Clinical commissioning group (CCG) funding

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This note provides information on the resource allocation formula for distributing funding for health services in England to local commissioning groups: clinical commissioning groups (CCGs). It includes the historical use of allocation formulas and the formula that was proposed and rejected for the 2013-14 funding round.

Following a fundamental review, NHS England announced on 17 December 2013 the funding formula for 2014-15. See section 3 of this note; for a full allocation list please see the annex at the end of this note. Individual funding allocations for CCGs for 2014-15 were announced on 18 December and can be found here.

Funding allocation formulas use information about local populations, such as age, gender, levels of deprivation and the size of a population, in order to predict the level of funding needed in each area to meet existing need. Funding formulas have been developed independently of ministers, most recently, by the Advisory Committee of Resource Allocation (ACRA). Many areas do not receive the full amount of funding allocated to them because increasing funding to one area within a limited budget would require reductions for another and significant funding reductions could destabilise health provision or provoke local opposition. The overall aim of allocations policy has been to—over time—secure 'equal opportunity of access for people with equal need across the country'.

The formula used for the 2013-14 allocations to CCGs is the same as was used to allocate funding to primary care trusts (PCTs). Library Standard Note, *Primary Care Trusts: Funding and expenditure*, provides a description of the allocation process as it was for PCTs in England.

Responsibility for health services is devolved to the Scottish, Welsh and Northern Irish administrations.

Headline expenditure figures are updated quarterly on the *Library Social Indicators page.*

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1 Background to the use of allocation formulas for health funding

1.1 What is NHS commissioning?

A significant proportion of the funding for the provision of health services is used for commissioning services. The Department of Health has defined commissioning as:

> The process of ensuring that the health and care services provided effectively meet the needs of the population.[1]

Commissioning is seen as a key means of helping achieve a wide range of policy objectives in the NHS, including improving the safety and quality of services; creating better value for money and wider patient choice; and reducing inequalities in health. Such objectives are partly achieved through allocating resources 'fairly' among the population. How the resources are divided among the population is determined by a resource allocation funding formula.

The Library Standard Note, *NHS commissioning* contains more information on the commissioning of NHS services.

Proportion of total health funding going to CCGs

Funding for health services comes from the total budget for the Department of Health (DH) of £110 billion (all figures are for 2013/14 unless otherwise indicated). This is divided between

[1] Department of Health, *commissioning*, webpage archived on 6 May 2010

NHS England (£95.6 billion) and DH's other agencies and programmes (£15.7 billion).[2] NHS England's budget is then used for delivering its mandate from the DH. It is responsible for allocating resources to local health economy commissioners: local authorities and clinical commissioning groups (CCGs). The overall budget for local commissioners was £65.6 billion with the vast majority, £63.4 billion, allocated to CCGs.

NHS England directly commissions certain services on a national level for which it has a budget of £25.4 billion, covering specialised healthcare, primary care and military and offender services. The remainder of NHS England's budget is divided as follows:

- £1.8 billion for NHS England's public health responsibilities on behalf of Public Health England, which broadly comprise immunisation, screening and health visiting
- £1.2 billion surplus carry forward from PCTs and SHAs, to be allocated to CCGs and NHS England for future investment (see section 3.20 onwards of *Everyone Counts: Planning for Patients 2013/14*)
- £1 billion for central health programmes to be administered by NHS England, such as clinical excellence awards and support for PFI schemes and
- £0.7 billion for technical accounting adjustments.[3]

1.2 What are funding formulas?

Funding or allocation formulas are a tool for distributing central funding for local health services. They are based on a longstanding principle that resources should be distributed in a way that eventually secures 'equal opportunity of access for people with equal need across the country'. If all regional populations had equal needs, and the costs to meet these needs did not vary across the country, then the funding formula would be simple; with every area receiving a target share in proportion to its population size (i.e. an equal per capita allocation). However, as costs and health needs do vary, the population estimates and indicators of need are 'weighted' to reflect these differences.

Allocations of health funding to service providers have been made using three broad 'need' indicators: the size of population (weighted for gender balance); the level of deprivation; and the age of the population. The principles behind funding formulas have changed periodically and as a result the weight given to each of these indicators has also changed.

These alterations in the weighting of—in particular, age and deprivation measures—have coincided with an ongoing wider political debate surrounding funding formulas and which indicators are the stronger determinants of 'need'. Because the distribution of areas with older and/or more derived populations across the country is not even, the weight given to each indicator alters the allocation of resources nationally. The 2008 paper *Health care equity, health equity and resource allocation: towards a normative approach to achieving the core principles of the NHS*, explains the tension between effectively meeting existing demand and reducing health inequality:

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2 The indicative budget allocations for 2013/14 were: Arm's length bodies (£0.7 billion); Health Education England (£4.9 billion); DH programmes and administrative expenditure (£3.9 billion); Public Health England (£0.5 billion); local authorities (£2.8 billion); service providers: NHS Trusts and Foundation Trusts (£2.9 billion). Department of Health, *Corporate Plan 2013 to 2014*, Updated 2 October 2013

3 NHS England, *NHS allocations for 2013/14*, (accessed on 22 November 2013)

In order to promote *"equal opportunity of access for equal needs"*, the distribution of funding should reflect the existing burden of disease. In order to promote an *"equal opportunity to be healthy"*, funding needs to be targeted so as to reduce the health gap between the most advantaged and least advantaged groups. This implies that resources should not necessarily be directed at populations with the highest absolute burden of ill-health, but at those which have the worst health in terms of age-standardised measures.[4]

2 How resource funding currently operates: From PCTs to CCGs and the proposed PBRA Formula.

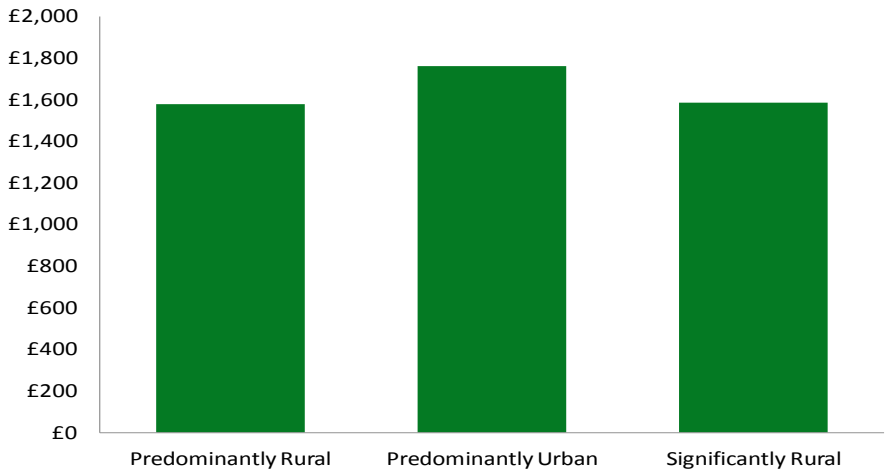
2.1 Primary Care Trusts and the Weighted Capitation formula

Prior to the creation of the current clinical commissioning groups (CCGs), funding was allocated to primary care trusts (PCTs). PCTs were responsible for commissioning health services from NHS providers and other organisations to ensure local health needs were met. A total of £164 billion was allocated to England's 152 PCTs over the 2009/10 and 2010/11 funding round; this constituted to around 80 per cent of planned NHS spending. For more information on PCTs see Library Standard Note *Primary Care Trusts: funding and expenditure*.

