allocating funding to local commissioners of healthcare, the Department of Health (the Department) and NHS England seek to balance fairness with the requirement not to destabilise the financial position of local health economies. This part of the report covers how these two objectives have been balanced, including the factors affecting allocation decisions and the effect of these decisions.

Distances from target funding allocations

2.2 The first step in allocating funding to local commissioners involves the Department or NHS England estimating the needs of each commissioner. They use this information to calculate a 'target allocation' for each body, equivalent to their fair share of the available resources. Part Three of this report covers the calculation of target allocations.

2.3 So as not to destabilise local health economies, the Department and NHS England have moved commissioners gradually from their current funding levels towards their target allocations. The difference between a commissioner's target allocation and its actual allocation is known as the 'distance from target'. In 2014-15, distances from target vary widely (**Figure 3**):

- Nearly two-fifths of clinical commissioning groups are more than 5 percentage points above or below target. Funding per person ranged from £137 under target to £361 over target.
- Over three-quarters of local authorities are more than 5 percentage points above or below target.
- NHS England's area teams are, in general, closer to their target allocations than clinical commissioning groups and local authorities. This is partly due to increased aggregation as the area teams cover larger geographical areas.

Figure 3

Distances from target funding allocations, 2014-15

	Commissioners	Average target allocation per person (£)	Range in distances from target ^{1,2}		Commissioners over 5 percentage points from target (above or below)	
			Percentage (%)	Per person (£)	Number	Percentage (%)
Hospital, community and mental health services	211 clinical commissioning groups	£1,133	-12.0 to +33.9	-£137 to +£361	83	39.3
Primary care	25 area teams	£211	-3.8 to +4.3	-£8 to +£9	0	0
Public health	152 local authorities	£51	-43.0 to +529.7	-£28 to +£156	118	77.6

Notes

1 Negative numbers are for commissioners that receive less than their target funding allocations.

2 Throughout the report, 'distance from target' refers to the position after commissioners have received their funding increase for the year. This is also known as the 'closing distance from target'.

Source: National Audit Office analysis of Department of Health and NHS England data

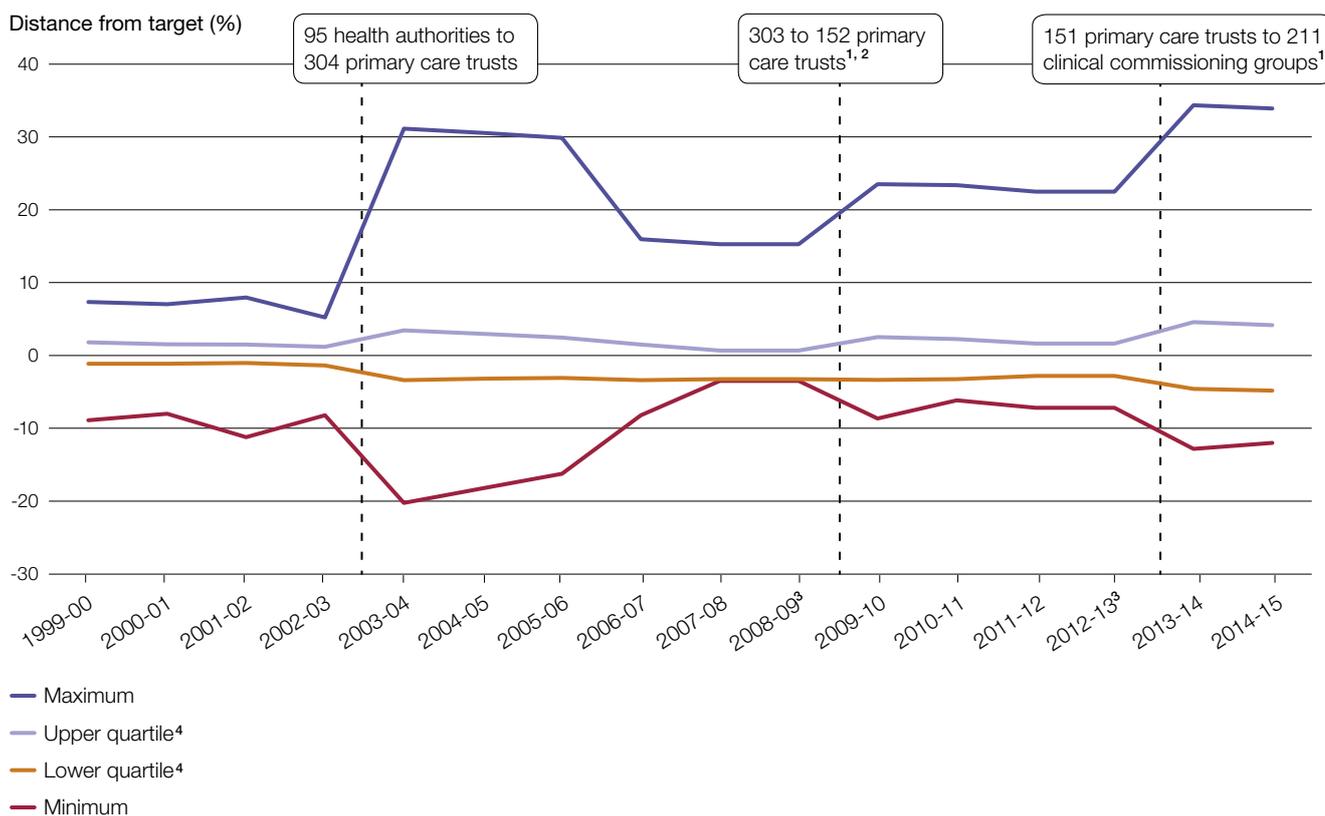
2.4 Commissioners' distances from target change from year to year. The Department and NHS England aim to reduce distances from target over time so that, ultimately, bodies reach their target allocations. Our analysis shows that distances from target have tended to increase following significant structural changes in the health system (**Figure 4** overleaf), and have narrowed during periods of stability. For example:

- In 2011-12, when targets were last calculated for primary care trusts, the range in primary care trusts' distances from target was 30 percentage points (with an interquartile range – within which half of commissioners fall – of 4 percentage points).
- In 2013-14, following the most recent reforms under the Health and Social Care Act 2012, the range in clinical commissioning groups' distances from target was 46 percentage points (with an interquartile range of 9 percentage points).

Figure 4

Distances from target funding allocations, 1999-2000 to 2014-15

As with previous reforms, distances from target funding allocations increased following the reforms to the health system in 2013



Notes

- Two primary care trusts merged between 2003-04 and 2008-09, causing the total to fall from 304 to 303, and between 2009-10 and 2012-13, causing the total to fall from 152 to 151.
- The number of primary care trusts changed from 303 to 152 in October 2006. However, funding allocations for 2007-08 had already been announced, and the Department then spent time developing a new funding formula. The new funding was applied from 2009-10.
- The Department did not estimate target funding allocations in 2008-09 or 2012-13. Instead, it gave all commissioners a uniform increase. We have therefore assumed that distances from target in those years were the same as distances from target in the previous year.
- Half of commissioners fall between the upper quartile and lower quartile.

Source: National Audit Office analysis of Department of Health and NHS England data

2.5 This increase in distance from target following the reforms in April 2013 may have been caused by various factors, including changes to the formulae used to calculate target allocations. Because the reforms introduced new structures for commissioning healthcare, the Department and NHS England had to develop new formulae for estimating the needs of the new commissioners. These estimated target allocations in a different way from the previous formula used for primary care trusts. They also had to divide funding in a different way geographically. Since funding had been moving towards the previous targets, changing the target allocations was likely to increase the average distance from target and this proved to be the case.

Progress towards target funding allocations

2.6 The framework for the extent to which each commissioner's funding moves towards its target allocation is known as the 'pace of change' policy. It usually includes a minimum level of growth for all commissioners and larger increases in funding for those bodies that are furthest away from target.

Recent progress

2.7 Over the last two years, progress in moving towards target allocations has been fastest for local authorities for public health, where the distances from target were the highest. For 2013-14 and 2014-15, the Department awarded local authorities increases of up to 10% (**Figure 5**). For 2013-14, NHS England increased funding for clinical commissioning groups and area teams by a flat rate, as the Department did for primary care trusts for 2012-13; therefore no progress was made in reducing distances from target for these bodies.

