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Research Briefing

9 October 2024

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NHS integrated care board (ICB) funding in England

Summary

1 Funding allocations for NHS integrated care boards (ICBs)
2 ICB funding allocation process

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Summary

Most funding for NHS services in England is distributed via Integrated Care Boards (ICBs), who use the funding to provide the majority of local health services in England, including for hospitals and GPs.

ICBs are provided with annual resource allocations to cover the costs of providing health services for the population they cover. For the current fiscal year (2024/25) NHS England has distributed a total of £127.2 billion.

The 2024/25 core services allocations for England were equivalent to around £1,732 per registered patient, a 5.0% real terms increase.

ICB core services allocations

	£ billions		£ per patient	
	Cash prices	Real terms 2024/25 prices	Cash prices	Real terms 2024/25 prices
2022/23	94.6	101.6	£1,535	£1,649
2023/24	101.3	102.1	£1,636	£1,649
2024/25	107.6	107.6	£1,732	£1,732

Source: NHS England Allocations data

Total 2024/25 ICB allocations for primary medical care in England were £11.2 billion, a 4.5% real terms increase compared with 2023/24.

Primary medical care allocations were around £180 per patient across England, a 4.3% real terms annual increase.

The starting point for determining the target allocation is the latest population estimate for the ICB area. However, health needs and costs do vary, and the population estimates are 'weighted' to reflect this.

The effect of the weighting means that, in general, ICBs with a larger proportion of the population in older age groups, those in urban areas or those in more deprived areas will have higher target allocations than they would under a simple population-based formula.

The highest ICB core services allocation per patient in 2024/25 was for NHS Cheshire and Merseyside (£1,986), and the lowest was NHS Buckinghamshire, Oxfordshire and Berkshire (£1,480).

1 Funding allocations for NHS integrated care boards (ICBs)

Most funding for NHS services in England is distributed via Integrated Care Boards (ICBs), who use the funding to provide the majority of local health services in England, including for hospitals and GPs.

The Health and Social Care Act 2022 made extensive changes to the structure of the NHS in England. In particular, the Act established 42 Integrated Care Boards (ICBs) across England. These took on statutory responsibility for most local NHS services on 1 July 2022.

List of NHS England integrated care boards (ICBs)

- Bath and North East Somerset, Swindon and Wiltshire
- Bedfordshire, Luton and Milton Keynes
- Birmingham and Solihull
- Black Country
- Bristol, North Somerset and South Gloucestershire
- Buckinghamshire, Oxfordshire and Berkshire West
- Cambridgeshire and Peterborough
- Cheshire and Merseyside
- Cornwall and The Isles of Scilly
- Coventry and Warwickshire
- Derby and Derbyshire
- Devon
- Dorset
- Frimley
- Gloucestershire
- Greater Manchester
- Hampshire and Isle of Wight
- Herefordshire and Worcestershire
- Hertfordshire and West Essex
- Humber and North Yorkshire
- Kent and Medway
- Lancashire and South Cumbria
- Leicester, Leicestershire and Rutland
- Lincolnshire
- Mid and South Essex
- Norfolk and Waveney
- North Central London
- North East and North Cumbria
- North East London
- North West London
- Northamptonshire
- Nottingham and Nottinghamshire
- Shropshire, Telford and Wrekin
- Somerset
- South East London
- South West London
- South Yorkshire
- Staffordshire and Stoke-On-Trent
- Suffolk and North East Essex
- Surrey Heartlands
- Sussex
- West Yorkshire

ICBs replaced clinical commissioning groups (CCGs) and have taken on many of their functions. However, ICBs are intended to be a different type of decision-making body to CCGs, bringing in a wider range of partners, with a greater focus on population health.

The Library Briefing paper The structure of the NHS in England provides further details on the current organization of the NHS.

NHS England is responsible for determining allocations of financial resources to Integrated Care Boards (ICBs).

ICBs are provided with annual resource allocations to cover the costs of providing health services for the population they cover. For the current fiscal year (2024/25) NHS England has distributed a total of £127.2 billion.

ICBs use this funding to commission a wide range of services including mental health services, urgent and emergency care, elective hospital services, primary care services, medicines and community care.

ICB allocations have been published covering the period from 2022/23 to 2024/25. Allocations are published for:

- core services: secondary care covering hospital, community, mental health and ambulance services
- primary medical care: general practice services
- other primary care: ICBs can take on delegated responsibility for other primary care services, which comprise dental services (primary, secondary and community), general ophthalmic services, community pharmacy services, and other elements of primary care services. A separate allocation is calculated for these services.

This paper focuses on core services and primary medical care, but details of other primary care allocations can be found in the accompanying excel file on the web landing page for this Briefing paper.

In 2024/25, core services ICB allocations across England totalled £107.6 billion. This represented a 5.4% real terms increase on 2023/24 allocations.

The 2024/25 core services allocations for England were equivalent to around £1,732 per registered patient, a 5.0% real terms increase.

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Source: NHS England, Allocation of resources 2024/25, ICB allocations (core services), 27 March 2024

Total 2024/25 ICB allocations for primary medical care in England were £11.2 billion, a 4.5% real terms increase compared with 2023/24.

