



Fair Shares

a guide to NHS allocations

Allocations infographics v3

Updated for ICB resource allocations 2023/24



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Download related documents here www.england.nhs.uk/allocations/

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We are continually refining the allocations formula and all supporting documentation
We welcome your comments and feedback



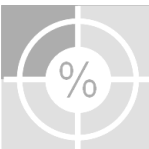
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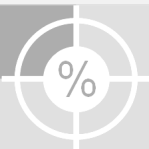
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Background: Introduction to allocations

NHS resource allocations

[NHS England](#) leads the National Health Service (NHS) in England. It is responsible for using or distributing more than £150 billion in funds and ensuring it is spent effectively, efficiently and in the interests of patients, holding commissioning and provider organisations to account.



Integrated Care

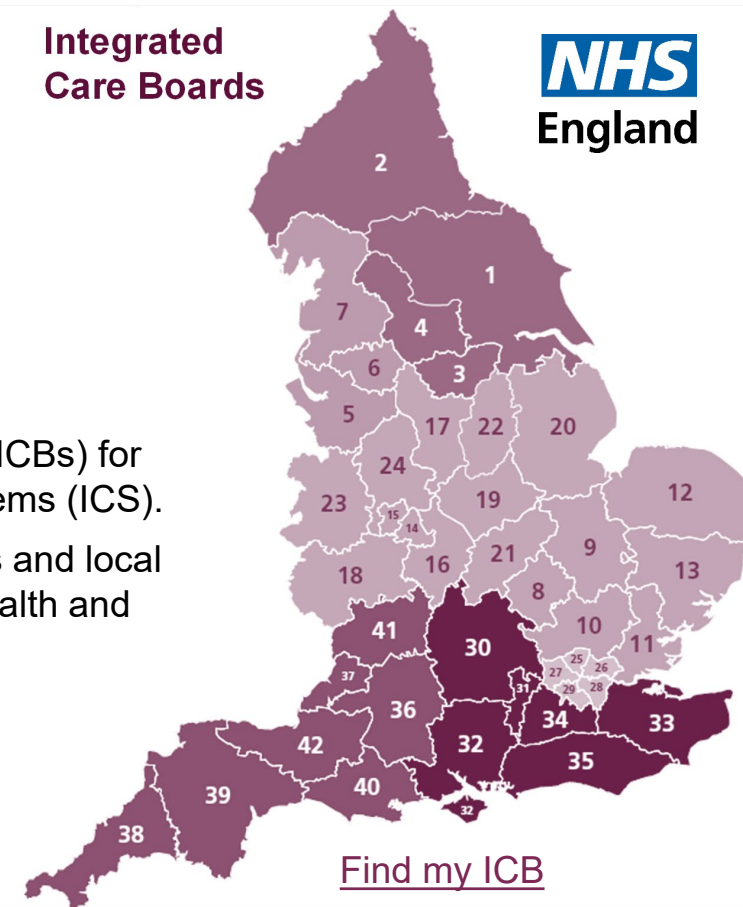
NHS England allocates financial resources to Integrated Care Boards (ICBs) for spending on health and care services within their Integrated Care Systems (ICS).

Integrated Care Systems bring together NHS providers, commissioners and local authorities to monitor local variation in need and collaboratively plan health and care services to support and improve the health of their population.

ICBs replaced CCGs as legal commissioning bodies in July 2022, under the Health and Care Act (2022). They are vital to the delivery of the NHS Long Term Plan.

Read more about [integrated care](#) and the [NHS Long Term Plan](#).

Integrated
Care Boards



[Find my ICB](#)

Allocations

We use a statistical formula to make the distribution of financial resources fair and objective, so that it clearly reflects local healthcare need and supports the reduction of health inequalities. This infographic slide pack aims to explain how allocations are determined by using visuals and metaphors to help make complex ideas easier to digest.

For more detail on our formulae including information on the latest updates, visit our most recent [Allocations Technical Documentation](#).

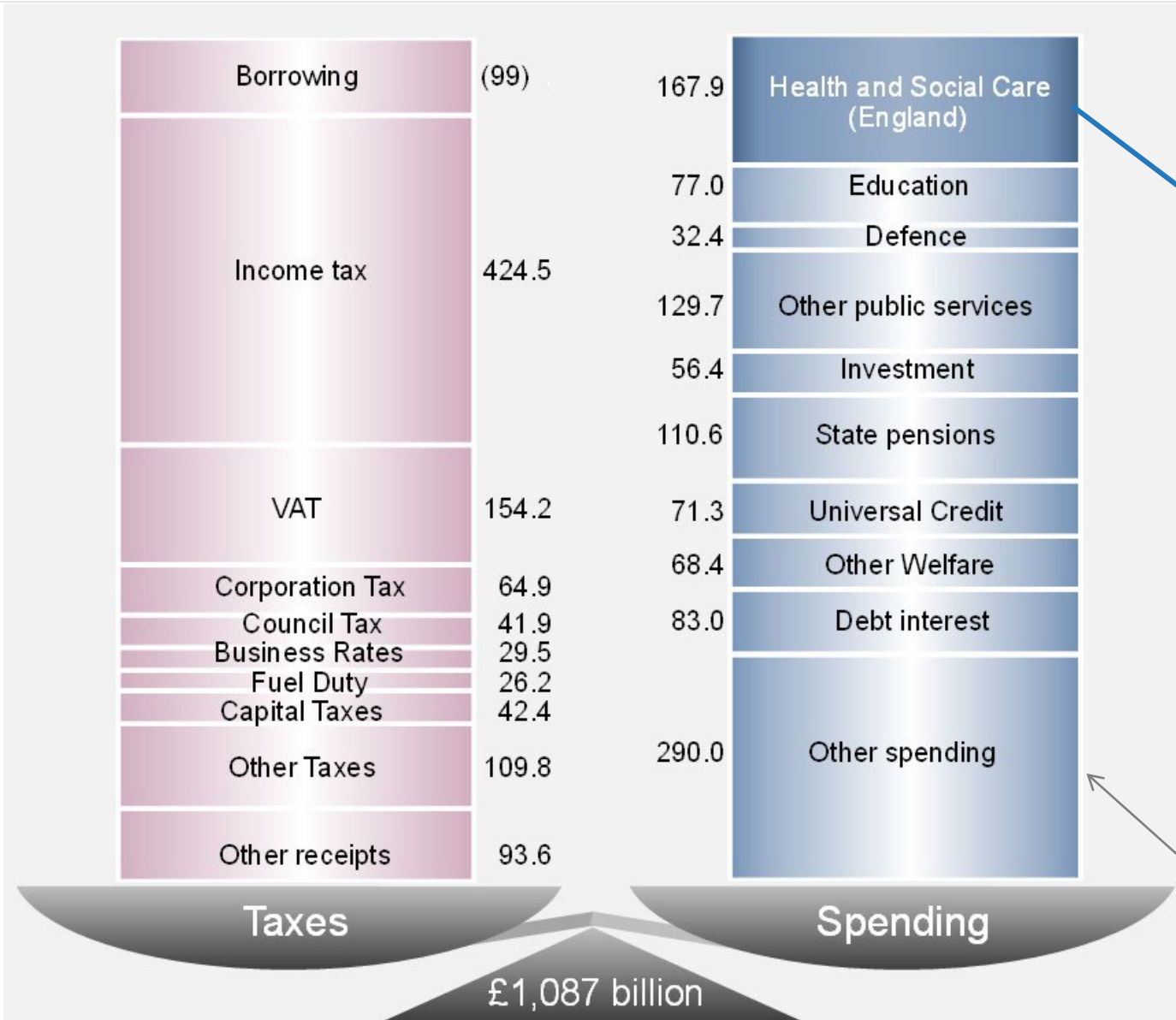


Background: Context of healthcare spending

UK budget

The budget balances public spending against money raised in taxes plus annual borrowing (deficit), reflecting current government values & priorities.

This slide shows income and expenditure in 2022/23



The NHS in England spent £151.8 billion in 2022/23, 90% of the Health and Social Care budget

Devolved parliaments in Scotland, Wales and Northern Ireland receive a public services budget (including health), to spend according to local priorities



Background: Health spending by activity type

Simplified funding flows

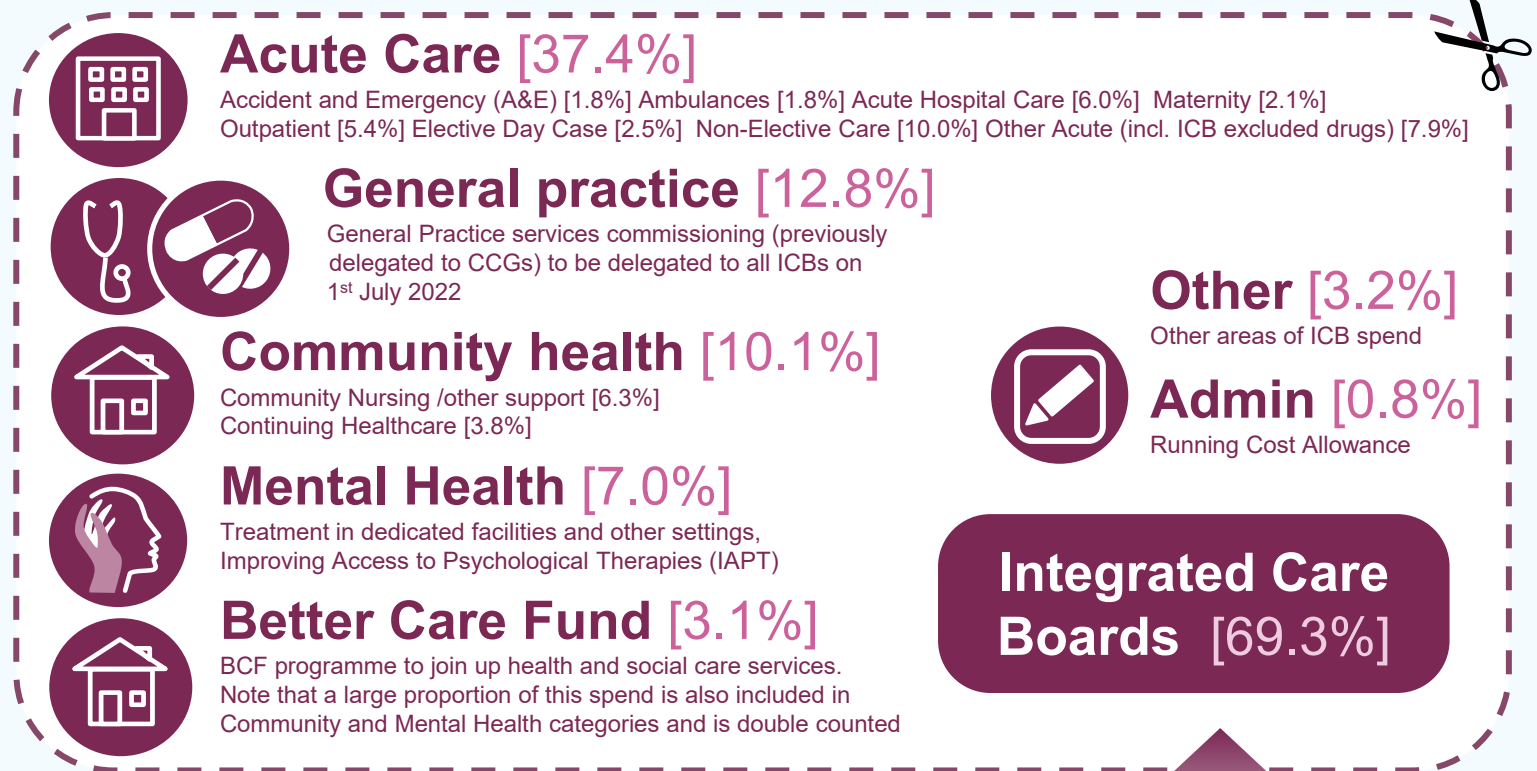
This slide is limited to commissioning activity funded by recurrent NHS allocations, showing areas of responsibility for ICBs and NHSE.

% of NHS England budget 2021/22 →

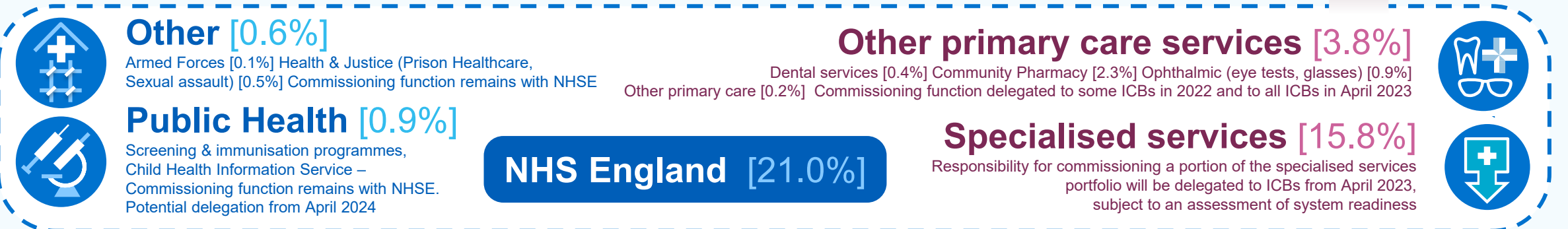
For specific details of spending flows and legal framework, see 'NHS Funding 101' at [ONE NHS Finance](#).

Note: These are just indicative measures. ICB and NHSE figures do not sum up to 100% because some central budgets and non-recurrent COVID funding are excluded.

Additionally, figures may not sum to ICB and NHSE totals due to double counting. For example, BCF is largely made up of community health care and other services.



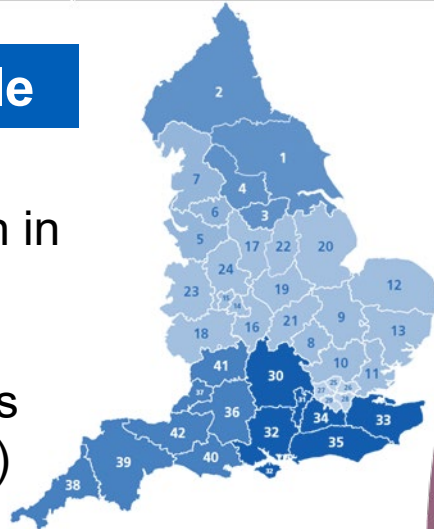
Direct commissioning - phased approach to delegating some of these services to ICBs starting July 2022



Fair shares: **How to share?**

Total resources available

NHS England distributes resources of over £110 billion in revenue between 42 ICBs, representing over 60 million people (registered as patients in six thousand GP practices)

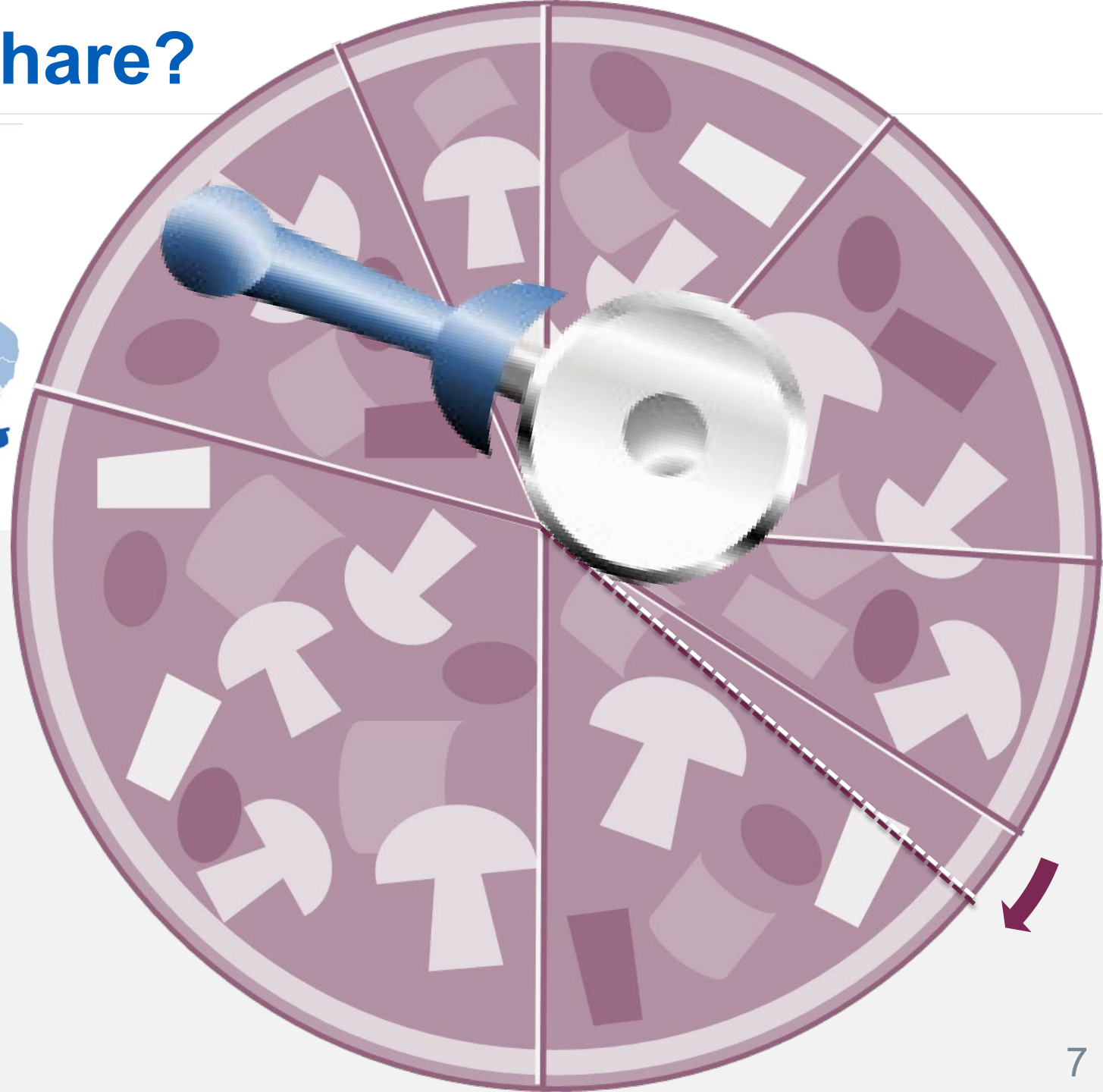


Would it be fair to simply have an equal allocation for each person?

Our health needs generally vary as we go through life. Some age groups have a much higher need for healthcare than others.

For example, general health spending on people aged over 65s is typically higher than for people in their 20-30s, though this group may have higher demand for maternity services.

Similarly people with long term or multiple conditions may have increased use of healthcare.

