

House of Commons Committee of Public Accounts

Funding healthcare: making allocations to local areas

Twenty-fifth Report of Session 2014–15

Report, together with the formal minutes relating to the report

Ordered by the House of Commons to be printed date 8 December 2014

Committee of Public Accounts

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Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No 148. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/pac. A list of Reports of the Committee in the present Parliament is at the back of this volume. Additional written evidence may be published on the internet only.

Committee staff

The current staff of the Committee is Sarah Petit (Clerk), Claire Cozens (Committee Specialist), James McQuade (Senior Committee Assistant), Sue Alexander and Jamie Mordue (Committee Assistants) and Janet Coull Trisic (Media Officer).

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Summary

The Department of Health (the Department) and NHS England have changed the way that they allocate health funding to local commissioners. The Department and NHS England have prioritised maintaining the financial stability of local health economies, but this means they have made only very slow progress towards ensuring that all areas receive their fair share of the available funding. Around two-fifths of clinical commissioning groups and three-quarters of local authorities are receiving allocations more than 5% above or below what would be their defined share. This has consequences for financial sustainability—of the 20 clinical commissioning groups with the tightest financial positions at 31 March 2014, 19 had received less than their defined share of funding. One of the main objectives of the funding formulae is to support the reduction of health inequalities, yet the Department and NHS England have only limited evidence on how best to make adjustments for this purpose. NHS England also has more work to do on tackling inaccuracies in GP list data, which are a key determinant in calculating an area's fair share of funding.

Conclusions and recommendations

- 1. In 2014-15, the Department and NHS England allocated a total of £79 billion to local commissioners of healthcare, equivalent to £1,400 per person. Following the reforms to the health system in 2013, there are three separate funding allocations. In 2014-15, NHS England allocated £64.3 billion to 211 clinical commissioning groups for hospital, community and mental health services and £12.0 billion to its 25 area teams for primary care; and the Department allocated £2.8 billion to 152 local authorities for public health services. The amount of funding that individual commissioners are allocated is calculated using 'funding formulae' that apportion the total funds available. 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. In deciding actual funding allocations, the Department and NHS England consider that they should only move local commissioners gradually from their current funding levels towards their fair shares, to ensure that local health economies are not destabilised.
- 2. The slow progress towards target funding allocations means the Government has not fulfilled its policy objective of equal access for equal need. In 2014-15, nearly two-fifths of clinical commissioning groups and over three-quarters of local authorities remain more than 5 percentage points above or below their target funding allocations. Funding for clinical commissioning groups varies from £137 per person below target to £361 per person above target. This has important implications for the financial sustainability of the health service as underfunded clinical commissioning groups are more likely to be in financial deficit: 19 of the 20 groups with the tightest financial positions at 31 March 2014 had received less than their target funding allocation. The Department and NHS England explained that there are trade-offs between moving commissioners more quickly towards their target funding allocations and safeguarding the stability of local health economies, and that making quicker progress would involve real-terms reductions in funding for some areas. However, the National Audit Office calculated that, if the slow pace of change were to continue, it would take around 80 years for all local commissioners to get close to their target funding allocations. NHS England said that it wanted to make faster progress and that it aimed to move all clinical commissioning groups to within 5 percentage points of their target allocations within around two years. For public health allocations to local authorities, the Department said that decisions, including the pace of change, were a matter for the government of the day.

Recommendations: NHS England should confirm its commitment to move clinical commissioning groups to within 5 percentage points of their target allocations and set out a precise timetable. NHS England should also better understand the correlation between funding allocations and poor performance among clinical commissioning groups.

The Department should develop an evidence base to inform government decisions on how quickly public health allocations to local authorities should move towards their target allocations.

3. Decisions about funding for the different elements of healthcare and social care have been made without fully considering the combined effect on local areas. NHS England accepts that decisions on the three separate health allocations have, to date, been made in isolation of each other. It wants to move towards 'place based' funding formulae, whereby allocations for clinical commissioning groups and primary care, and potentially the Department's funding to local authorities for public health, are combined. In addition, local authorities receive funding which covers social care from the Department for Communities and Local Government. Many people need both healthcare and social care, and lower spending in one sector may cause additional costs in the other. There is growing understanding of the interdependence of health and social care funding but the causal relationship between the two is not understood, and the Department and NHS England did not take account of local authority spending on social care or the Department for Communities and Local Government's funding for local authorities in making decisions on health funding.