The majority of PCT allocations were determined by a funding formula which calculated the target share of resources to which a PCT should be entitled, based on its population, the local cost of health services provision, the level of healthcare need and health inequality: this target share was known as the "Weighted Capitation Formula"[5]. PCTs did not receive their funding entitlement in full, but instead moved towards it over time*:* see the *'pace of change'* section below.

The effect of this weighting on each PCT's target allocation is illustrated in figure 1, below. It shows that, in general, PCTs in rural areas tended to have lower allocations per-head than they would under a simple population-based formula; whereas urban PCTs have a slightly higher allocation per-head. The reason for this is that the health needs, as measured by the formula, seem to appear greater in urban areas. However this could be due to the effect of having an increased weighting on the deprivation indicators within the formula.

Figure 1: Average PCT allocation per-head by urban/rural areas for year 2012/13



4 Asthana S and Gibson A, *Health care equity, health equity and resource allocation: towards a normative approach to achieving the core principles of the NHS,* University of Plymouth, 2008

5 Department of Health, *Resource Allocation: Weighted Capitation Formula, 7th ed*., March 2011

The 'pace of change'

The weighted capitation formula set a target allocation to each PCT for what they should receive in funding; in order to reduce the effects of health inequalities and unmet need. Some PCTs were above their target (i.e. receive more funding than the formula suggests they should) and some were under (i.e. receive less than they should). Each year all PCTs received an increase in funding, however, the percentage increase varied depending on their 'distance from target' (DFT). All PCTs significantly above target received less than the national average funding increase while all PCTs significantly under target received more than the national average. This meant that most PCTs did not receive their full target allocation, but were moved towards their target over a number of years. It is important to note however, that PCTs which were close to their target but were only slightly above or below may have received similar levels to the national average.

The 'pace of change' is an important concept which is often overlooked when trying to understand the weighted capitation funding formula. It refers to the degree to which a PCT moves towards its target in any given year. The pace at which PCTs moved towards their target was set by ministers at the start of each funding round. When allocation formulas are reviewed and updated, there is potential for substantial changes in funding entitlements or DFTs. For example, when a funding formula is updated in an area where there has been significant population change, large swings in targets can occur; with PCTs being as much as 30 per cent above or below their target. Due to these large distances from targets that can occur, an immediate change would be both politically controversial and financially disastrous for many areas. A 'pace of change'—determined by ministers—is therefore required to ensure a steady move towards a target year on year without causing extreme disruptions to local health services or political outcry.

The following two tables give examples of large distances from target that have occurred. As the tables show, although under target PCTs, such as Barking and Dagenham PCT, do not receive their full target entitlement, they will receive more than the national average. Similarly PCTs over target, such as Westminster PCT received less than the national average.

The figures for Barking and Dagenham show how the DFT affects the allocation amount. From 2003/04 to 2007/08, Barking and Dagenham was under target and therefore received a higher than national average allocation. However from 2009/10 to 2011/12 a new formula meant that the PCT was over target and therefore received a slightly smaller allocation than the national average.

Barking & Dagenham PCT distance from targets and percentage change in revenue resource allocations 2003/04 to 2012/13

	DFT %	Barking and Dagenham % change in allocations	England % change in allocation	Resource allocation formula used
2003/04	-14.7%			4th edition
2004/05	-12.7%	13.0%	9.6%	
2005/06	-10.7%	12.0%	9.3%	
2006/07	-4.8%	30.2%	19.3%	5th edition
2007/08	-3.5%	10.9%	9.4%	
2008/09	n/a	n/a	5.5%	
2009/10	0.5%	5.3%	5.5%	6th edition
2010/11	1.6%	5.2%	5.5%	
2011/12	0.8%	2.1%	2.2%	7th edition
2012/13	n/a	3.1%	2.8%	

Source: Department of Health Exposition Books

The following table displaying Westminster's allocations show that its significantly high DFT means it has a lower funding allocation than the national average.

Westminster PCT distance from targets and percentage change in revenue resource allocations 2003/04 to 2012/13

	DFT %	Westminster % change in allocations	England % change in allocation	Resource allocation formula used
2003/04	31.1%			4th edition
2004/05	30.5%	9.7%	9.6%	
2005/06	29.9%	9.4%	9.3%	
2006/07	15.9%	16.0%	19.3%	5th edition
2007/08	11.6%	8.1%	9.4%	
2008/09	n/a	5.5%	5.5%	
2009/10	22.3%	5.2%	5.5%	6th edition
2010/11	20.8%	5.1%	5.5%	
2011/12	16.5%	2.0%	2.2%	7th edition
2012/13	n/a	2.8%	2.8%	

Source: Department of Health Exposition Books

A criticism of the pace of change was that the resulting slow movement towards the funding target prevented PCTs from receiving the appropriate level of funding. On the 2009/11 pace of change, it would have taken until 2028/29 for more than half of PCTs to come within 1 per cent of their target share.

2.2 Abolition of PCTs and the creation of clinical commissioning groups (CCGs)

The Coalition Government announced on 25 May 2010 that a Health Bill would be brought forward to facilitate the creation of the NHS Commissioning Board and the implementation of commissioning by GPs. This restructuring of commissioning meant that instead of PCTs controlling cash budgets, GPs were given powers to control budgets and hold contracts with providers.

Many of the provisions under the *Health and Social Care Act 2012* came into force on 1 April 2013: when NHS England and CCGs took on statutory responsibility for commissioning NHS

services. The Act makes CCGs directly responsible for commissioning NHS services they consider appropriate to meet reasonable local needs.[6] Also at this time local authorities took on new public health responsibilities; local Healthwatch organisations came into being; and strategic health authorities and PCTs were formally abolished. For more information on the reformed structure of the NHS and commissioning see Library Note, *The reformed health service, and commissioning arrangements in England*.

PCT allocations are not comparable with CCG allocations; even if a CCG covers the same area as a PCT, CCGs have different commissioning responsibilities. For instance, in the new system local authorities have greater responsibility for public health; previously such responsibility, and the funding for it, resided with PCTs. This is why funding levels for CCGs may be significantly different from PCTs.