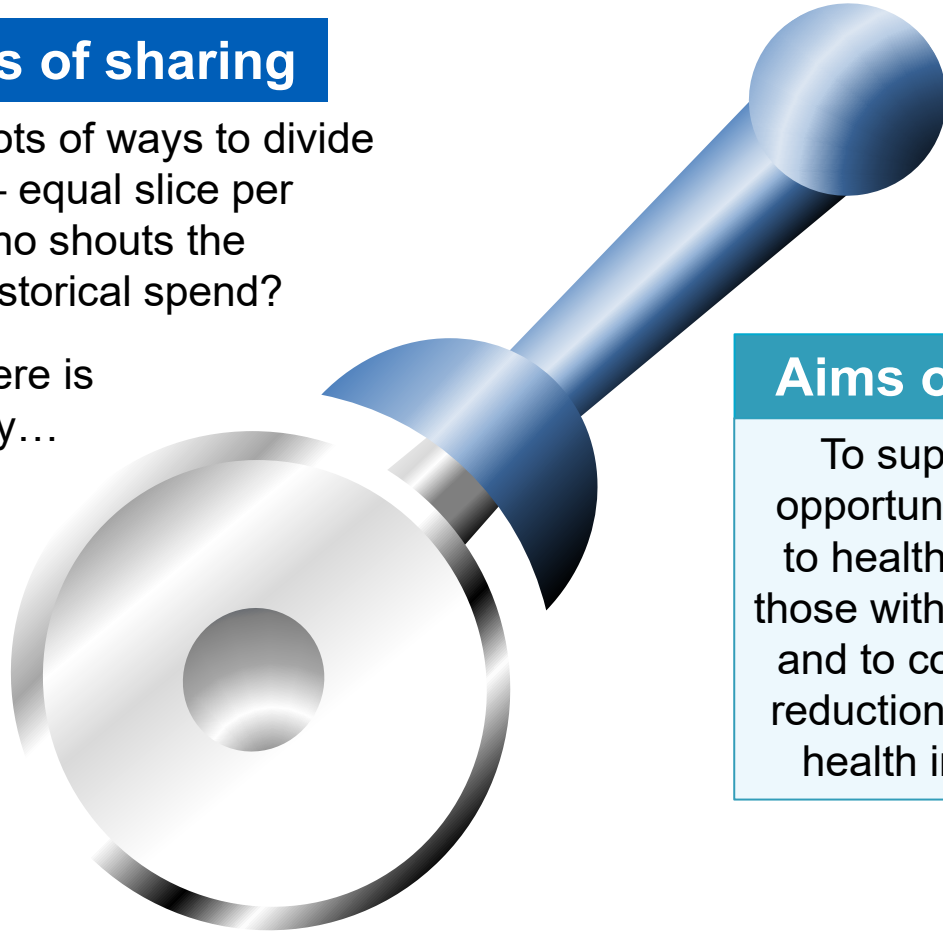


Fair shares: Population based formula

Methods of sharing

There are lots of ways to divide resources – equal slice per person? Who shouts the loudest? Historical spend?

Perhaps there is a better way...



Aims of formula

To support equal opportunity of access to health services by those with equal needs, and to contribute to a reduction in avoidable health inequalities.

Develop an impartial objective formula

To support decisions around allocations, a **statistical formula**, or **'model'** (a complex set of formulas) has been developed, which calculates a target fair share of the national budgets for local areas.

'Weighted Capitation' Formula

This type of model has proved adaptable over many years and has been used effectively since the 1970s to distribute NHS resources between health care organisations. These models take information on a local population and advise what share of funding they should get.

Using this method, more resources are directed to areas estimated to have higher health needs, or where health inequalities can be reduced by investing in healthcare. For example, larger populations, more older people, worse health and higher levels of deprivation.

Additional funds also support services delivered in high cost areas, due to the going rate of staff and buildings, or unavoidable costs – for example, due to remoteness.

Fair shares: Target shares to allocations



These icons have been designed to help users navigate through the slides (see top left corner for slide theme)

Target % shares	Target £ allocations	ICB £ baselines	Convergence	Final £ allocations
<p>The allocations model calculates weighted populations (% target share) for each relevant funding stream. Each component part of the model contributes a need index or weighted population, combined in accordance with the relative spending these areas represent. Targets are affected by population changes, source data updates, new technology, formula improvements and NHS policy changes.</p>	<p>The NHS has a fixed resource. National budgets are set across various funding streams, depending on historic spend, need and current priorities.</p> <p>These include ICB ‘core’ allocations (hospitals and secondary care), Primary Medical Care (combining funds for GP practices and other Primary Care) and some Direct Commissioning.</p> <p>Target shares (%) are applied to total budgets to calculate individual ICB target allocations (£).</p>	<p>Baselines (current ICB budgets) are based on published allocations, including any relevant adjustments and additional funding.</p> <p>Starting with current budgets ensures a level of stability between years.</p> <p>Changes to budgets may include adjustments for boundary changes.</p>	<p>After base growth is applied to all ICBs, to offset common pressures such as population growth, convergence (previously ‘pace of change’) applies differential growth, to move ICBs below target towards their ‘fair share’ target allocation over time.</p> <p>It determines how quickly ICBs are moved from their baselines towards target, constrained by available resources and without creating instability which could damage local health economies.</p>	<p>A final ICB £ allocation, also expressed as £ per head (for comparison) includes any other additional allocations.</p> <p>The overall allocation provides ICBs with the autonomy to determine their own spending based on local need.</p>

Target shares: Based on statistical evidence

Individual data

The allocations formula is built up from analysis of **anonymised NHS data** regarding demographics of individuals and their use of NHS health services.

This person-based approach to calculating target shares helps ensure accuracy and takes account of local variation in health needs.

Informed by actual patient spending

Data from records of GP practice patients are linked to treatment records, to calculate overall cost of care.

Costs of health services for millions of real patients over a number of years are reviewed.

Statistical analysis identifies factors that can be used to predict future share of spending, for a given sex-age group in any GP practice in England (all data used are non-identifiable).



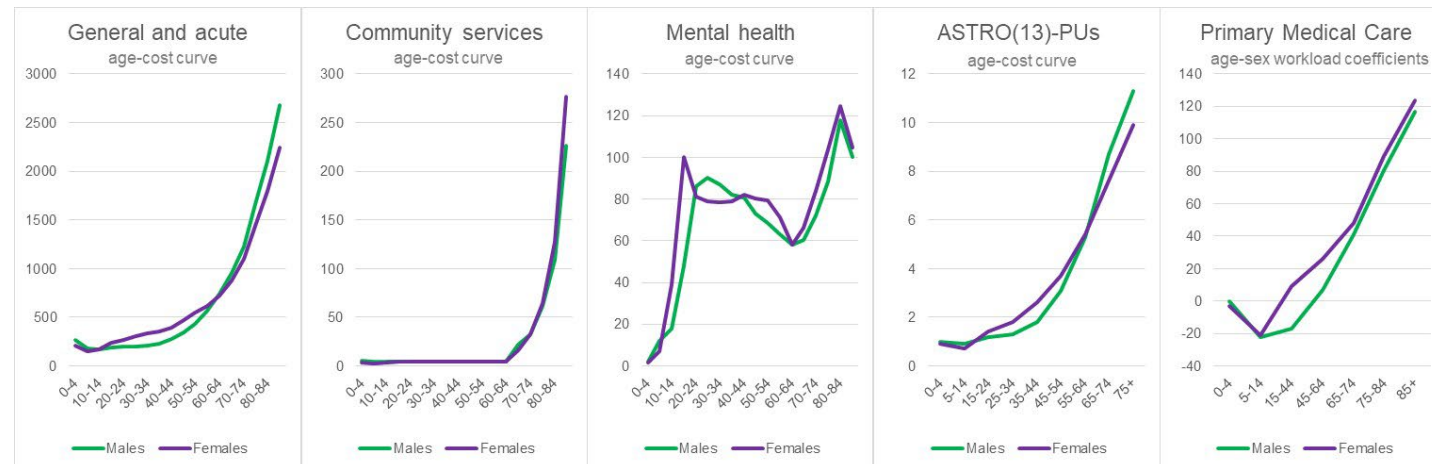
Testing predicted spending

These predictions are then re-tested on further patient data where costs are already known, allowing the model to be refined, then retested.

The measure of need derived from the person-based research is effectively the expected relative cost of specified healthcare services by age and sex in a GP practice.

Age cost curves to show predictions

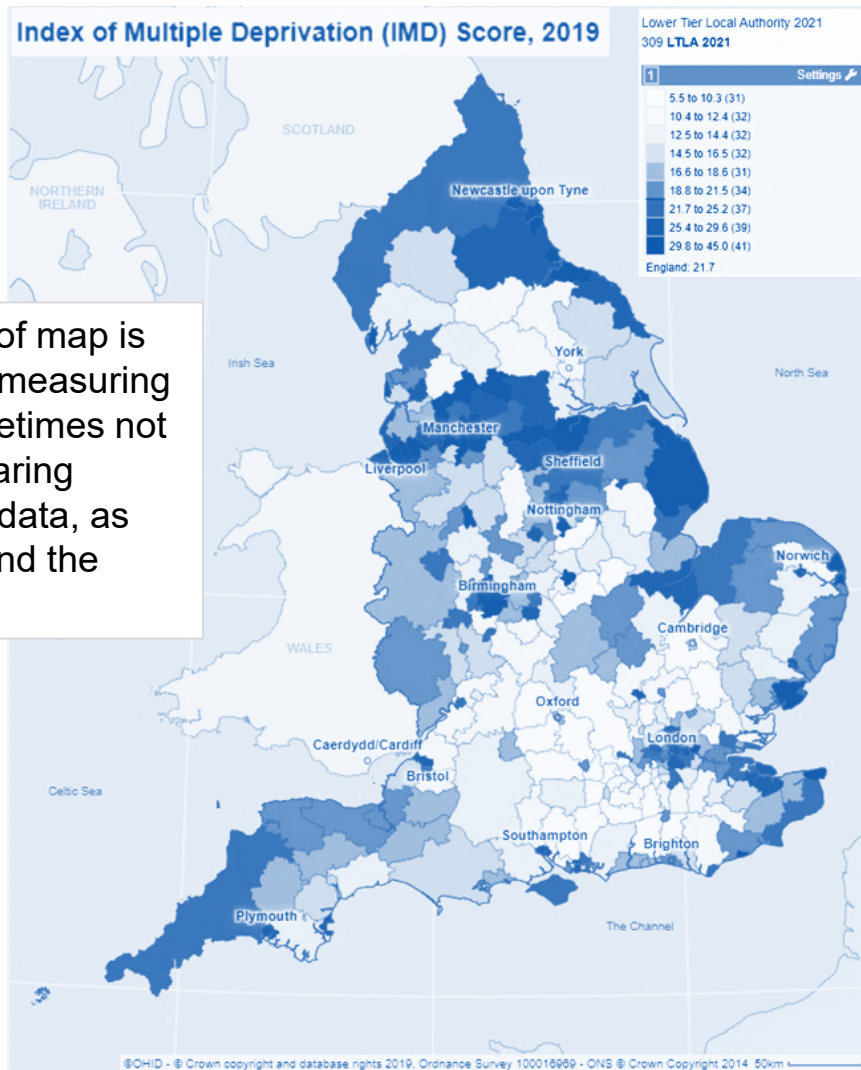
Different streams of spending on health services can vary significantly depending on age and sex. The graphs below show age-cost curves for the main parts of the allocations model. Full details can be found in the [Allocations Technical Guide](#)



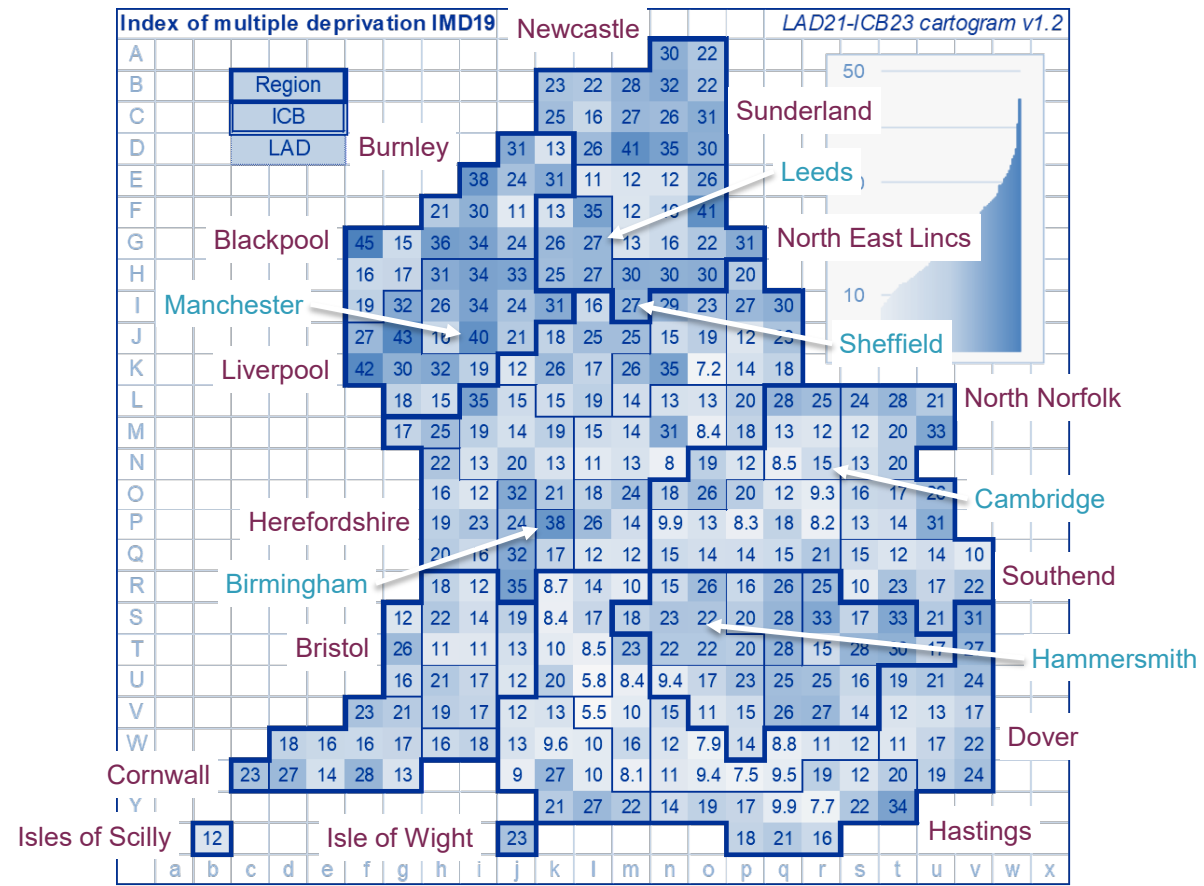


Target shares: Geographic variation in need

Both maps below show the same data - deprivation score by Local Authority District (LAD)



This familiar type of map is great for travel or measuring distance, but sometimes not so good for comparing population based data, as cities look small and the countryside vast.



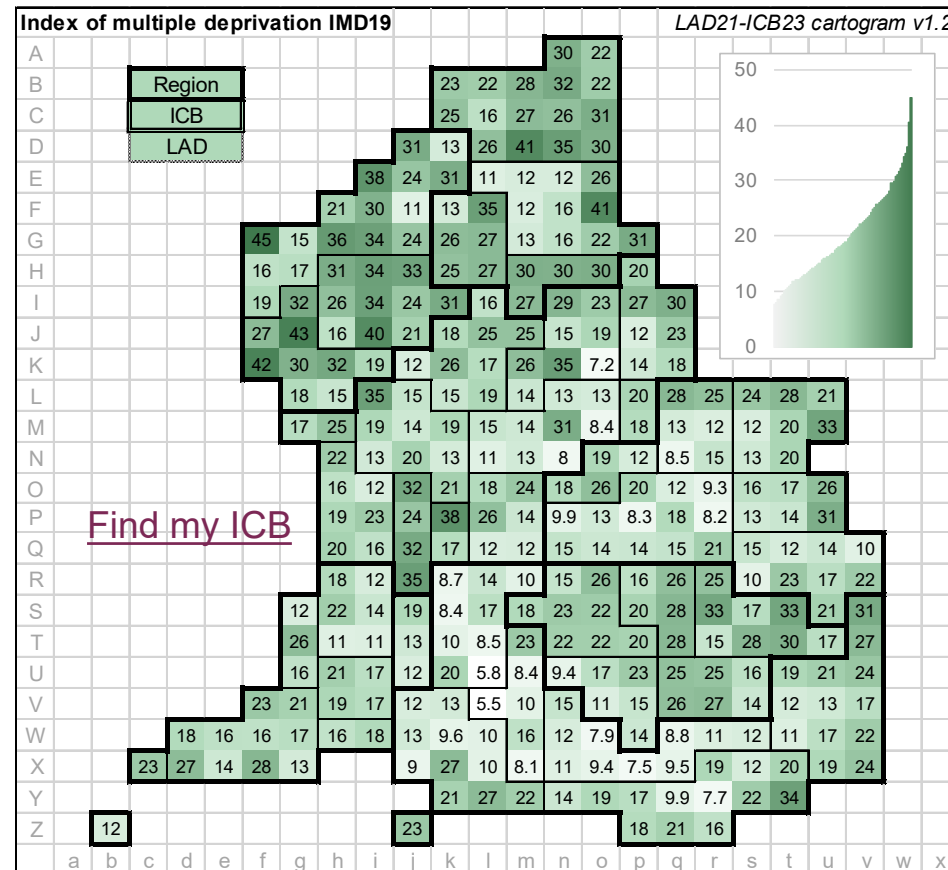
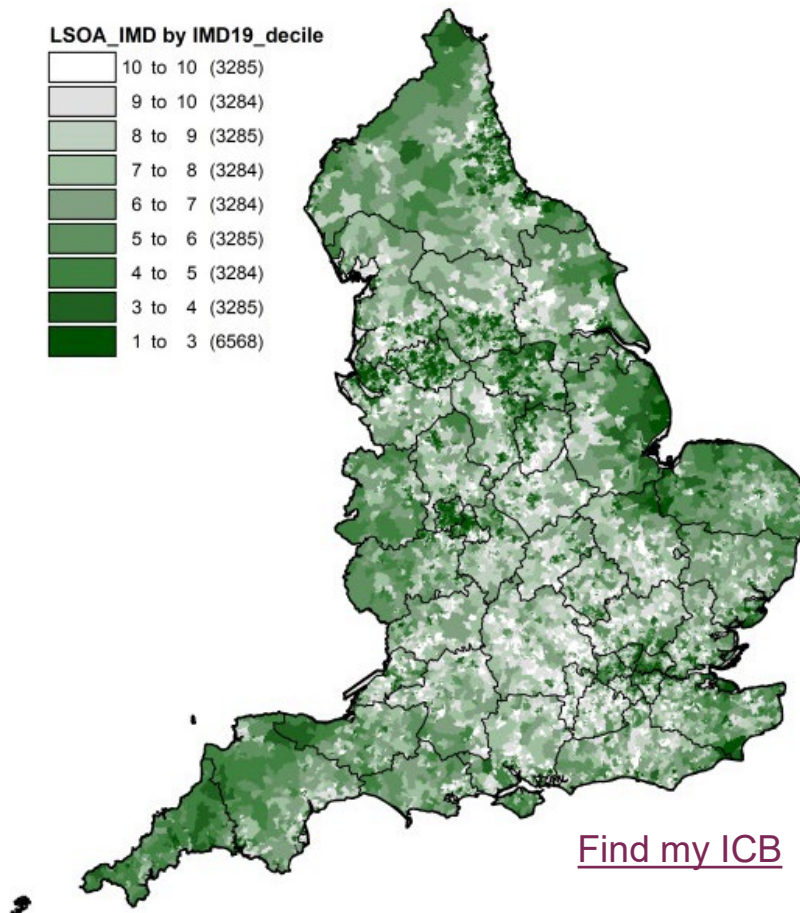
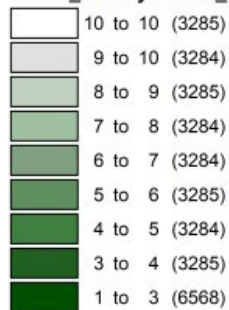
This cartogram assigns each Local Authority District (LAD) to one cell. Although more simplified, it maintains approximate relative positions. This map also builds up to ICBs and Regions, though not perfectly, as health and administrative boundaries do not always line up.