Recommendation: The Department and NHS England, working with the Department for Communities and Local Government, should carry out work to understand the interaction between the funding of healthcare and social care, and use this information to inform funding decisions.

4. There is a lack of evidence to underpin the adjustment that is made for health inequalities. NHS England adjusts target allocations by 10-15% to move funding towards areas with lower life expectancies, with the aim of reducing health inequalities. The current indicator is better able than the past methodology to detect small pockets of ill-health in otherwise healthy areas. However, there is no clear health justification for deciding what weighting should be given to the inequality indicator. The Advisory Committee on Resource Allocation, which advises the Department and NHS England, does not consider there is any evidence that the current health inequalities adjustment is appropriate. NHS England stressed the importance of retaining the health inequalities adjustment as a matter of principle, while acknowledging the lack of supporting evidence on what weight to give it.

<u>Recommendation:</u> The Department and NHS England should improve the evidence base for the health inequalities adjustment, including collecting evidence on whether their approach is fair and cost-effective and properly meets the objective of reducing health inequalities.

5. The proportion of total funding devoted to primary care has fallen, even though primary care is an important way of tackling health inequalities. NHS England told us that primary care is expected to have more impact than clinical commissioning group spending on reducing inequalities. However, between 2003-04 and 2012-13, the proportion of total spending committed to primary care fell from 29% to 23% as a consequence of the NHS prioritising hospital initiatives such as reducing waiting times. NHS England said it planned to reverse this trend and increase the proportion of healthcare funding being spent on primary care. It would also like to bring together the budgets for clinical commissioning groups and primary care to increase local flexibility with the intention of better targeting local priorities.

Recommendation: The Department and NHS England should set out the rationale for decisions about how funding is split between different funding streams, including assessing the implications of any changes in the distribution of funding.

6. The primary care funding formula was developed with limited input from the advisory body and remains an interim approach. NHS England has improved the funding formula for clinical commissioning groups, which is now based on more detailed data. However, these improvements have not been made for primary care. NHS England did not seek input from the Advisory Committee on Resource Allocation until three months before it had to make decisions about primary care allocations and there was insufficient time to improve the formula. As a result, NHS England's approach for primary care allocations to area teams for 2014-15 and 2015-16 was heavily based on what the Department had done previously for primary care trusts and is regarded as interim.

<u>Recommendation:</u> NHS England should improve the primary care funding formula in time for the next round of funding allocations for 2016-17, with early input from the Advisory Committee on Resource Allocation.

7. The target funding allocations may be unreliable in some areas due to shortcomings in the GP list data which are used to estimate population size. Population size is the factor that has the most significant effect on funding allocations. While there have been some improvements to the population data, GP list numbers still tend to be inflated as people may remain on lists after they have moved out of an area. This is a particular issue in areas with more transient populations. At the same time, GP lists do not include unregistered patients which may affect areas with high levels of inward migration. Most of NHS England's area teams have done some work to validate GP lists, but NHS England accepts that it needs to do more. It told us that its area teams will be required to implement detailed guidance on validating GP lists so that it has more assurance about the data. It also intends, from spring 2015, to procure a new primary care services 'back office' that should make GP list validation consistent across the country.

Recommendation: NHS England should take immediate action to ensure that all area teams are complying with its guidance on GP list validation, at the same as taking forward its longer-term plans to gain greater assurance over the data.

1 Fairness of funding allocations

- 1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and NHS England about how funding is allocated to local healthcare commissioners in England.¹ Following the reforms to the health system in 2013, there are now three separate funding allocations.² In 2014-15, a total of £79 billion was allocated to local commissioners of healthcare, equivalent to £1,400 per person. The Department allocated £2.8 billion to 152 local authorities to commission public health services, such as smoking cessation programmes. NHS England, the Department's largest arm's-length body, allocated £64.3 billion to 211 clinical commissioning groups to commission hospital, community and mental health services; and NHS England also allocated £12.0 billion to its 25 area teams to commission primary care.³
- 2. The first step in allocating funding involves the Department or NHS England calculating a 'target funding allocation' for each local commissioner. This represents their fair share of the money that is available. The Department of Health and NHS England have changed the way that they allocate health funding to local commissioners. The aim is to give those local areas with greater healthcare needs—defined in the main by population age with some weighting for health inequalities—a larger share of the available funding.⁴ 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.⁵
- 3. In 2014-15, nearly two-fifths of clinical commissioning groups and over three-quarters of local authorities remain more than 5 percentage points above or below their target funding allocation.⁶ This means that these areas are receiving substantially more or less than their fair share. For clinical commissioning groups, funding varies from £137 per person below target in Corby to £361 per person above target in West London; for local authorities, funding varies from £28 per person below target in Slough to £156 per person above target in the City of London.⁷
- 4. Whether or not local commissioners receive their target funding allocations is one of the factors that may affect their financial sustainability, and there is a clear link between the financial positions of clinical commissioning groups and whether they are under- or overfunded. For example, of the 20 groups with the tightest financial positions at 31 March 2014, 19 received less than their target funding allocation; whereas, of the 20 groups with the largest financial surpluses, 18 received more than their target allocation. The National Audit Office's exploratory work suggested that, on average, for every £100 a clinical