2.3 The proposed person-based resource allocation (PBRA) formula

Since 2005 and the introduction of 'practice based commissioning' a 'fair shares toolkit'[7] had been used by PCTs to allocate funding to groups of commissioning GP practices within their area. This formula changed from that used for allocating funds to the PCTs in 2010/11 when 'person-based resource allocation' (PBRA) was introduced. This new approach meant that more detailed population data related to each separate practice area was used to create a prediction for need that was more accurate at a local level. The additional patient data used included previous diagnoses and not just individual characteristics.[8]

Following the development of plans to abolish PCTs in favour of local GP-led CCGs it was also proposed that a funding formula similar to that used for practice based commissioning should be used to fund CCGs. In 2011, the Department of Health commissioned the Nuffield Trust to develop the person-based resource allocation model for CCG funding.[9]

In 2012 the then Secretary of State for Health Andrew Lansley proposed that the new allocation formula should give greater emphasis to the age of populations rather than deprivation levels. The *Health Service Journal* reported in April 2012 that:

> Health secretary Andrew Lansley has suggested clinical commissioning group funding should take into account the age of a population rather than indices of deprivation, arguing that "age is the principal determinant of health need" in an area. [...]

Mr Lansley said that, a future allocation formula should mean that:

> Wherever you are in the country you should broadly have resources equivalent with access to NHS services.[10]

Professor of Health Policy at Plymouth University, Sheena Asthana, supported the proposal arguing that: "age is a far more significant determinant of morbidity and mortality than

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6 However CCGs can buy in support from external organisations including the NHS commissioning support services and private and voluntary sector bodies, although responsibility for commissioning decisions remains with the CCG. The detailed strategy is set out in NHS England, *Developing Commissioning Support: Towards Service Excellence*, February 2012.

7 The term 'fair shares formula' is often used to refer to the PBRA formula.

8 Department of Health, *Practice Based Commissioning: Budget guidance for 2011/12*, March 2011, p6

9 The Nuffield Trust's report, *Person-based Resource Allocation: New approaches to estimating budgets for GP practices*, December 2011

10 David Williams, 'Lansley: health allocations should be based on age, not poverty', *Health Service Journal*, 26 April 2013

deprivation"[11]. This, she said, was because measures of deprivation highlight areas of health inequality where morbidity and mortality are higher, excluding the effects of age. However, as age is the greater determinant of morbidity and mortality, measures of depravation do not indicate true 'demand' for health services.

Based on the original PBRA, developed by the Nuffield Trust, the Advisory Committee of Resource Allocation (ACRA) created a new formula (also known as PBRA) which it recommended for use in 2012/13.[12] This formula seemed to reflect the view that age is a more significant determinant of need: increasing its weighting within the formula. ACRA stated that testing of the Nuffield formula at GP practice level against the current PCT formula gave plausible results and was more accurate than the PCT formula in predicting expenditure at this level.

Concern was raised, however, that ACRA's recommendations would move funding away from the north of England towards the south and midlands, where the population is, on average, older. Papers published by the NHS England showed that:

> The proposed formula would have allocated the 68 CCGs in the north of England £46 less per person than they received in the actual 2013-14 allocation. CCGs in London would have been £25 a head worse off with the new formula than with the actual 2013-14 allocations. On the other hand, CCGs in the Midlands and the east of England would have received £39 more a head with the new formula, and those in the south would have got an extra £20 a head.[13]

Table 3 in the appendix shows that—under the proposed PBRA formula—CCGs located in the north of the country, such as Cumbria and Sunderland, would receive 10 per cent and 11 per cent less respectively under the new PBRA formula (compared to the current Weighted Capitation Formula (7th Edition)). Certain CCGs in London would suffer the worst reductions in funding, with West London CCG receiving 37 per cent less and Camden CCG receiving 27 per cent less. In contrast, CCGs in the east and the middle of the country, such as Southend and Leicestershire and Rutland, would each receive an increase of around 13 per cent. CCGs in the south of England would also benefit, with South Eastern Hampshire and Fareham and Gosport CCGs receiving 14 per cent and 12 per cent increases in funding respectively.

Allocation formula for 2013/14

Originally the transfer from PCTs to CCGs was meant to coincide with a new funding formula, provisionally ACRA's 'PBRA' formula. However, due to the concerns discussed above, the weighted capitation formula (that used for PCTs with a 2.3 per cent uprating) will continue to be used while the PBRA formula is reviewed.

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11 Professor Sheena Asthana, 'Lansley is right to say that age trumps poverty', *Health Service Journal*, 17 May 2012

12 The Nuffield Trust report, *Person-based Resource Allocation: New approaches to estimating budgets for GP practices*, December 2011. The Advisory Committee of Resource Allocation (ACRA) wrote to Health Secretary Jeremy Hunt in October 2012 to confirm its recommendation that the formula developed by Nuffield should be used for CCG allocations: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213327/DF-letter-to-SoS.pdf

13 'NHS England outlines review of funding allocation for CCGs', *British Medical Journal*, 20 August 2013

In December 2012 NHS England made the decision not to apply the allocation formula recommended by ACRA for 2013/14 and is now undertaking a fundamental review of how it allocates funding to CCGs.[14] Announcing the review, NHS England said that it was:

> concerned that while the formula accurately predicted need as currently met, it did not capture unmet need, and that the formula on its own would have resulted in higher allocations to areas with better health outcomes.[15]

This review (which has now made its initial report: see section 3 of this note) for the 2014/15 and 2015/16 allocations. In answer to a Parliamentary Question,[16] Parliamentary Under-Secretary of State for Health, Dr Daniel Poulter explained why a uniform 2.3 per cent increase was adopted for 2013/14 instead of the new formula:

> **Dr Poulter:** The NHS Commissioning Board adopted a uniform 2.3% uplift for clinical commissioning groups (CCGs) because of concerns that, when combined with the estimated CCG baselines, the population-based formula implied a movement of resources away from areas with the worst health outcomes towards those with the best. The formula was recommended by the Advisory Committee on Resource Allocation.[17]

Details of the 2013/14 allocations for each CCG can be found here.

Debate in the run-up to the new formula

Appearing before the Health Committee on 5 November 2013, Chief Financial Officer for NHS England, Paul Baumann, had said that the most deprived areas will not lose out under the proposed new CCG allocation formula for 2014/15:

> "The most deprived areas will get the most money; the least deprived will get the least subject to age and population," he said.