Target shares: Variation in need (deprivation)

Deprivation Score – Index of Multiple Deprivation (IMD 2019)

LSOA_IMD by IMD19_decile

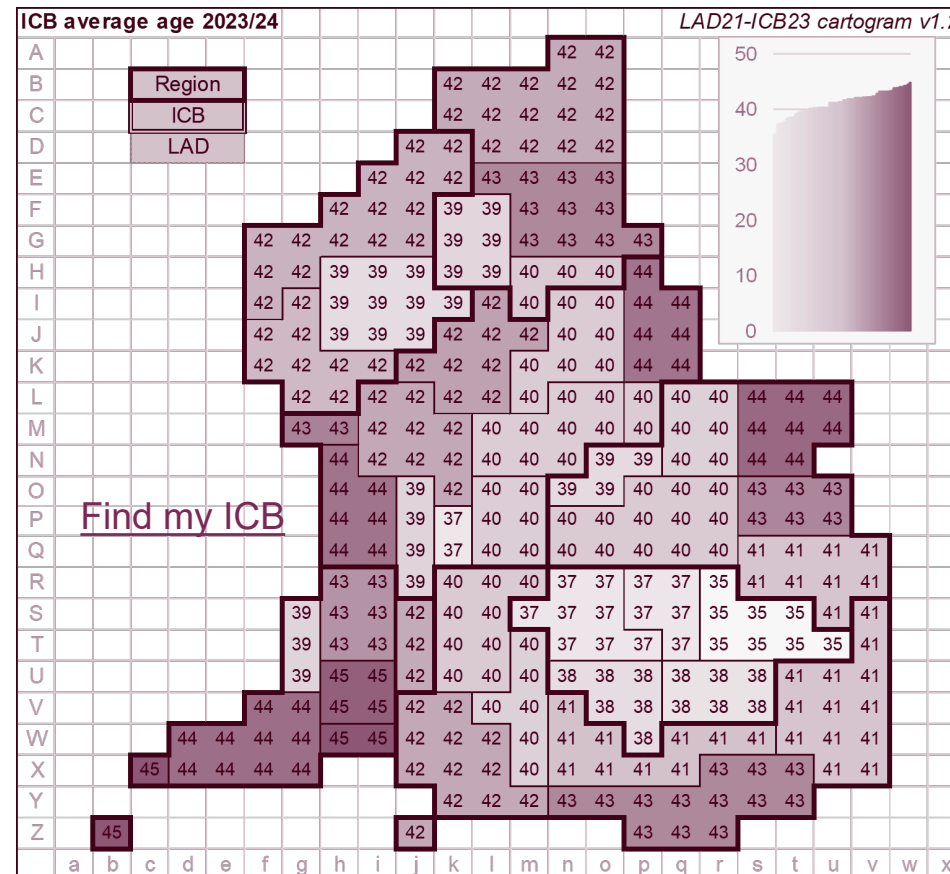
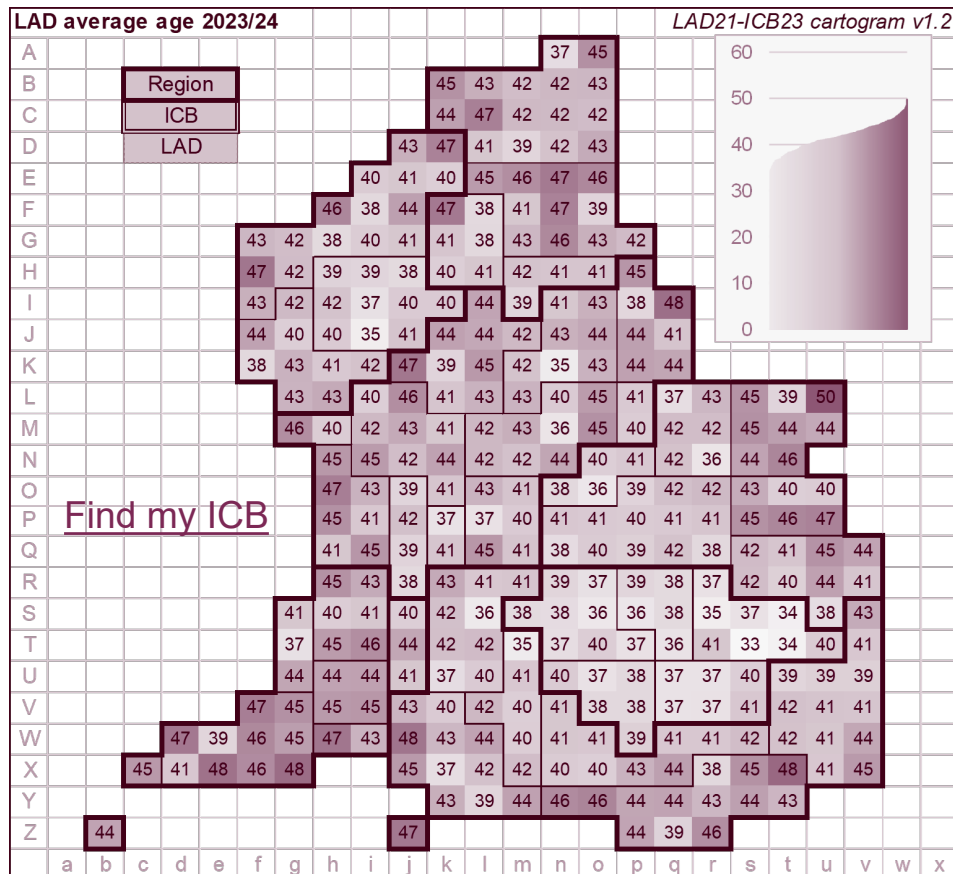


Deprivation varies significantly around the country. LOW deprivation scores (lightest colours) can be clearly seen in the areas around London, extending north through more rural areas of the central Midlands and Yorkshire. HIGH deprivation scores (darkest colours) are concentrated in the most dense urban areas, particularly within former industrial centres of the Midlands and north, but also in the more remote rural and coastal areas.



Target shares: Variation in need (age)

Age of population – average age



Urban areas show the lowest average age - young, mobile populations, but this also can correlate with areas showing high excess mortality. Average age is higher in more rural and coastal areas.

The picture is not so clear when data is aggregated at ICB level, because it hides local details. Within our models, we have used LADs (grouping GP practices by location) as a way of retaining this local variation, for example to calculate average need weights for new practices.

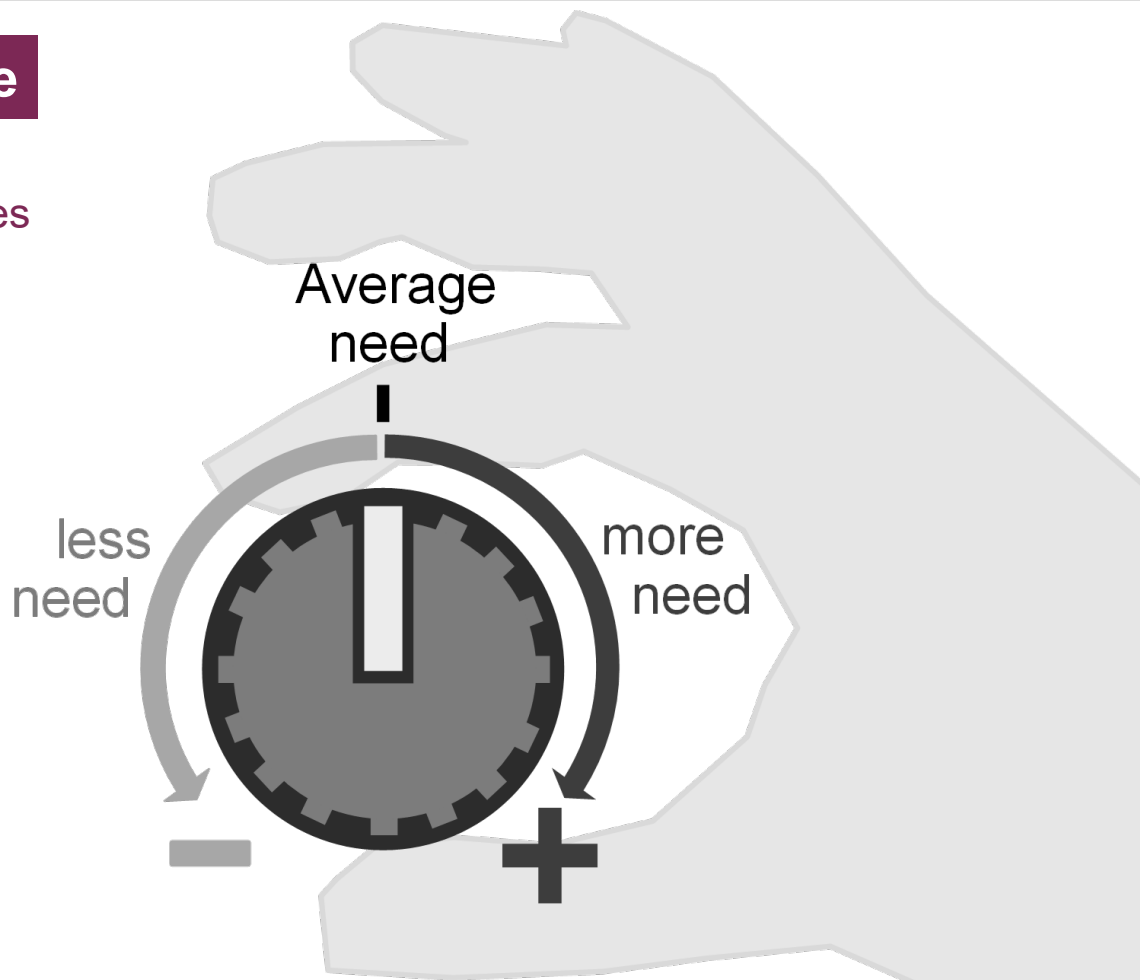


Target shares: **Need weighted populations**

Statistical evidence

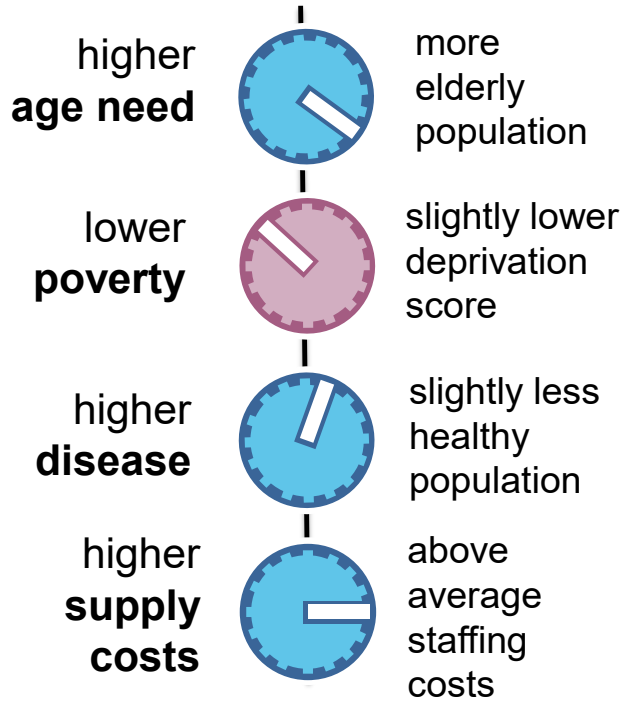
Research into variation of healthcare need determines the direction and level for each dial

These rotating dials are simply a way to illustrate the level of need in one ICB compared with all the others.
For example, turning the dial right represents higher need than average.



'Sunnyside'

This is an example area including some coastal resorts, popular for retirement.



Evidence of need can adjust an ICB share up or down

Statistical analysis of data regarding service use at patient level identifies factors which can be used to predict future costs. ICB levels for each dial would impact their % share, increasing it where need is high (dials to the right) and decreasing it where low (left).

Examples of need values

All the individual adjustments are combined with populations in the model to calculate an overall area target share.



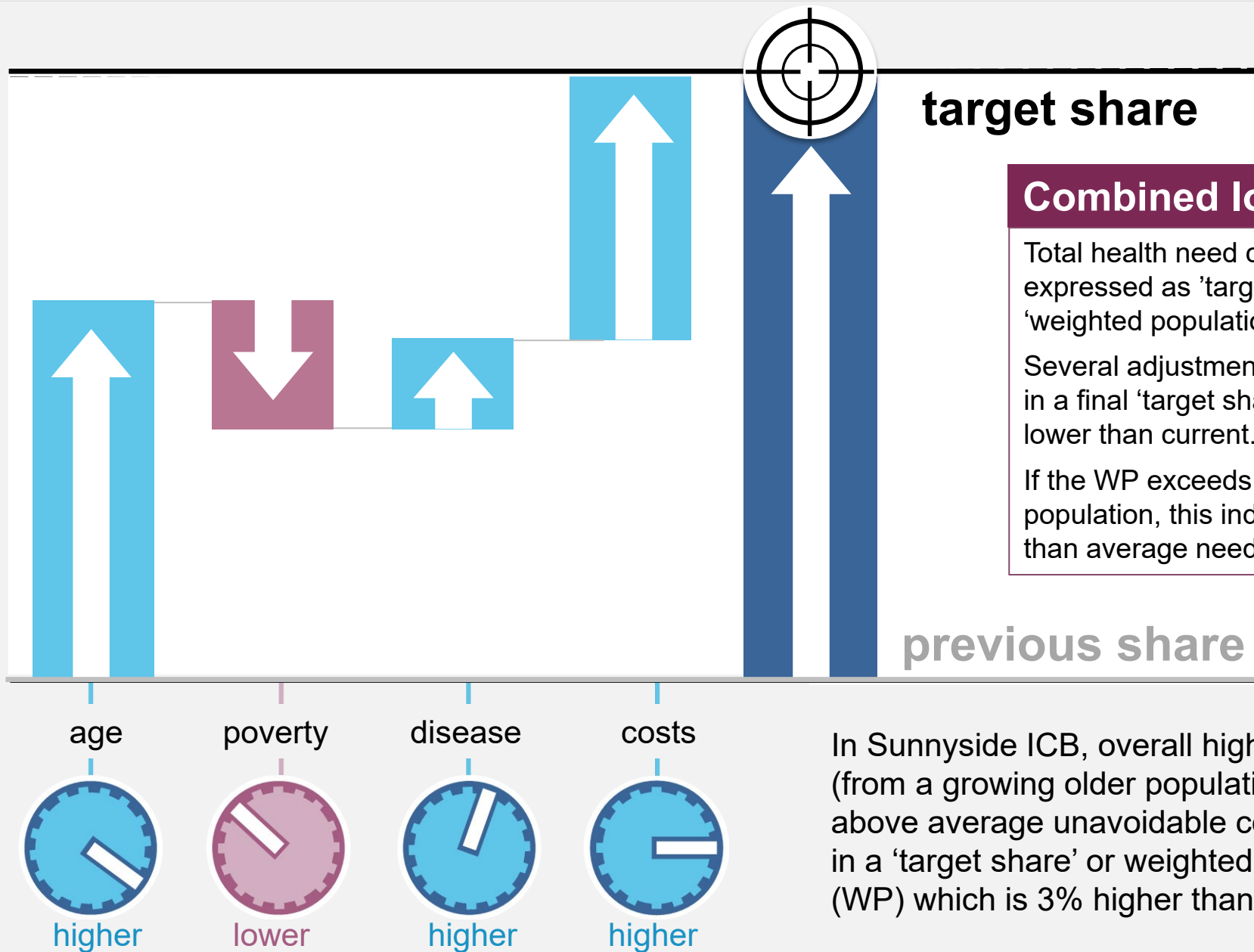
Target shares: Combining need weights

Waterfalls

Waterfall charts are useful to show cumulative impact of adjustments, by following their sequence through the model, applying each adjustment in turn.

Dial values (our simplified need weights) become bars on the graph, starting from the end point of the previous one.

We have created waterfalls by ICB to show the impact of components within the formula.



In Sunnyside ICB, overall high need (from a growing older population and above average unavoidable costs) results in a 'target share' or weighted population (WP) which is 3% higher than before



Target shares: **Components of formula**

The ICB allocations model is made up of 3 distinct formulae for which we calculate target shares

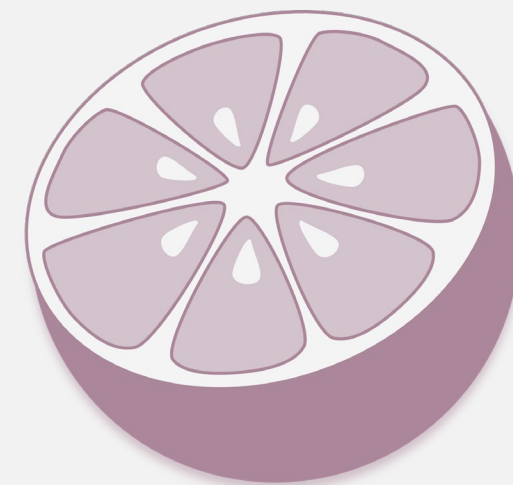
ICB Core Services

Primary Medical Care

Specialised Commissioning

The ICB core services model is made up of a number of components or ‘segments’:

General and acute	hospital inpatient, outpatient and A&E services
Maternity	services relating to births
Mental health	acute and community MH and LD services plus IAPT services
Community services	district nursing and intermediate care
Prescribing	costs of medicines prescribed in primary care
Remoteness, MFF, PFI	unavoidable costs of delivering services, including <u>MFF</u> and <u>PFI</u>
Health inequalities	adjustment based on rates of avoidable mortality



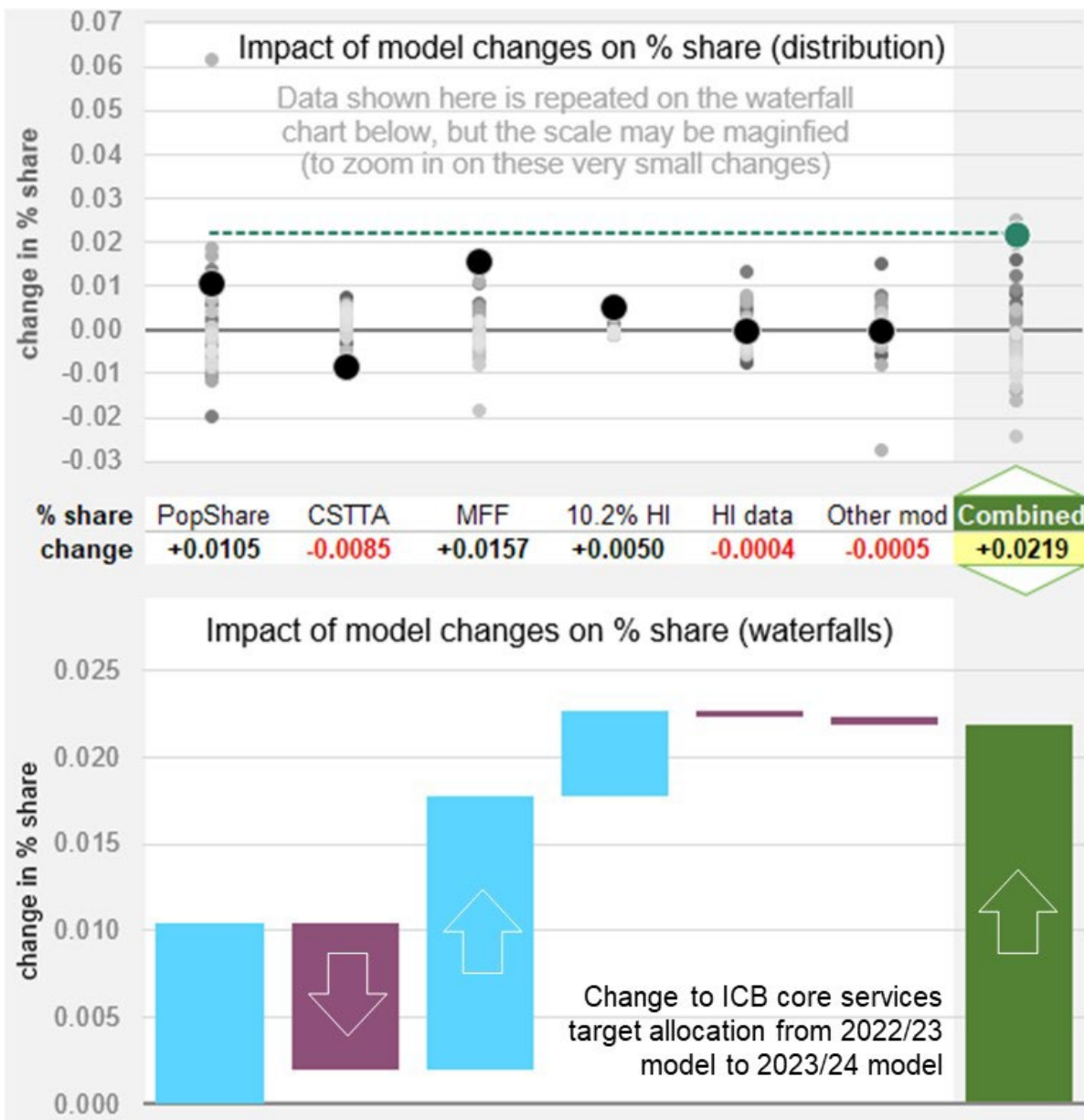
Any part of the model may be affected by local population demographics.
For example, sex, age, morbidity (number and severity of physical and mental health conditions), rates of disability, excess deaths and deprivation, plus wider factors associated with health needs including housing status and unemployment.

