Department of Health & Social Care

NHS England

Terms of Reference

Advisory Committee on Resource Allocation (ACRA)

2021 update

Terms of Reference

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Contents

1 Introduction

The Advisory Committee on Resource Allocation (ACRA) makes recommendations on the preferred, relative, geographical distribution of resources for health services.

ACRA is an independent, expert committee comprising of GPs, public health experts, NHS managers and academics.

ACRA was established in September 1997[1] as the successor body to the Resources Allocations Working Group (RAWP) that was established in 1976.

The terms of reference, reporting arrangements and objectives of the funding formula may be subject to change. Should there be substantial changes, a new version of the terms of reference will be issued.

2 Role of ACRA

The aim of ACRA is to provide recommendations and advice on the target, relative geographical distribution of funding for health services in England, given the objectives of the funding formula. This is currently:

i. to the Secretary of State for public health allocations, and

ii. to the Chief Executive of NHS England for NHS allocations.

The objectives of the formulae are set by NHS England and the Department of Health and Social Care. They are presently that the allocation formulae support equal opportunity of access for equal need and contribute to the reduction in avoidable health inequalities.

ACRA's recommendations should be based on the best available evidence and be clear when judgements have necessarily been made where the available data are limited.

ACRA's current principles and objectives are in Annex D.

3 Accountability

ACRA is an independent advisory group commissioned by the Secretary of State for Health and Social Care and NHS England. Annex 1 gives a summary of the reporting arrangements.

ACRA's work programme is commissioned through a remit letter from the Secretary of State for Health and Social Care for public health allocations and a remit letter from the Chief Executive of NHS England for NHS allocations. ACRA submits its recommendations in letters to the Secretary of State for Health and Social Care and the Chief Executive of NHS England for public health allocations and NHS allocations respectively.

[1] As proposed in the 1997 White Paper *The new NHS: modern, dependable*

4 Membership

The Chair of ACRA is appointed jointly by the Secretary of State for Health and Social Care and the Chief Executive of NHS England.

NHS England, the Department of Health and Social Care and the Chair of ACRA shall discuss and agree the balance of expertise required for the group. The group shall broadly consist of representatives from GPs, public health experts, NHS managers, academics and local government representatives.

The membership shall be regularly reviewed to ensure the balance of expertise is adequate to achieve the aims and objectives of the group and the current work programme. The balance of expertise may therefore change over time. Reviews of membership should have regard for the need to comply with the public sector equality duty and strive to ensure that diversity is reflected in the membership of ACRA.

Members shall be invited to join ACRA by the Secretariat. NHS England and the Secretary of State will be consulted on new members.

Membership of ACRA is offered in a personal capacity to individual experts to ensure continuity, other than for up to six members who have organisation specific roles – a representative for each of the key departments involved in allocations – NHS England, the Department of Health and Social Care and the Office for Health Improvement and Disparities (usually the Chief Economist or equivalent) plus the head of each of the allocations policy and analytical teams at NHS England, and the head of the Secretariat.

The current membership is set out at Annex E.

5 Sub-groups

ACRA will be supported by a Technical Advisory Group (TAG). Further, the ACRA and TAG Chairs and the members may agree to form sub-groups on a permanent or ad hoc basis for specific work areas. Terms of reference for such groups shall be agreed by ACRA.

6 Communication and transparency

ACRA shall strive to be as transparent and open as it can be by publishing documents on websites as and when ACRA believes is appropriate.

All external communications shall be carried out through existing Department of Health and Social Care / NHS England channels.

Documents published publicly may include progress reports, papers and minutes of the ACRA meetings as appropriate. The minutes shall clearly show firm agreements and areas under discussion. Certain parts of the minutes may be withheld for a time at the discretion of the Chair, NHS England and the Department of Health and Social Care, due to the area being under policy development or awaiting wider ministerial or NHS England announcements. ACRA papers and minutes will be redacted if necessary, in-line with freedom of information principles.

Arrangements shall be made to draw the attention of key stakeholders when new items have been published on the website and superseded documents shall be properly archived.

