NIHR | National Institute for Health Research

MANCHESTER 1824
The University of Manchester

Workshop on Integrated Care Boards (ICBs) Resource Allocation: National and Local Developments

May 2023

Working in Collaboration with:

The University of Manchester, funded by the National Institute for Health and Care Research (NIHR), supported by the Healthcare Financial Management Association (HFMA) and by NHS Greater Manchester Integrated Care.

Report writing

Laura Anselmi & Melissa Surgey
The University of Manchester

Contributors

Laura Anselmi (University of Manchester), **Warren Heppolette** (NHS Greater Manchester Integrated Care), **Tarryn Lake** (North East Ambulance Service NHS Foundation Trust), **Lee Outhwaite** (South Yorkshire ICB and Healthcare Financial Management Association, HFMA), **Heather Ross**, **Elbereth Puts** (NHS England Strategic Finance – Allocation Team), **Chris Bentley** (Independent Consultant) **Ben Barr**, **Chris Kypridemos**, **Olga Anosova** (University of Liverpool), **Sean Urwin**, **Charlie Moss**, **Melissa Surgey** (University of Manchester), **Marie Sanderson** (LSHTM), **Ben Galbraith** (Greater Manchester ICB), **David Chandler** (North East and North Cumbria ICB), **Jonathan Webb** (West Yorkshire ICB), **Mike Spence**, **Lily Mott** and **Joanna Ferguson** (NIHR Applied Research Collaboration Greater Manchester) and **Anne Liu** (NIHR Applied Research Collaboration West Coast).

Citing this document: Anselmi, L., Heppolette, W., Lake, T., Outhwaite, L., Ross, H., Puts, H., Bentley, C., Barr, B., Kypridemos, C., Anosova, O., Urwin, S., Sanderson, M., Surgey, M., Galbraith, G., Chandler, D., Webb, J., Spence, M., Mott, L., Ferguson, J., Liu, A., (2023). Workshop on Integrated Care Boards (ICBs) Resource Allocation: National and Local Developments. NIHR ARC Greater Manchester: University of Manchester

This event was funded by the National Institute for Health and Care Research (NIHR). The views expressed in the report are those of the participant and not necessarily those of the NIHR or the Department of Health and Social Care, nor NHS or HFMA.

1. Aim and Background

The workshop aimed to enable discussion of current national and local development on resource allocation and related research and provided Integrated Care Boards (ICBs) the opportunity to come together and discuss their approaches to resource allocation. The workshop took place on Thursday 17th of November 2022, 9.30am to 4.30pm at etc.venues Manchester, 11 Portland St, Manchester M1 3HU.

ICBs were established in 2022 under the Health and Care Act 2022. They assumed the previous statutory responsibilities held by now-abolished NHS Clinical Commissioning Groups (CCGs), including a duty to promote population health and tackle health inequalities. They receive funding for health inequalities on top of their core allocations (here). There is an expectation in national guidance that much of ICBs' allocations will be delegated to the ICBs' constituent places: towns or boroughs usually aligning with local authority boundaries covering populations of 250-500,000. A key tool in achieving this is the effective allocation of resources to places relative to need, whilst supporting the effective use of resources within those places. Place-based resource allocation tools and approaches currently exist, but they may require adaption or innovation, particularly considering the institutional and organisational setting of newly formed ICBs, and the opportunities that they offer.

NHS England currently uses a set of resource allocation formulae to distribute healthcare budgets to local areas, previously used for CCGs and now ICBs, to support equal access for equal need and to reduce avoidable health inequalities. These formulae produce relative need estimates, which are used as population weights to determine target shares, adjusted for unmet needs and health inequalities, as well as differences in unavoidable costs. The full approach is described here, with available related ICB place-based tool (here) and guide (here).

NHS England continuously develops and refines this methodology. The formulae are refreshed regularly to reflect service changes and improved data availability. The health inequalities adjustment is currently being reviewed (here) and a research project is developing enhanced approaches to adjust for unmet needs (here).

The Integrated Care Systems (ICSs) which ICBs govern have large footprints, including NHS organisations, councils and voluntary institutions providing health and care. An important challenge for ICBs will be how to allocate their resources to services and across the communities which they serve, exploiting opportunities in a way that is fair and reduces health inequalities. They may need to question existing approaches to allocation and identify opportunities for innovation.

2. Workshop objectives and agenda

This workshop aimed to explore approaches for achieving a fair and effective distribution of resources, drawing on national and local experience and expertise. The workshop aimed to:

- Explore current approaches for resource allocation, methodological developments and their implications, challenges and areas for future innovation and development;
- Share ICBs' experiences, discuss their approaches to allocations and their needs for further research, networks and tools to support further developments;
- Offer ICBs the opportunity to discuss emerging approaches and critically contribute to policy development.