For each distinct formula a health inequalities and unmet need adjustment is added.

Analysis overseen by ACRA (Advisory Committee on Resource Allocation) is used to define the metric, but the weighting of the adjustment (within overall target allocations) is a policy decision determined by NHS England.



Target shares: **Impact of model updates**



Impact on target share

The impact of component updates on the ICB's % share can be shown in a 'waterfall chart'. Individual changes stack on top of each other, building up to the final target share.

Although the waterfalls look dramatic, the scale reveals that in 2022/23 the effects of data updates in the model are very small.

The scatterplot shows the same changes, including comparable values for other ICBs (grey dots) to give a sense of scale.

These graphs are part of a wider dashboard [shown on slide 36](#) which also includes context of baseline changes and demographics

[Link to waterfall charts for all ICBs](#)

	Impact of model component changes 2022/23
PopShare	Changes in population share
CSTTA	Community services travel time adjustment
MFF	Market forces factor update
10.2% HI	Change to 10.2% health inequalities weighting
HI data	Update to health inequalities data
Other mod	Other data, model component and population changes
TOTAL	Cumulative effect of baseline/ model changes

Waterfalls



Target allocations: Summary of adjustments

	ICB Core Services	Primary Medical Care
2023/24	£101.7 billion	£10.6 billion
Need adjustments <i>% of overall spend shown, though needs may vary for services across the country</i>	69.6% General and acute 11.8% Mental Health 9.3% Prescribing 5.6% Community 3.7% Maternity Utilisation models 89.8%	100% Formula No other adjustments Utilisation models 85%
	<i>Health inequalities and Unmet need</i> 10.2%	<i>Health inequalities and Unmet need</i> 15%
Cost adjustments <i>Estimate of effects on healthcare spend of unavoidable cost differences between health care providers, based on location</i>	Staff and buildings Market forces factor (MFF)	Staff and buildings Market forces factor (MFF)
	Transport in rural areas Emergency ambulance cost adjustment (EACA)	Supply factors In calculating the target allocation, only the health needs of the population are taken into account. 'Supply factors' such as the number of hospital facilities available, shouldn't influence that estimation of the level of need. However they might affect how much healthcare people receive, so we measure those factors and then neutralise them in an area's allocation calculation. This helps to balance the funding between urban and rural areas.
	Inefficiently small hospitals Unavoidable remoteness	
	Historic private contracts in trusts Unavoidable costs of Private Finance Initiative (PFI)	

Each formula within the model represents a national budget stream.

Within each formula, segments may include evidence of variation in 'need' or 'cost'.

The relative weight of health inequalities and unmet need is determined by the NHS England Board.

Weighted populations are calculated for each component/ segment.

The **target allocations** are a combination of the target shares (need adjustments), their relative weight and cost adjustments.

Impact of each segment is determined by relative spend.





Baselines: **Where do we start?**

Approach

As a starting point for calculating final allocations, we need to understand the current position for each ICB, to see how it compares with their new **target allocation** (an expression of what would be a fair share based on need, if there were no other constraints). We refer to the current position as the **baseline**.

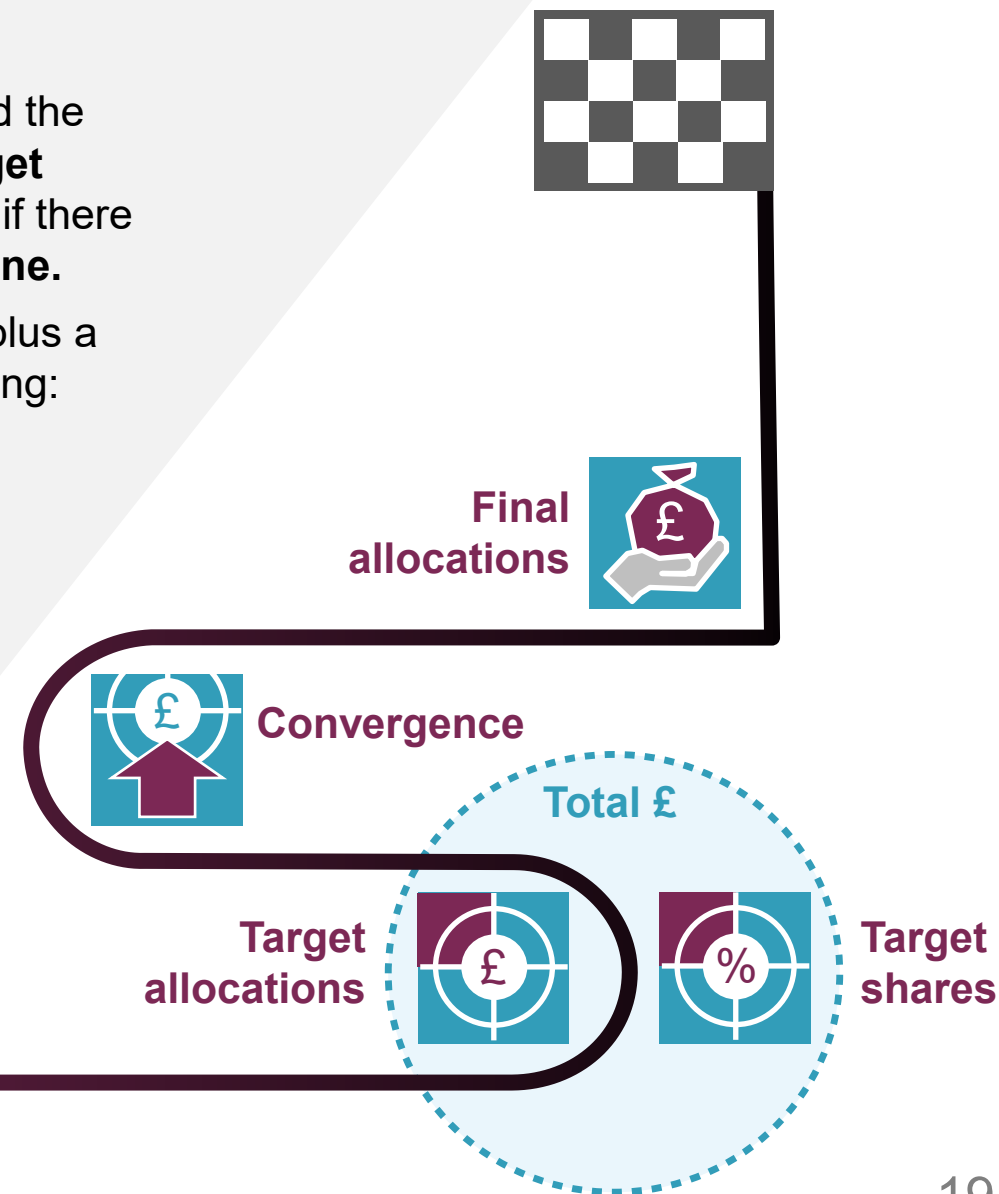
The baseline for 2023/24 is based on the published 2022/23 allocation, plus a number of adjustments ([see slide 36 for their relative importance](#)) including:

- additional funding for maternity and health inequalities
- corrections for recurrent adjustments made in 2022/23 for inflation and pay
- a baseline reset, to address some residual issues from legacy funding flows in the COVID emergency financial framework
- locally agreed transfers and population adjustments

You are here



baseline

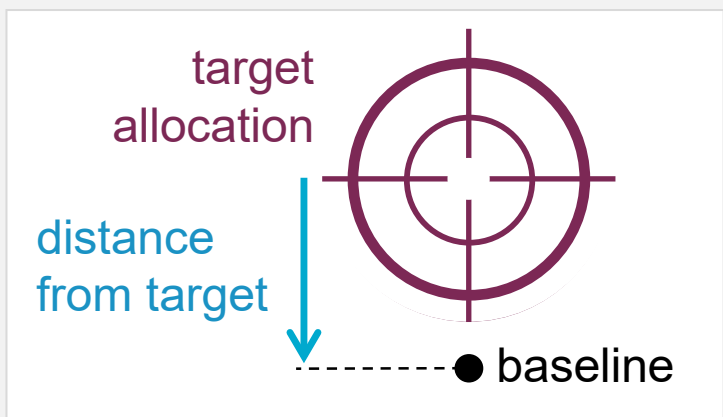




Convergence: **Convergence core ideas**

Distance from Target (DfT)

DfT is the gap between an ICB's baseline and target allocation. Baselines that are significantly below target indicates a much higher need than their current budget, so additional growth is required.

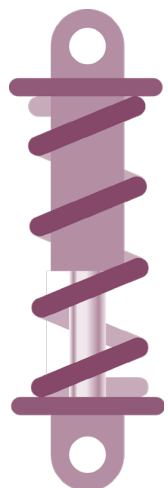
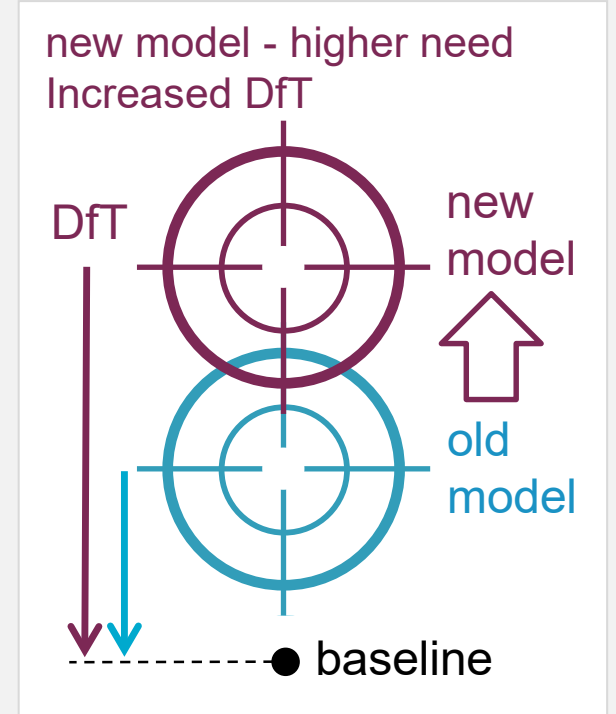


Change in DfT

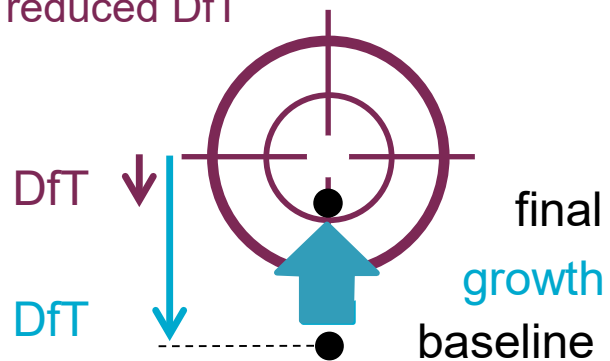
Each revised model produces new target allocations, which may have changed.

Updated populations and other data, along with improvements and revisions in the formula, cause target allocations to move (higher need in diagram).

Compared with the same baselines, updated models produce revised targets and therefore a change in DfT.



baseline moved towards target
reduced DfT



Convergence (previously called 'pace of change')

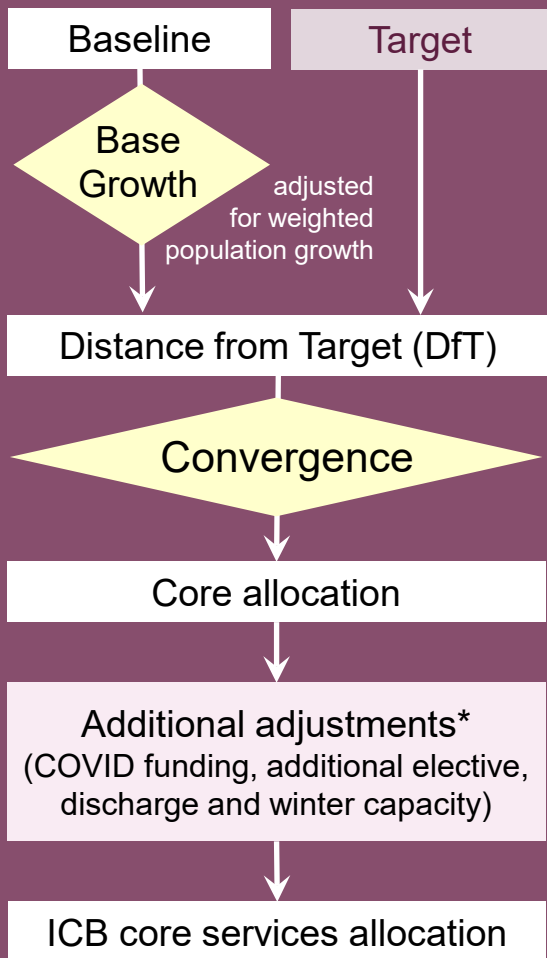
Targets can change due to improvements in the formula or unexpected changes in underlying data, so using them directly could create shocks to budgets.

To dampen this effect, final allocations are based on applying growth to the baseline to move towards the target, rather than moving directly to target (even if resources allow). The level of growth is set according to convergence policy. This is done for each major component of the model, to calculate minimum allocations within each stream.

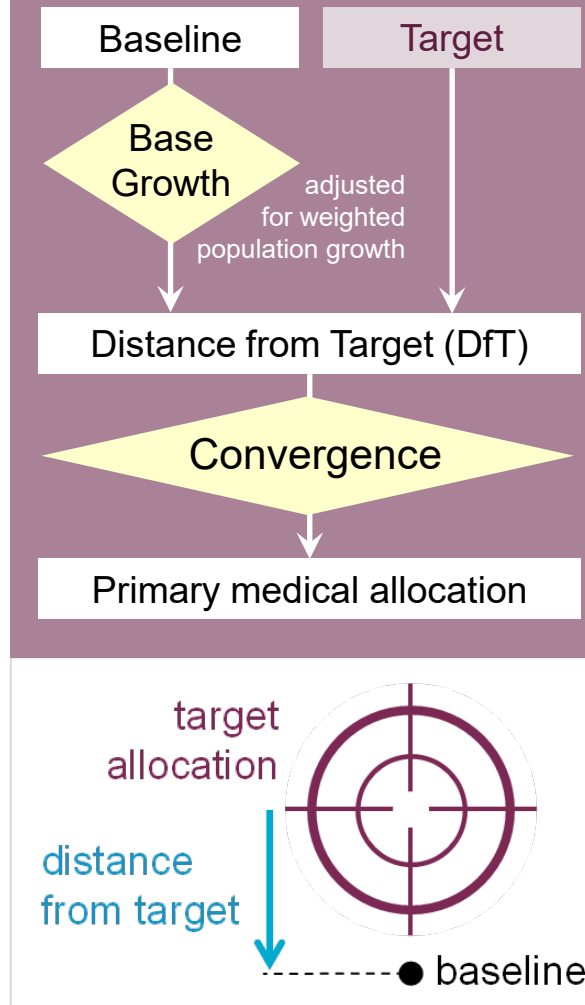


Convergence: **Convergence calculations**

Core Allocations



Primary Medical



Convergence

Distance from target (DfT) is the gap between the Baseline and Target allocations.

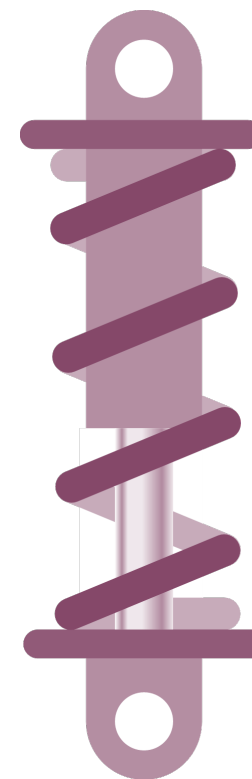
After base growth is applied to all ICBs, to offset common pressures such as population growth, convergence applies differential growth, to move ICBs below target towards their 'fair share'.

Key considerations

Finding a balance between reducing disparity in DfT, minimizing budget volatility and staying within available resources.

Pace of change is gradual, so that the adjustment in an ICB's allocation will not destabilise the short-term provision of services and maintains value for money.

Convergence is applied to the main funding streams separately.



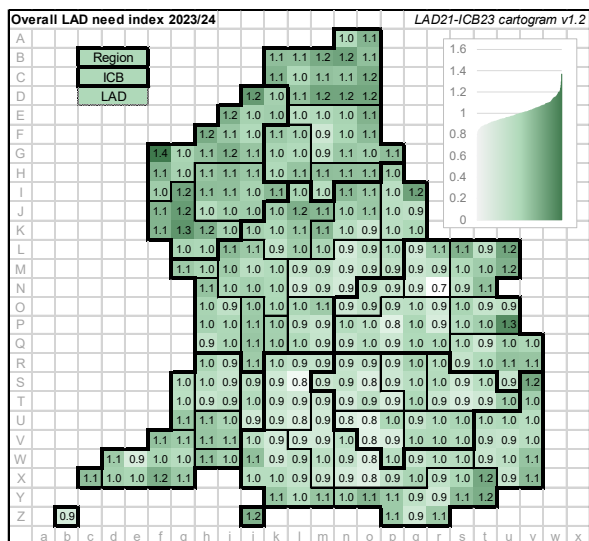
Note*: Additional funding adjustments in 2022/23 for health inequalities and maternity are now included in recurrent allocations for 2023/24



Final allocations: Getting there from here...



Need index by LAD

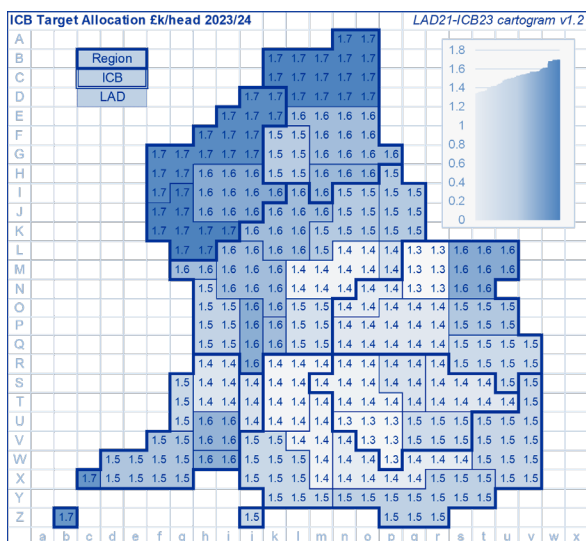


darker shading = higher relative need

This shows the effect of the combined 'need weights' in the formula, or relative health need across the country.

Although the cartogram shows LAD local variation, the ICB average need index (from ICB weighted populations) determines the target shares.