7 Performance review

It is important to review the relative effectiveness of ACRA and identify any performance and progress gaps on a regular basis in light of these terms of reference. Reviews will be undertaken by NHS England, the Department of Health and Social Care and the ACRA Chair. The reviews may include but are not limited to feedback from stakeholders, commissioners, sub-groups or individuals.

The findings of reviews shall be shared with ACRA members.

8 Confidentiality and information legislation

Due to the sensitivity of the recommendations on the funding formula, ACRA members shall agree not to discuss or share any unpublished documents external to the group, nor shall any work be replicated in any form. All correspondence will only be via the secretariat and the Chair of ACRA.

Some discussion may take place with peers external to ACRA members who can provide additional expertise on issues and data, however members must make it clear that the discussion must be kept confidential.

ACRA members may be subject to "Freedom of Information" legislation and therefore under a statutory requirement to disclose certain information on request and to abide by commitments set out in NHS England's and the Department of Health and Social Care's Freedom of Information Publication Scheme[2]. Those that are not subject to Freedom of Information legislation are expected to abide by the spirit of Freedom of Information legislation.

ACRA members shall abide by the General Data Protection Regulation (GDPR). The principles of GDPR are in Annex B.

9 Proceedings of meetings

9.1 Agenda

The Chair with support from the secretariat shall set the agenda for each meeting.

9.2 Management of the work programme

The Chair and the secretariat shall have an overview of all the work being undertaken by ACRA and its sub-groups to ensure there is no duplication of work and that the work programme is successfully completed.

Agendas, minutes and all papers of ACRA and all sub-groups will be shared with all the chairs so that there is no duplication of work. The Chair of ACRA shall have a standing invitation to all ACRA sub-groups.

9.3 Early identification of issues and risks

[2] http://transparency.dh.gov.uk/2012/07/20/freedom-of-information-publication-scheme/

In order to ensure successful completion of this work, ACRA shall keep under review current and potential issues and opportunities, internal and external risks together with mitigation strategies. An up-to-date register of issues and risks shall be maintained by the secretariat.

9.4 Frequency of meetings

The frequency of meetings is for ACRA to determine to achieve its objectives and work programme. Typically ACRA has met around 4-6 times per year.

9.5 Format of meetings

It is for ACRA to decide the format of the meetings. These are typically held virtually and last for up to four hours. However, to ensure effective working relationships occasional face to face meetings will be held.

9.6 Quorum and decision making

Each member shall have the right to be fully heard as equal partners. There should be genuine dialogue.

Whilst achieving consensus should be the aim, ACRA should not seek unanimity at the risk of failing to recognise different views or approaches on an issue. Once a position (or major/ minor positions) is established by the group, the members shall support that decision and recognise their responsibility not to undermine the authority of the group.

The quorum for the meeting shall be 50% of ACRA members. If a quorum is not achieved the meeting may still proceed.

If ACRA does not reach a consensus, members may, if they wish, call for a vote. Members are able to:

a. call for a vote if there is a quorum;
b. call for delay of a vote until a quorum is achieved; or
c. proceed with voting subject to ratification by other members at the next meeting or by correspondence.

In the event of a tie, the Chair will have a casting vote. Special attendees and the secretariat, where they are not also members of ACRA, are not eligible to vote.

9.7 Communication with members

The main communication route will be via agendas, minutes of meetings and meeting papers. These will be circulated to all members and copied to various key personnel at NHS England and the Department of Health and Social Care.

10 Responsibilities of the Chair, members and the secretariat

10.1 Declaration of interest

The Chair and members shall declare any interests[3] that are relevant to the overall work of ACRA and the specific agenda item under discussion. The secretariat shall review and maintain such declarations and publish details as part of routine progress updates. Members shall withdraw from discussion of matters in which they feel that they cannot act impartially. Where this occurs, it shall be recorded in the minutes of the meeting.