¹ C&AG's Report, Funding healthcare: Making allocations to local areas, Session 2014-15, HC 625, 11 September 2014

^{2 &}lt;u>C&AG's Report, paras 8, 1.9-1.10</u>

^{3 &}lt;u>C&AG's Report, paras 2, 1.2-1.3</u>

⁴ Qq 88-89, 90-92

^{5 &}lt;u>C&AG's Report, paras 3, 2.1-2.3</u>

⁶ Qq 7, 34; C&AG's Report, paras 11, 2.3

Q 14; C&AG's Report, paras 11, 2.3, Allocations to local commissioners online appendix Figure 1

commissioning group was below target its financial position worsened by around an estimated £10 to £17.8

- 5. Progress in moving commissioners towards their target funding allocations has been very slow. NHS England highlighted that it is more difficult to move allocations towards the shares determined by the formula when, as now, the overall financial position is tight and there is less money to go around. The National Audit Office calculated that, at the current pace of change, it would take approximately six years before no clinical commissioning group remained below its target allocation by more than 5%. For local authorities and the expenditure on public health, this would take 10 years. However, it would take much longer before no commissioner remained above its target allocation by more than 5% (60 years for clinical commissioning groups and 80 years for local authorities). Of the property of the prop
- 6. The Department and NHS England told us that there are trade-offs between moving commissioners more quickly towards their target funding allocations and maintaining the stability of local health economies. NHS England said that making faster progress would mean real-term reductions in funding in some parts of the country, which has not happened in the past. The Department told us that it had decided that it should not reduce the amount of money that had previously been spent on public health by local NHS bodies, at the point it transferred responsibility for these services to local authorities.¹¹
- 7. NHS England said that it would like to make faster progress in moving areas towards their target funding allocations. Specifically, it would like to get to a position within a year or two where no clinical commissioning group was more than 5% from its target allocation, although this would depend, to some extent, on the size of the total health budget. The Department also said that it hoped to move local authorities' public health allocations to within 5% of target more quickly. However, it said it could not commit to a timetable because decisions about public health allocations and the pace of change were a policy matter for the government of the day. 13
- 8. Whereas previously primary care trusts received a unified allocation for local health services, since the reforms to the health system in 2013 funding has been fragmented into three pots with separate allocations for clinical commissioning groups, primary care and public health. Addressing the needs of local populations requires an integrated approach to commissioning healthcare. However, the Department and NHS England decided current funding allocations without fully considering the combined effect on local areas. NHS England accepted that the separate health allocations had been made in isolation of each other but said that it wanted to move towards 'place-based' funding formulae,

⁸ Q 96, C&AG's Report, paras 15, 2.21-2.22

⁹ Q 3, C&AG's Report, paras 13, 2.9-2.10

^{10 &}lt;u>Q 2</u>, <u>C&AG's Report para 2.14</u>

¹¹ Qq 3, 4, 7

¹² Qq 5, 13-15, 37

¹³ Qq 34-36, 39-40

^{14 &}lt;u>C&AG's Report, para 8, 1.9-1.10</u>

¹⁵ C&AG's Report, paras 16, 2.25-2.26

incorporating its allocations for clinical commissioning groups and primary care and, potentially, the Department's allocations to local authorities for public health. The Department, however, did not think it would necessarily be appropriate to have a single formula, citing the different nature of public health funding, which largely concerns the population's health in the future while the funding allocated by NHS England is largely intended to meet current healthcare needs. The support of the population of the support of th

9. The National Audit Office report highlighted an association between health funding and social care spending. Many people receive both healthcare and social care, and lower spending in one of these sectors might be expected to case additional costs in the other. A survey in June 2014 identified that nearly a third of clinical commissioning group chief financial officers considered that cost pressures in social care were causing cost pressures in their organisation. The Department acknowledged that there was a clear link between health and social care but said that the causal relationships between the two were not clear. 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 for local authorities. Plans for funding for local authorities.