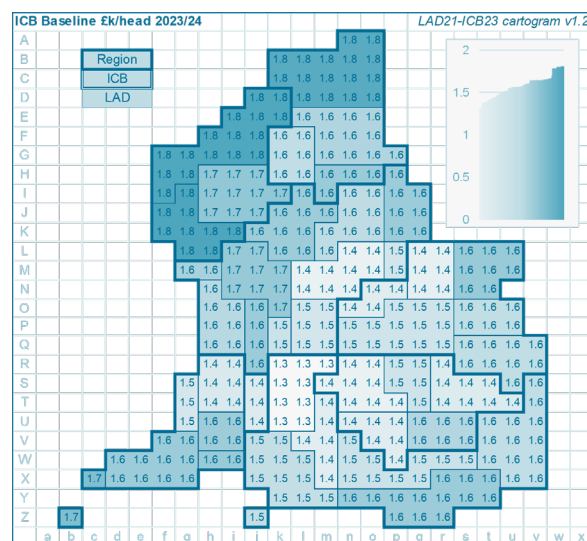
ICB target allocations



darker shading = higher £ target

Once the total budget is confirmed, the weighted populations (or target shares) can be used to calculate target allocations for each ICB (£ thousands per head). ICB value is shown above.

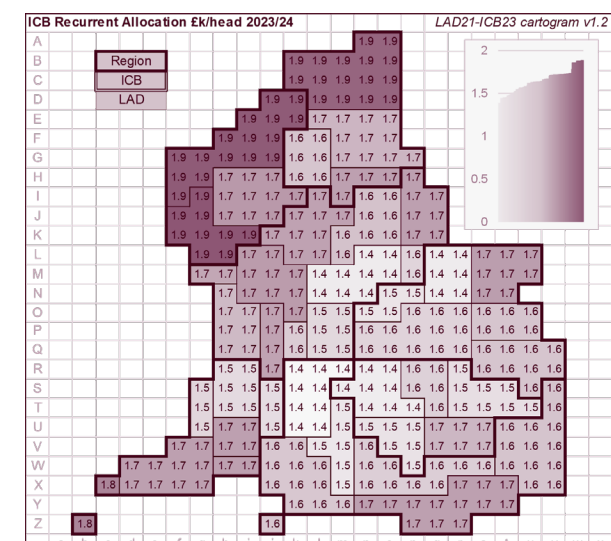
ICB baselines



darker shading = higher £ baseline

Current baseline spend per head from previously published allocations, including relevant adjustments

ICB final allocations



darker shading = higher final £ allocation

Final allocations, aside from being subject to convergence, may also include other funding streams.

[Find my ICB](#)



Final allocations: Summary of recent updates

Summary of recent updates

	Process	Description	2022/23 allocations	2023/24 allocations
1	Base population and projections	GP registered patients (12 month average), growth uses ONS age-sex-LAD projections	Used Oct 2021 registrations (issues during pandemic). Boundary changes in the Midlands, transfer from CCGs to ICBs in July 2022.	Return to annual average GP registrations (Nov 2021 to Oct 2022). One GP transfer and a small boundary change.
2	Adjustment for age	Apply evidence that elderly and very young have higher healthcare need	General & Acute services (data update and revised methodology).	-
3	Adjustment for need (over and above that due to age)	Apply evidence of higher need due to health status, morbidity, deprivation	General & Acute services (data update and revised methodology). New use of LAD average for missing values in older models.	Community services – introduction of Travel Time adjustment (for district nursing part)
4	Adjustment for unavoidable differences in costs	Neutralise unavoidable costs of providing services due to geography (using MFF, sparsity adjustment)	Update to adjustment for unavoidable small provision in remote areas, and addition of some Private Finance Initiative (PFI) costs	Update to values of Provider Trust Market Forces Factor (MFF) and remapping to LAD and GP practice (spend weighted average)
5	Health inequalities HI and unmet need adjustment	Adjustment based on rates of avoidable mortality	Health inequalities metric changed to use 'avoidable mortality' (instead of SMR<75)	Change in the weighting of adjustment from 10.0% to 10.2% (ICB core services)
6	Combine adjustments above	Bring together the above to get overall weighted population or target % shares	Revised expenditure weights	Revised expenditure weights
7	Calculate Target Allocation (% shares changed to cash)	Weighted population (% share) determines target allocations, by applying available quantum	-	-
8	Set baselines	Baseline starts with latest published allocation, plus relevant adjustments	Used later half of 2021/22 (x2), with system top-up and growth funding (glide path quantum). Applied boundary changes (and CCG to ICB)	Locally agreed transfers, corrections for 2022/23 adjustments (inflation and pay), population adjustments and baseline reset
9	Apply convergence	Compare baseline with target allocation (Distance from Target DfT) and move ICBs towards target, while maintaining stability and staying within budget	Convergence was previously referred to as 'pace of change', revised process for ICB allocations.	-



Fair shares: Glossary of terms

Term used	Description
ACRA	Advisory Committee on Resource Allocation (independent expert advisory group) also with Technical Advisory Group (TAG)
Allocations	Annual recurrent revenue funding, allocated to an ICB to commission services
Allocations model	Complex set of formulas which combine to calculate target shares
Baselines	Latest available updated ICB budgets (including in-year adjustments)
CCG	Clinical Commissioning Groups (former statutory commissioning organisations, closed June 2022)
Commissioners	Organisations which plan, fund & monitor healthcare for their population
Convergence	Process of gradually moving budgets towards calculated target allocations
Distance from target	Difference between calculated target allocation (ideal) and baseline or final allocation (actual)
Healthcare need	Measure of relative cost of healthcare (expressed as a weighted population or need index, above or below 1 as an average)
ICB	Integrated Care Boards (42 statutory commissioning organisations, from July 2022) (Find your ICB)
ICP	Integrated Care Partnerships – Statutory committees between ICB, LAs and a broad alliance of partners - see full definitions
ICS	Integrated Care Systems – 42 partnerships of health and administrative organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.
LA (UTLA)	Local Authority (Upper Tier LA) – higher level administrative geography
LAD (LTLA)	Local Authority District (Lower Tier LA) – lower level administrative geography. (Find your LAD)
LSOA	Lower Level Super Output Areas – ONS geography hierarchy for small area statistics (population around 1,500)
MSOA	Mid-Level Super Output Areas - ONS geography hierarchy for small area statistics (population 2,000-6,000) – fit within LAs
Market Forces Factor (MFF)	Estimate of unavoidable cost differences between providers, based on location, buildings and staff
Normalised	Weighted populations adjusted so that they add up to the original total, maintaining the calculated % share
Providers	Organisations providing healthcare services to the NHS – for example acute, ambulance, community, mental health, specialist, private and voluntary
Private Finance Initiative (PFI)	Method of funding public capital projects using private investment to pay for upfront costs of design, build and maintenance.
Target allocation	Target share applied to national budget – nominal 'ideal' share of budget (£)
Target share	% share of overall budget, expressed as weighted population
Weighted population	Population x need (normalised to the total registered population)
Unmet need	Hidden need, for example unawareness of a health issue lack of service provision



Annex

Background and methods

Allocations infographics v3

Updated for ICB resource allocations 2023/24



Input data: Update to baseline populations

Annual average populations

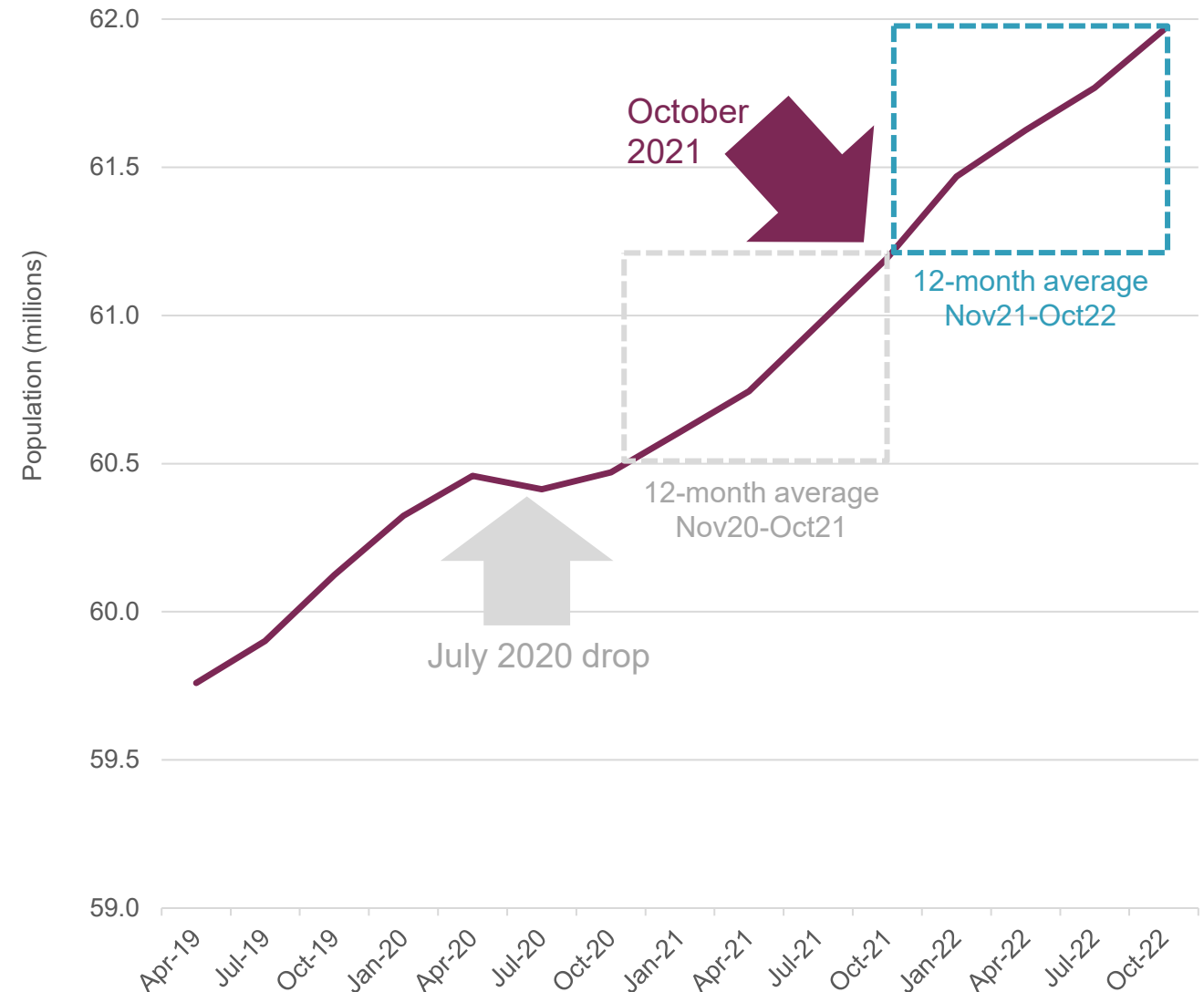
For the 2023-24 allocations, we have reverted to 12 month average registrations by GP practice, which takes account of areas with wide seasonal variation (students or temporary workers).

The model includes a cohort of all practices that were active in any part of that year (with the calculated average including 12 months for all practices).

COVID-19 and 2022/23 allocations

There was some concern that the registration growth during the pandemic was unstable, particularly following a rare drop in registrations in July 2020, which prompted use of Oct 2021 only for 2022/23 allocations. As growth has continued to recover, ACRA has recommended that we reinstate our previously agreed approach for 2023/24 12 month average (Nov21-Oct22)

Number of patients registered at a GP practice in England April 2019 – October 2022 (by quarter)





Input data: Projecting future GP registrations

To project allocations for future years, we need to estimate how GP practice populations are likely to change.

Registered populations

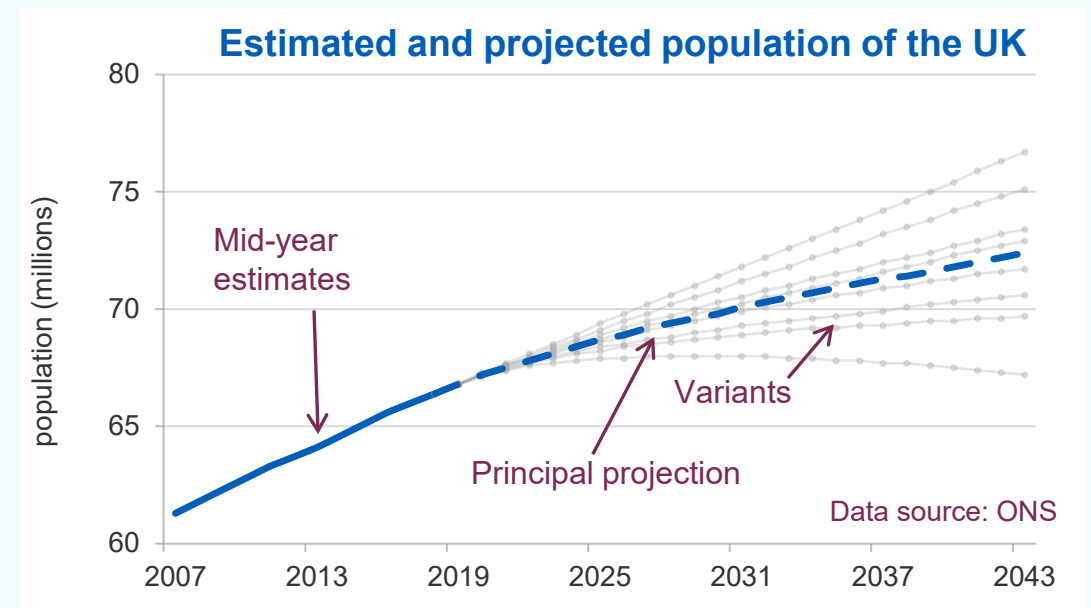
Populations used in the allocations model are 'Patients registered with a GP Practice', published monthly by NHS Digital. These are used because ICBs are responsible for the patients registered in their associated GP practices, rather than geographic area of residence.

Future projection estimates

We apply the most recent percentage annual growth by local authority (ONS) to the latest available GP registrations for 5-year age and gender groups, to estimate how these populations will change over the next couple of years. This allows us to project allocations forward for 2-3 years.

Resident populations

The Office for National Statistics (ONS) publishes population projections for resident population estimates at local authority level, from which we calculate projected percent annual growth at system level, on a consistent basis across England 2011 Census populations roll forward each year by adding births and net migration and subtracting deaths (small area). Trends for fertility rates, death rates and net migration are then used (every 2 years) to project forward into the future.





Input data: Issues with GP registrations

Cross-boundary flows

When using ICB populations, it is important to know whether we are referring to **residents of a geographical area** or **GP practice membership**.

These two groups overlap. Counts of GP patients can be mapped to either, as they include LSOA (small area) of patient residence. Comparing these can indicate the amount of cross-boundary flows between ICBs or across the borders with Wales and Scotland.

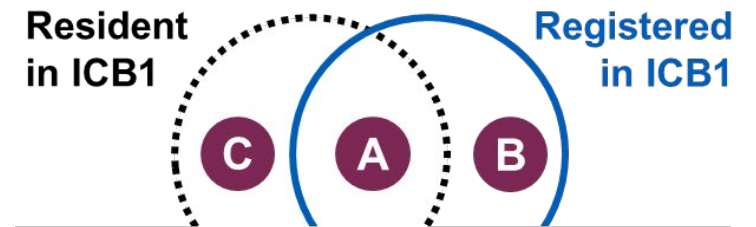
In some cases, the formulae of the allocations model include an adjustment for the ratio of registered and ONS populations.

Migration and over-coverage

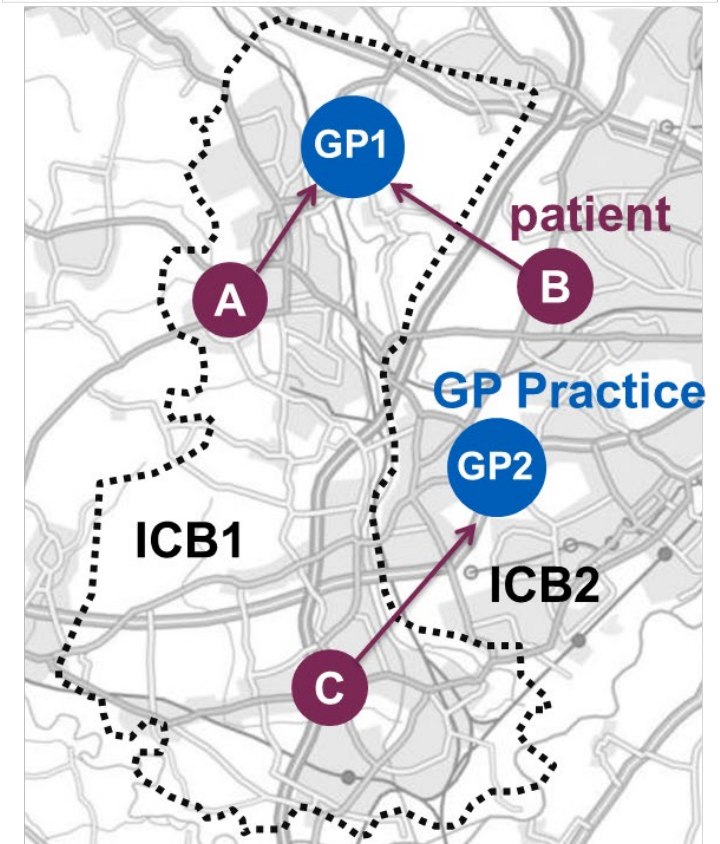
Nationally the number of registered patients exceeds the ONS population estimate (based on 2020 population estimate) by 5%.

Differences may be due to data issues, short term migration or over-coverage (including 'ghost patients' not removed from GP practice lists when they move away or die).

However, these extra patients have no effect on the total amount allocated, which is set first by NHS England and then shared across all ICBs (rather than setting a specific budget per patient, which could result in uncontrolled totals)

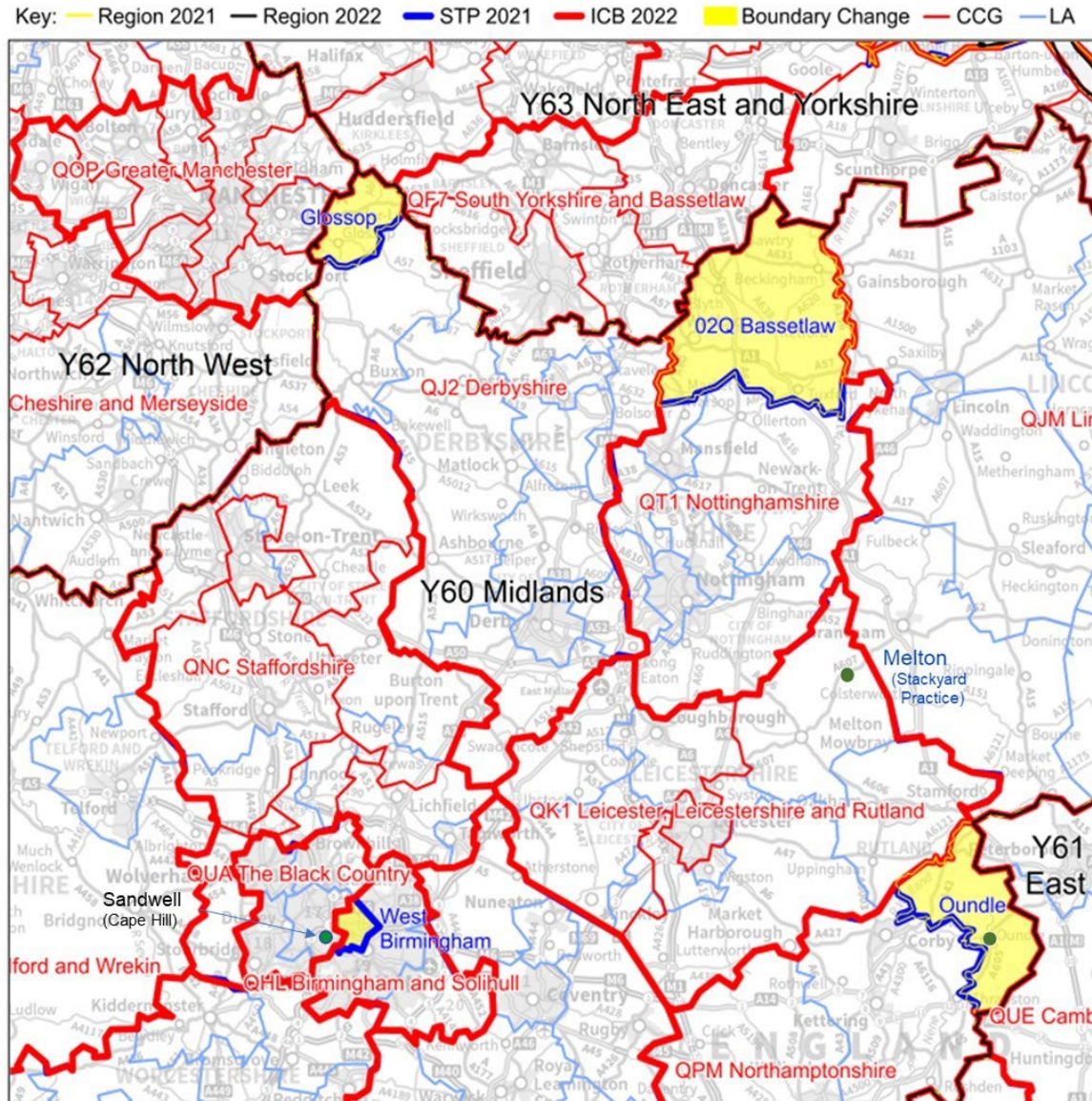


- A – The vast majority of patients live in the ICB where their GP has membership
- B – Some come in from another ICB
- C – Some go to a GP in another ICB





Input data: **Boundary changes, revised baseline**



Contains National Statistics data and OS data © Crown copyright and database right 2021

Legal transfer from CCGs to ICBs

The Health and Care Act 2022 included the transfer of commissioning responsibility (in July 2022) from 109 Clinical Commissioning Groups (CCGs) to 42 Integrated Care Boards (ICBs)

Applying boundary changes to older data

The map shows some major boundary changes in July 2022, to align some Midlands CCGs/ ICBs with their Local Authorities. These changes also had to be applied to 2021 CCG baselines to make them comparable with new 2022/23 ICB target allocations.