Figure 5
Recent pace of change levels, 2013-14 and 2014-15

	Commissioners	Increases in allocations		Distances from target
		2013-14 ¹ (%)	2014-15 (%)	2014-15 (%)
Hospital, community and mental health services	211 clinical commissioning groups	+2.3 (flat rate)	+2.1 to +4.9	-12.0 to +33.9
Primary care	25 area teams	+2.6 (flat rate)	+1.6 to +3.0	-3.8 to +4.3
Public health	152 local authorities	+2.2 to +10.0	+2.8 to +10.0	-43.0 to +529.7

Note

1 No targets were calculated for clinical commissioning groups or area teams in 2013-14, and each area was given a flat rate of growth. The pace of change in 2013-14 was therefore nil.

Source: National Audit Office analysis of Department of Health and NHS England data

2.8 We identified that some of the commissioners that are furthest below their target allocations have in fact received smaller increases in funding per person than those commissioners that are above their target allocations. This is a result of applying percentage uplifts where there are large differences in starting allocations. For instance, analysis of the Department's allocations for local authorities in 2014-15 shows that:

- Surrey, which was 43% below target at £20 per person, received the maximum 10% uplift in allocations, equating to an increase of £2 per person; whereas
- City of London, which was 513% above target at £180 per person, received the minimum 2.8% uplift, equating to an increase of £5 per person (over double that of Surrey).

Effect of tighter financial position

2.9 The Department has been able to increase the rate of progress towards target allocations when the total funding for health has grown significantly in real terms. At these times more money is available for redistribution, even after all local areas have received real-terms growth in funding. For example, in 2006-07 funding increased by 9.2% and the most under-target primary care trusts received a 15.7% increase. In contrast, in 2011-12 funding increased by 2.2% and the most under-target primary care trusts received a 4.2% increase (**Figure 6**).

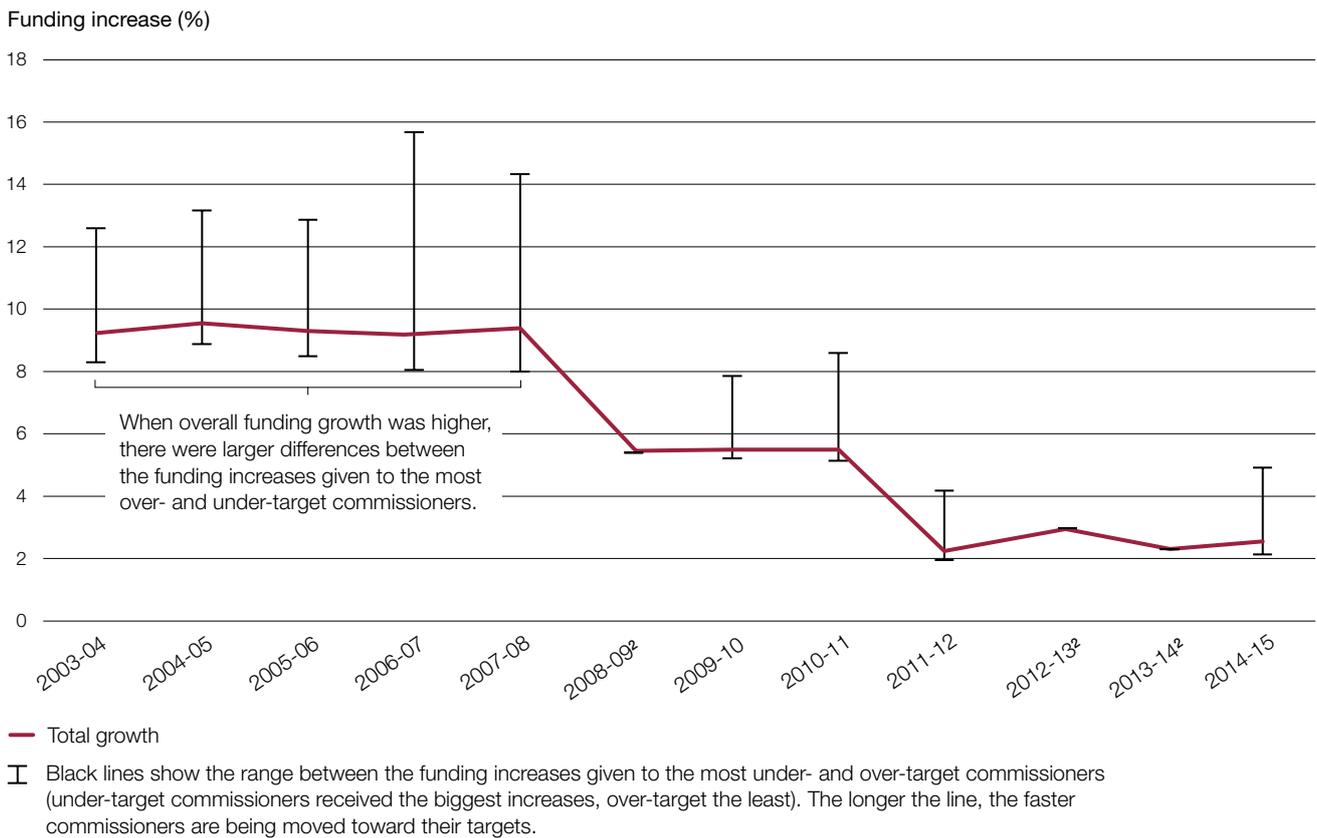
2.10 It is more difficult to make progress towards target allocations when the overall financial position is tighter. In 2014-15, NHS England's total funding increased by 0.2% above inflation. NHS England increased funding for its local commissioners by 0.4% above inflation, by reducing funding for its other activities.

2.11 In total, the Department and NHS England made £1.98 billion available to increase funding for local commissioners in 2014-15. They used this total in the following ways:

- **Giving all commissioners a minimum funding increase, at a cost of £1.61 billion.** They increased allocations for clinical commissioning groups and local authorities by at least inflation, continuing the long-standing approach that no commissioner's budget should be reduced in real terms. However, the minimum increase for area teams was 1.6%, with 9 teams receiving increases below inflation.
- **Using the remaining £0.37 billion 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. It left 222 commissioners below target and the remaining 166 commissioners above target.

Figure 6
Progress towards target funding allocations, 2003-04 to 2014-15¹

Progress towards target funding allocations has increased when total funding has grown significantly



Notes

- 1 Data to 2012-13 are for primary care trusts, and from 2013-14 are for clinical commissioning groups.
- 2 In 2008-09, 2012-13 and 2013-14 all commissioners received the same increase.

Source: National Audit Office analysis of Department of Health and NHS England data

2.12 Had the Department and NHS England used all of the £1.98 billion to move under-target commissioners towards target, the total amount that commissioners were below target would have fallen by 39% to £1.20 billion. The remaining commissioners would have been above target by the same amount. In this scenario, above-target commissioners would have received no increase in funding (that is, a real-terms reduction).

Future distance from target

2.13 If the Department and NHS England maintain their current pace of change policies, some local commissioners will continue to receive funding that is a considerable distance from their target allocations. In 2011, the Committee of Public Accounts recommended that departments should commit to giving the right funding for an area's needs within a set time period. The government disagreed with this recommendation because it did not consider it was practical due to target allocations constantly changing.⁶

2.14 The Department and NHS England have not announced allocations beyond 2015-16.⁷ As noted earlier, it is more difficult to make progress towards target allocations when the overall financial position is tighter. Were the current pace of change and tight financial position to continue, it would take approximately 6 years before no clinical commissioning group was below its target allocation by more than 5%. For local authorities for public health, this would take 10 years. As some commissioners currently receive considerably more than their target allocations, the time taken before no commissioner was above target by more than 5% would be much longer: approximately 60 years for clinical commissioning groups and 80 years for local authorities.⁸ All of NHS England's area teams are already within 5% of target for primary care funding.

Factors affecting pace of change policies

2.15 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 for moving local areas towards their target allocations. Therefore, decisions about pace of change are a matter of judgement relating to 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.

Capacity to tolerate changes in funding

2.16 Local bodies may be able to tolerate changes in funding that are more significant than those allowed under current pace of change policies. Using data from 2009-10 to 2012-13, we calculated the average year-on-year change in the amount that each primary care trust chose to spend on hospital, community and mental health services. We compared these figures to NHS England's pace of change policy for 2014-15 for clinical commissioning groups, which now commission most hospital, community and mental health services and so are the nearest proxy.⁹ This exploratory analysis suggests that an estimated:

6 HM Treasury, *Progress on implementing recommendations on 19 Committee of Public Accounts reports (Session 2010-12)*, Cm 8539, February 2013.

7 NHS England has published indicative allocation growth assumptions for 2016-17 to 2018-19 to help clinical commissioning groups to plan.

8 Appendix Two outlines how we estimated these figures.

9 The data for primary care trusts and clinical commissioning groups are not completely comparable. For example, the former are spending data and the latter are allocations data. Appendix Two provides more details of this analysis.

