Moving local commissioners to their fair share of resources is a balance between fairness and stability. But is the balance right and is there good evidence for the current pace of change? Steve Brown reports

The right speed

There is understandably huge media interest in the subject of financial performance. With some areas able to remain in balance or even generate surpluses, inefficiency is often the prime suspect for local bodies in deficit. But what if one commissioner is simply receiving too little compared to a better funded, better performing neighbour? Getting allocations right is fundamental to the equitable provision of services. Yet – perhaps because of its complexity – the allocation process does not receive anything like the same scrutiny as the financial bottom line.

Chair of the Commons Public Accounts Committee Margaret Hodge is one person determined to get the right spotlight on allocations. Suggesting the current approach 'doesn't' add up', she says: 'Given the pressure on NHS resources, it is more important than ever that money is distributed fairly. It hardly seems right that funding for clinical commissioning groups can vary from £137 per person less than their fair share to £361 per person more.'

She goes further, suggesting it is 'outrageous' that the 104 CCGs receiving more than their fair share of funding reported a combined surplus of more than £500m. 'This is all the more ridiculous when you learn that 19 of the 20 CCGs with the tightest financial position received less than their fair share of resources,' she says.

Ms Hodge's comments have been sparked by September's report from the National Audit Office – *Funding healthcare: making allocations to local areas*. The watchdog reported on the allocation process in 2011, but this is its first review since the Health and Social Care Act changes.

The new report looks at three specific allocation streams, including two overseen by NHS England – the £64.3bn allocated to CCGs for commissioning hospital, community and mental health services and the £12bn allocated to area teams to commission primary care – and the Department of Health's £2.8bn allocation to local authorities for public health services.

According to the NAO, the post-reform system has reduced local ability to flex funding to meet local needs. Previously, primary care trusts received a unified budget including funding for all three streams and could move funds in-year between them. However, the centre can now decide how money is divided between primary care, hospital and community, and public health.

Funding and policy

There is only partial evidence that the Department has directed funding to support policy objectives. Public health funding clearly increased in the two years to 2014/15 by more than 10% in line with policy (although it was announced in September that funding for 2015/16 would remain at the 2014/15 level). But it is harder to see funding backing up the policy to shift more care out of hospital. NHS England has increased funding to CCGs, but there is no current data to show whether this has resulted in an increase in spending on community services. This increase in CCG budgets also has to be seen alongside a lower increase to area teams for primary care.

The meat of the report focuses on the current variation in funding across local areas and the speed with which the service is moving towards having all organisations receiving their fair shares of resources. The allocation formula sets a target funding level – how much the CCG should receive if it was getting a fair share of all funding. In 2014/15, more than three quarters of local authorities and nearly two fifths of

SHUTTERSTOCK

CCGs are more than five percentage points above or below target. Funding for CCGs varies, as Ms Hodge points out, from £137 per person below target to £361 above target.

Bringing everyone to target in one fell swoop would mean actual cuts to over-target CCGs, freeing up the resources to boost under-target CCGs. So pace of change is the key issue. To date, the approach has been to give all commissioners a basic increase in funding and use the remainder of any growth money on under-target organisations.

This can be a slow process any time, but when the overall level of growth is broadly flat in real terms, progress can become glacial. In 2014/15, the Department and NHS England made £1.98bn available to increase funding to local commissioners. Some £1.61bn was used to give all CCGs, area teams and local authorities a minimum increase, broadly in line with inflation, with just £0.37bn used to push under-target commissioners towards target.

This still left the 222 under-target commissioners a combined £1.87bn below target. If the Department and NHS England had used all the £1.98bn on under-target commissioners, the total amount that commissioners were below target would have fallen by 39% to £1.2bn.

Pace of change

The NAO says that if the current pace of change policy and tight financial position continue, it will take six years for all CCGs to be no more than 5% below target, and 10 years for local authorities. Meanwhile it would take 60 years for above target CCGs to get down to the same margin above target (80 years for local authorities).