When there are boundary changes financial adjustments to baselines must be agreed by ICBs. Estimating the weighted population for transferring practices may be helpful. The [ICB place based tool](#) can be used for this.

For 2023/24 allocations there were no major boundary changes. Just a small LSOA correction in the South East and a legacy GP practice move in Birmingham. See [Workbook X](#) (current or previous) for details.



Input data: Importance of diagnosis coding

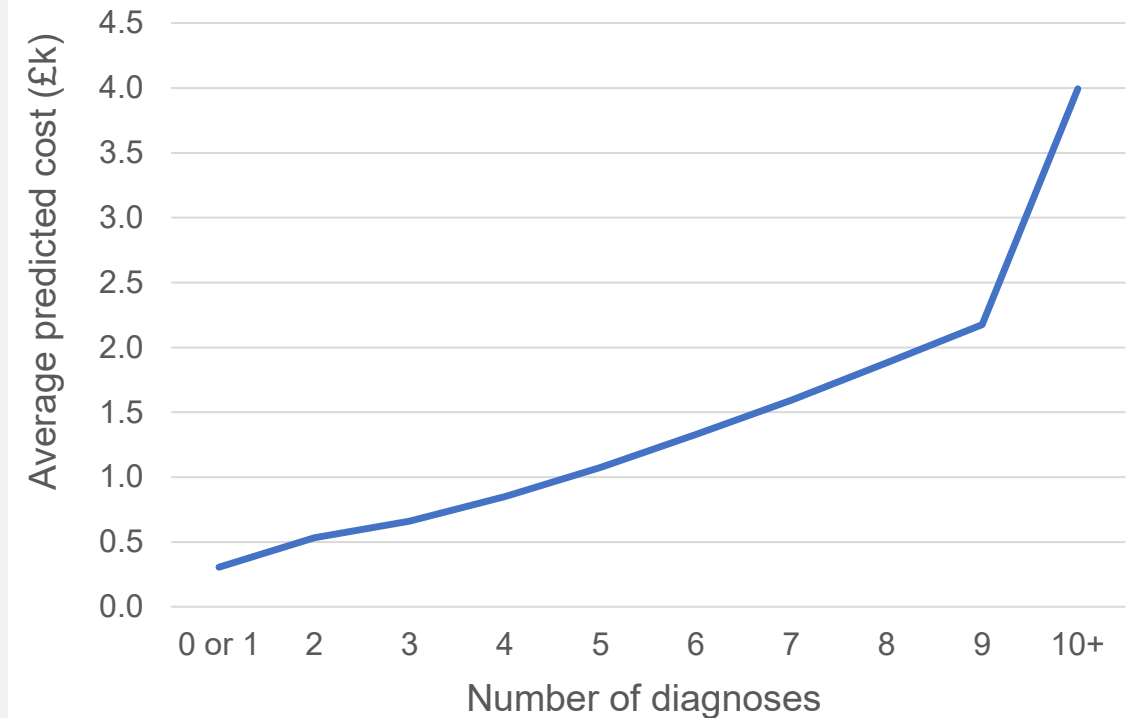
Accurate coding of diagnosis / treatment

Providers and commissioners should recognise the importance of accurate coding of diagnoses.

Previous morbidity indicators (historical diagnoses) are one of the most important factors in determining need for health care.

The development of the general and acute model has demonstrated the impact that the depth of coding can have on allocations and the distribution of resources. The chart shows the importance of the relationship between number of different historic diagnoses and average predicted costs from the general and acute model, showing the importance of comorbidities in predicting future need for health care.

Predicted average costs for general and acute services for people with different numbers of historic diagnoses recorded



Any drop in the quality of recording of diagnostic information will affect the ability to accurately model need and so may have an adverse impact on the robustness of the target allocations. A change in diagnostic recording practices at an individual provider or system level will have an impact on the target fair share for the system.



Target shares: Understanding the formula

At the heart of the ICB allocations model is a mathematical formula, which includes plenty of mathematical symbols and Greek letters, so on first sight can seem a bit intimidating

$$\widehat{C}_p = \widehat{\alpha} + \frac{\sum_{i \in p} (\sum_j \widehat{\beta}_j N_{ipj})}{L_p} + \frac{\sum_{i \in p} (\sum_k \widehat{\gamma}_k S_{ipk})}{L_p}$$

To understand what's going on, let's look at each part and build up the formula gradually...

The formula is based on lists

Subscripts (*in maths called 'indices', plural of 'index'*) denote the position in a list (index is like an ID or Key in a database)

List of practices (indexed by p)

Index (p)	GP practice
1	practice 1
2	practice 2
.	.
p	practice p
.	.
.	.

Each GP practice has an associated list of patients

The number L_p tells us how many patients are registered at practice p

List of patients registered at practice p (indexed by i)

Index (i)	patient
1	patient 1
2	patient 2
.	.
i	patient i
.	.
L_p	patient L_p

There are also needs variables N (indexed by j), which have 3 indices

N_{ipj} is the needs variable for the i^{th} patient at practice p and the j^{th} needs variable

List of variables for patient i at practice p (indexed by j)

Index (j)	Needs variable
1	N_{ip1}
2	N_{ip2}
.	.
j	N_{ipj}
.	.

The same applies for any supply variables S, (indexed by k)

Again S_k has a different value for each patient i at practice p, hence S_{ipk}

List of variables for patient i at practice p (indexed by k)

Index (j)	Supply variable
1	S_{ip1}
2	S_{ip2}
.	.
k	S_{ipk}
.	.



Target shares: Constructing the formula

Building blocks required

Σ is a mathematical symbol meaning sum

\widehat{C}_p is what we want to know – cost per head at GP practice p

$\widehat{\beta}_j$ and $\widehat{\gamma}_k$ are the predicted coefficients associated with each needs and supply variable respectively – these are the results of the regression modelling

$\widehat{\alpha}$ is a predicted constant term – could consider this as a fixed cost per patient (if all needs and supply variables were zero, then $\widehat{C}_p = \widehat{\alpha}$)

Cost per head at practice p

fixed cost per patient

$$\widehat{C}_p = \widehat{\alpha}$$

(if all needs and supply variables were zero)

Total needs based cost for patient i at practice p

$$+ \frac{\sum_{i \in p} (\sum_j \widehat{\beta}_j N_{ipj})}{L_p}$$

Average cost over all L_p patients at practice p from needs variables

Averaging (add up cost for all patients and divide by number of patients)

Total supply based cost for patient i at practice p

$$+ \frac{\sum_{i \in p} (\sum_k \widehat{\gamma}_k S_{ipk})}{L_p}$$

Average cost over all L_p patients at practice p from needs variables

Averaging (add up cost for all patients and divide by number of patients)

Final formula

$$\widehat{C}_p = \widehat{\alpha} + \frac{\sum_{i \in p} (\sum_j \widehat{\beta}_j N_{ipj})}{L_p} + \frac{\sum_{i \in p} (\sum_k \widehat{\gamma}_k S_{ipk})}{L_p}$$



Target shares: Recent update of G&A model

The current general and acute (G&A) model was updated last year for 2022/23 allocations (based on 2018/19 activity). The previous model from 2016/17 had been based on 2013/14 activity.

Changes to the model

- + Additional variables - household type, individual ethnicity, morbidity counts
- + Change in the age functional form - based on splines rather than 5 year age dummies
- + Increase in the number of diagnostic positions used to create the morbidity variables in the model
- + Interaction of age and household type – to reflect for example, the impact of living alone on need for healthcare will be different for a younger person than an older person

Age by deprivation matrix

This table shows the resulting G&A need indices by age and deprivation quintiles.

More information

Further detail in the [G&A report](#)

Age quintile

(A1 = youngest quintile, A5 = oldest quintile)

Deprivation quintile

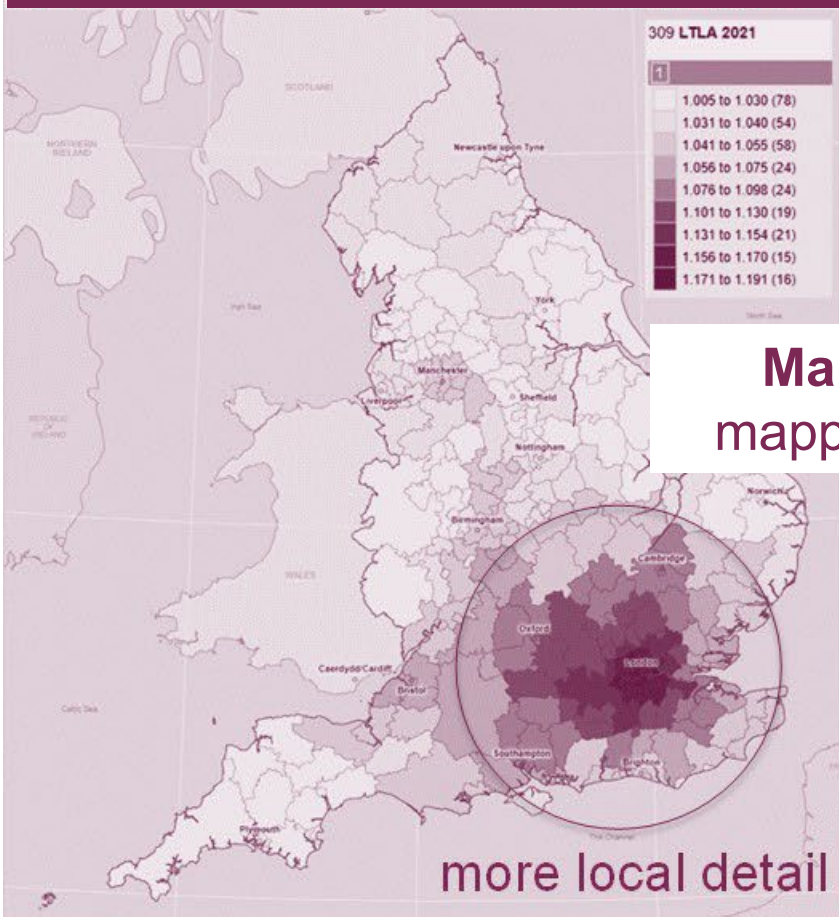
(D1 = least deprived, D5 = most deprived)

	A1	A2	A3	A4	A5	
D1	0.60	0.80	0.90	0.99	1.10	0.96
D2	0.61	0.86	0.97	1.05	1.15	1.00
D3	0.69	0.92	1.04	1.12	1.22	1.00
D4	0.76	0.98	1.10	1.18	1.26	1.00
D5	0.86	1.07	1.18	1.24	1.42	1.06
	0.74	0.95	1.03	1.08	1.16	

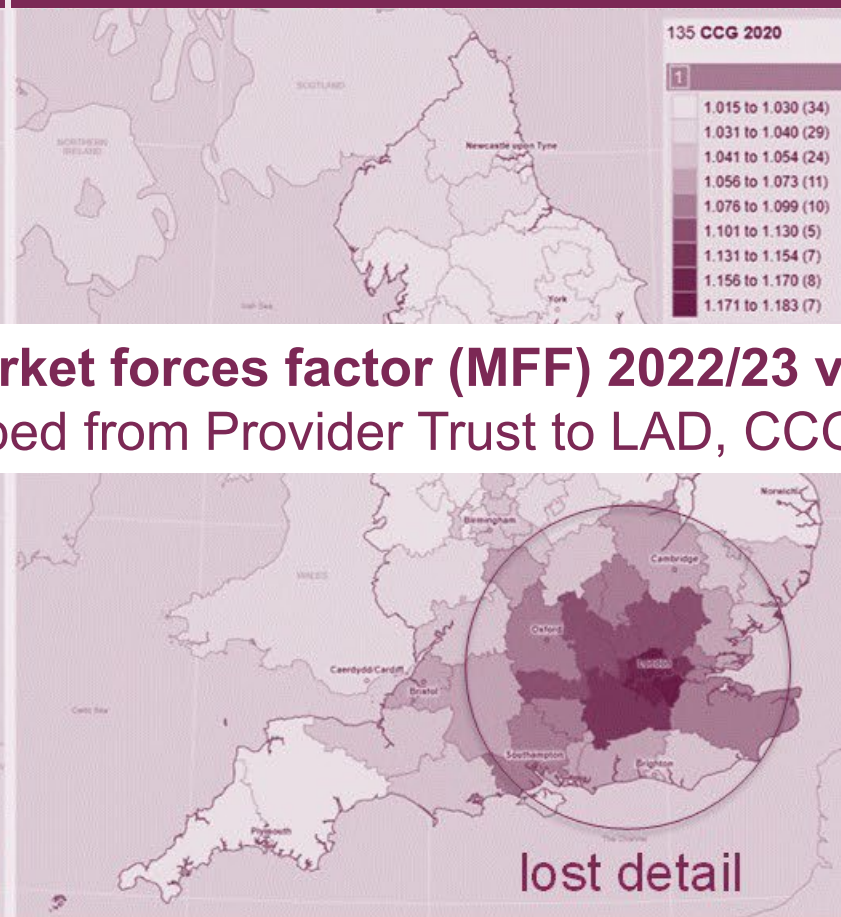


Target shares: LADs provide extra local detail

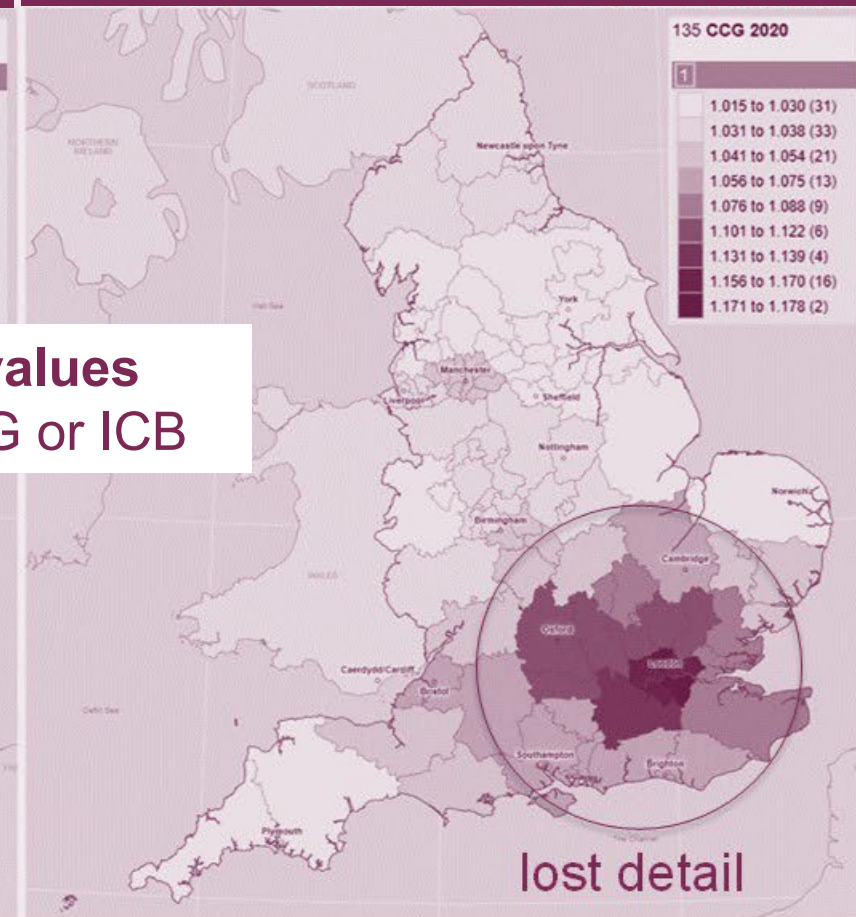
Local authority district (LAD)



Former CCGs



Integrated Care Boards (ICB)



Market forces factor (MFF) 2022/23 values mapped from Provider Trust to LAD, CCG or ICB

The maps above show how smaller areas (LAD) can provide additional detail, within the larger health geographies. In parts of the model, we need to estimate missing need values for new GP practices. CCG average was previously used, but in recent years, most of these no longer provide any higher resolution than ICB. To calculate more meaningful and fair local average need values, we have grouped together GP practices by LAD of their postcode location.



Target shares: **Need variation within ICBs**

Time Period: 2024/2025

Create New Place

ICB Filter: NHS Bath and North East Somerset...

Local Authority District Filter: Choose an option

Select GP Practices: Choose an option

Select all

Name your Place

Save Place

Advanced Options

Show Session Data



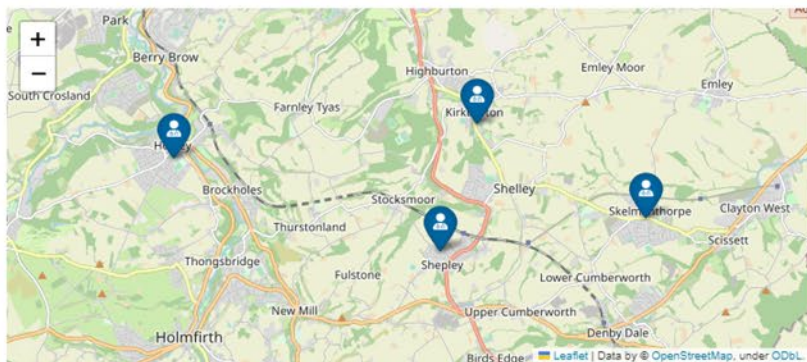
ICB Place Based Allocation Tool 2023/24 and 2024/25

Last Updated 17th January 2023

Select Place

Default Place

Delete Current Selection



**Selected GP Practices: ** Shepley Health Centre, Honley Surgery, Skelmanthorpe Family Doctors, Kirkburton Health Centre

Place-based tool

Core Index: 0.94

For relative weighting of components, see the 2nd rows in [workbook J](#) tabs 'ICB weighted population' and 'GP weighted population'.