The Invitation letter with agenda are included in Appendix 1.

The workshop was attended by 49 participants representing 23 different organisations, including 17 different ICBs. The list of attendees is included in Appendix 2.

Following an introduction, the day was organised in four parts:

1. An introduction to NHS England approaches to allocating resources to ICBs;
2. The presentation of initial findings from an NIHR research project proposing methods to better account for unmet needs in the national allocations;
3. Lightning presentations of research around resource allocation and use within ICBs;
4. Shared experiences and discussion of challenges and priorities for allocations within ICBs.

The presentations delivered in each session are available in Appendices 3-6. The following sections include a summary of the discussion points raised.

3. Introduction and welcome

Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester Integrated Care, welcomed colleagues and opened the day.

Warren started by posing questions and highlighting the need to think about the role of resource allocation in supporting the transformation of health outcomes. Key elements to think about included:

There may have been dust settling on how the health and social care (HSC) system is organised leaving space to "existential and comfort factors" of how system comes together.

Elements that could “facilitate or frustrate” integration include:

- the national allocation formula in promoting change in health outcomes; the slimming down of transactional processes e.g. ICBs contracting once;
- the relaxation of the commissioner/provider split;
- the connection between resources and activities to transform health;
- the use of resources to impact wide determinants of health through collaboration between NHS and Local Authorities.

National guidance has tried to “hold the line” on health needs, inequalities, and allocations, for example through needs-based formula, but it is unclear how this is translated into resource allocation internally within ICSs. There are also some potential concerns that current allocations fuel historic patterns of resourcing and a potential risk of pull of resources towards large acute trusts in some ICSs.

Issues have been raised around how resource allocation to unmet needs and the impact on outcomes is monitored, as well as around incentives related to the approach to value and how we define value, again especially regarding health inequalities and unmet needs. Some of these will be explored during the day.

Each ICS will need an agreed framework for addressing health inequalities and address unmet need, including through funding distribution. Whilst there is some guidance, it is not fully comprehensive and there is no detailed framework available.

4. NHS England approach to Allocations

Dr. Heather Ross and Dr. Elbereth Puts, from NHS England Strategic Finance - Allocation Team presented the current methodology for allocating resources to ICBs. Heather discussed how population weight, target shares and pace of change (or speed of convergence) are determined and how they are combined to determine the final allocations. She also discussed which data are used, and how they are tested and questioned, and provided an example for general and acute services. She also highlighted how a proportion of resources is redistributed based on premature mortality, to adjust for health inequalities. There is an Advisory Committee on Resource Allocation (ACRA), that provides scrutiny to the process. All information is available online: https://www.england.nhs.uk/allocations/.
Elbereth Puts introduced the Place Based Allocation Tool (https://aif-allocation-tool-202324-202425.streamlit.app/) which provides the same weight used in the national formula for places within ICBs and target shares based on each ICB, rather than national, standardisation.

The slides from the presentation are available in Appendix 3.

The discussion was chaired by Prof. Chris Bentley, chair of the Technical Advisory Group on Resource Allocation. The following questions were raised and discussed.

Q1: What is the level of confidence on the model and the data being fed into it? How is data quality assured and validated?

A1: ACRA applies a high degree of scrutiny to the allocation model during the review process, including the data used in the development of each model. For CCGs, target allocations were considered to be accurate to within +-5% and the pace of change policy (now convergence) implemented at that time had the aim to bring CCG target allocations to a distance from target +-5%. The margin of confidence for the allocations will be further improved by the move to ICBs as there are fewer of them. Gradual convergence is applied to prevent shock from any numbers that are slightly off these bounds. With respect to the data, the general and acute methodology put a threshold on number of SUS+ diagnoses in calculation to minimise impact of differences in coding between providers, as agreed by ACRA. Diagnostic recording has improved and become more equal between areas. As the payment process may change, there is a need to consider how changes in payment processes may impact diagnostic recording.

Q2: There was a suggestion of moving from using the language “fair shares” to “population shares”.

Q3: It is unclear how the cost of Private Financial Initiatives are picked-up, especially in areas with large numbers of them?

A3: To be picked up offline between this ICB and the NHSE team.

Q4: How do primary care allocations pull through, taking into account needing to reconcile national contract and NHSE allocations?

A4: There is a recognition that the contracting and allocations formulae for primary care are not aligned. There are resources available on top of core national contract that allocations aim to distribute more fairly. Lots of challenges around changing national contract formula, but there are opportunities for ICBs to exert some discretion taking advantage of opportunities over local funding.

Q5: What are lessons learned from services that have focused more specifically on unmet needs, such as COVID vaccinations? Does the current formula really capture the resource needed for these?