- 27 primary care trusts (18% of the total) had changed the amount spent on hospital, community and mental health services by less than the minimum change in allocations to clinical commissioning groups; and
- 27 primary care trusts (18%) had changed by more than the maximum change for clinical commissioning groups.

2.17 Despite limitations, this analysis indicates that some primary care trusts changed the amount they spent on hospital, community and mental health services by more or less than the changes allowed under NHS England's current pace of change policy. More work is needed to understand the effect of such changes on the financial stability of commissioners and their local providers, and the delivery of services and outcomes for patients. All these factors need to be considered in deciding an appropriate pace of change policy.

Impact of local population changes

2.18 In considering what is an appropriate pace of change, the Department has focused on ensuring stability of funding at local area level. This approach does not, however, take account of the fact that changes in population may cause funding per person to rise or fall significantly regardless of stability in total funding. Each year, local populations may change due to high rates of births and/or deaths, or cross-boundary migration. These changes in population are accounted for in calculating target allocations. But a slow pace of change policy limits the extent to which actual funding reflects the changes.

2.19 To quantify this risk, we investigated local areas that have previously experienced significant changes in their populations. The most recent available data, for 2011-12, show that:

- 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%).
- The 20 primary care trusts that had the largest falls in population all received more funding per person than they had in the previous year (by an average of 5.3%).
- One of the largest changes in population was in Kensington and Chelsea primary care trust, which fell by 6.4%, while in nearby Wandsworth the population rose by a similar percentage. Both primary care trusts received a funding increase of around 2%. As a result, funding per person rose by 9.0% in Kensington and Chelsea but fell by 4.2% in Wandsworth. Therefore, despite the stability in total funding, funding per person changed significantly in both areas.

2.20 NHS England has recognised this risk, and has mitigated it in its pace of change policy for clinical commissioning groups. For 2014-15 it introduced a rule to increase the funding for every clinical commissioning group by as much as its population had increased, or by inflation, whichever was greater.¹⁰ Taking the example in paragraph 2.19, this policy would have ensured that funding per person in Wandsworth at least stayed the same, rather than falling by £78. NHS England has not adopted this approach for its area teams, nor has the Department for local authorities.

Effect of commissioners not receiving their target funding allocations

Financial position

2.21 The financial position of individual commissioners is affected by a range of factors, including how well they manage their costs and whether they have received any additional non-recurrent financial support during the year. We found evidence suggesting an association between clinical commissioning groups receiving funding that is above or below their target allocation and their financial position.¹¹ Our analysis showed that at 31 March 2014:

- The 20 clinical commissioning groups with the tightest financial positions received, on average, 5.0% less than their target funding allocation.¹² 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.

2.22 While the relationship between financial position and distance from target allocation is likely to be complex and vary from area to area, we carried out analysis to investigate the association. This exploratory work, which assumes a constant effect between the two factors, suggests that, on average, for every £100 a clinical commissioning group is below target its financial position worsens by around an estimated £10 to £17. The actual effect may be smaller or larger than this for any individual clinical commissioning group and, as shown in **Figure 7**, some groups that received substantially less than their target allocation were in surplus at the end of 2013-14. Distance from target allocation explains around 23% of the variation in clinical commissioning groups' financial position. More work is needed to understand the effect of funding on the financial position of commissioners and their local providers.

¹⁰ This rule was supplemented by a further rule that clinical commissioning groups who were more than 5% over target could not receive more than the minimum increase. This affected one area, Tower Hamlets, which received the minimum 2.14% increase despite its population increasing by 2.47%.

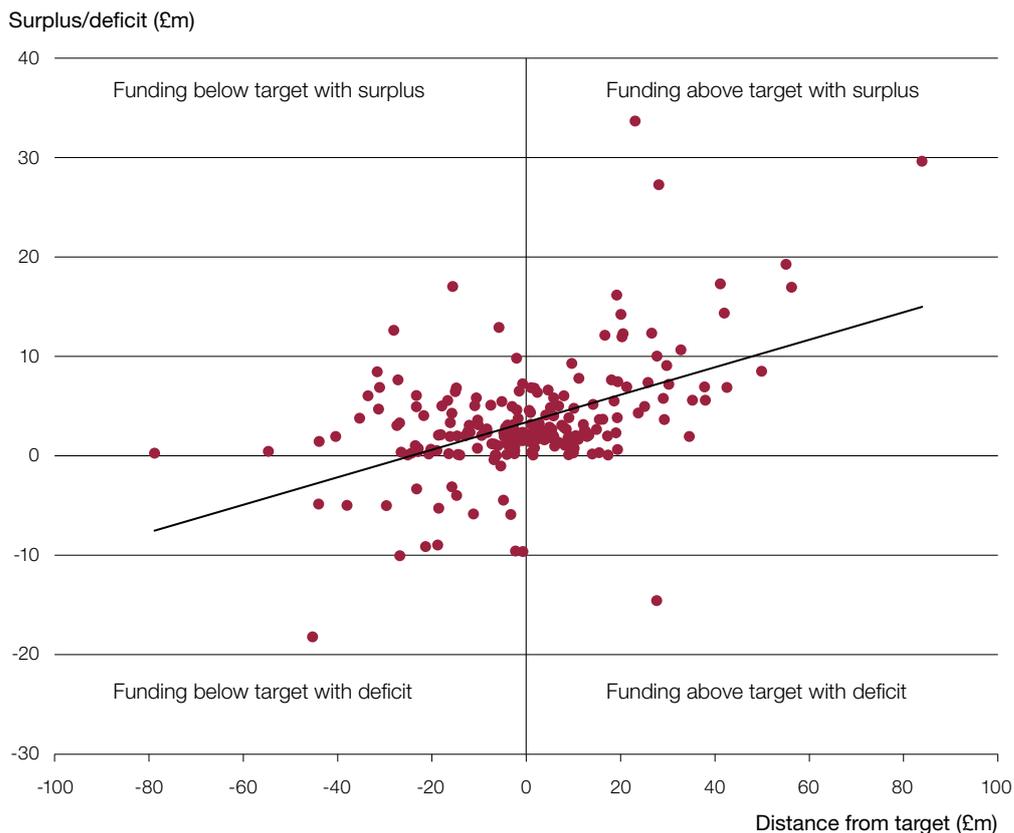
¹¹ Similar analysis was not possible for either area teams or local authorities because a substantial proportion of these organisations' funding – which will affect their financial position – is provided outside of the funding formula for other services.

¹² Of these clinical commissioning groups, 19 had a deficit and one had a surplus of 0.01%.

Figure 7

Relationship between distance from target funding allocation and financial position by clinical commissioning group, 2013-14

Areas with lower levels of funding, relative to target, are more likely to report a financial deficit



Note

1 The trend line is the straight line that best represents the data on the scatter plot.

Source: National Audit Office analysis of NHS England data

2.23 We identified a weaker relationship between distance from target allocation and financial position for primary care trusts at 31 March 2013. Distance from target explained 8% of the variation in financial position.

Provision of health services

2.24 We also sought to investigate whether receiving funding that is above or below target allocation appears to affect a local area's health services or outcomes.¹³ Given the multiple factors that affect health outcomes, we explored the relationship between distance from target at a local level and measures of how health services are provided, namely the number of GPs, hospital beds and hospital-based NHS staff. Our exploratory analysis did not identify any significant associations between the resourcing of health services by NHS providers and commissioners' distances from target allocations.

Balancing fairness and financial stability across different funding streams

2.25 The challenges of meeting the complex care needs of the ageing population and addressing the public health problems associated with unhealthy lifestyles require a more transparent and integrated approach to commissioning across the health system and more widely. To balance fairness and financial stability, the Department and NHS England need to consider the aggregate funding position of local areas, rather than making allocations in isolation. Knowledge of the overall funding position would also help local commissioners better plan their services.

Across the health system

2.26 Creating an aggregate position of health funding is more challenging following the reforms to the health system. Money is provided in three separate allocations and the geographies used for the different allocations vary. In setting primary care and hospital, community and mental health services allocations for 2014-15 in December 2013, NHS England considered the combined effect of the three health allocations at the level of the 25 area teams. It did not calculate the combined effect at a more local level until June 2014. The Department did not provide us with any evidence that it has considered the wider funding position when deciding its public health allocations.

2.27 We investigated combined health funding at the local level – based on clinical commissioning group areas – by mapping allocations across different geographical boundaries and using primary care funding patterns from 2012-13, when such data were last collected at this level (**Figure 8** on page 30). The lack of data on, for example, local primary care funding meant that we had to make several broad assumptions in order to do this mapping.¹⁴ We estimate that in 2013-14:

¹³ Appendix Two provides more details of this analysis.