When asked whether the new formula would adjust for the "sparsity" of an area's population, Mr Baumann said that it did not as a mechanism to do that had not been developed. However, he said, a separate piece of work had been commissioned to look at the issue.[18]

Speaking in the House of Lords on 27 November 2013 Parliamentary Under-Secretary of the Department of Health, Lord Howe answered questions about the proposed new formula:

> **Lord Hunt of Kings Heath:** My Lords, my understanding of the formula is that it would move resources from areas where people have worse health outcomes to areas where they have better health outcomes. The noble Earl has said that he and his ministerial colleagues are in discussion with NHS England. Can he confirm that this is a decision for NHS England? If that is so, what is the nature of the discussion that has taken place between Ministers and NHS England? Is it being left to NHS England to decide?
>
> **Earl Howe:** My Lords, very definitely yes. It is precisely to avoid any perception of political interference that we made NHS England responsible for the allocation of resources to clinical commissioning groups. However, we were very specific in the mandate, as the noble Lord will recall, that the principle on which NHS England has to operate is equal access for equal need, with particular attention being paid to health

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14 For more information about the NHS England review see: www.england.nhs.uk/2013/08/15/rev-all-wrkshp

15 NHS England, Fundamental Review of Allocations Policy – Annex C: Technical Guidance to Weighted Capitation Formula for Clinical Commissioning Groups, 2013, 13 August 2013

16 HC Deb, 11 March 2013, c4W

17 HC Deb, 11 March 2013, c4W

18 "Baumann: deprived areas will not lose out under new formula", *Health Service Journal*, 6 November 2013

> inequalities while not destabilising the NHS. Those are the things we discuss in our regular meetings with NHS England but the actual nature of the formula that it will decide in its board meeting next month is entirely up to it.[19]

The full text of the questions to Lord Howe can be found here.

CCG overspends for 2013/14

In August 2013 the *Health Service Journal* (HSJ) reported that nine CCGs were forecasting large overspends in their first year of operation. The article suggested that the planned overspends were partly due to some CCGs underestimating how much of their commissioning budget would be transferred to NHS England for commissioning specialist services under the changes to the health system. HSJ reported, on 17 December 2013, that during the meeting of the NHS England Board that day:

> Paul Baumann has revealed that out of the 34 CCGs that are expected to end year in deficit, 31 are under-funded.

3 Funding formula for 2014/15 onwards as announced by NHS England on 17 December 2013

For a full list of CCG allocations for the year 2014/15 and 2015/16 please refer to the appendix at the end of this note. They can also be found here.

Following the fundamental review announced in December 2012 the NHS England Board decided on a new funding formula for CCGs on 17 December 2013. This was the first time that the final decision on funding allocations had been made independently of the Department of Health. The Board paper on allocations for the meeting on the 17th sets out the recommendations made to the Board for allocating resources for 2014/15 and 2015/16 to NHS England and the commissioning sector, including CCGs. The key decisions before the Board were:

- How to allocate funds between the five main areas of commissioning spend (public health, primary care, CCGs, specialised/health & justice/armed forces and the integration transformation fund)
- How to allocate funds within each stream, i.e. the distribution between localities
- The pace of change associated with any change in allocation policy.[20]

The Board meeting was held in public for the first time and broadcast live on the NHS England website. The *Health Service Journal* produced a live news and comment feed from the meeting. It also produced the following summary of the options for CCG funding allocations which were before the Board:

> An NHS England spokesman confirmed that under the first of these options, some CCGs would receive below inflation budget increases for the next two financial years.
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> Under this option, all CCGs would receive increases averaging 0.9 per cent in 2014-15 to reflect population growth, and additional increases ranging from 1.2 per cent to 3.3 per cent, depending on how far their current allocations are from target.

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19 HL 27 November 2013, Column 1410

20 NHS England, Board paper NHSE121305, 17 December 2013

> However, the total increase available for the most over-funded CCGs would be capped at the level of inflation − estimated at 2.14 per cent for 2014-15 − to "maximise the funding for those who are most underfunded".
>
> A similar approach would be adopted the following year, leaving just 18 CCGs significantly under-funded by the end of 2015-16.
>
> An NHS England spokesman said: "The downside of this approach is that some CCGs, particularly those that are above target and have low population growth, can still see very low growth in their overall funding."
>
> The alternative recommended option would set a "floor" to ensure that all CCGs saw their total allocations grow by at least inflation, but this would reduce the resources available for underfunded CCGs, cutting the maximum per capita growth available to 2.6 per cent.
>
> NHS England is working on inflation assumptions of 2.14 per cent in 2014-15 and 1.7 per cent the following year.
>
> The spokesman said it was clear that no change in allocations was "not an option".
>
> He added: "Failure to change will mean that CCGs or providers are unable to provide the services required by their populations or live within their financial resources − or most likely both.
>
> "Already this is becoming apparent in a growing minority of CCGs forecasting financial deficits in 2013-14."
>
> The paper going to the board will also confirm that NHS England plans to reintroduce a weighting for "unmet need" − intended to tackle health inequalities − in the formula for CCG allocations.[21]

At the meeting, the Board decided to reject proposals for a faster move towards CCGs' allocation targets (which would have resulted in some CCGs which were above target receiving a reduction in funding). Instead, all CCGs will receive at least flat real terms growth for 2014-15 to 2015-16. In addition, £180 million will be available in 2014-15 to provide above inflation increases for the CCGs which are furthest from their target allocations.[22] Details of the decision are available on the NHS England website. NHS England explained that 10 per cent of the total funding for CCGs will now be based on deprivation levels to reflect unmet need, which it said would enable "CCGs to tackle the impact of health inequalities."[23]

The allocations for individual CCGs for the 2014-15 are available here.

In a press release following the decision, Paul Baumann, chief financial officer for NHS England, said that:

> "We must ensure funding is equitable and fair and we have used the review period to ensure that funding is based on up-to-date and detailed information and it takes into account the three main factors in healthcare needs: population growth, deprivation and the impact of an ageing population.

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21 NHS England to consider real terms cuts for some CCGs, *Health Service Journal*, 17 December 2013

22 *Health Service Journal*, Live feed: 3.20pm, 17 December 2013, See also, http://www.lgcplus.com/briefings/joint-working/health/new-ccg-funding-formula-approved/5066553.article?blocktitle=Latest-Local-Government-News&contentID=2249

23 NHS England, *NHS England publishes CCG funding allocations for next two years following adoption of new formula*, 18 December 2013

"What is clear is that doing nothing is not an option. Some areas have not had the funding per head that they need, particularly where population has grown quickly and funding has remained relatively static. These areas are now at risk of not being able to provide the services needed by their population, so we need to tackle these differences in funding as a matter of urgency.

"That is exactly what these changes are about and this will mean that some local health services need to receive a settlement that is bigger than inflation to start reducing the local underfunding which has arisen, whether this reflects deprivation, ageing or population growth.

"Over the last year we have developed and refined the funding formulae to ensure that they accurately predict the needs of individual communities. A particular challenge in this respect is the best way to reflect the needs of the most deprived communities, who may not currently be accessing the services they need at the right time. The new formula now includes a measure for 'unmet need' which aims to address this.

"This is a very testing period for the NHS and every pound we spend needs to be invested wisely to drive the best outcomes for the patients and communities we serve. We now have a funding formula that we think does this more accurately and more fairly."[24]

4 The history of allocation formulas in the NHS

Allocation formulas can be used to make a 'fair' allocation of resources to areas based on various measures of need and current usage. They can also be used, as The King's Fund argued in April 2013, as a policy tool "to support the NHS in delivering its mandate and changes to the wider system".[25] The rest of this section sets out the ways in which funding formulas have been used since 1971.