A5: There is a delay in turning this learning from COVID into reflecting it in the formula in terms of the impact feeding through into the data used in development. COVID enabled much better data collection around factors impacting unmet need e.g. ethnicity but data use is currently restricted. It is hoped that this might change in the future.

Q6: How is it possible to carve out population health transformation funding? The core funding allocation doesn't take into account programme-specific funding that comes down to ICBs throughout year. It would be helpful for this to be included in overall allocations at beginning of year so ICBs know the total they can work with.

A6: NHSE is not opposed to trying to incorporate more programme-specific funding into core allocation and wherever possible, when funding is recurrent it will be included in allocations.

Q7: Can unavoidable costs of social care be built into allocations to better reflect integrated working across NHS and LA? Are the NHS-LA partnership costs accounted for in allocations?

A7: This is challenging as social care funds are not part of the NHS allocations budget, the NHS contribution to adult social care is through the Better Care Fund.

5. Unmet needs in resource allocation: presentation of ongoing works and discussion

This session was chaired by Prof. Ben Barr, University of Liverpool, who is principal investigator of a project focusing on how unmet needs may be better captured by the current methodology for allocating resources to ICBs. The session included an overview of the project and the concept of unmet need, followed by ongoing work as part of the project.

Slides from the presentations are available in Appendix 4.

5.1 Project overview

The project aims to:

- clarify what is meant by unmet needs;
- examine how methodology for resource allocation can better address unmet need;
- estimate variation in unmet need and how these affects allocations; and
- investigate what changes may be needed.

Need is conceptualised as the number of people with a health problem weighted by their cost of diagnosing and treating health problem, as an aggregate measure of resources required. This approach can be inaccurate as it may not account for undiagnosed or under-treated. Allocations need to be adjusted to factor in these forms of unmet need. Adjustments to the current methods should allow to better account for those and shift distribution of resources to be in proportion of total needs for healthcare locally.

5.2 Measuring unmet need: epidemiological approach

Dr. Chris Kypridemos, University of Liverpool, presented ongoing work. This approach aims at estimating variation in unmet need by assessing costs of diagnosing and treating estimated undiagnosed chronic conditions. Methods and estimates were presented for a specific set of 12 diseases. Those were based on data from different sources combined and used for cross validation whenever possible. Undiagnosed individuals were estimated from the number of newly diagnosed individuals and number of not previously diagnosed individuals but dying from a given disease. However, some data limitations remain, and specific assumptions are required.

Q1: The sum of costs is not totally accurate as it doesn't consider LA spend on public health. Should this be looked at as well (on assumption more spend on public health = prevention). Working in silos means we might be missing wider context.

A1: Allocation of resources being divided may prevents a total public services approach to resource distribution. There are issues that can't be resolved solely by amending formula. Whether we need truly place-based budgets for all public services to join this up may be beyond scope of this work. This may involve exploring options for combining assumptions made from different diseases.

Q2: How can this work be helpful for future trends when there is an increasing proportion of need in cancer and mental health and the approach uses retrospective data only?

A2: This limitation remains, but ICBs could do this better than a national team as they have access to more recent data and will have a closer connection to broader context.

Q3: Does the formula need to link to life expectancy?

A3: The formula applies a correction for avoidable mortality, this should take into account life expectancy to a certain extent.

Q4: How is over-use (i.e. wrongly met need) being considered, for example for high cost, low value interventions?

A4: Differences in supply are partially accounted for in the formula, for example in terms of differences in access. Formula currently doesn't take into account value for money in terms of benefit of intervention, this would be a different objective.

Q5: Quantitative data alone are interesting but not helpful in terms of policymaking. It is important to know gaps in social interventions (so the bigger picture stuff around wellbeing that impacts on health inequalities).

A5: This project only addresses the distribution of NHS resources, even if this still doesn't move us towards adequately addressing wider determinants (e.g. impact of income, housing on diabetes).

Q6: One of the challenges of this approach is how it is applicable to a multi-morbidity context. These results are helpful but need to be more widely contextualised.

5.3 An adjustment for unmet need based on responsiveness

Dr Sean Urwin, University of Manchester, presented ongoing work. This approach aims at differentiating areas based on their expenditure responsiveness to population needs. How responsive different areas are is reflected in the coefficients of the formulae produced from a sub-sample of more responsive areas. By removing areas that are less responsive, the weights generated by the formula will be more reflective of the needs of populations, therefore reducing unmet need of populations.

Q1. Is responsiveness to variation related to lower avoidable mortality?

Q2. How is responsiveness unrelated to management and performance?

A1 and 2. These results are associations and do not carry a causal interpretation. There is no evidence of the measure of responsiveness being specifically related to one measure of performance, but it is not negatively correlated with health outcomes.