¹⁴ Appendix Two provides more details of this mapping and the assumptions we made.

- On average, local areas received £1,371 per person for funding healthcare, ranging from £1,076 (Oxfordshire) to £1,845 (Knowsley).¹⁵
- The most under-target area (Corby) was below target by £186 per person (12.8%), while the most over-target area (West London) was above target by £508 per person (39.3%).
- 18 areas received at least £100 more per person than their target allocation while 20 areas received at least £100 per person less.
- There were positive relationships between distances from target at a local level across the three separate funding allocations. While these associations were generally weak, this suggests that in 2013-14 the Department and NHS England were over- or under-funding the same areas to some extent.

Healthcare and adult social care

2.28 Given the link between healthcare services and social care, we also explored the relationship between the two. Local authorities receive funding for providing a range of local services, including social care.¹⁶ The funding allocations are based in part on an estimate of the relative need for social care within each area. However, this funding is not ring-fenced and local authorities decide how much of their total budget to spend on social care.

2.29 Many people receive both healthcare and social care and, therefore, lower spending in one of these sectors might be expected to cause additional costs in the other. A recent survey found that nearly a third of clinical commissioning group chief finance officers considered that cost pressures in social care were causing cost pressures in their clinical commissioning group.¹⁷ Our exploratory analysis supports this view. In local areas where aggregate health funding is below the target allocations, local authorities tend to spend more than expected – based on relative need – on adult social care. More work is needed to understand the extent of, and causation in, this relationship.

2.30 The apparent association between health funding and social care spending suggests that decisions about each should not be made in isolation. NHS England has recognised the need to analyse social care funding in assessing the local impact of its funding decisions. However, in making decisions about 2014-15 health funding allocations, neither the Department of Health nor NHS England took account of local authority spending on social care or the Department for Communities and Local Government's plans for funding local authorities. In June 2014, NHS England calculated total levels of local funding, covering both health and social care.

¹⁵ These per person estimates use NHS England's estimates of the population covered by each clinical commissioning group.

¹⁶ Social care comprises personal care and practical support for adults with physical disabilities, learning disabilities or physical or mental illnesses, as well as support for their carers.

¹⁷ Healthcare Financial Management Association, *NHS financial temperature check*, June 2014. Based on 63 responses.

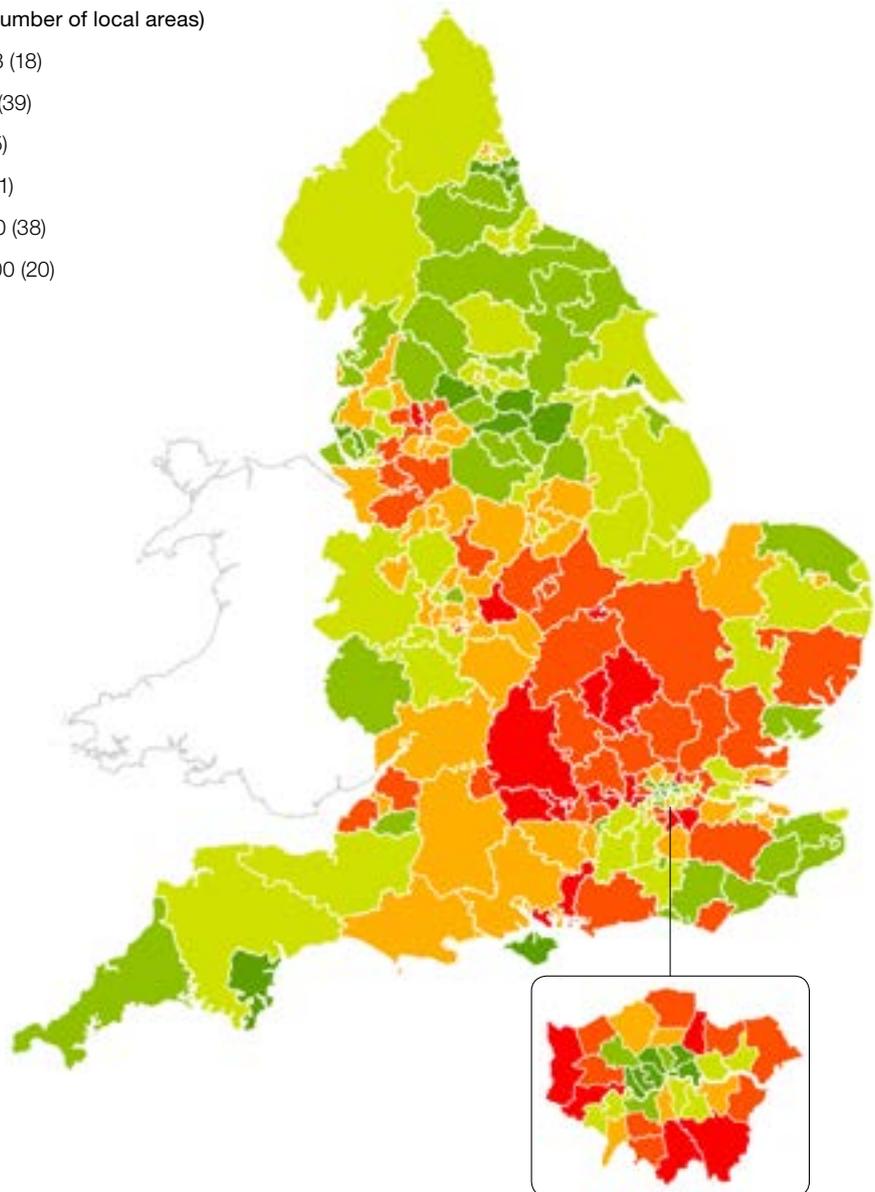
Figure 8

Aggregated distances from target funding allocations for healthcare by local area, 2013-14

Eighteen local areas received at least £100 more per person than their target funding allocation, while 20 received at least £100 per person less

£ per head (number of local areas)

- 100 to 508 (18)
- 50 to 100 (39)
- 0 to 50 (45)
- -50 to 0 (51)
- -100 to -50 (38)
- -186 to -100 (20)



Source: National Audit Office analysis of Department of Health, NHS England and Office for National Statistics data

Part Three

Setting target funding allocations

3.1 This part of the report covers how the Department of Health (the Department) and NHS England set target allocations for each local commissioner of healthcare. Specifically, we examine how they estimate population size and adjust for relative need and health inequalities.

3.2 The 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. The allocations are based on predictions of need, taking account of the size and characteristics of local populations. They are not designed to cater for unpredictable events, such as sudden outbreaks of infectious disease, which can be costly for the local areas affected. The new structures for commissioning healthcare are intended to reduce unpredictability by centralising the commissioning of specialised services needed by relatively small numbers of people in any local area.

Overall approach

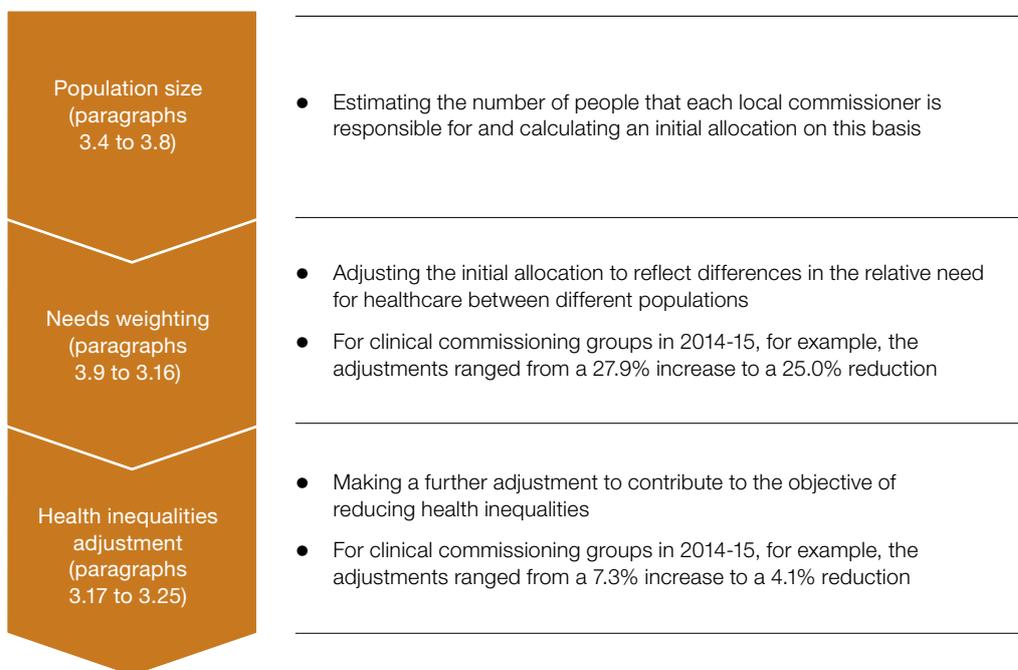
3.3 The principles underpinning the approach of the Department and NHS England are that local areas with higher healthcare needs should get a larger share of NHS resources and that allocations should be used in support of the aim of reducing health inequalities. The overall approach that both organisations adopt involves calculating funding allocations based on population size and then adjusting them for relative needs and health inequalities (**Figure 9** overleaf).