10.2 Responsibilities of the Chair

The Chair shall be responsible for:

i. Reporting ACRA's recommendations to the Secretary of State for Health and the Chief Executive of NHS England.

ii. Effectively chairing meetings.

iii. Ensuring ACRA operates effectively.

iv. The management and output of ACRA.

v. Ensuring every member has a fair opportunity to be heard and that no views are ignored or overlooked.

vi. Allowing genuine dialogue to take place and diversity fully explored and discussed.

vii. Endeavouring to achieve a consensus of opinion.

viii. Ensuring voting is carried out fairly, should it be necessary to vote on an issue.

ix. Ensuring the secretariat accurately documents the proceedings and there is a clear audit trail showing how decisions were made.

x. Ensuring there is the right balance of expertise to fulfil the aims of ACRA.

xi. Ensuring all members have a good grasp of the underlying subject matter, expertise and if necessary arranging training to enable them to fulfil their roles and ensuring records are kept of member's performance as necessary.

xii. Ensuring good knowledge management principles are adhered to.

10.3 Members' roles and responsibilities

Members will be expected to abide by the "Seven Principles of Public Life" (sometimes referred to as the Nolan Principles, which are in Annex C)[4].

Members of ACRA shall ensure they understand why they have been appointed and in what capacity, and the role they are expected to play in the group. Members shall understand the nature of any expertise that they are asked to contribute. Members

[3] http://www.civilservice.gov.uk/about/resources/public-appointments

[4] http://www.public-standards.org.uk/

with a particular expertise have a responsibility to make the group aware of the full range of opinion within the discipline.

Members shall confirm before accepting an invitation to serve on ACRA that they are clear about the period of appointment and that they can fulfil the commitment required in terms of continuity, meeting attendance, the group's business and preparation for meetings.

A member's role on ACRA shall not be constrained by the expertise or perspective they were asked to bring to the group. Members shall regard themselves as free to question and comment on the information provided or the views expressed by any of the other members, notwithstanding that the views or information do not relate to their own area of expertise.

If members believe the group's method of working is not rigorous or thorough enough they shall raise this initially with the Chair and subsequently the Senior Responsible Officer at NHS England and the Department of Health and Social Care. They have the right to ask that any remaining concerns be put on the record.

Members will be expected to attend at least 75% of the meetings and missing three consecutive meetings will be brought to the attention of the Chair.

Substitutes during meetings will only be allowed at the discretion of the Chair. Members shall advise the Chair / secretariat if they are not able to attend a meeting. Members are encouraged to submit written views / comments on agenda items when they are not able to attend a meeting.

Members will be expected to read papers and other material in advance to enable full participation. Some email communication will also be required.

Members joining ACRA for the first time shall undergo an induction process. This shall cover the following:

i. Explanation of the group's aims and objectives.
ii. The role of the group.
iii. Basis of decision-making.
iv. The group's work plan.
v. The role of the Secretariat and other officials.
vi. Roles and responsibilities of members.
vii. Conflicts of interest.
viii. The commitment required for meeting attendance, group business and preparation for meetings.
ix. Confidentiality of proceedings and papers.
x. How members shall deal with media enquiries.
xi. Disclosure of members' personal details to the public, bearing in mind personal security and other considerations.
xii. The rules governing declarations of outside interests, potential conflicts of interest, and gifts and hospitality.
xiii. How conflicts of opinion are resolved.
xiv. Terms of appointment of the Chair and members,

xv. Remuneration of expenses, and

xvi. Personal liability.

11 Role of the secretariat

The secretariat shall:

i. Support the ACRA members by assembling and analysing information and recording conclusions of meetings.

ii. Advise members on relevant process and procedure.

iii. Bring to the attention of the ACRA Chair and members, emerging issues of concern to NHS England and the Department of Health and Social Care, so as to inform the group's deliberations.

iv. Arrange regular briefing meetings with the Chair.

v. Be an impartial facilitator and guard against introducing bias during the preparation of papers, during meetings, or in the reporting of the group's deliberations.

vi. Ensure that the proceedings of the ACRA meetings are documented in sufficient detail and within a reasonable period after a meeting so that there is a clear audit trail showing how the group reached its decisions.

vii. Project manage the work to ensure successful completion.

viii. Maintain an updated register of issues and risks.