6. Resource allocation and use within local health systems

This session was chaired by Dr Laura Anselmi, University of Manchester, and included three lightning presentations on different aspects of resource use within local health systems, mainly CCGs, given ICBs are newly formed. Slides are available in Appendix 5.

6.1 Variation in resource use within CCGs

Laura presented evidence on how the use of services by different individuals can be benchmarked against their measure of need as estimated for the purpose of feeding into the allocation formula. Those differences can then be aggregated for meaningful unit, such as places and using specific metrics that capture different concepts of inequality. There are different criteria through which equity can be measured (total inequity, proportion underserved, variation in unfair healthcare, vertical inequity, or extent to which unfair healthcare favours the neediest, horizontal inequity, or extent to which unfair healthcare favours the most deprived). Every CCG differs in terms of performance against the different criteria. Variation applies also to GP practices, for example.

6.2 Expenditure on health and care by Clincal Commission Groups (CCGs) and Local Authorities (LAs)

Charlie Moss, University of Manchester, presented evidence on how CCGs and LAs spent funding for health and care from 2013/14 to 2019/20. Overall there was an increase in primary care spending, and a greater increase in absolute terms in acute and social care/continuing healthcare, compared with public health and community care. The breakdown of CCG expenditure composition revealed variation between CCGs in proportion of expenditure in different areas (e.g. primary care, mental health, etc). The percentage of expenditure on acute generally decreased for most CCGs, and there were huge variations in the change in percentage of expenditure on community, social care, continuing healthcare and mental health between individual CCGs.

Q1: Would it be worth looking at data for ICB spend, given that some variation will be absorbed or masked due to larger footprint. Look at tool mapping CCGs up to ICBs.

Q2: There may be difference in expenditure where CCGs host services, for example specialised, on behalf of other CCGs.

Q3: It would be interesting to look at differential deprivation across CCGs and ICBs to test hypotheses about general and acute spend being higher where social deprivation is higher (i.e. poorer access to primary care, role of prevention / wellbeing).

Q4: It would be helpful to incorporate specialised commissioning to understand the whole picture – for some ICSs that is the biggest commissioning spend (i.e. where there is a high number of tertiary provider).

Q5: There are different strategic approaches to how CCGs agreed their spend and what transformation priorities and programmes they funded. Interpretation of data needs to take into account wider context of how individual CCGs were operating and key service changes or transformation programmes. An example was given of a CCG where there is a large acute spend recorded, but this is part of planned transformation also involving community services.

6.3 Developments in Integrated Care Systems (ICSs)

Dr Marie Sanderson, London School of Hygiene and Tropical Medicine and PRUComm (https://prucomm.ac.uk/) , presented on the initial development of decision-making arrangements in ICSs. ICSs are networked forms of collaboration, based on collective decision-making to “do better” in terms of more effective use of resources, more appropriate delivery of care and improvement in population of health. Systems make decisions in light of organisational sovereignty that system partners need to balance, for example “Best for the system ” with “best for organisation”, and ICSs use a ‘consensus’ approach to making decisions. Decision making responsibility for ICBs have increased following the Health and

Care Act 2022, but also with an expectation of delegation to places, with a minimal specification of governance arrangements in the guidance.

PRUComm research looks at how collaboration is being governed; how collective and individual interests are balanced; what type of decisions are being undertaken. The research suggests agreeing governance arrangements in ICSs is challenging and collective decision making takes place in light of individual organisational responsibilities and accountabilities. There is general positivity around principle of collective decision making to address contentious win/lose decisions. It is unclear how much decision space ICSs have in practice given central direction (e.g. national "must dos"). At end of the research fieldwork, issues around financial sustainability nationwide had not been resolved in the three case studies, which may be related to the challenges of making difficult decisions using the collective decision-making model of ICSs.

Q1: There is guidance for ICBs around funding "better care", but it is not clear "better for whom, better when and measured how"? There is agreement that ICBs are restricted by lack of financial sustainability as none are in a "good" financial position.

Q2: This overt conversation about unwarranted variation within ICSs, when this would usually be segregated by organisation. This aspect can be stretched further.

Q3: The current focus doesn't take into account ICS borders where patient flows cross more than one ICS. Baselines aren't accurate and there is no explicit guidance from NHSE on this.

Q4: The old financial regime was an "arms race" with insular and adversarial decisions having to be made (e.g. build a bigger A&E department because of lack of reliance on community services). We need to think what the win-win opportunities can be now.

7. ICBs experiences and approaches to allocations: Common challenges and future priorities, including research and networks of practice

This session included four presentations and a related discussion. Slides available in Appendix 6.

7.1 Finance Strategy for Integrated Care Boards and "Approach to Allocations"

Lee Outhwaite, Chief Finance Officer at South Yorkshire ICB, started off by highlighting how organisational changes may bring disruption, but also how they may represent an opportunity, for a big change, rather than just a re-organisation.