Estimating population size

Data sources

3.4 Population size is the factor that has the most significant effect on each commissioner's target funding allocation. It is important that, where possible, the data used are responsive to changes in the size of local area populations and their need for healthcare. Any large inaccuracies in population estimates would lead to inequitable target allocations.

Figure 9
Approach to calculating target funding allocations



Note

- 1 The Department and NHS England make a further adjustment to reflect unavoidable differences in costs due to location alone, for example higher staff or buildings costs. These calculations are made at provider level, and the allocations of commissioners are then adjusted to reflect the providers from which they purchase healthcare.

Source: National Audit Office

3.5 Before April 2013 the Department used population projections from the Office for National Statistics to calculate funding allocations for primary care trusts. The Department continues to use these projections to estimate local authority populations and calculate allocations for public health. Its approach is consistent with how the Department for Communities and Local Government allocates grant funding to local authorities. In contrast, NHS England uses data from GP lists to calculate population estimates for clinical commissioning groups and area teams.

Data quality

3.6 Compared with Office for National Statistics projections, GP list data offer benefits including:

- **More responsive to changes in population.** Office for National Statistics projections are based on the census, which is carried out every 10 years. They are therefore less responsive to changes in population than GP list data, which are updated more frequently.
- **More detailed understanding of relative need.** Data from GP lists allow need to be assessed more precisely, at the level of individual patients rather than local areas (paragraph 3.14).

3.7 There are, however, known concerns about the accuracy of GP list data. In 2012, a report commissioned by the Advisory Committee on Resource Allocation¹⁸ noted several issues affecting accuracy including:

- **'List inflation'.** GP lists tend to be inflated (6% higher on average than Office for National Statistics projections). Areas with more transient populations tend to have more inflated GP lists. This is because, for example, patients who move may not tell their GP, and may remain on the GP's list after they have left the area. NHS England adjusts allocations for clinical commissioning groups to reduce the effect of list inflation to some extent.
- **Unregistered patients.** GP lists do not include unregistered patients, such as homeless people. Providing healthcare for such patients costs an estimated £240 million per year. These costs are not distributed evenly across the country, and are highest in London, Birmingham and Southampton.

3.8 The Department previously estimated that changing from Office for National Statistics projections to GP list data could affect a local area's estimated population by up to a 12.6% increase or 4.0% fall.¹⁹ In its 2011 report on formula funding, the Committee of Public Accounts recommended that, working with HM Treasury, departments should set standards for the accuracy and timeliness of the data sources they use, focusing in particular on strengthening data where it will be central to proposed new arrangements. The Department accepted this recommendation, and undertook an exercise to consolidate the two data sources and clean the new GP list data. However, assurance that the data are accurate remains limited:

- All 8,000 GP practices are responsible for maintaining their own lists. The Advisory Committee on Resource Allocation has noted that GP practices have an incentive to over-state their lists, because the funding they receive is directly related to list size.

¹⁸ Nuffield Trust, *Updating and enhancing a resource allocation formula at general practice level based on individual level characteristics*, January 2012.

¹⁹ Analysis underlying Advisory Committee on Resource Allocation, *The comparative performance of the PCT and CCG allocation formulae*, June 2013.

- NHS England published guidance on ‘tackling list inflation’ in June 2013.²⁰ This noted that some degree of list inflation was inevitable, but that current trends of inflation were excessive with regional variation. NHS England’s area teams are expected to work with GP practices to manage lists. NHS England centrally does not routinely assure itself that the guidance is being followed but collected evidence for us of the work that most area teams have done.

Adjusting for relative need

3.9 Estimates of the relative healthcare needs of local populations also have a significant impact on target funding allocations. The Department and NHS England adjust allocations on this basis which is intended, for example, to reflect the additional demand for healthcare in areas with higher proportions of elderly people.

3.10 NHS England adjusted 90% of each clinical commissioning group’s target allocation for 2014-15 for relative need. The adjustments ranged from a 27.9% increase to a 25.0% decrease, compared with what target allocations would have been based on population size alone. The adjustment increased the target allocations by at least 15% for 26 clinical commissioning groups and reduced them by at least 15% for 18 clinical commissioning groups (**Figure 10**). The needs adjustment also changed area teams’ allocations by up to 18%, and local authorities’ allocations for public health by up to 79%.

Approaches to assessing need

3.11 Given the lack of consensus on the best way to measure need, we do not offer judgement on which is the most appropriate method. Both approaches currently used in England have strengths and limitations:

- NHS England’s utilisation-based approach (paragraphs 3.13 to 3.15) benefits from drawing on comparatively rich data on past consumption of health services. However the calculations do not account for need for healthcare that is not currently being met, where this unmet need is distributed differently to met need.
- The Department’s outcomes-based approach (paragraph 3.16) uses a measure of the actual health of the population. However, it is difficult to establish what resources should be used to meet this need.

3.12 The Advisory Committee on Resource Allocation plans to investigate the approaches to assessing need used in other countries, including Wales. The Welsh Government uses a formula based on population and health need for allocating funding to local health boards. The main data source for measuring need is self-reported information on illness from the Welsh Health Survey. This is supplemented by other data on specific conditions.

20 NHS England, *Tackling list inflation for primary medical services*, June 2013.

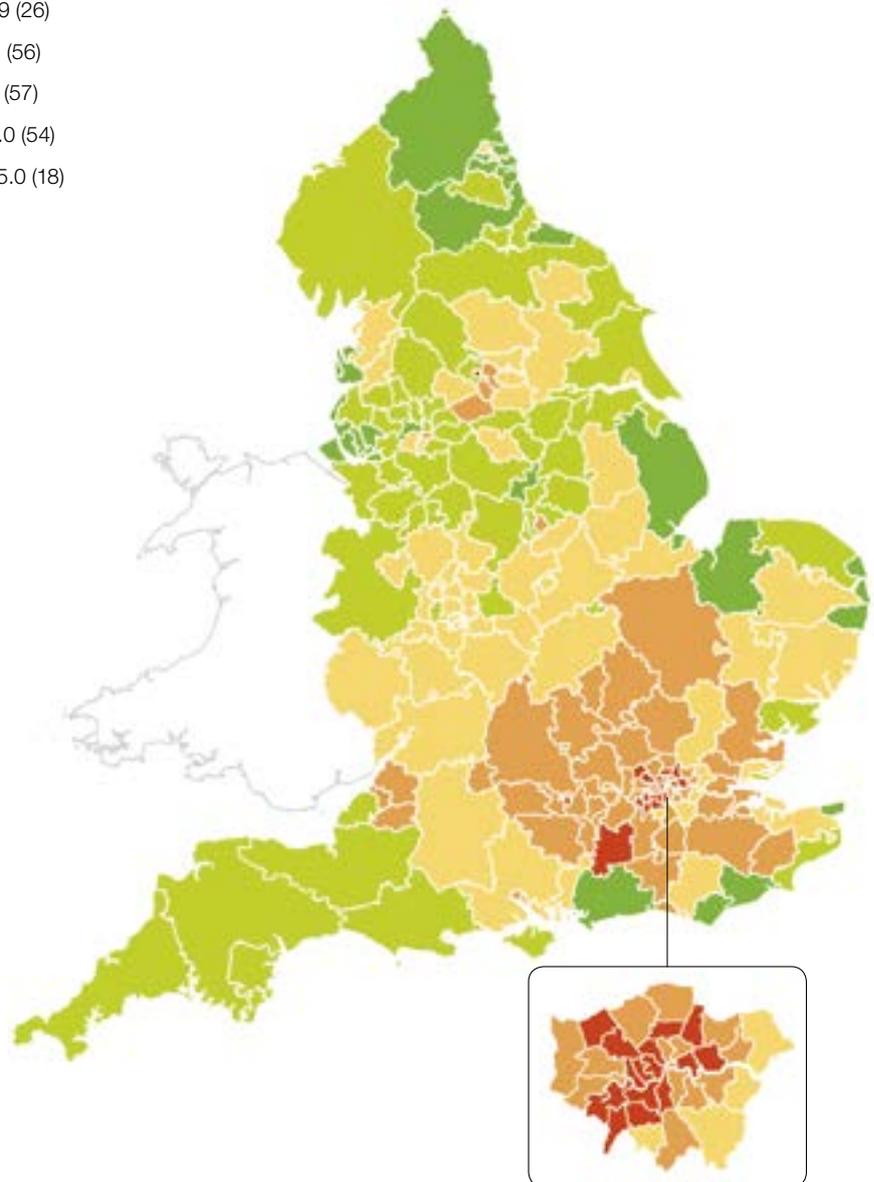
Figure 10

Impact of adjusting for relative need by clinical commissioning group, 2014-15

The needs-adjustment changed clinical commissioning groups' target funding allocations by up to a 27.9% increase or a 25.0% decrease