Since 1971 allocations of health funding to regional service providers have been made using three broad criteria: the size, age, gender of each population and, from the 1990s the level of deprivation. The principles behind the allocation of resources in the NHS in England have changed periodically and the weight given to each of the three criteria has been altered.

The 'Crossman formula': 1971/72 to 1976/77

Prior to the mid-1970s regional funding for hospital and community health services (HCHS) was allocated on the basis of the number of NHS staff and beds in each area which was increased incrementally each year. Because hospitals inherited by the NHS in 1948 were unevenly distributed—with more of them located towards the south of England—funding remained very uneven under this system. The formula was widely criticised for this reason. After the *1973 NHS Reorganisation Act*, the "Crossman" formula (named for Richard Crossman MP) was used. It was designed to reverse regional inequalities within ten years by allocating more resources to areas with greatest need. This funding formula introduced 'target allocations' for each area which were based on population size, weighted by age and gender, and the utilisation of available hospital beds. The formula thus introduced the principle of 'weighted capitation'.

The RAWP formula: 1977/78 to 1988/89

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[24] NHS England, *NHS England publishes CCG funding allocations for next two years following adoption of new formula*, 18 December 2013

[25] The King's Fund, *Improving the allocation of health resources in England: Deciding who gets what*, April 2013, p1

By 1975 concerns about the sensitivity of the Crossman formula to levels of need led to a review being launched. The Resource Allocation Working Party (RAWP) established the principle that "there would eventually be equal opportunity of access to health care for people at equal risk". The RAWP formula subsequently introduced used standardised mortality ratios (SMRs) as a proxy measure for morbidity to indentify health needs over and above those which were age-related. The use of SMRs meant that the allocations were responsive to differences in death rates between regions; the result was a transfer of resources from Regional Health Authorities in the South East to those in the North.

The RoR formula: 1990/91 to 1995/96

The RAWP formula received criticism for its use of SMRs which were seen as an inadequate proxy for non age-related need. The review into RAWP (known as RoR) used 1981 Census data to assess how hospital utilisation related to local socioeconomic and demographic variables. RoR recommended in 1988 that the measures of deprivation it had developed should be used alongside SMR among under 75s in order to measure need.

Although the RoR review process changed the way reviews of health allocations were performed—having established that need could be determined empirically rather than by informed judgment—its recommended formula was rejected by the Department of Health. SMR continued to be used on its own as a measure of need albeit with less weight given to it.[26]

The York formula: 1996/97 to 2002/03 and the AREA formula: 2003/4 to 2007/08

Two further reviews resulting in the York formula (1996/97 to 2002/03) and the AREA formula (2003/03 to 2007/08) followed. The 'York' approach used a statistical method (known as regression analysis) for quantifying the relationships between variables to determine which of them best predict health utilisation. These were then used to create an allocation formula to better address need.

The later 'AREA' approach had the additional goal of reducing health inequalities by using indices of multiple deprivation to calculate need. This method involved quantifying the relationship between socioeconomic factors and the healthcare need that was currently being met. It also involved calculating 'unmet' need, which was done using a complex process which is described in the formula handbook.[27]

From 1999/2000 the hospital and community health services (HCHS) component of NHS funding was merged with prescribing and primary medical service funding. This meant that the 28 Strategic Health Authorities, which replaced the 14 Regional Health Authorities abolished in 2002,[28] received a 'unified' allocation of funding.

CARAN formula: 2009/10 onwards

Library Standard Note*, Primary Care Trusts: funding and expenditure*, provides a description of the allocation process as it was for Primary Care Trusts (PCTs) in England from 2009/10 onwards and includes an analysis of local differences in funding levels.

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[26] Rather than a constant weight being applied, the square-root of the SMR was used; in short, this means the importance of the SMR diminishes as it increases in value.

[27] Department of Health, *Resource allocation: weighted capitation formula*, 6th Ed., 2008, p18

[28] Initially, around 100 Health Authorities took over the responsibilities of Regional Health Authorities but these were quickly amalgamated into 28 Strategic Health Authorities.

The current—age related and additional needs (CARAN)—formula is based on a review that ran from 2005 to 2008. The most significant change, in terms of its impact on allocations, was in the way health inequalities were measured. It was determined that it was not technically possible to fully achieve both objectives of equal access for equal need and a reduction in health inequalities within a single needs-based weighting. Therefore, the review recommended a separate component be added to address the objective of reducing avoidable health inequalities: an estimate of disability-free life expectancy (DFLE). However, the weighting of this component (ie how much money should be allocated to reducing health inequalities) within the overall additional need adjustment was left for Ministers to decide. This weight was set at 15 per cent, meaning that 15 per cent of PCTs' allocations were top-sliced and distributed according to the health inequalities component. It has been suggested that the decision to set the weighting at this level was a calculated effort to dampen the impact of the new formula, which would otherwise have resulted in some transfer of resources from urban to rural areas, thus preserving the previous *status quo*.[29]

Another significant but more technical change involved the way in which acute and maternity needs were modelled within the HCHS component of the formula. Specifically, maternity need is now calculated separately from acute need.

In addition, acute need, which had previously been measured using indices of age-related need and additional need[30] has been replaced by a one-stage approach that allows for the relationship between age-related need and additional need to vary between age bands.

4.1 Further information

There were a number of oral PQs on CCG funding in June 2013 which can be found here: HC Deb 11 June 2013 c141.

The seventh edition of a Department of Health booklet which describes the weighted capitation formula used to inform revenue allocations to primary care trusts for 2011-12 can be found here.

Archived information on NHS allocations can be found on the Department of Health website.

The King's Fund, *Improving the allocation of health resources in England*, April 2013

Board meeting papers for the NHS England meeting on 17 December 2013 can be found here: http://www.england.nhs.uk/2013/12/10/board-meet-17-dec13/.

The transcript of the evidence taken by the Health Select Committee on 5 November 2013 from Chief Executive, Sir David Nicholson and Chief Financial Officer, Paul Baumann from NHS England, in connection with its inquiry into public expenditure on health and social care, can be found here.