He highlighted how clinical care represents only one part of the causes of ill-health, with health behaviours, socio-economic factors, and built environment representing some important ones. An ICB financing strategy and approach to allocations should take this into account and embrace three multi-disciplinary challenges including:

1) Different approach to primary and secondary care;

2) Transitions between health and social care;

3) Move towards a health and wellbeing service rather than an illness service (broader determinants of health).

A fourth one to consider could also be recognising and influencing personal responsibility for health behaviour.

The architecture of ICSs is complex, and it is not clearly defined who does what between the ICB, the Integrated Care Partnership (ICP), places, and provider collaboratives. The legislation is permissive and there is no prescribed model, so the relationships are still being defined.

There are questions open for allocations around how do we define value-based healthcare and how do we deliver savings from current costs of provision to enable investment in unmet need and upstream intervention? Key questions relate to how the demand for services can be influenced and how the way in which demand is met can be influenced. There are factors outside ICB control, including lack of influence on clinical models due to national constraints, lead times for influence to have short-medium term impact. However, there are also factors that may be affected through a different model.

7.2 Experience from Greater Manchester

Ben Galbraith, GM ICB Finance Programme Director, illustrated the experience from Greater Manchester, which works on a Target Operating Model, according to which some services are better provided at the GM level, while others within each locality. For example urgent care, community and elective services budget is led at GM level (75% total GM budget) and overseen by ICS level redesign boards. This model brings the benefit of simplifying contracting arrangements with providers whilst the budget can be held by localities.

There is a top-down revenue plan for 2023/24 whilst planning processes are setting up for bottom-up planning based on activities. Unsolved challenges include:

- Disconnect between hospital provider and locality funding streams;
- How to set differential savings targets between organisations; and
- Investing across GM differentially (for now still default to weighted capitation).

The future operating model is one where ICS level boards are responsible for financial and operational performance, where funding is allocated by sector or service, not to place. Formal governance and responsibility is with the ICB but financial and operational performance would be discharged through programme-specific system boards.
The endgame is that the ICS level boards consider whole expenditure and performance across the system and operate with delegated authority from ICB.

7.3 Experience from North East and North Cumbria

David Chandler, Executive Director of Finance for the North East and North Cumbria ICB, started off by presenting a picture of NENC ICB. NENC is considered to be over-funded, because of a low population growth but high need reflected in short life expectancy.

There is an ICS finance steering group and technical group which are multi-disciplinary, in line with the principle that there is a need to ask all partners what they think their share of the allocation should be. This reflects the fundamental change from commissioner conversation to a system conversation including ICB, providers, clinicians, universities, public health, finance, business intelligence, and performance. There needs to be a rounded view including multiple stakeholders about what the best approach to allocations is.

Allocations for one year cover a short term, during which more happens at place than at system level. Some places work really well, with good relationships, and it would be a backward step to move to system. But this requires working out what the share of finances is. Every place could rightly argue that they should get more. Covid has led to a fundamental realignment of allocations, this is something that may be more perceptible to finance that other policy leaders.

It is very difficult to disinvest in services. The pace of change is very important, locally and nationally. It does not always feel gradual. Moreover the national formula is weighted heavily to general and acute, but perhaps this does not do justice to the challenges in NE Cumbria. There is a plan for the longer term, to come up with a local formula addressing where to allocate resources. But there also need to be considerations on where funding is actually spent.

Slides were not available for this presentation.

7.4 Experience from West Yorkshire

Jonathan Webb, Director of Finance West Yorkshire ICB, started off by presenting the ICB health and care landscape and the agreed financial planning principles to which there are additional proposed approaches for 2022/23 including:

- having resources delegated to place where possible;

- having financial flows to providers routed via place boards rather than via system level ICB;
- having service development funding managed by WY programme boards;
- core allocation would be divided amongst places, then adjusted and re-allocated;
- any allocation that would have gone direct to providers now reallocated to relevant place based on patient flows;
- having service development funding managed via ICS level programmes;
- meet the mental health standard at system and place level, and keep the national commitment about investment in primary and community systems.

The general principle is to recognise population health need and agree these through system conversations.

For the financial year 2023/24 there is a plan to focus on population health improvement as one of ICS core objectives. There is a plan to use the place-based tool to work out place target allocations and compare it with the actual spend. A local convergence adjustment (0.25% of baseline) has been created. The links between allocations and contract values (e.g. primary care and health inequalities) should be considered and a key issue remains what happens once resources are in place and how that is deployed.