Effect on target allocation, % (number of clinical commissioning groups)

- 15.0 to 27.9 (26)
- 5.0 to 15.0 (56)
- -5.0 to 5.0 (57)
- -15.0 to -5.0 (54)
- -25.0 to -15.0 (18)



Source: National Audit Office analysis of NHS England data

Utilisation-based approaches for allocations to clinical commissioning groups and NHS England's area teams

3.13 NHS England uses proxy indicators, such as age, gender and previous diagnoses, to estimate the relative healthcare needs of different local areas. It bases the estimate on the indicators' association with variations in service use or spending. For example, if the analysis suggests that spending on healthcare tends to be higher for elderly people then, all else being equal, NHS England assesses local areas with a larger proportion of elderly people as having higher relative need.

3.14 The Department adopted a similar approach in calculating funding allocations for primary care trusts until 2012-13. NHS England refined the approach for allocations to clinical commissioning groups for 2014-15. By using newly available data at the level of individual patients to create a more detailed model of healthcare utilisation, NHS England's new approach is better at predicting relative needs.

3.15 In contrast, NHS England's approach for primary care allocations for area teams for 2014-15 was heavily based on the relevant component of the previous primary care trust formula. It did not seek the Advisory Committee on Resource Allocation's views until three months before the primary care allocations were announced. As a result, the Advisory Committee did not have time to develop an alternative approach. NHS England regards the current approach as interim and intends to refine how it assesses need for future years.

Outcomes-based approach for allocations to local authorities for public health

3.16 The Department adopted a new approach to assessing need in calculating funding allocations to local authorities for public health for 2013-14. This involved estimating relative need based predominantly on a measure of life expectancy, a proxy for health inequalities. The Advisory Committee on Resource Allocation advised that, given the pivotal role of public health in supporting the objective of reducing health inequalities, this formula would benefit from being based on a measure of health status. As a result, target allocations were increased in local areas with lower life expectancies (broadly parts of London and the north-west of England) and reduced where life expectancies were higher.

Adjusting for health inequalities

Approach to assessing health inequalities

3.17 Since 1999 health funding formulae have included adjustments to move money towards areas with lower life expectancies, with the aim of reducing health inequalities (paragraph 1.7). In its 2010 report on tackling inequalities,²¹ the Committee of Public Accounts recommended that in allocating funding the Department and NHS England²² should consider how to correct funding shortfalls in the most deprived areas.

3.18 NHS England uses a measure of life expectancy as the basis for adjusting for health inequalities in calculating target allocations for clinical commissioning groups and its area teams.²³ This approach is based on the rationale that moving money towards areas with lower life expectancies will reduce health inequalities and allow unmet need to be addressed.

3.19 NHS England has improved the basis for adjusting for health inequalities, although the approach remains an interim measure. Compared with the measure used previously (disability-free life expectancy), the current indicator (standardised mortality ratios) is updated more often. It is also better at detecting small pockets of ill-health in otherwise healthy areas as it is calculated for smaller areas. The Advisory Committee on Resource Allocation considers that, while the current measure is an improvement, it is only an interim approach. It plans to conduct further work on estimating unmet need for health services.

Effect of health inequalities adjustment

3.20 The adjustment for health inequalities is less than the adjustment for relative need. NHS England adjusted 10% of the target allocation for each clinical commissioning group for 2014-15 for health inequalities. The effect of the adjustment ranged from a 7.3% increase to a 4.1% decrease (**Figure 11** overleaf). The range in adjustments (11.4 percentage points) is around a fifth of the range for the relative needs adjustment (52.9 percentage points).

3.21 Broadly, the adjustment for health inequalities moves funding towards parts of London and the north-west of England. For 2014-15, it increased the target allocations of 25 clinical commissioning groups by more than 3%, and decreased the target allocations of 9 clinical commissioning groups by more than 3%.

3.22 NHS England adjusted 15% of the target allocation for each of its area teams for health inequalities. This larger amount reflects NHS England's view that improving primary care will have more impact on reducing health inequalities.

21 HC Committee of Public Accounts, *Tackling inequalities in life expectancy in areas with the worst health and deprivation*, Third Report of Session 2010-11, HC 470, November 2010.

22 Then known as the NHS Commissioning Board.

23 The Department does not adjust for health inequalities since its allocations to local authorities for public health already reflect a measure of life expectancy (paragraph 3.16).

Figure 11

Impact of adjusting for health inequalities by clinical commissioning group, 2014-15

The health inequalities adjustment changed clinical commissioning groups' target funding allocations by up to a 7.3% increase or a 4.1% decrease

Effect on target allocation, % (number of clinical commissioning groups)

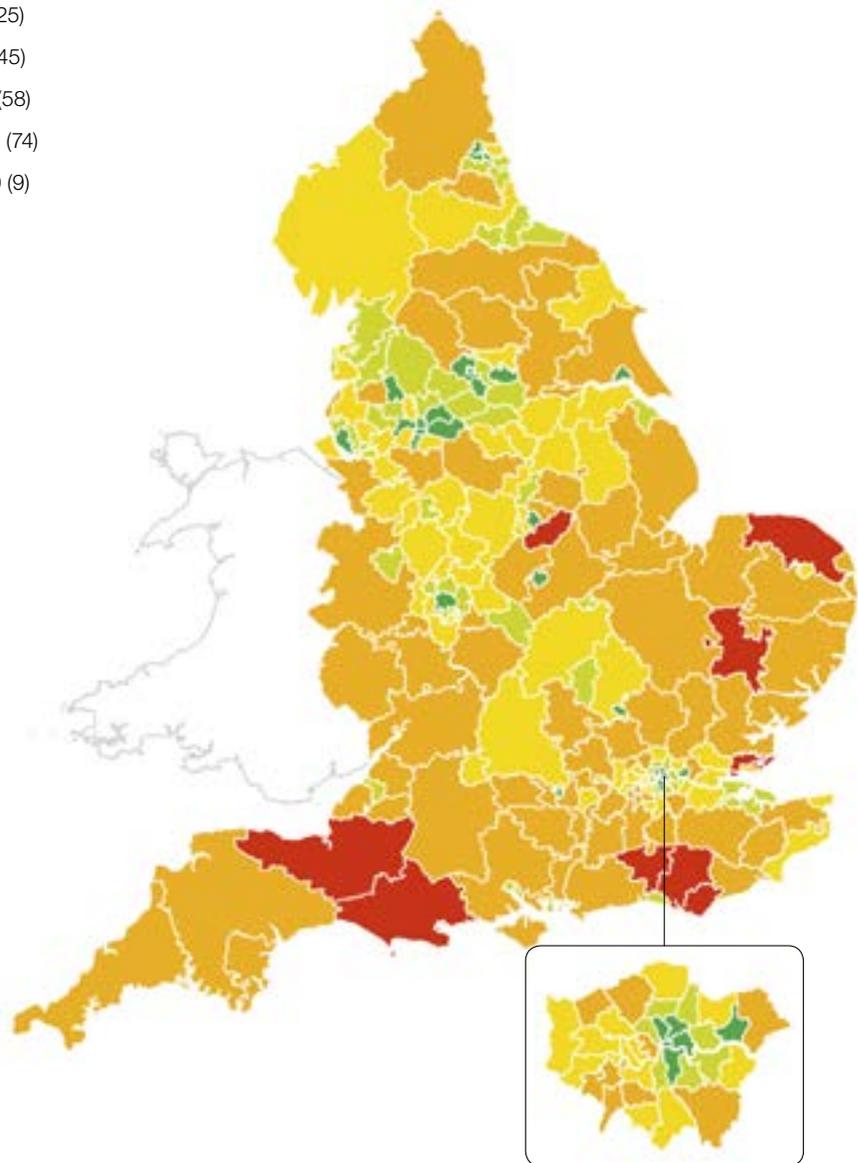
3.0 to 7.3 (25)

1.0 to 3.0 (45)

-1.0 to 1.0 (58)

-3.0 to -1.0 (74)

-4.1 to -3.0 (9)



Source: National Audit Office analysis of NHS England data

3.23 The evidence is unclear on the extent to which increasing funding can help to reduce health inequalities. For example, it is uncertain how far health inequalities reflect the provision of health services, rather than other social factors such as income, education and child welfare. And while there is evidence of some benefits, the cost-effectiveness of previous funding adjustments has not been demonstrated. The Advisory Committee on Resource Allocation also does not consider there is any evidence about the appropriate weight to give to any health inequalities adjustment.