Reaction to the proposed funding formula for 2014-15

CCG funding could be based on population age, not deprivation, says Lansley, *British Medical Journal*, 14 May 2012

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29 Department of Health, *Resource Allocation: Weighted Capitation Formula*, 2008, 6th ed., p18

30 The effect of setting the health inequalities weight at 15 per cent was acknowledged by the then Health Minister Ben Bradshaw in a written response to Andrew Lansley MP: "Ministers decided to apply the [separate health inequalities] formula to 15 per cent of the allocations [...] This keeps the distribution of funding between the most and least deprived areas in line with the previous formula." [HC Deb 12 January 2009 c178W]

Lancashire health chiefs call on Hunt to reconsider NHS plans, *Lancashire Telegraph*, 3 December 2013

GPs fear impact of CCG overhaul, *GP*, 8 November 2013

CCGs could share primary care commissioning with NHS England, *GP*, 29 November 2013

Move to cure health inequalities, *Nottingham Post*, 28 November 2013

New CCG funding formula 'will exacerbate north-south divide', *Pulse*, 17 October 2013

C Bowler, Breaking: NHS England to consider real terms cuts for some CCGs, *Health Service Journal*, 17 December 2013

Revised formula for 2014-15

Health chiefs debate NHS funding shift,*The Financial Times*, 17 December 2013

NHS urged to drop plan to shift health funding to areas with more old people, *The Guardian*, 16 December 2013

5 Appendix: CCG Allocations for 2014/15 and 2015/16

Table 3 below shows the current CCG allocations until 2015/16. The first column is the current 2014/15 CCG allocation; the second is the percentage change in allocations on the year prior. Column 3 is the allocation per head. Finally, columns 4, 5 and 6 show the same information for the year 2015/16. At the bottom of the table you can find the regional breakdowns of these allocations.

Table 3: CCG Allocations for 2014/15 and 2015/16

	2014/15			2015/16		
Name	**CCG Allocation (£000)**	**Total Growth on Prior Year**	**Allocation per head**	**CCG Allocation (£000)**	**Total Growth on Prior Year**	**Allocaiton per head**
Airedale, Wharfedale and Craven	187,706	2.14%	£1,140	190,897	1.70%	£1,154
Ashford	133,492	2.14%	£1,000	135,761	1.70%	£1,012
Aylesbury Vale	200,256	2.54%	£1,028	205,169	2.45%	£1,041
Barking & Dagenham	239,974	3.55%	£1,138	246,864	2.87%	£1,152
Barnet	402,317	3.20%	£1,068	414,839	3.11%	£1,081
Barnsley	347,037	2.14%	£1,237	352,937	1.70%	£1,252
Basildon and Brentwood	306,153	2.14%	£1,102	311,358	1.70%	£1,115
Bassetlaw	143,656	2.14%	£1,217	146,098	1.70%	£1,232
Bath and North East Somerset	211,985	2.14%	£1,027	215,589	1.70%	£1,039
Bedfordshire	444,097	3.96%	£1,069	460,192	3.62%	£1,082
Bexley	256,635	3.44%	£1,167	263,082	2.51%	£1,181
Birmingham CrossCity	860,748	2.14%	£1,167	875,381	1.70%	£1,181
Birmingham South and Central	268,975	2.14%	£1,118	273,548	1.70%	£1,131
Blackburn with Darwen	199,835	2.14%	£1,201	203,233	1.70%	£1,216
Blackpool	226,856	2.14%	£1,336	230,713	1.70%	£1,353
Bolton	343,069	2.17%	£1,200	350,361	2.13%	£1,215
Bracknell and Ascot	135,040	3.92%	£1,035	139,913	3.61%	£1,048
Bradford City	116,159	2.15%	£960	118,134	1.70%	£971
Bradford Districts	398,309	2.15%	£1,184	405,081	1.70%	£1,199
Brent	374,262	2.14%	£987	380,624	1.70%	£999
Brighton & Hove	340,240	2.14%	£1,056	346,024	1.70%	£1,069
Bristol	509,588	2.37%	£1,073	518,415	1.73%	£1,086
Bromley	369,834	3.97%	£1,185	383,386	3.66%	£1,199
Bury	215,503	3.41%	£1,202	222,198	3.11%	£1,217
Calderdale	263,441	2.14%	£1,099	267,919	1.70%	£1,112
Cambridgeshire and Peterborough	873,808	2.90%	£1,028	895,489	2.48%	£1,040
Camden	335,953	2.14%	£1,078	341,664	1.70%	£1,091
Cannock Chase	151,248	2.14%	£1,149	153,820	1.70%	£1,163
Canterbury and Coastal	241,808	2.14%	£1,067	245,919	1.70%	£1,080
CastlePoint and Rochford	202,804	2.14%	£1,156	206,252	1.70%	£1,171
Central London(Westminster)	248,999	2.14%	£985	253,232	1.70%	£997
Central Manchester	235,901	2.14%	£1,081	239,911	1.70%	£1,095
Chiltern	308,250	3.26%	£1,002	317,433	2.98%	£1,014
Chorley and South Ribble	216,714	2.14%	£1,200	220,398	1.70%	£1,215
City and Hackney	348,044	2.14%	£1,126	353,961	1.70%	£1,139
Coastal West Sussex	603,433	3.68%	£1,280	620,084	2.76%	£1,295
Corby	78,013	4.28%	£1,207	81,069	3.92%	£1,222
Coventry and Rugby	525,271	2.68%	£1,112	535,949	2.03%	£1,125
Crawley	144,092	2.14%	£1,054	146,542	1.70%	£1,067
Croydon	406,356	3.55%	£1,138	419,564	3.25%	£1,152
Cumbria	677,324	2.14%	£1,198	688,839	1.70%	£1,212
Darlington	133,478	2.14%	£1,239	135,747	1.70%	£1,255
Dartford, Gravesham and Swanley	277,880	2.24%	£1,110	282,604	1.70%	£1,123
Doncaster	414,792	2.14%	£1,229	421,843	1.70%	£1,244