7.5 General discussion

There were various points raised during the general discussion, including:

- There are differences in the approaches to providers, e.g. funding does directly to providers in GM, but via place in West Yorkshire.
- It is still open over what time period success can be managed, both from a national perspective and at ICB level.
- There is also a role for community activation e.g. Healthier Fleetwood in Lancashire and South Cumbria, community choirs, breakfast club, table tennis. There is a 5:1 return on investment, but money isn't released back into system. This requires thinking micro as well as macro.
- It will be important to gather case studies of how different systems are working, right down to micro changes to share best practices.
- There is a need to understand what the impact on allocation formula (and allocation) would be if utilisation was massively reduced.
- There is a need to understand the double running costs when having to invest upstream whilst still meeting immediate acute health need.
- There needs to be an agreement on how to distribute the savings around the system, because often the party who invests upstream doesn't enjoy the benefits of the savings.
- Some ICBs have very strong voluntary and community sector relationships and proper community asset mapping. Looking at these may help in counterfactual analysis to understand the impact they have on demand.

- Case studies on small interventions that make big changes may also be helpful.
- There may be system financial benefit from keeping people in work.
- Monitoring could include priority wards work (council wards) – priority neighbourhood dashboards.

8. Workshop Organisation

The event was organised by the University of Manchester, funded by the National Institute for Health and Care Research (NIHR), supported by the Healthcare Financial Management Association (HFMA) and by NHS Greater Manchester Integrated Care.

The organisation was led by Dr Laura Anselmi, Senior Research Fellow in Health Economics at University of Manchester and NIHR Applied Research Collaboration Greater Manchester (ARC-GM), Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester Integrated Care, Tarryn Lake, Director of Finance and Digital, North East Ambulance Service NHS Foundation Trust, Lee Outhwaite, Chief Finance Officer at South Yorkshire ICB and chair of the Policy and Research Committee at the Healthcare Financial Management Association, HFMA.

Additionally, named presenters contributed to each specific session: Dr Heather Ross and Dr Elbereth Puts (NHS England Strategic Finance – Allocation Team) and Prof. Chris Bentley (Independent Consultant) to NHS England approach to Allocations; Prof. Ben Barr, Dr Chris Kypridemos, Dr Olga Anosova (University of Liverpool), Dr Sean Urwin (University of Manchester) to Unmet needs in resource allocation; Dr Laura Anselmi (University of Manchester, Charlie Moss (University of Manchester), Dr Marie Sanderson (LSHTM), Melissa Surgey (University of Manchester) to Resource allocation and use within local health systems; Ben Galbraith (GM ICB), David Chandler (North East and North Cumbria ICB), Jonathan Webb (West Yorkshire ICB) to ICBs experiences and approaches to allocations.

Mike Spence, Lily Mott and Joanna Ferguson (NIHR Applied Research Collaboration Greater Manchester) and Anne Liu (NIHR Applied Research Collaboration West Coast) supported logistical organisation.

The report was compiled by Dr Laura Anselmi and Melissa Surgey (University of Manchester), and benefited from notes taken by Sarah Day (HFMA).

Please contact Laura Anselmi (laura.anselmi@manchester.ac.uk) for further information.

Appendix 1 – Workshop Invitation and Agenda

Workshop
Integrated Care Boards (ICBs) Resource Allocation:
National and Local Developments

Location: etc.venues Manchester, 11 Portland St, Manchester M1 3HU

Date: Thursday 17th of November 2022, 9.30am to 4.30pm

This event will enable discussion of current national and local development on resource allocation and related research and will provide ICBs the opportunity to come together and discuss their approaches to resource allocation.

The event is organised by the **University of Manchester,** funded by the **National Institute for Health and Care Research (NIHR)** and supported by the **Healthcare Financial Management Association (HFMA)**.

Please contact Laura Anselmi for queries related to the day.

We look forward to welcoming participants from ICBs and from research institutions and we hope that this event will offer a shared learning environment and enable networks of practice to be developed.

We would like to thank you in advance for any inputs you will provide during the workshop and for your support in shaping this work moving forward.

Dr. Laura Anselmi, *Senior Research Fellow in Health Economics at University of Manchester and NIHR Applied Research Collaboration Greater Manchester (ARC-GM)*
Warren Heppolette, *Chief Officer for Strategy & Innovation, NHS Greater Manchester Integrated Care*
Tarryn Lake, *Director of Finance and Digital, North East Ambulance Service NHS Foundation Trust*
Lee Outhwaite, *Chief Finance Officer at South Yorkshire ICB and chair of the Policy and Research Committee at the Healthcare Financial Management Association, HFMA*

Background

Integrated Care Boards (ICBs) have a duty to promote population health and tackle health inequalities. They receive funding for health inequalities on top of their core allocations (here). A key tool in achieving this is the effective allocation of resources to places relative to need, whilst supporting the effective use of resources within those places. Place-based resource allocation tools and approaches currently exist, but they may require adaption or innovation, particularly considering the institutional and organisational setting of newly formed ICBs, and the opportunities that they offer.