3.24 In funding primary care trusts, the Department applied a weighting of 15% in 2009-10 and 2010-11, and a weighting of 10% after that. For 2013-14, the Department initially commissioned the Advisory Committee to develop a formula with no health inequalities adjustment.²⁴ However, NHS England considered that the proposed formula risked increasing health inequalities by awarding more money to areas with better health outcomes. It therefore commissioned the Advisory Committee to propose a health inequalities adjustment for clinical commissioning groups. NHS England adopted this adjustment for 2014-15. It also applied it in calculating primary care allocations for area teams.

Addressing health inequalities and the needs of ageing populations

3.25 In allocating funding, NHS England faces a particular challenge in addressing health inequalities and meeting the complex care needs of the ageing population at the same time. Areas with low life expectancy (which tend to be deprived) tend to have fewer elderly people. For example, in the 20 clinical commissioning groups with the lowest life expectancy, on average 3.4% of the population was aged over 80, compared with 4.5% in the 20 groups with the highest life expectancy. As a result, increasing funding for areas with low life expectancy will tend to reduce funding in areas with more elderly people. In other words, there appears to be a trade-off between addressing health inequalities and not reducing funding in areas with ageing populations.

²⁴ The Department initially commissioned the Advisory Committee to advise on allocations for 2013-14, because NHS England was not established until October 2012.

Appendix One

Our audit approach

1 This report examines how the Department of Health and NHS England allocate funding for healthcare to local areas. In particular, we reviewed how the Department and NHS England:

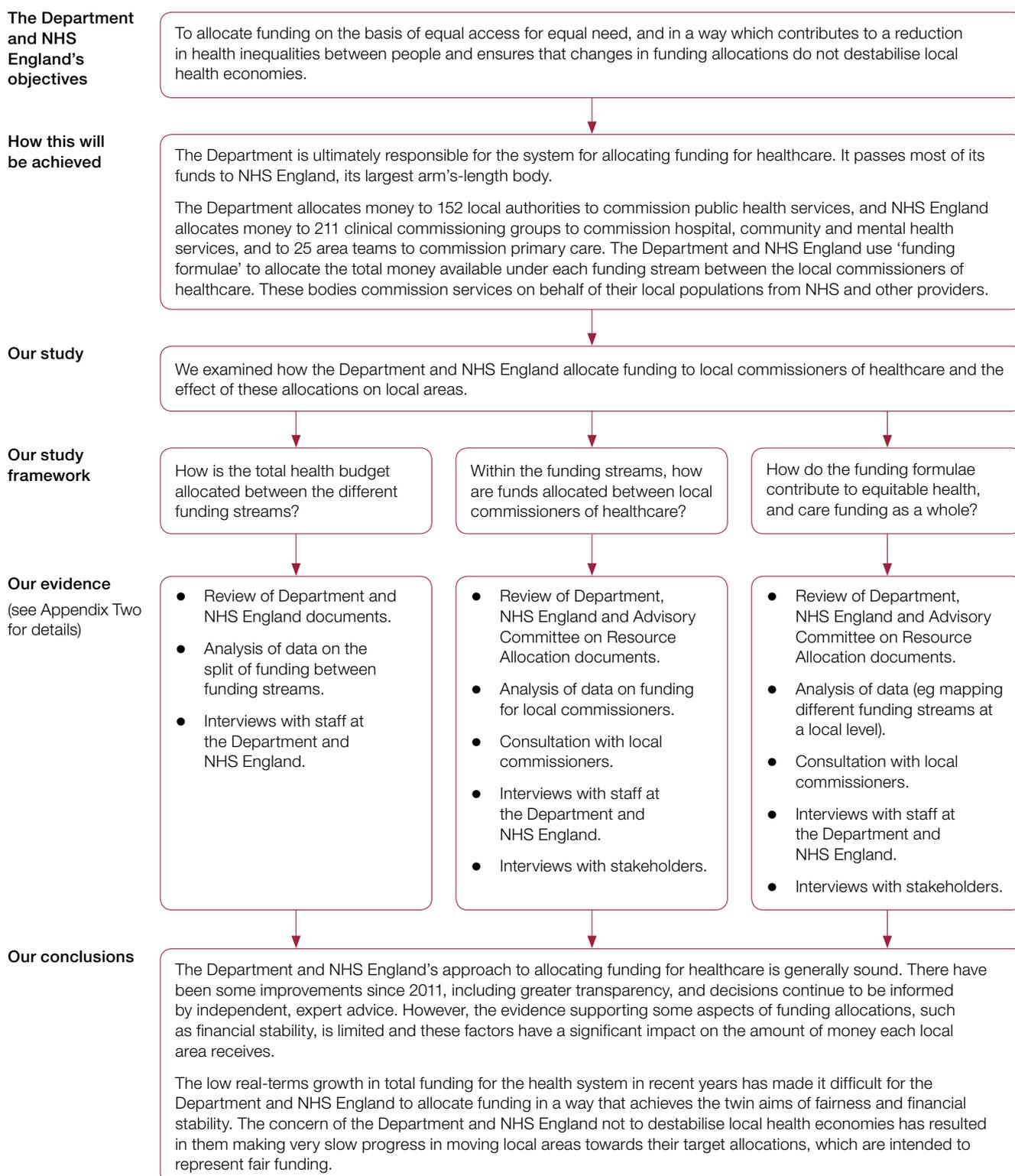
- allocate funding between the different funding streams (hospital, community and mental health services, primary care, and public health);
- balance fairness and financial stability when making allocations to local areas; and
- calculate each local commissioner's fair share of the available funding.

2 To support accountability and transparency, we examined how allocations are made. In reviewing these issues we also, where appropriate, drew conclusions by applying an analytical framework based on: policy objectives; comparing the three approaches now in place with each other and with the approach previously used for primary care trusts; and relevant recommendations made by the Committee of Public Accounts in 2011.

3 Our audit approach is summarised in **Figure 12**. Our evidence base is described in Appendix Two.

Figure 12

Our audit approach



Appendix Two

Our evidence base

1 We reached our independent conclusions on how funding for healthcare is allocated to local areas after analysing evidence collected between March and July 2014. Our audit approach is outlined in Appendix One.

2 We reviewed key documents. These covered the arrangements currently in place for allocating funding to local commissioners, and the approach previously used for primary care trusts. The documents included: Department of Health, NHS England and Advisory Committee on Resource Allocation documents; academic articles; and previous National Audit Office and Committee of Public Accounts reports.

3 We interviewed staff from a range of organisations. The interviews were designed to help us understand the technical detail of the funding formulae and the effect of key decisions. The organisations included: the Department of Health; NHS England; the King's Fund; the Nuffield Trust; the University of Liverpool; the University of Manchester; the University of Plymouth; the Association of Directors of Public Health; NHS Clinical Commissioners; and the Healthcare Financial Management Association.

4 We consulted clinical commissioning groups. This exercise was designed to help us understand the effect of funding allocations on commissioners and on local health economies. We spoke to the chief finance officers from four clinical commissioning groups, and received written submissions from four others.