The NAO believes there should be a greater evidence base for decisions around pace of change. 'The starting point for the Department and NHS England is to balance fairness and financial stability, not destabilising local health economies,' says Laura Brackwell, the NAO's allocation study director. 'The evidence shows they have largely prioritised the second of these and put a lot of weight on not destabilising local economies, so the progress towards fair shares has been slower than it might have been.'

The NAO stops short of calling for an increase in pace, but believes the two bodies should be able to back up their decisions with greater evidence. In particular this might include challenging the assumptions on how big a change in funding, up or down, commissioners can handle.

'The evidence-base is doubtful – there is an assumption and widely held belief [that there is a limit to how big an increase an organisation can spend effectively], but this is not something that has been tested out even through consultation. And in other sectors – local government for example – changes in funding can be much more significant.'

Ms Brackwell points at the NAO's own exploratory analysis of PCT spending on hospital services, averaged between 2009/10 and 2012/13, compared to the 2014/15 pace of change policy for CCGs. It found that 27 PCTs changed the amount they spent on hospital services by less than the minimum change in allocations and 27 changed by more than the maximum change.

The NAO accepts its analysis is far from comprehensive, but believes further work needs to be done to back up the key pace-of-change decision. This is vital in light of the fact that the watchdog found a clear link between allocations and financial position. The 20 CCGs with the tightest financial positions received, on average, 5% less than their target funding allocation, with 19 of them being under-target in allocation terms. In contrast the 20 CCGs with the largest surpluses received on average 8.8% more than their target allocation, with 18 actually being over-target.

The 107 under-target CCGs, receiving a combined £1.6bn less than target allocations, had a combined deficit of £165m. The 104 groups that are above target had a combined surplus of £547m.

"The Department and NHS England need to consider carefully whether this approach is fast-moving enough to sustain hard-pressed local areas in the next few years"
Amyas Morse, NAO

Although the NAO accepts the relationship is likely to be complex, further exploratory work makes interesting reading. Assuming a constant effect between the two factors, for every £100 a CCG is below target, its financial position worsens by an estimated £10-£17. However the NAO also acknowledges that some under-target CCGs were in surplus in 2013/14. It believes that distance from target explains around 23% of the variation in CCGs' financial position and again more work is needed to understand this relationship.

Evidence is also what is needed in terms of adjusting allocations to take account of health inequalities. The NAO says that the adjustments for need ranged from a 27% increase to a 25% decrease to CCG allocations compared with a straight capitation-based allocation. While the revised approach for CCGs is better than previous approaches as it uses more detailed data, the smaller adjustment for health inequalities – from +7.3% to -4.1% – needs greater justification. 'The evidence for basing this adjustment on life expectancy is unclear,' the report says.

The NAO has made a number of recommendations for the Department and NHS England (see box). Overall it is calling for the two bodies to justify their current approach. 'Funding allocations have reflected, among other factors, a desire not to upset local health economies by taking funding away or even by increasing it by less than inflation,' says Amyas Morse, head of the NAO. 'This has significantly slowed progress towards a fair distribution where funding fully reflects need across the country. The Department and NHS England need to consider carefully whether this approach is fast-moving enough to sustain hard-pressed local areas in the next few years.'

They will get an early opportunity to respond to this challenge when the two bodies appear before Ms Hodge and the Public Accounts Committee later this month.

NAO proposals

The NAO made six recommendations for change. Five of these call on the Department and NHS England to:

- Develop an evidence base to inform their decisions about how quickly to move commissioners towards their fair share of funding
- Gain appropriate assurance over the quality of all data used to set target funding allocations
- Use emerging data to develop their evidence base on how best to use funding allocations to reduce health inequalities
- Set out how the funding framework supports their key policy objectives
- Consider the combined effect of their different allocations as part of the process of making funding decisions.

In addition, NHS England should:

- Work with the Advisory Committee on Resource Allocation to develop the approach for allocating funding to its area teams for primary care