NHS England currently uses a set of resource allocation formulae to distribute healthcare budgets to local areas, previously Clinical Commissioning Groups (CCGs) and now ICBs, to support equal access for equal need and to reduce avoidable health inequalities. These formulae produce relative need estimates, which are used as population weights to determine target shares, adjusted for unmet needs and health inequalities, as well as differences in unavoidable costs. The full approach is described here, with available related ICB place based tool (here) and guide (here).

NHS England continuously develops and refines this methodology. The formulae are refreshed regularly to reflect service change and improved data availability. The health inequalities adjustment is currently being reviewed (here) and a research project is developing enhanced approaches to adjust for unmet needs (here).

Integrated Care Systems (ICSs) have large footprints, including NHS organisations, councils and voluntary institutions providing health and care. An important challenge for ICBs will be how to allocate their resources to services and across the communities which they serve, exploiting opportunities in a way that is fair and reduces health inequalities. They may need to question existing approaches to allocation and identify opportunities for innovation.

This workshop will explore approaches for achieving a fair and effective distribution of resources, drawing on national and local experience and expertise. **The workshop aims to:**

- Explore current approaches for resource allocation, methodological developments and their implications, challenges and areas for future innovation and development;

- Share ICBs experiences, discuss their approaches to allocations and their needs for further research, networks and tools to support further developments;

- Offer ICBs the opportunity to discuss emerging approaches and critically contribute to policy development.

A document summarising the main points from the discussions will be produced and circulated to participants. Participants may also be contacted for follow-up discussions after the event (please let us know if you do not wish to be contacted).

Workshop
Integrated Care Boards (ICBs) Resource Allocation:
National and Local Developments
17th November 2022
9.30am – 4.30pm

	Agenda Item
9.30 – 10.00	**Registration**
10.00 – 10.15	**Introduction and welcome** (Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester Integrated Care)
10.15 – 10.45	**NHS England and Improvement approach to Allocations** (Presenters (online): Heather Ross and Elbereth Puts, NHS England Strategic Finance - Allocation Team)
10.45 – 11.00	**Discussion and Q & A** (Moderator: Prof. Chris Bentley, Independent Consultant)
11.00 – 11.15	**Break for refreshments**
11.15 – 12.00	**Unmet needs in resource allocation: presentation of ongoing works and discussion – Part I** (Chair: Prof. Ben Barr, University of Liverpool, Presenters: Dr Chris Kypridemos and Dr Olga Anosova, University of Liverpool)
12.00 – 13.00	**Lunch**
13.00 – 13.30	**Unmet needs in resource allocation: presentation of ongoing works and discussion – Part II** (Chair: Prof. Ben Barr, University of Liverpool, Presenter Dr Sean Urwin, University of Manchester)
13.30 – 14.10	**Resource allocation and use within local health systems** (Chair: Dr. Laura Anselmi, University of Manchester, Presenters: Charlie Moss, University of Manchester, Dr. Marie Sanderson, LSHTM, Melissa Surgey, University of Manchester)
14.10 – 14.30	**Break for refreshments**
14.30 – 16.20	**ICBs experiences and approaches to allocations: Common challenges and future priorities, including research and networks of practice** (Chair: Lee Outhwaite, Chief Finance Officer at South Yorkshire ICB and chair of the Policy and Research Committee at the Healthcare Financial Management Association, HFMA; Presenters: ICBs representatives willing to share their experiences)
16.20 – 16.30	**Wrap-up and next steps** (Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester Integrated Care)

The space will be accessible **from 8.00am** (breakfast available) **until 6.00pm** for informal discussions or networking.