12 Liabilities and indemnities of members

Legal proceedings by a third party against individual members of advisory groups are very exceptional. An advisory group member may be personally liable if he or she makes a fraudulent or negligent statement which results in a loss to a third party; or may commit a breach of confidence under common law or criminal offence under insider dealing legislation, if he or she misuses information gained through their position.

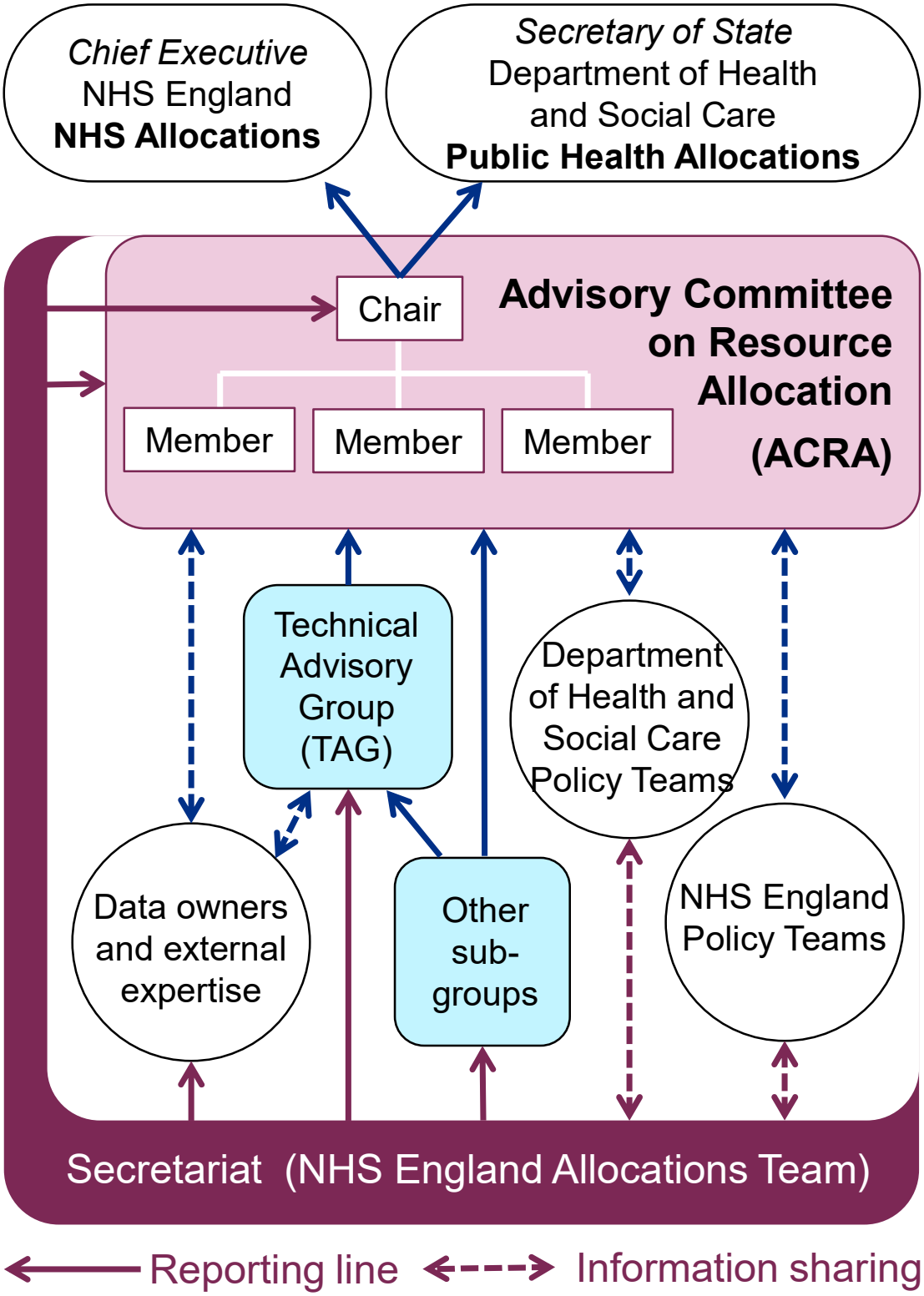
If legal proceedings are brought against any ACRA member by a third party, NHS England and the Department of Health and Social Care will meet any personal civil liability that is incurred in the execution of their functions, unless they acted recklessly and provided that they have acted honestly, in good faith and without negligence[5].