10. The Department and NHS England also referred to the Better Care Fund which will help to test how the NHS and local government can pool funding. They told us that the Fund is intended to increase integration between health and social care, help services deal with the pressures they are facing and improve understanding about the interaction between the two sectors.²⁰

¹⁶ Qq 53-54, 93

^{17 &}lt;u>Q 76</u>

^{18 &}lt;u>Q79</u>, <u>C&AG's Report, para 2.29</u>

^{19 &}lt;u>Q 79-80</u>, <u>C&AG's Report, paras 2.30</u>

²⁰ Qq 12, 79-81

2 Using funding to tackle health inequalities

- 11. The health funding formulae include adjustments to move money towards areas with lower life expectancies, with the aim of reducing health inequalities. The Department and NHS England have improved how they make these adjustments, with the current indicator better able to detect small pockets of ill-health in otherwise healthy areas. NHS England adjusts 10% of target allocations for clinical commissioning groups and 15% for area teams. The Department adjusts the whole of the public health allocations to local authorities on the basis of a measure of life expectancy—a proxy for health inequalities. 22
- 12. We asked NHS England whether it knew if the current adjustments were applied at the correct level.²³ NHS England explained that it relied on advice from the Advisory Committee on Resource Allocation on how to adjust allocations to reflect health inequalities. However, it acknowledged that the Advisory Committee did not consider there was any evidence about the appropriate weight to give to any adjustment. Nevertheless, NHS England considered that retaining the health inequalities adjustment was important as a matter of principle.²⁴ It expected the Advisory Committee to advise further on the health inequalities element of the funding formulae in time for the 2016-17 allocations.²⁵
- 13. NHS England explained that it adjusts a higher proportion of area team allocations for health inequalities, compared with those for clinical commissioning groups, because it considers that improving primary care will have more impact on reducing health inequalities. However, the National Audit Office found that between 2003-04 and 2012-13, primary care trusts reduced the proportion of total spending committed to primary care from 29% to 23%. NHS England thought this trend was a consequence of the NHS focusing on hospital activity during this period, such as initiatives to reduce waiting times. It said that it planned to reverse the trend and devote an increased proportion of funding to primary care in future. In addition, it would like clinical commissioning groups and local authorities to have more flexibility to move money to where they think it will have the biggest impact. The said that it planed to reverse the trend and devote an increased proportion of funding to primary care in future. In addition, it would like clinical commissioning groups and local authorities to have more flexibility to move money to where they think it will have the
- 14. NHS England also highlighted the impact that other parts of government have on health inequalities.²⁹ The Department said that it had regular contact with other government departments about these issues, in particular with the Department of

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21 <u>Q 61</u>; <u>C&AG's Report, para 3.17</u>
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²² Qq 42, 87; C&AG's Report, para 3.16

²³ Qq 43, 61-63

^{25 &}lt;u>Q 65, 70-73</u>

²⁶ Qq 43-44

^{27 &}lt;u>Qq 48-49</u>; <u>C&AG's Report, para 1.14</u>

²⁸ Qq 45, 50, 55

^{29 &}lt;u>Qq 43, 67</u>

Communities and Local Government about housing and local government, and with the Department for Work and Pensions about the benefits system, and that it sought to encourage other departments to take account of health inequalities in their policies.³⁰

3 Calculating target funding allocations

15. The Department and NHS England set target funding allocations for each local commissioner by predicting healthcare needs, taking account of the size and characteristics of local populations.³¹ There have been some improvements since we reported on formula funding in 2011.³² There is more transparency around key decisions, with, for example, NHS England deciding its funding allocations at a public board meeting. The Department and NHS England continue to be advised by the independent Advisory Committee on Resource Allocation in developing and applying the funding formulae.³³

16. In addition, NHS England's approach to setting clinical commissioning groups' target allocations is better at predicting need because it is based on more detailed data. However, NHS England acknowledged that its formula for primary care funding remained an interim approach. It did not seek the views of the Advisory Committee on Resource Allocation until three months before the primary care allocations were announced. The Advisory Committee, therefore, did not have sufficient time to develop an alternative approach.³⁴ As a result NHS England's approach for primary care allocations for 2014-15 and 2015-16 was heavily based on what the Department had done previously for primary care trusts.³⁵