Core Sub Indices					
Gen & Acute	Community*	Mental Health	Maternity	Prescribing	Health Ineqals
1.08	1.07	0.66	0.59	1.04	0.55

Primary Medical Care Index: 0.90

Based on weighted populations from the formula for ICB allocations, not the global sum weighted populations**

Primary Medical Care Sub Indices	
Primary Medical Care Need***	Health Ineqals
0.98	0.55

Download Data

Preview data download

Place / ICB	GP pop	Weighted G&A pop	Weighted Community pop	W
NHS West Yorkshire ICB	2637943	2646657	2576924	
Default Place	32127	34800	33441	

We have produced an interactive [place based tool](#) to help ICB colleagues understand patterns of health need within their geography. This tool allows users to compare relative need (calculated in the allocations model) within the ICB, between user defined 'places', built from groups of GP practices.

Results showing weighted populations and need indexes for multiple 'places' can be downloaded and definitions of 'places' can be downloaded for future sessions. A user guide is available on the [Allocations](#) webpage. The underlying dataset is in the allocations technical guide (workbook J).



Target shares: What has driven the changes?

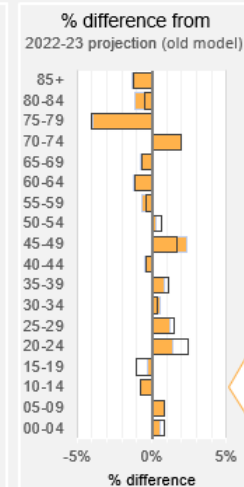
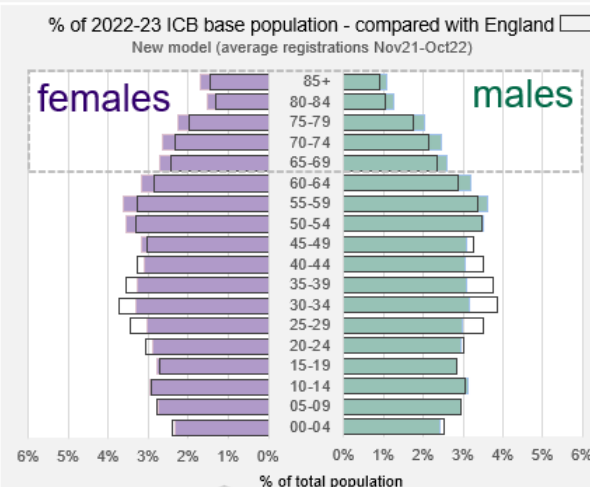
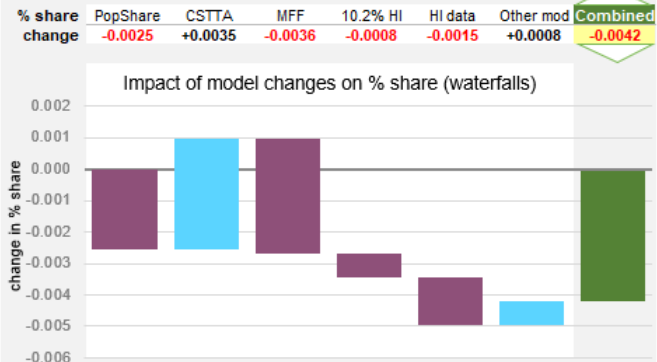
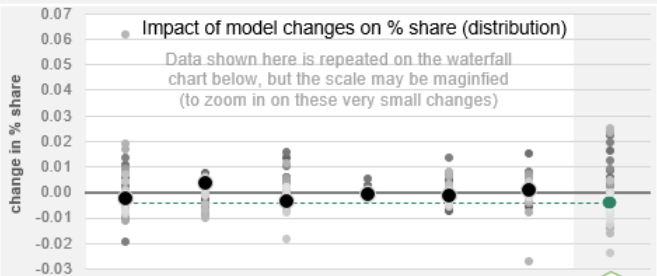
ICB - Integrated Care Board

1 QOX

NHS Bath and North East Somerset, Swindon and Wiltshire ICB

South West Commissioning Region Y58

- NHS Bath and North East Somerset, Swindon and Wiltshire ICB
- NHS Bedfordshire, Luton and Milton Keynes ICB
- NHS Birmingham and Solihull ICB
- NHS Black Country ICB
- NHS Bristol, North Somerset and South Gloucestershire ICB
- NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
- NHS Cambridgeshire and Peterborough ICB
- NHS Cheshire and Merseyside ICB
- NHS Cornwall and The Isles Of Scilly ICB
- NHS Coventry and Warwickshire ICB
- NHS Derby and Derbyshire ICB
- NHS Devon ICB
- NHS Dorset ICB
- NHS Frimley ICB
- NHS Gloucestershire ICB
- NHS Greater Manchester ICB
- NHS Hampshire and Isle Of Wight ICB
- NHS Herefordshire and Worcestershire ICB
- NHS Hertfordshire and West Essex ICB
- NHS Humber and North Yorkshire ICB
- NHS Kent and Medway ICB
- NHS Lancashire and South Cumbria ICB
- NHS Leicester, Leicestershire and Rutland ICB
- NHS Lincolnshire ICB
- NHS Mid and South Essex ICB
- NHS Norfolk and Waveney ICB
- NHS North Central London ICB
- NHS North East and North Cumbria ICB
- NHS North East London ICB
- NHS North West London ICB
- NHS Northamptonshire ICB



2022-23 base population compared to 2022-23 projection (old model)

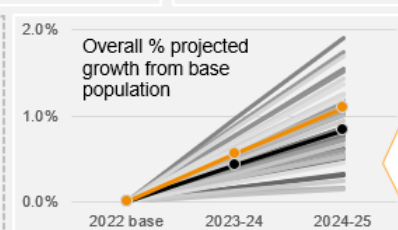
	males	females	patients
New model - average pop Nov21-Oct22			
patients	483,186	498,003	981,188
% total	49.2%	50.8%	100%
England	30.9m	30.7m	61.6m
% total	50.1%	49.9%	100%
Old model - 2022-23 projected population			
patients	482,885	497,630	980,516
% total	49.2%	50.8%	100%
England	30.8m	30.7m	61.5m
% total	50.1%	49.9%	100%
Pop change from projected to revised 2022-23			
patients	300	372	+673
% growth	0.06%	0.07%	+0.07%
England	+0.07m	+0.07m	+0.14m
% growth	0.23%	0.22%	+0.23%
% share	old%	new%	change
ICB pop	1.59	1.59	-0.0025

Overall summary changes in DFT

	Open	Close	Difference
2022/23	-1.10%	-0.48%	+0.62%
DFT	1,390,593	1,417,606	+27,013
Target	1,375,295	1,410,869	+35,574

Age profile for ICB and England compared with 2022-23 projection (old model)

Model	% 65+	change	mean age
New model	20.2%	-0.20%	41.9
2022-23 base	17.6%	-0.18%	40.4
England	17.8%	-	40.5
Old model	20.4%	-	42.1
2022-23 projection	17.8%	-	40.5



ICB average % growth projection from 2022-23 base year population (base22)

Year	ICB % Growth	England % Growth
2023-24	+0.56%	+0.43%
2024-25	+1.10%	+0.84%

% DFT change	Quantum	HI extra	Contract	Pay/infla	Other adj	PopShare	CSTTA	MFF	10.2% HI	HI data	Other mod	Total
change	+0.17%	-0.05%	+0.37%	-0.21%	+0.06%	+0.17%	-0.23%	+0.24%	+0.05%	+0.10%	-0.05%	+0.62%

% DFT change	Quantum	HI extra	Contract	Pay/infla	Other adj	PopShare	CSTTA	MFF	10.2% HI	HI data	Other mod	Final DFT
DFT	-0.93%	-0.97%	-0.60%	-0.81%	-0.75%	-0.58%	-0.81%	-0.57%	-0.52%	-0.42%	-0.48%	-0.48%
Target	1,388,169	1,391,207	1,385,558	1,428,116	1,421,518	1,419,136	1,422,406	1,419,001	1,418,276	1,416,881	1,417,606	1,417,606
Baseline	1,375,295	1,377,852	1,377,248	1,416,508	1,410,869	1,410,869	1,410,869	1,410,869	1,410,869	1,410,869	1,410,869	1,410,869

Key to waterfall components (charts to left)

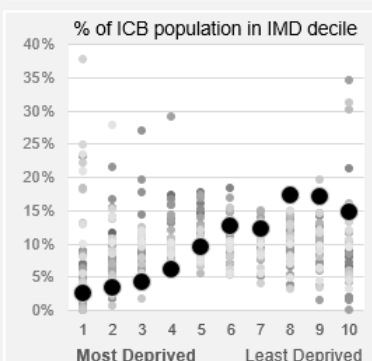
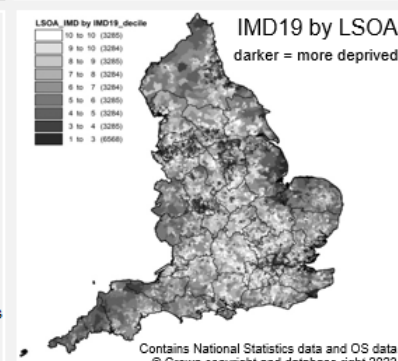
Impact of baseline changes 2022/23

- Quantum Change in target quantum
- HI extra Additional health inequalities funding
- Contract Contract rebasing exercise
- Pay/infla Recurrent pay & inflation funding
- Other adj Other baseline adjustments

Impact of model component changes 2022/23

- PopShare Changes in population share
- CSTTA Community services travel time adjustment
- MFF Market forces factor update
- 10.2% HI Change to 10.2% health inequalities weighting
- HI data Update to health inequalities data
- Other mod Other data, model component and population changes

TOTAL Cumulative effect of baseline/model changes



Expert Advisory Group

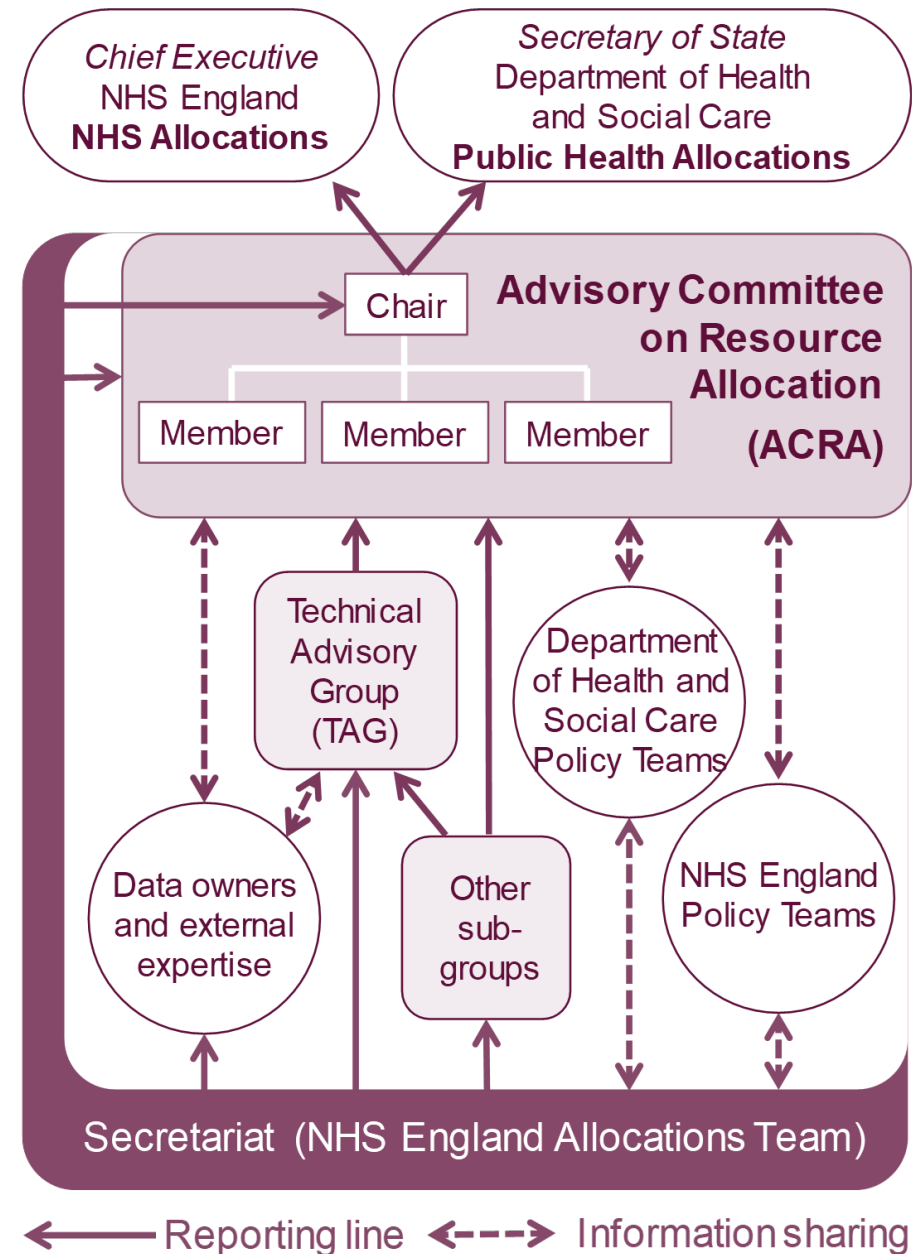
The **Advisory Committee on Resource Allocation (ACRA)** provides recommendations and advice provides advice on the relative geographical target distribution of funding for health services in England.

It is supported by a **Technical Advisory Group (TAG)** and a team of analysts in NHS England.

ACRA is an independent, expert committee, comprising academics including health economists, public health experts, NHS managers and clinicians.

This group makes recommendations to both NHS England (on ICB allocations) and the Department of Health and Social Care (on public health allocations).

Source: [ACRA Terms of Reference](#)





Next steps: **Model limitations, further work**

Difficult to precisely measure ‘need’ for healthcare

There is no perfect measure of health needs. We therefore have to estimate them using other measures, typically the use of NHS services in an area. But this is then affected by local choices around how much care is supplied and how that care is delivered. The formula takes account of this by applying a national average for the amount of health care supplied rather than a local value, but it won't be a perfect adjustment.

Modelling isn't perfect

There will always be some variation in health needs that is inherently unpredictable. For example, a small number of high-cost cases could mean that an area with a smaller population sees their actual costs vary a great deal from their target allocation. That's one benefit of pooling resources at ICBs rather than GP practice level.

Difficult to measure ‘unmet need’ for healthcare

The models typically assess need as it is currently met by NHS services and therefore may not capture unmet need or inappropriately met need. NHS England also has a duty to have regard to the need to reduce inequalities between patients with respect to access to, and outcomes from, health services. The health inequalities and unmet need adjustment, based on a measure of premature mortality, addresses this.

We are conducting research to better understand how much unmet need there is and how this is distributed across the country, so to develop a separate adjustment for unmet need. This research is funded by the National Institute for Health and Care Research (NIHR), and is led by the University of Liverpool. For more information about this research, [follow this link](#). Our research will also consider how an unmet need adjustment will affect the health inequalities adjustment.



Data quality and availability

The quality of the output of the model is dependent on the quality and availability of data sources. More data of better quality, for example, ethnicity and mental health could improve the model output.

Improvements in data collection as a result of COVID-19 may provide an opportunity to draw on more and/or better quality data.



Next steps: Health inequalities and unmet need

ACRA review

Following a review of the health inequalities and unmet need adjustment by ACRA, who were commissioned in the [Long Term Plan](#), a new measure is implemented to:

- support equal opportunity of access for equal need
- contribute to the reduction in avoidable health inequalities.

The **conclusion of the review** was that the metric to calculate the adjustment should be changed from using the standardised mortality ratio for people under 75 years of age (**SMR<75**) to a measure of **avoidable mortality** that takes into account mortality for all ages, for some specific causes.

Avoidable mortality is a better fit to the definition of health inequalities than SMR<75 as the causes of death included have been identified as those that could have been avoided through public health measures and/or timely and effective health care intervention.

The impact of this change is very small because the measures are closely correlated.

For the 2022/23 resource allocations, the adjustment was also used to distribute additional funding made available for ICBs to address health inequalities and unmet need. For the 2023/24 and 2024/25, this additional funding has been merged into the baseline.

Areas for development

ACRA identified 10 areas for further work on the adjustment:

1. Review the relationship between **mental health** and health inequalities, and how this can be captured by the adjustment.
2. Investigate how the adjustment captures **disability** for different population groups.
3. Revisit the **ONS Health Index** as a potential measure.
4. Consider how the current adjustment should change if an **unmet need** adjustment is introduced.
5. Influence **improvements in data collection** to support allocation of resources to address health inequalities.
6. Review **standardisation** methods.
7. Map where/how **costs for providing care** to disadvantaged groups occur in ICB-funded services to inform a review on whether the 5-15% adjustment is appropriate.
8. Raise **awareness** of the adjustment with ICBs and seek their views where appropriate.
9. Monitor the impact of **COVID-19** on health inequalities and how this impact resource allocation.
10. Assess the adjustment within each **model segment** and consider different measures for different components of the model.