5 We analysed existing data. The analysis was designed to understand: how funding is distributed between local commissioners; how this has changed over time; and the effects of the current funding distribution. We analysed data including: total Department of Health budget from 2003-04 to 2014-15; actual allocations and target allocations for local commissioners from 1999-2000 to 2015-16; primary care trust spending from 2009-10 to 2012-13; clinical commissioning groups' financial position; adult social care need (from formula grant) and spending (from personal social services expenditure data); and hospital bed numbers. Details of some of the key pieces of analysis are described below:

- **Estimating the time required for all local commissioners to be within 5% of their target funding allocations** (paragraphs 2.13 to 2.14). We estimated how long it would take for all commissioners to be within 5% of their target allocations if current pace of change policies continued. In practice the time will depend on many factors, such as the total funding available and the way commissioners' target allocations change. Our analysis therefore made several broad assumptions, including that overall funding growth, commissioners' population sizes and relative needs, and the minimum funding growth which commissioners can receive all remain the same as for 2014-15 for local authorities and for 2015-16 for clinical commissioning groups (the most recent years for which the decisions have been made). Our calculation also assumed that all commissioners that are more than 5% above target receive the minimum funding increase, and all commissioners that are more than 5% below target receive the maximum funding increase.²⁵ Within the constraints of the minimum and maximum funding increases, this is the pace of change policy which would move all commissioners to within 5% of their target allocations most quickly.
- **Assessing the pace of change policy by comparing it with primary care trust spending patterns** (paragraphs 2.16 to 2.17). We examined whether primary care trusts had previously changed how much they spent on hospital, community and mental health services more quickly than current pace of change policies allow. To do this, we calculated the average annual change between 2009-10 and 2012-13 in the amount that each primary care trust spent on these services, based on financial data provided by the Department. After adjusting for inflation, we compared these figures with NHS England's pace of change policy for 2014-15 for clinical commissioning groups. Clinical commissioning groups now commission most of these services and so are the closest proxy to primary care trusts. However, as clinical commissioning groups and primary care trusts cover slightly different services, the comparison should be treated with caution. For example, only the primary care trust figures include specialised services. Spending on these services is less predictable, which potentially increases the variation from year-to-year. We used the average annual change in spending on hospital, community and mental health services over a three-year period, rather than just a single year, to mitigate this risk.

²⁵ For clinical commissioning groups we assumed that each year the maximum funding growth percentage would increase. This is because each year there will be fewer commissioners significantly under-target, so these can receive a greater share of additional funding. NHS England confirmed that this assumption is in line with its pace of change policy. Data did not exist to conduct a similar analysis for local authorities, so for them we assumed that maximum growth remained the same as in 2014-15.

- **Investigating the effect of commissioners not receiving their target funding allocations** (paragraphs 2.21 to 2.24). We would have liked to understand the relationship between commissioners' 'distance from target' and patient outcomes. However, the limited data available meant that we could not carry out this analysis. Instead, we used a mathematical technique called linear regression analysis to explore the relationship between distance from target and various proxy measures. We looked at the relationship between clinical commissioning groups' distance from target and: clinical commissioning groups' financial surplus/deficit;²⁶ average hospital bed numbers (adjusted for relative need); and hospital staffing²⁷ levels (adjusted for relative need). We also looked at the relationship between NHS England's area teams' distance from target and GP numbers, again adjusted for relative need.
- **Combining different funding streams at a local level** (paragraphs 2.25 to 2.27). We estimated the funding received by each local area for locally commissioned healthcare, based on clinical commissioning group areas. We also calculated aggregate target funding allocations for each local area. For this analysis, we had to estimate how current and target levels of funding for primary care (allocated to 25 area teams) and for public health (allocated to 152 local authorities) are divided between the 211 clinical commissioning group areas. Our approach was:
 - For **primary care targets** we used the data that NHS England had used to calculate targets for area teams, as most of these data were available at clinical commissioning group level. Data on dentistry targets were not available. However, as dentistry is a relatively small proportion of spending, we assumed that need for dentistry is distributed between clinical commissioning group areas in the same way as need for other primary care services.

26 We carried out this analysis both including and excluding the effects of non-recurrent financial support given to clinical commissioning groups.

27 Comprising nursing, midwifery and health visiting staff, scientific, therapeutic and technical staff, ambulance staff, clinical support staff and infrastructure support staff.

- For **primary care allocations** we used data on how much primary care trusts planned to use to fund primary care in 2012-13, the last year these data were collected at a local level, and projected it forward to 2013-14. We divided each primary care trust's planned primary care spending between its 'Lower Layer Super Output Areas'.²⁸ We then summed these Output Area level estimates to clinical commissioning group level. Finally, we increased the estimated spending for each clinical commissioning group by 2.6%, in line with the overall growth in primary care funding between 2012-13 and 2013-14. This analysis makes several significant assumptions including that all primary care trusts divided their funding equally across their population. It also depends on data on primary care trusts' planned spending, which are known to contain errors. While we attempted to cleanse these data, some inaccuracies are likely to remain.
- We mapped **local authority targets and allocations for public health** to clinical commissioning groups by attributing them to Lower Layer Super Output Areas, using the same approach as described above for primary care allocations.

28 The Office for National Statistics divides England into 32,844 'Lower Layer Super Output Areas', which are small geographical areas with populations of between 1,000 and 3,000.

Appendix Three

The government's response to the recommendations made by the Committee of Public Accounts in 2011

1 In July 2011 we published a report on formula funding of local public services which covered – among other things – the formula used at that time by the Department of Health to allocate funds to primary care trusts.²⁹ This report formed the basis of a hearing of the Committee of Public Accounts. The Committee then produced its own report in November 2011,³⁰ with recommendations to which the government responded in February 2012. **Figure 13** shows the recommendations and the government's assessment of progress against them.

2 As shown, the government disagreed with two of the Committee's recommendations. One of these recommendations – that departments should use independent advisory groups to provide technical expertise – was aimed at other departments covered by our 2011 report, as the Department of Health already used the Advisory Committee on Resource Allocation. The government's reason for disagreeing with the other recommendation – that departments should commit to giving the right funding for an area's need within a set time period – was as follows: "While the Government welcomes the Committee's support for the aim of ensuring stability of funding, it does not believe it is practical to set a time limit by which the needs-assessed levels should be achieved. The needs-assessed level of funding, for instance due to demographic changes, is constantly changing. This would risk destabilising some organisations and jeopardises the sustainability of funding systems."

29 Comptroller and Auditor General, *Formula funding of local public services*, Session 2010-12, HC 1090, National Audit Office, July 2011.

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

Figure 13

Progress against previous recommendations made by the Committee of Public Accounts

Recommendation	Current status
Departments should identify the primary objective for formula funding models, and design their models to establish transparent, equitable allocations which achieve that objective.	Implemented
Departments should commit to giving the right funding for an area's needs within a set time period.	Disagreed
Departments should set out publicly the basis for their judgements, and how they affect the distribution of funding relative to their primary objective.	Implemented
Working with the Treasury, departments should set standards for the accuracy and timeliness of data sources they use, focusing in particular on strengthening data where it will be central to proposed new arrangements.	Implemented
Departments should use independent advisory groups to provide technical expertise.	Disagreed
The Treasury should report back to the Committee to explain how each of our recommendations is incorporated within new funding arrangements.	Implemented

Sources:

HM Treasury, *Treasury Minutes: Progress on implementing recommendations on 19 Committee of Public Accounts reports (Session 2010–2012)*; 3 National Audit Office reports; 12 updates from Treasury Minute progress reports (January 2012); and a progress report on Government Cash Management, Cm 8359, February 2013; and HM Treasury *Progress report on the implementation of Government accepted recommendations of the Committee of Public Accounts – Sessions 2010–2012 and 2012-13*, Cm 8899, July 2014

Appendix Four

Key elements of the three funding streams, 2014-15

	Hospital, community and mental health services	Primary care	Public health
Local commissioners	211 clinical commissioning groups	25 NHS England area teams	152 local authorities
Total funding allocation (£bn)	64.3	12.0	2.8
Average allocation, per person (£)	1,133	211	51
Basis for estimating population size	GP lists	GP lists	Office for National Statistics population projections, based on the census
Adjustment for relative need			
Approach to estimating relative need	Mainly utilisation-based, using data on past spending on healthcare	Mainly utilisation-based, using data on past GP workload	Mainly outcomes-based, using a measure of life expectancy
Effect on target allocations ¹ (%)	-25.0 to +27.9	-16.2 to +17.6	-53.9 to +79.2
Adjustment for health inequalities			
Approach to adjusting for health inequalities	A measure of life expectancy, given a 10% weighting ²	A measure of life expectancy, given a 15% weighting ²	No separate adjustment – the needs adjustment for public health is largely based on a measure of life expectancy
Effect on target allocations ³ (%)	-4.1 to +7.3	-2.0 to +2.5	
Range of allocations, by local commissioner			
Actual allocations, per person (£)	878 to 1,517	181 to 249	22 to 185
Target allocations, per person (£)	960 to 1,434	185 to 250	23 to 105
Distance from target, per person (£)	-137 to +361	-8 to +9	-28 to +156
Distance from target (%)	-12.0 to +33.9	-3.8 to +4.3	-43.0 to +529.7

Notes

- 1 Amount by which target allocations adjusted for relative need would differ from target allocations based simply on population size.
- 2 Proportion of each commissioner's target allocation that is adjusted for health inequalities.
- 3 Amount by which actual target allocations (which include adjustments for health inequalities, relative need and unavoidable cost differences) differ from target allocations adjusted only for relative need and unavoidable cost differences.

Source: National Audit Office analysis of Department of Health, NHS England and Office for National Statistics documents

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