17. Population size is the factor that has the most significant effect on target funding allocations. The accuracy of population data is therefore a key factor in ensuring that target allocations are right. He accuracy of population uses data from GP lists to calculate local population estimates. The National Audit Office found that such data are more responsive to changes in population and enable a more detailed understanding of relative need than the Office for National Statistics projections which were used previously. However, GP list numbers tend to be inflated as people remain on lists after they have moved out of an area, although NHS England told us that list inflation is a third less now than five years ago. Inaccuracies in GP lists are a particular issue where there are transient populations, such as those areas with high levels of migration and unregistered patients.

18. NHS England said that some of the bias caused by shortcomings in GP list data was mitigated by other data used in calculating target funding allocations, such as benefit claimant rates. However, it recognised that there had been little consistency in how GP lists

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30 <u>Qq 74-77</u>
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³¹ C&AG's Report, paras 3.1-3.2

³² Q 2; C&AG's Report, para 20

³³ Qq 2, 17; C&AG's Report, para 10, 18, 1.4, 1.15, 3.14

³⁴ Qq 17-18; C&AG's Report 3.14

^{35 &}lt;u>C&AG's Report, paras 18, 3.15</u>

^{36 &}lt;u>Q 105</u>; <u>C&AG's Report, para 3.4</u>

³⁷ Qq 10, 16, 24, 33; C&AG's Report, paras 3.5-3.7

were validated in the past, and in the current year a third of its area teams had not undertaken list validation exercises.³⁸ NHS England has published guidance on tackling list inflation but the National Audit Office found that there was little routine assurance that this guidance was being followed by area teams. NHS England plans to require all area teams to implement the detailed guidelines on validating GP lists by the end of 2014-15. It also said that it intended, from spring 2015, to procure a new primary care services 'back office' that would make GP list validation more consistent across the country.³⁹

Formal Minutes

Monday 8 December 2014

Members present:

Mrs Margaret Hodge, in the Chair

Guto Bebb Austin Mitchell
Mr David Burrowes Stephen Phillips
Meg Hillier John Pugh
Stewart Jackson Nick Smith

Anne McGuire

Draft Report (Funding healthcare: making allocations to local areas), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 18 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Twenty-fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 10 December at 2.00 pm

Witnesses

Monday 20 October 2014

Question

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at www.parliament.uk/pac.

Paul Baumann, Chief Financial Officer, NHS England; **Richard Douglas CB**, Director General of Finance and NHS, Department of Health; and **Simon Stevens**, Chief Executive, NHS England

Q1-122

List of printed written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at www.parliament.uk/pac. fhm numbers are generated by the evidence processing system and so may not be complete.

1 NHS CCGs (<u>fhm 000 1</u>)

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2014-15

First Report	Personal Independence Payment	HC 280
Second Report	Help to Buy equity loans	HC 281
Third Report	Tax reliefs	HC 282
Fourth Report	Monitor: regulating NHS Foundation Trusts	HC 407
Fifth Report	Infrastructure investment: impact on consumer bills	HC 406
Sixth Report	Adult social care in England	HC 518
Seventh Report	Managing debt owed to central government	HC 555
Eighth Report	Crossrail	HC 574
Ninth Report	Whistleblowing	HC 593
Tenth Report	Major Projects Authority	HC 147
Eleventh Report	Army 2020	HC 104
Twelfth Report	Update on preparations for smart metering	HC 103
Thirteenth Report	Local government funding: assurance to Parliament	HC 456
Fourteenth Report	DEFRA: oversight of three PFI waste projects	HC 106
Fifteenth Report	Maintaining strategic infrastructure: roads	HC 105
Sixteenth Report	Early contracts for renewable electricity	HC 454
Seventeenth Report	Child maintenance 2012 scheme: early progress	HC 455
Nineteenth Report	The centre of government	HC 107
Twentieth Report	Reforming the UK Border and Immigration System	HC 584
Twenty First Report	The Work Programme	HC 457
Twenty Second Report	Out-of-hours GP services in England	HC 583
Twenty Third Report	Transforming contract management	HC 585
Twenty Fourth Report	Procuring new trains	HC 674