13 Remuneration of expenses

ACRA members will be eligible to claim the cost of travel and subsistence expenses in line with NHS England's and the Department of Health and Social Care's policies. Members are entitled to fair and prompt repayment provided they follow the rules governing the submission of claims and their timing.

[5] http://www.civilservice.gov.uk/wp-content/uploads/2011/09/public_appt_guide-pdf_tcm6-3392.pdf Para 11.6

Annex A: Reporting arrangements



Annex B: Data Protection

General Data Protection Regulation (GDPR)

Article 5 of the GDPR sets out the main principles of data protection responsibilities for organisations under GDPR.

a) **lawfulness, fairness and transparency** – all personal data must be processed lawfully, fairly and in a transparent manner

b) **purpose limitation** – data must only be collected and processed for legitimate purposes which are specifically and explicitly stated

c) **data minimisation** – only data which is relevant for the purpose should be collected and processed

d) **accuracy** – reasonable steps should be taken to ensure that data remains accurate and is kept up to date

e) **storage limitation** – data should not be kept for any longer than is necessary (unless it is being processed for archiving purposes in the public interest, for scientific purposes, or for statistical or historical purposes)

f) **integrity and confidentiality** – data must be kept securely and technical and organisational measures should be put in place to protect it from hackers etc

g) **accountability** – data controllers must be able to demonstrate compliance will all the GDPR principles

Annex C: “Seven Principles of Public Life”

(Sometimes referred to as the Nolan Principles)

Selflessness

Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

14 Annex D: ACRA's current objectives and principles

1. ACRA is an independent, expert advisory committee on resource allocation. We make recommendations to NHS England on the distribution of financial resources for NHS services and to the Department of Health and Social Care on the distribution of financial resources for public health services. Our remit covers allocations within England.
2. Our terms of reference are set by NHS England and the Department of Health and Social Care. The Department of Health and Social Care sets out the priorities for our work programme on public heath allocations and NHS England for NHS allocations.
3. The first advisory committee on NHS allocations was the Resource Allocation Working Group (RAWP) set up in 1976. ACRA is a successor to RAWP and was established in 1997.

Weighted capitation formulae

4. ACRA makes recommendations on the weighted capitation formulae which set target shares of the national budgets for local areas. The local areas for allocations have changed over time with changes in commissioning responsibilities. They have included health authorities, primary care trusts, clinical commissioning groups and local authorities.
5. The objectives of the formulae are:
    - to support equal opportunity of access to services for equal need
    - to contribute to the reduction in avoidable health inequalities.
6. To meet these objectives, ACRA makes recommendations on the relative weights per head of each area's population. The weights reflect the best estimates of:
    - the relative need for health services; and
    - relative unavoidable differences in the costs of providing services.
7. In estimating the relative need for health services, we seek to remove from the estimates of the target shares use of services which is not related to need, such as higher use due to the greater availability of services. We also seek wherever feasible to adjust the estimates to account for need that is not currently being met or not appropriately being met.

Evidence base

8. ACRA makes its recommendations based on the best evidence available. We review and analyse the evidence available and commission research from academics.
9. We develop statistical models of need for health care. Variables in the models typically include age, sex, morbidity and indicators of morbidity such as deprivation. Wherever data allow, we undertake the modelling at the person level to best capture differences in need between different populations.
10. Our criteria for assessing formulae are in the table below.