Find my ICB: Map

Key

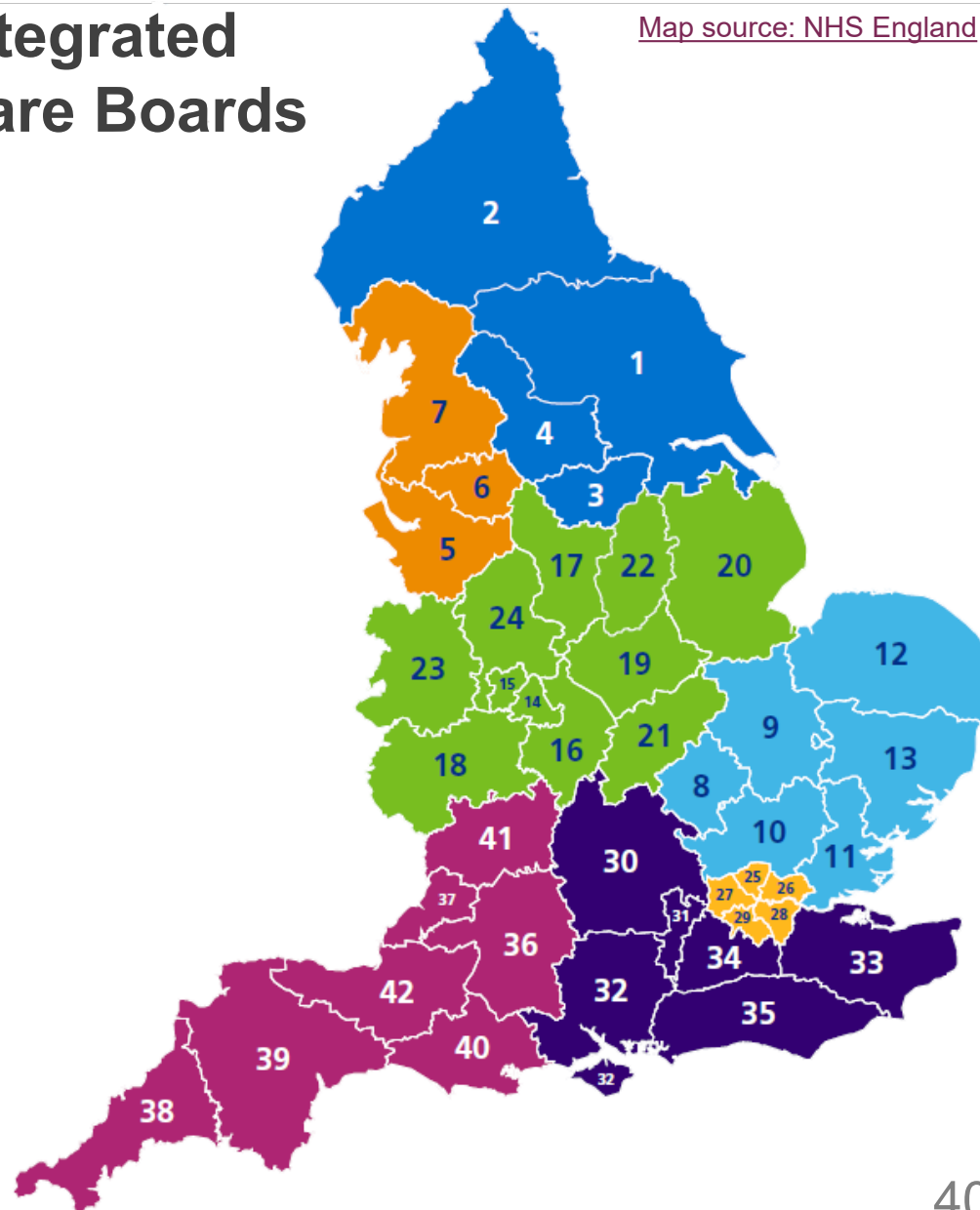
R22 Region	Map	ICB22 Integrated Care Board	Practices	Population
Y63 North East and Yorkshire	1	QOQ NHS Humber and North Yorkshire ICB	181	1,776,221
	2	QHM NHS North East and North Cumbria ICB	360	3,150,772
	3	QF7 NHS South Yorkshire ICB	175	1,479,724
	4	QWO NHS West Yorkshire ICB	276	2,622,253
Y62 North West	5	QYG NHS Cheshire and Merseyside ICB	353	2,717,400
	6	QOP NHS Greater Manchester ICB	421	3,160,705
	7	QE1 NHS Lancashire and South Cumbria ICB	202	1,814,825
Y61 East of England	8	QHG NHS Bedfordshire, Luton and Milton Keynes ICB	95	1,077,382
	9	QUE NHS Cambridgeshire and Peterborough ICB	88	1,013,985
	10	QM7 NHS Hertfordshire and West Essex ICB	137	1,611,195
	11	QH8 NHS Mid and South Essex ICB	150	1,252,554
	12	QMM NHS Norfolk and Waveney ICB	105	1,080,827
	13	QJG NHS Suffolk and North East Essex ICB	92	1,047,412
	Y60 Midlands	14	QHL NHS Birmingham and Solihull ICB	183
15		QUA NHS Black Country ICB	181	1,288,917
16		QWU NHS Coventry and Warwickshire ICB	119	1,051,850
17		QJ2 NHS Derby and Derbyshire ICB	117	1,109,764
18		QGH NHS Herefordshire and Worcestershire ICB	80	815,391
19		QK1 NHS Leicester, Leicestershire and Rutland ICB	135	1,188,617
20		QJM NHS Lincolnshire ICB	84	805,536
21		QPM NHS Northamptonshire ICB	69	812,441
22		QT1 NHS Nottingham and Nottinghamshire ICB	136	1,242,390
23		QOC NHS Shropshire, Telford and Wrekin ICB	52	519,467
24		QNC NHS Staffordshire and Stoke-on-Trent ICB	145	1,171,024
Y56 London	25	QMJ NHS North Central London ICB	181	1,748,337
	26	QMF NHS North East London ICB	274	2,359,737
	27	QRV NHS North West London ICB	354	2,771,172
	28	QKK NHS South East London ICB	198	2,052,559
	29	QWE NHS South West London ICB	181	1,729,594
Y59 South East	30	QU9 NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	159	1,942,356
	31	QNQ NHS Frimley ICB	72	811,078
	32	QRL NHS Hampshire and Isle Of Wight ICB	144	1,920,469
	33	QKS NHS Kent and Medway ICB	194	1,964,644
	34	QXU NHS Surrey Heartlands ICB	104	1,124,470
	35	QNX NHS Sussex ICB	162	1,819,614
	Y58 South West	36	QOX NHS Bath and North East Somerset, Swindon and Wiltshire ICB	92
37		QUY NHS Bristol, North Somerset and South Gloucestershire ICB	79	1,060,591
38		QT6 NHS Cornwall and The Isles Of Scilly ICB	58	597,847
39		QJK NHS Devon ICB	121	1,271,298
40		QVV NHS Dorset ICB	73	820,051
41		QR1 NHS Gloucestershire ICB	72	675,049
42		QSL NHS Somerset ICB	64	594,527

England

6,518 61,625,745

Integrated Care Boards

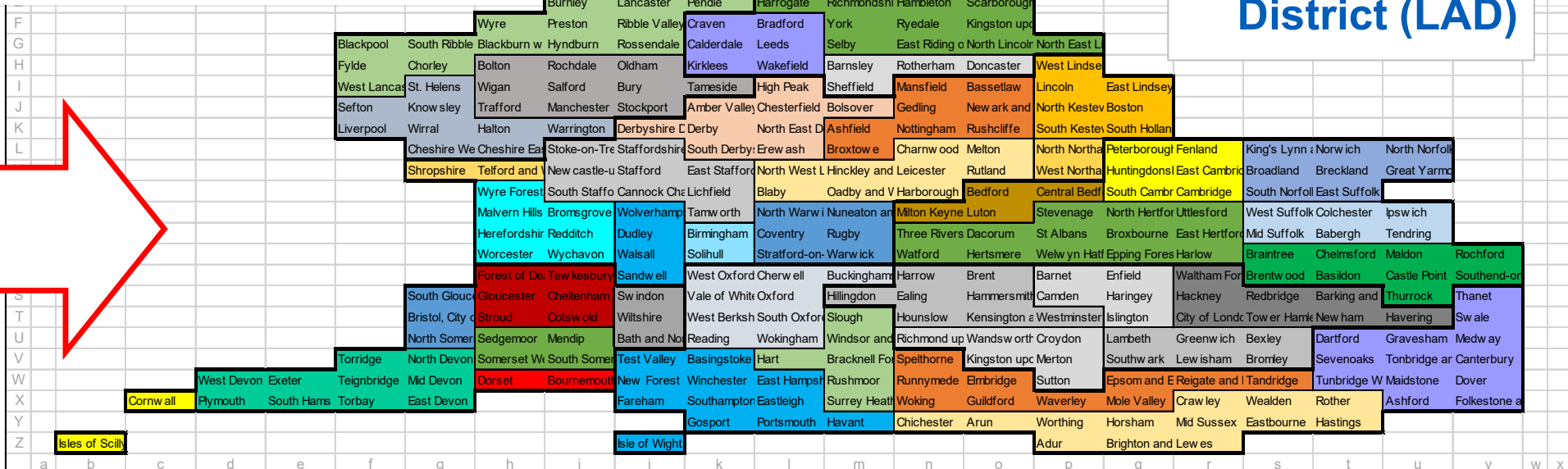
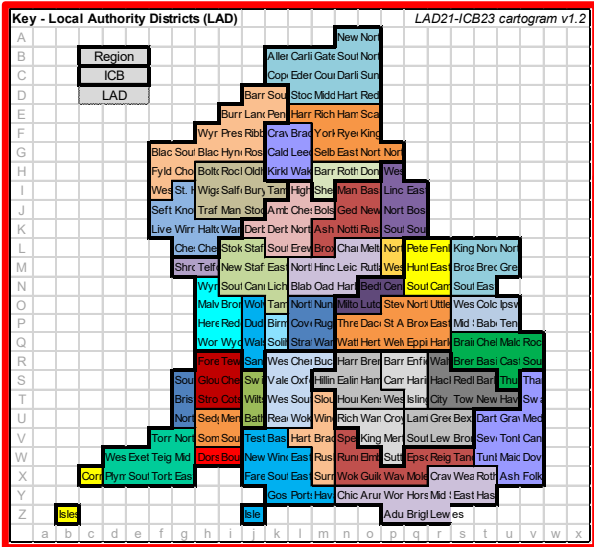
Map source: NHS England





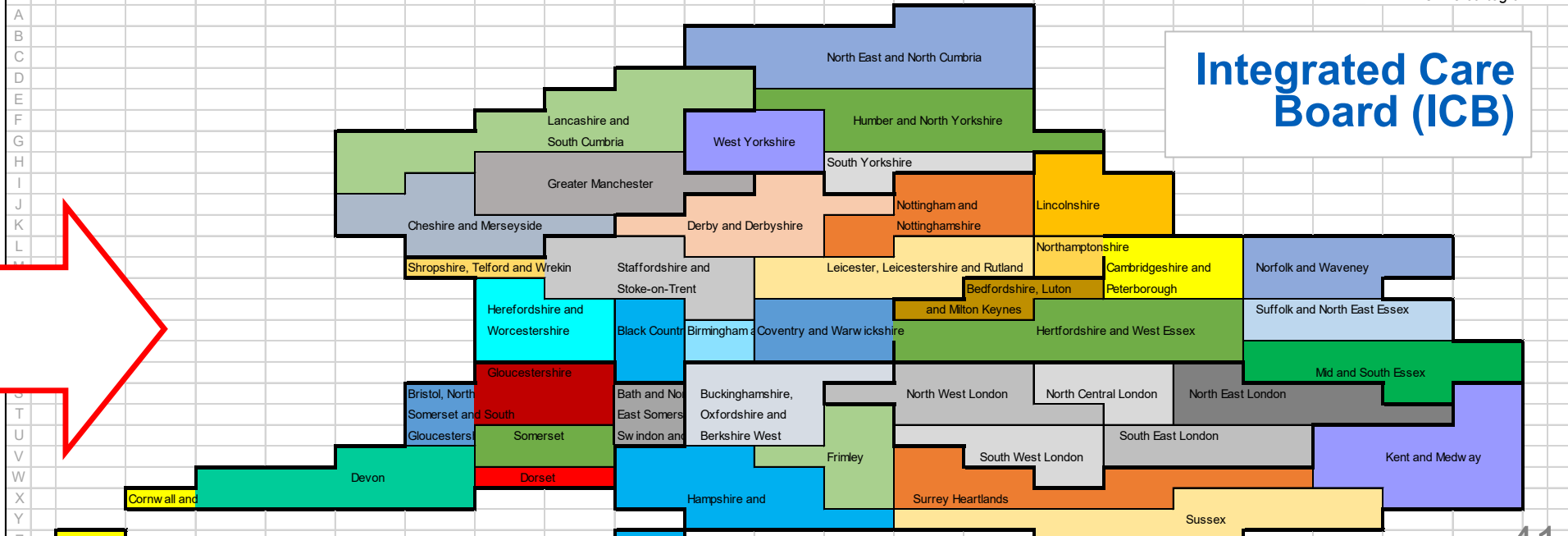
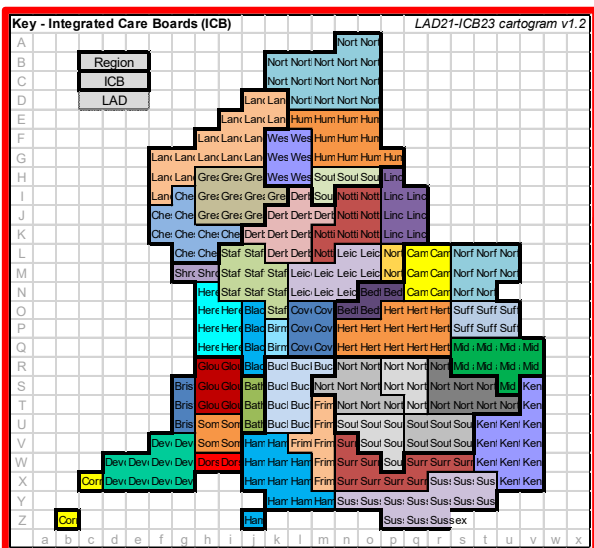
Find my ICB: Cartogram

Local Authority District (LAD)



Integrated Care Board (ICB)

Excel cartogram template is available to plot your own data (LAD / ICB)



www.england.nhs.uk/allocations



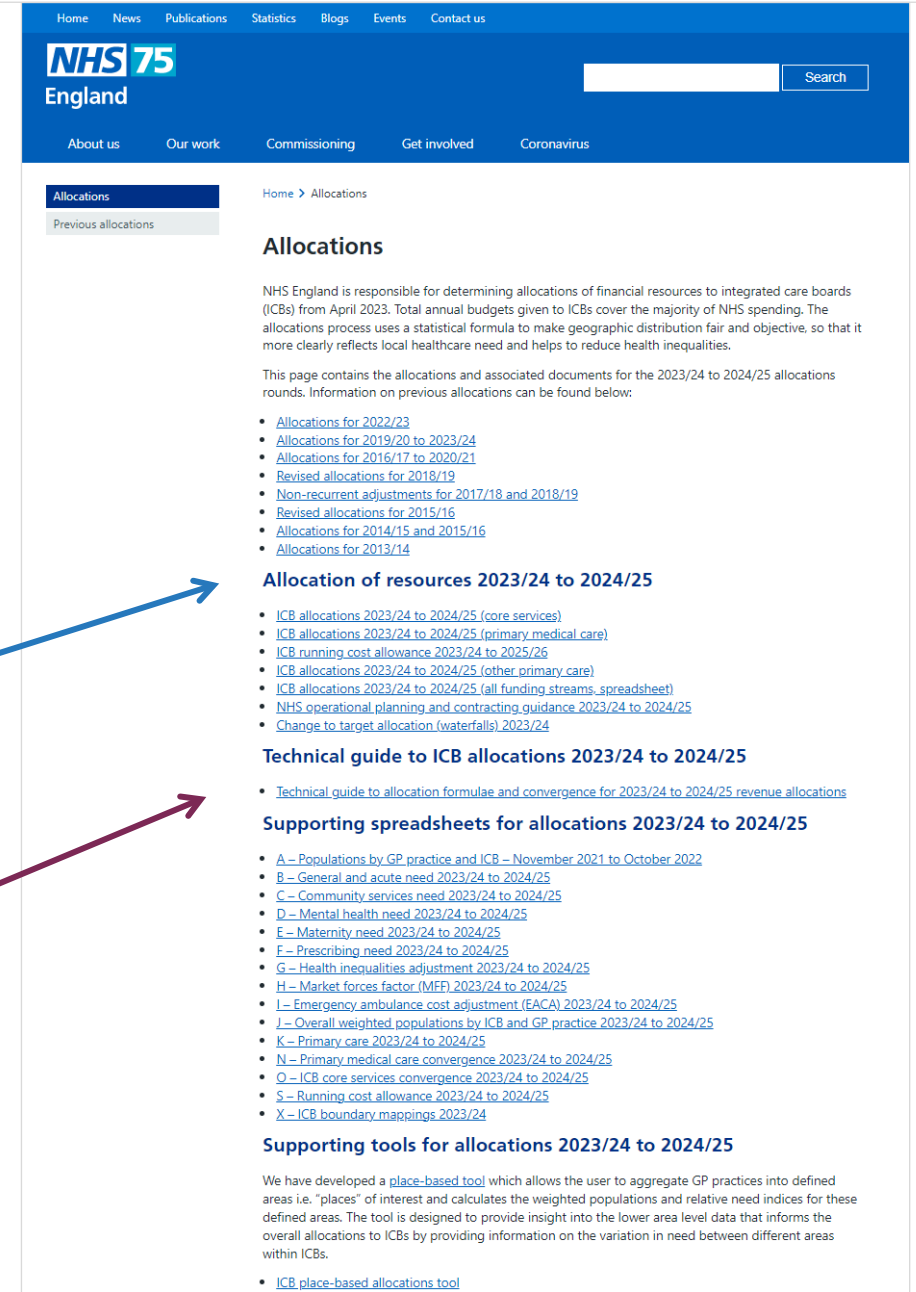
Follow link above
or scan QR code

ICB financial resource allocations

New ICB and historic CCG allocations are published here
Latest include financial years 2023/24 and 2024/25.

Technical guidance documentation

Also our technical guide documents, which describe the
allocations formula, along with supporting workbooks,
research reports, calculations and infographics



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Allocations

Previous allocations

Home > Allocations

Allocations

NHS England is responsible for determining allocations of financial resources to integrated care boards (ICBs) from April 2023. Total annual budgets given to ICBs cover the majority of NHS spending. The allocations process uses a statistical formula to make geographic distribution fair and objective, so that it more clearly reflects local healthcare need and helps to reduce health inequalities.

This page contains the allocations and associated documents for the 2023/24 to 2024/25 allocations rounds. Information on previous allocations can be found below:

- [Allocations for 2022/23](#)
- [Allocations for 2019/20 to 2023/24](#)
- [Allocations for 2016/17 to 2020/21](#)
- [Revised allocations for 2018/19](#)
- [Non-recurrent adjustments for 2017/18 and 2018/19](#)
- [Revised allocations for 2015/16](#)
- [Allocations for 2014/15 and 2015/16](#)
- [Allocations for 2013/14](#)

Allocation of resources 2023/24 to 2024/25

- [ICB allocations 2023/24 to 2024/25 \(core services\)](#)
- [ICB allocations 2023/24 to 2024/25 \(primary medical care\)](#)
- [ICB running cost allowance 2023/24 to 2025/26](#)
- [ICB allocations 2023/24 to 2024/25 \(other primary care\)](#)
- [ICB allocations 2023/24 to 2024/25 \(all funding streams - spreadsheet\)](#)
- [NHS operational planning and contracting guidance 2023/24 to 2024/25](#)
- [Change to target allocation \(waterfalls\) 2023/24](#)

Technical guide to ICB allocations 2023/24 to 2024/25

- [Technical guide to allocation formulae and convergence for 2023/24 to 2024/25 revenue allocations](#)

Supporting spreadsheets for allocations 2023/24 to 2024/25

- [A – Populations by GP practice and ICB – November 2021 to October 2022](#)
- [B – General and acute need 2023/24 to 2024/25](#)
- [C – Community services need 2023/24 to 2024/25](#)
- [D – Mental health need 2023/24 to 2024/25](#)
- [E – Maternity need 2023/24 to 2024/25](#)
- [F – Prescribing need 2023/24 to 2024/25](#)
- [G – Health inequalities adjustment 2023/24 to 2024/25](#)
- [H – Market forces factor \(MEF\) 2023/24 to 2024/25](#)
- [I – Emergency ambulance cost adjustment \(EACA\) 2023/24 to 2024/25](#)
- [J – Overall weighted populations by ICB and GP practice 2023/24 to 2024/25](#)
- [K – Primary care 2023/24 to 2024/25](#)
- [N – Primary medical care convergence 2023/24 to 2024/25](#)
- [O – ICB core services convergence 2023/24 to 2024/25](#)
- [S – Running cost allowance 2023/24 to 2024/25](#)
- [X – ICB boundary mappings 2023/24](#)

Supporting tools for allocations 2023/24 to 2024/25

We have developed a [place-based tool](#) which allows the user to aggregate GP practices into defined areas i.e. “places” of interest and calculates the weighted populations and relative need indices for these defined areas. The tool is designed to provide insight into the lower area level data that informs the overall allocations to ICBs by providing information on the variation in need between different areas within ICBs.

- [ICB place-based allocations tool](#)



Background: Further reading (continued)

Research reports on the allocations formulae

- [Report on ACRA review of the health inequalities and unmet need adjustment 2022/23](#)
- [Report on changes to the allocation model for General & Acute services for 2022/23 allocations](#)
- [Developing a community services model for allocation 2019/20](#)
- [Updating the mental health model for allocation 2019/20](#)
- [Refreshing the Formulae for CCG Allocations from 2016/17 – Report on methods and modelling](#)
- [Primary medical care – new workload formula for allocations to CCG areas 2016/17](#)
- [Specialised services formula 2016/17](#)

Additional background documentation, including ACRA papers can be found at www.england.nhs.uk/allocations

Other background reading

Suggested materials listed below (may not represent the views of NHS England)

- [Unmet need in healthcare funding allocations \(Academy of Medical Sciences Roundtable Jul 2017\)](#)
- [Unmet need literature review \(University of York\) – research paper \(Jan 2017\)](#)
- [ACRA Health Inequalities adjustment review \(2016\)](#)
- [Public health formula for local authorities from April 2016 \(Consultation Oct 2015\)](#)
- [Fundamental Review of Allocations Policy \(NHS England – Aug 2013\)](#)
- [Person-based Resource Allocation \(PBRA\) - \(Nuffield Trust - Dec 2011\)](#)



Contact

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Allocations infographics v3

Updated for ICB resource allocations 2023/24