Dorset	918,931	2.14%	£1,214	934,553	1.70%	£1,229
Dudley	370,320	2.14%	£1,194	376,616	1.70%	£1,209
Durham Dales, Easington & Sedgefield	405,554	2.14%	£1,334	412,448	1.70%	£1,351
Ealing	424,700	3.82%	£1,077	439,339	3.45%	£1,090
East and North Hertfordshire	607,048	3.38%	£1,094	622,368	2.52%	£1,107
East Lancashire	490,720	2.14%	£1,237	499,062	1.70%	£1,252
East Leicestershire and Rutland	320,515	3.59%	£1,065	330,862	3.23%	£1,078
East Riding of Yorkshire	355,617	2.14%	£1,123	361,662	1.70%	£1,137
East Staffordshire	139,910	2.14%	£1,064	142,289	1.70%	£1,077
East Surrey	182,623	2.45%	£1,056	186,050	1.88%	£1,069
Eastbourne, Hailsham and Seaford	235,613	2.15%	£1,316	240,518	2.08%	£1,332
Eastern Cheshire	220,413	3.15%	£1,145	226,701	2.85%	£1,159
Enfield	336,327	4.35%	£1,128	349,727	3.98%	£1,142
Erewash	114,949	2.14%	£1,216	116,904	1.70%	£1,231
Fareham and Gosport	204,361	3.49%	£1,098	210,843	3.17%	£1,111
Fylde & Wyre	199,254	2.14%	£1,277	202,641	1.70%	£1,293
Gateshead	286,890	2.14%	£1,272	291,767	1.70%	£1,287
Gloucestershire	667,524	2.14%	£1,088	678,872	1.70%	£1,101
Great Yarmouth & Waveney	297,454	2.14%	£1,222	302,511	1.70%	£1,237
Greater Huddersfield	272,490	2.14%	£1,053	277,122	1.70%	£1,066
Greater Preston	244,659	2.14%	£1,151	248,818	1.70%	£1,165
Greenwich	326,009	2.14%	£1,186	331,552	1.70%	£1,200
Guildford and Waverley	226,440	2.14%	£994	230,618	1.85%	£1,006
Halton	178,459	2.14%	£1,350	181,493	1.70%	£1,366
Hambleton, Richmondshire & Whitby	173,028	2.14%	£1,136	175,969	1.70%	£1,150
Hammersmith and Fulham	244,607	2.14%	£1,079	248,765	1.70%	£1,092
Hardwick	133,884	2.14%	£1,265	136,160	1.70%	£1,280
Haringey	306,153	2.54%	£1,067	311,988	1.91%	£1,080
Harrogate and Rural District	176,786	2.14%	£1,058	179,791	1.70%	£1,071
Harrow	234,162	4.20%	£1,022	243,174	3.85%	£1,034
Hartlepool and Stockton-on-Tees	365,657	2.14%	£1,250	371,874	1.70%	£1,265
Hastings & Rother	251,481	2.14%	£1,304	255,756	1.70%	£1,320
Havering	297,205	2.49%	£1,187	302,943	1.93%	£1,202
Herefordshire	209,571	2.14%	£1,096	213,134	1.70%	£1,109
Herts Valleys	641,664	2.49%	£1,085	656,229	2.27%	£1,099
Heywood, Middleton & Rochdale	274,531	2.99%	£1,286	279,549	1.83%	£1,301
High Weald Lewes Havens	187,932	2.14%	£1,087	191,127	1.70%	£1,100
Hillingdon	290,919	4.36%	£1,068	302,518	3.99%	£1,081
Horsham and Mid Sussex	235,453	2.14%	£1,045	239,456	1.70%	£1,058
Hounslow	286,628	4.38%	£1,080	298,008	3.97%	£1,094
Hull	360,264	2.14%	£1,139	366,388	1.70%	£1,153
Ipswich and East Suffolk	403,530	2.85%	£1,071	412,376	2.19%	£1,084
Isle of Wight	199,514	2.14%	£1,155	202,906	1.70%	£1,169
Islington	303,411	2.14%	£1,241	308,569	1.70%	£1,256
Kernow	687,123	2.14%	£1,141	698,804	1.70%	£1,155
Kingston	196,257	3.66%	£995	201,914	2.88%	£1,007
Knowsley	244,694	2.14%	£1,434	248,854	1.70%	£1,451
Lambeth	412,970	2.28%	£1,126	419,991	1.70%	£1,139
Lancashire North	195,658	2.14%	£1,133	198,984	1.70%	£1,147
Leeds North	232,873	2.14%	£1,056	236,832	1.70%	£1,068

Leeds South and East	341,288	2.14%	£1,200	347,090	1.70%	£1,215
Leeds West	382,187	2.14%	£1,001	388,684	1.70%	£1,013
Leicester City	383,496	3.17%	£1,090	394,396	2.84%	£1,103
Lewisham	366,650	2.87%	£1,210	374,883	2.25%	£1,225
Lincolnshire East	310,398	2.14%	£1,219	316,493	1.96%	£1,233
Lincolnshire West	258,934	2.14%	£1,115	263,336	1.70%	£1,129
Liverpool	719,111	2.14%	£1,351	731,336	1.70%	£1,368
Luton	224,845	4.19%	£1,088	233,385	3.80%	£1,102
Mansfield & Ashfield	232,107	2.14%	£1,255	236,053	1.70%	£1,270
Medway	316,893	2.18%	£1,079	322,280	1.70%	£1,092
Merton	208,458	4.92%	£1,018	217,810	4.49%	£1,030
Mid Essex	391,149	2.98%	£1,066	399,951	2.25%	£1,079
Milton Keynes	255,195	4.30%	£995	265,221	3.93%	£1,007
Nene	663,376	3.81%	£1,098	686,458	3.48%	£1,111
Newark & Sherwood	148,017	2.14%	£1,146	150,534	1.70%	£1,160
Newbury and District	112,595	3.71%	£1,064	116,419	3.40%	£1,077
Newcastle North and East	173,776	2.14%	£1,113	176,731	1.70%	£1,127
Newcastle West	183,297	2.14%	£1,335	186,413	1.70%	£1,351
Newham	391,114	2.14%	£1,031	398,242	1.82%	£1,044
North & West Reading	110,590	3.50%	£1,083	114,031	3.11%	£1,096
North Derbyshire	369,807	2.14%	£1,167	376,094	1.70%	£1,182
North Durham	312,966	2.14%	£1,222	318,286	1.70%	£1,237
North East Essex	407,644	2.14%	£1,164	416,095	2.07%	£1,178
North East Hampshire and Farnham	227,146	2.14%	£1,065	231,008	1.70%	£1,078
North East Lincolnshire	209,953	2.14%	£1,193	213,522	1.70%	£1,208
North Hampshire	213,478	2.32%	£999	217,144	1.72%	£1,011
North Kirklees	220,927	2.14%	£1,067	224,683	1.70%	£1,080
North Lincolnshire	205,754	2.14%	£1,170	209,252	1.70%	£1,184
North Manchester	253,845	2.14%	£1,302	258,160	1.70%	£1,318
North Norfolk	211,907	2.14%	£1,185	215,509	1.70%	£1,200
North Somerset	242,687	4.18%	£1,177	250,149	3.07%	£1,191
North Staffordshire	253,921	2.14%	£1,203	258,238	1.70%	£1,218
North Tyneside	287,531	2.14%	£1,260	292,419	1.70%	£1,276
North West Surrey	392,066	2.14%	£1,042	398,898	1.74%	£1,055
North, East, West Devon	1,060,716	2.14%	£1,134	1,078,748	1.70%	£1,148
Northumberland	418,508	2.14%	£1,246	425,623	1.70%	£1,261
Norwich	216,236	2.25%	£1,039	219,913	1.70%	£1,051
Nottingham City	391,789	2.14%	£1,081	398,449	1.70%	£1,094
Nottingham North & East	163,977	2.14%	£1,152	166,765	1.70%	£1,166
Nottingham West	104,926	3.42%	£1,171	107,733	2.68%	£1,185
Oldham	298,069	2.14%	£1,218	303,136	1.70%	£1,233
Oxfordshire	617,603	3.32%	£984	635,912	2.96%	£996
Portsmouth	245,486	2.14%	£1,139	249,660	1.70%	£1,153
Redbridge	290,992	4.79%	£1,056	303,827	4.41%	£1,069
Redditch and Bromsgrove	182,693	2.14%	£1,044	185,799	1.70%	£1,057
Richmond	208,597	2.83%	£992	213,194	2.20%	£1,005
Rotherham	333,413	2.14%	£1,210	339,081	1.70%	£1,224
Rushcliffe	125,013	2.14%	£1,050	127,139	1.70%	£1,062
S.East Staffs and Seisdon & Peninsular	221,618	2.14%	£1,061	225,386	1.70%	£1,074
Salford	326,755	2.72%	£1,340	335,102	2.55%	£1,356