Criteria	*Definition*
Transparency and simplicity	The construction and application of the formula should aim for simplicity, be well documented and be open to scrutiny.
Comprehensibility	The formula and its derivation should be explainable to non-specialists in plain English and be capable of common sense justification, even if the detail is understood only by specialists.
Evidence base	The formulae are based on the best evidence available.
Technical robustness	The techniques used must be consistent with best practice methods for statistical and econometric modelling and be applied appropriately.
Objectivity	Formula should be based on plausible relationships and there should be tests of bias, robustness, statistical significance and explanatory power.
Flexibility	The recommendations can respond to changes of commissioning responsibilities (e.g. coverage of services) and size.
Parsimony	The formula should not include relationships of low materiality. All other things being equal fewer rather than more variables are preferred.
Plausibility	The measures & relationships in the formula should be plausible and have face validity.
Clarity of contribution of indicators	The contribution made by individual components in the formula should avoid ambiguity. Where multiple indicators are used the purpose, weighting and selection must be clear.
Reliability of data	The data are available and consistent for all local areas (units of allocation) where possible and not subject to local variations in reporting.
Freedom from perverse incentives	The methods and data sources used to calculate the formula should not create perverse incentives either for manipulating data or other negative behaviours.
Durability and stability	The relationships used to drive the formula should be durable and the data used to derive the formula should be stable.
Updateable	The scale of the work required to update the formula is manageable within the time constraints of the allocation cycle.

11. Where judgements have necessarily been made in the absence of adequate evidence, we clearly set out these judgements.

Actual allocations

12. Actual allocations also depend on the national budgets available and how far each year local areas move closer to their target allocations though differential growth. The latter is known as pace of change policy. ACRA's remit does not cover pace of change policy or advice on the size of the national budgets. These are the responsibility of NHS England for NHS allocations and the Department of Health and Social Care for public health allocations.

15 Annex E: ACRA Membership List 2021

Prof Peter Smith – Chair	Emeritus Professor of Health Policy, Imperial College Business School
Dr Sheena Asthana	Director, Plymouth Institute of Health and Care Research
Dr Chris Bentley	HINST Associates
Bob Butcher*	Deputy Director, Care and Transformation Directorate, Department of Health
Ben Chilcott	Deputy Director of Finance, NHS Devon CCG
Dr Mike D'Souza	GP, Kingston Multi-fund GP consortium (Former)
Kerstin Parker*	Head of Financial Strategy and Allocations, NHS England,
Dr Heather Ross*	Senior Analytical Lead for Allocations, Analysis and Insight for Finance, NHS England
Shaun Donaghy*	Chief Economist, Office for Health Improvement and Disparities
Dr Sunil Gupta	GP and Member of the Governing Body of Castlepoint and Rochford CCG
Prof Sir Brian Jarman	Emeritus Professor of Primary Care, Imperial College of Medicine
Tarryn Lake	Associate Director of Finance, NHS Sunderland CCG
Andrew Lloyd-Kendall	Head of Research, Public Health and Healthcare, BMA
Dr Stephen Lorrimer*	Head of Analysis and Insight for Finance, NHS England
Prof Eugene Milne	Director of Public Health, Newcastle City Council
Nicola Morton	Head of Local Government Finance, Local Government Association
Dave Roberts	Head of Primary Care Information, NHS Digital
Prof Colin Sanderson	Professor of Operational Research in Health Care, London School of Hygiene and Tropical Medicine
Rob Shaw	Head of Forecasting, Data and Analytics, NHS England
Steve Smallwood	Head of Population Statistics Transformation Unit, Office for National Statistics
Prof Matt Sutton	Professor of Health Economics, University of Manchester
Dr Ian Trimble	Independent GP Adviser, NHS Rushcliffe CCG

*Organisation specific members

Recent resignations

Prof Richard Cookson	Centre for Health Economics, University of York
Dr Janet Atherton	PH Consultant
Prof Gwyn Bevan	Professor of Policy Analysis, London School of Economics and Political Science
Professor Brian Ferguson	Public Health England