Appendix 2 – List of Attendees

Name	Job title	Organisation
HFMA		
Sarah Day	Senior policy manager	HFMA
Hayley Ringrose	Policy and research manager	HFMA
University of Manchester		
Laura Anselmi	Senior Research Fellow	The University of Manchester
Joanna Ferguson	NIHR ARC-GM Comms and PCIE Coordinator	The University of Manchester
Mike Spence	NIHR ARC-GM Senior Programme Lead	The University of Manchester
Katherine Checkland	Professor of Health Policy and Primary Care	The University of Manchester
Lynsey Warwick-Giles	Research Associate	The University of Manchester
Melissa Surgey	NIHR ARC-GM PhD Fellow	The University of Manchester
Charlie Moss	Research Associate	The University of Manchester
Marie Sanderson	Assistant Professor	LSHTM
NIHR Unmet Needs Project		
Chris Bentley	Independent Consultant	
Ben Barr	Professor in Applied Public Health Research	University of Liverpool
Chris Kypridemos	Senior Lecturer in Public Health Informatics & Data Science	University of Liverpool
Sean Urwin	Research Fellow in Health Economics	University of Manchester
Olga Anosova	Research Associate in Public Health	University of Liverpool
NHS England Allocations		
Heather Ross (online)	Senior Analytical Lead - Allocations	NHS England and NHS Improvement
Elbereth Puts (online)	Senior Analytical Manager - Allocations	NHS England and NHS Improvement
NHS Regional		
Nikhil Khashu	Regional Director of Finance - North West	NHS England North West region
Alex Kirkpatrick	Director of Operational Finance	NHS England North West region
Carol Stubley	Director of Commissioning Finance	NHS England North West region
NHS Integrated Care Boards		
Warren Heppolette	Chief Officer for Strategy & Innovation	NHS Greater Manchester Integrated Care Board
Ben Galbraith	Finance Programme Director	NHS Greater Manchester Integrated Care Board
Kathy Roe	Director of Finance	NHS Greater Manchester Integrated Care Board
Sam Simpson	Chief Finance Officer	NHS Greater Manchester Integrated Care Board

Name	Job title	Organisation
Ian Holmes	Director of Strategy and Partnerships	NHS West Yorkshire Integrated Care Board
Jonathan Webb	Director of Finance	NHS West Yorkshire Integrated Care Board
Sam Proffitt	Chief Finance Officer	NHS Lancashire and South Cumbria Integrated Care Board
Andrew Harrison	Director of Finance for Place and Programme	NHS Lancashire and South Cumbria Integrated Care Board
Will Cleary Gray	Executive Director of Strategy and Partnerships	NHS South Yorkshire Integrated Care Board
Lee Outhwaite	Chief Finance Officer	NHS South Yorkshire Integrated Care Board
Frankie Moss	Associate Director of Provider Assurance, Capital and Financial Strategy	NHS Cheshire and Merseyside Integrated Care Board
Claire Wilson	Director of Finance	NHS Cheshire and Merseyside Integrated Care Board
Amanda Bloor	Chair	NHS Humber and North Yorkshire Integrated Care Board
Karina Ellis	Director of Corporate Affairs	NHS Humber and North Yorkshire Integrated Care Board
David Chandler	Director of finance – strategic	NHS North East and North Cumbria Integrated Care Board
Kate Hudson	Director of Finance	NHS North East and North Cumbria Integrated Care Board
Tom Jackson	Director of Finance	NHS Black Country Integrated Care Board
Dr Angela Brady	Chief Medical Officer	NHS Coventry and Warwickshire Integrated Care Board
Madi Parmar	Chief Finance Officer	NHS Coventry and Warwickshire Integrated Care Board
Alan Pond	Chief Financial Officer	NHS Hertfordshire and West Essex Integrated Care Board
Yin Yau	Deputy Director of Finance, Strategic Financial Planning and Partnerships.	NHS Kent and Medway Integrated Care Board
Phill Wells	Chief Finance Officer	NHS North Central London Integrated Care Board
Gary Sired	Director of System Financial Planning	NHS North Central London Integrated Care Board
Andrew Morton	Operational Director of Finance	NHS Nottingham and Nottinghamshire Integrated Care Board

Name	Job title	Organisation
Laura Clare	Deputy Director of Finance	NHS Shropshire, Telford and Wrekin Integrated Care Board
Helen Jameson		NHS South West London Integrated Care Board
Helen Dempsey	Director of Planning	NHS Staffordshire and Stoke-on-Trent Integrated Care Board
Matthew Shields	Head of System Finance	NHS Staffordshire and Stoke-on-Trent Integrated Care Board
Matthew Knight	Chief Finance Officer	NHS Surrey Heartlands Integrated Care Board

Appendix 3: Allocation of resources to ICBs

File: 0 - Allocation presentation.pdf

Available on request

Appendix 4: Unmet needs in resource allocation: presentation of ongoing works and discussion

File: 1 - Intro Unmet Needs project.pdf
File: 2 - Unmet needs project - part I.pdf
File: 3 - Unmet needs project - part II.pdf

Available on request

Appendix 5: Resource allocation and use within local health systems

File: 4 - Resource allocation and use.pdf

Available on request

Appendix 6: ICBs experiences and approaches to allocations: Common challenges and future priorities, including research and networks of practice

File: 5 - Finance Strategy for ICBs and approach to allocations 171122.pdf
File: 6 - GM Allocation approach - Draft slides - ICB event - 17 Nov
File: 7 - Resource allocation workshop 17 November 2022 - West Yorkshire

Available on request

For more information, please contact Dr Laura Anselmi (laura.anselmi@manchester.ac.uk)

Produced by NIHR Applied Research Collaboration Greater Manchester (ARC-GM), May 2023