Sandwell and West Birmingham	602,138	2.14%	£1,132	612,375	1.70%	£1,146
Scarborough and Ryedale	150,045	2.14%	£1,184	152,596	1.70%	£1,199
Sheffield	694,638	2.14%	£1,122	706,447	1.70%	£1,136
Shropshire	353,212	2.14%	£1,130	359,217	1.70%	£1,143
Slough	153,041	4.12%	£1,109	158,789	3.76%	£1,123
Solihull	266,271	2.14%	£1,119	270,798	1.70%	£1,133
Somerset	646,371	2.14%	£1,162	657,359	1.70%	£1,176
South Cheshire	197,482	3.15%	£1,187	203,116	2.85%	£1,202
South Devon and Torbay	374,867	2.14%	£1,173	381,240	1.70%	£1,187
South Eastern Hampshire	220,129	3.12%	£1,145	226,366	2.83%	£1,159
South Gloucestershire	248,841	3.70%	£1,027	257,132	3.33%	£1,040
South Kent Coast	257,217	2.14%	£1,194	261,590	1.70%	£1,209
South Lincolnshire	183,497	2.56%	£1,114	187,096	1.96%	£1,128
South Manchester	205,818	2.14%	£1,241	209,317	1.70%	£1,256
South Norfolk	241,426	2.22%	£1,058	245,531	1.70%	£1,071
South Reading	119,554	3.30%	£991	122,931	2.82%	£1,003
South Sefton	226,643	2.14%	£1,330	230,496	1.70%	£1,346
South Tees	385,005	2.14%	£1,282	391,550	1.70%	£1,298
South Warwickshire	292,720	2.14%	£1,069	297,697	1.70%	£1,082
South West Lincolnshire	147,865	2.14%	£1,083	150,450	1.75%	£1,097
South Worcestershire	308,705	2.14%	£1,049	313,953	1.70%	£1,062
Southampton	280,223	2.14%	£1,021	284,987	1.70%	£1,033
Southend	211,895	3.31%	£1,218	218,263	3.01%	£1,233
Southern Derbyshire	603,271	2.17%	£1,162	613,527	1.70%	£1,176
Southport and Formby	163,122	2.14%	£1,279	165,895	1.70%	£1,295
SouthTyneside	227,683	2.14%	£1,339	231,554	1.70%	£1,355
Southwark	359,553	3.54%	£1,153	369,562	2.78%	£1,167
St Helens	267,394	2.14%	£1,328	271,940	1.70%	£1,344
Stafford and Surrounds	154,797	2.14%	£1,064	157,429	1.70%	£1,077
Stockport	342,685	2.14%	£1,186	348,511	1.70%	£1,200
Stoke on Trent	347,575	2.14%	£1,256	353,484	1.70%	£1,271
Sunderland	417,232	2.14%	£1,319	424,325	1.70%	£1,335
Surrey Downs	326,479	2.14%	£1,035	332,029	1.70%	£1,048
Surrey Heath	108,150	2.14%	£1,064	109,989	1.70%	£1,077
Sutton	206,710	4.22%	£1,175	214,762	3.90%	£1,189
Swale	122,409	2.63%	£1,154	124,916	2.05%	£1,168
Swindon	228,966	4.11%	£1,051	235,906	3.03%	£1,063
Tameside and Glossop	309,717	2.14%	£1,283	314,983	1.70%	£1,299
Telford & Wrekin	187,765	2.14%	£1,062	190,957	1.70%	£1,075
Thanet	193,402	2.14%	£1,293	196,690	1.70%	£1,308
Thurrock	183,333	2.64%	£1,079	187,063	2.03%	£1,092
Tower Hamlets	329,033	2.14%	£1,100	334,627	1.70%	£1,113
Trafford	267,316	2.14%	£1,141	271,861	1.70%	£1,155
Vale of York	367,439	2.14%	£1,027	373,685	1.70%	£1,039
Vale Royal	116,708	2.14%	£1,172	118,693	1.70%	£1,186
Wakefield	457,483	2.14%	£1,163	465,260	1.70%	£1,178
Walsall	349,717	2.14%	£1,157	355,662	1.70%	£1,171
Waltham Forest	297,149	3.97%	£1,065	307,916	3.62%	£1,078
Wandsworth	384,753	2.14%	£960	391,294	1.70%	£972
Warrington	238,742	3.66%	£1,206	246,654	3.31%	£1,221

Warwickshire North	201,223	3.21%	£1,211	207,086	2.91%	£1,226
West Cheshire	304,243	2.14%	£1,189	309,416	1.70%	£1,204
West Essex	322,798	3.70%	£1,128	331,089	2.57%	£1,142
West Hampshire	576,598	2.14%	£1,070	586,401	1.70%	£1,084
West Kent	476,809	3.86%	£1,064	492,214	3.23%	£1,077
West Lancashire	136,185	2.14%	£1,209	138,500	1.70%	£1,223
West Leicestershire	372,194	3.71%	£1,048	382,124	2.67%	£1,061
West London(K&C&QPP)	335,133	2.14%	£1,065	340,830	1.70%	£1,078
West Norfolk	213,788	2.14%	£1,272	217,423	1.70%	£1,288
West Suffolk	268,594	2.14%	£1,089	273,160	1.70%	£1,102
Wigan Borough	411,662	2.14%	£1,263	418,660	1.70%	£1,278
Wiltshire	512,194	2.14%	£1,090	520,902	1.70%	£1,104
Windsor, Ascot and Maidenhead	146,475	3.80%	£1,050	151,655	3.54%	£1,062
Wirral	456,484	2.14%	£1,336	464,244	1.70%	£1,352
Wokingham	149,579	4.42%	£1,008	155,597	4.02%	£1,020
Wolverhampton	318,270	2.14%	£1,173	323,681	1.70%	£1,188
Wyre Forest	126,443	2.14%	£1,098	128,593	1.70%	£1,112
Regional Breakdown						
North	19,808,433	2.21%	£1,207	20,161,485	1.78%	£1,221
Midlands & East	18,724,507	2.58%	£1,116	19,122,112	2.12%	£1,129
London	10,019,864	3.07%	£1,092	10,282,651	2.62%	£1,105
South	15,783,623	2.56%	£1,100	16,113,898	2.09%	£1,113
Total	**64,336,427**	**2.54%**	**£1,133**	**65,680,146**	**2.09%**	**£1,147**

Source: NHS England CCG Allocations 2014/15 and 2015/16, Janurary 2014