Primary medical care allocations were around £180 per patient across England, a 4.3% real terms annual increase.

ICB primary medical care allocations

	£ billions		£ per patient	
	Cash prices	Real terms 2024/25 prices	Cash prices	Real terms 2024/25 prices
2022/23	9.7	10.4	£157	£169
2023/24	10.6	10.7	£171	£172
2024/25	11.2	11.2	£180	£180

Source: NHS England Allocations data

1.1 Geographical differences in funding

The starting point for determining the target allocation for each ICB is the population of the area the ICB covers. If all ICB populations had equal need, and costs didn't vary across the country, funding could simply be allocated on a per person basis.

In reality, health needs vary according to the age, health status and deprivation levels of the local population. Cost also vary across different geographical areas: e.g. staff, land and building costs are higher in London. Funding allocations are weighted to take these factors into account.

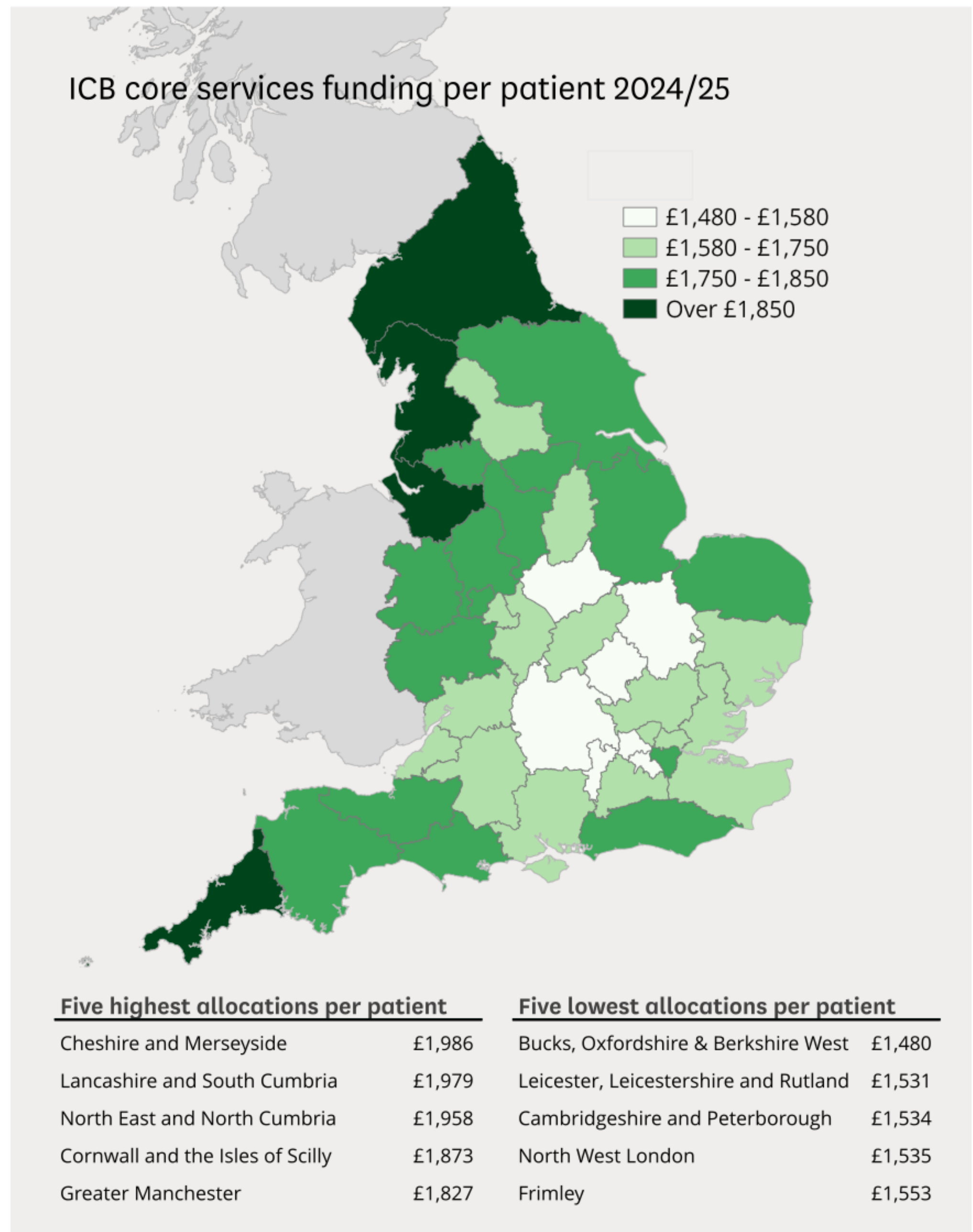
The effect of the weighting means that, in general, ICBs with a larger proportion of the population in older age groups, those in urban areas or those in more deprived areas will have higher target allocations than they would under a simple population-based formula.

A detailed explanation of the ICB funding allocation process is provided in Section 2 of this briefing.

The maps overleaf show the distribution of ICB allocations per registered patient in 2024/25.

The tables beneath the map show the ICBs with the five highest and lowest allocations per registered patient in 2024/25.

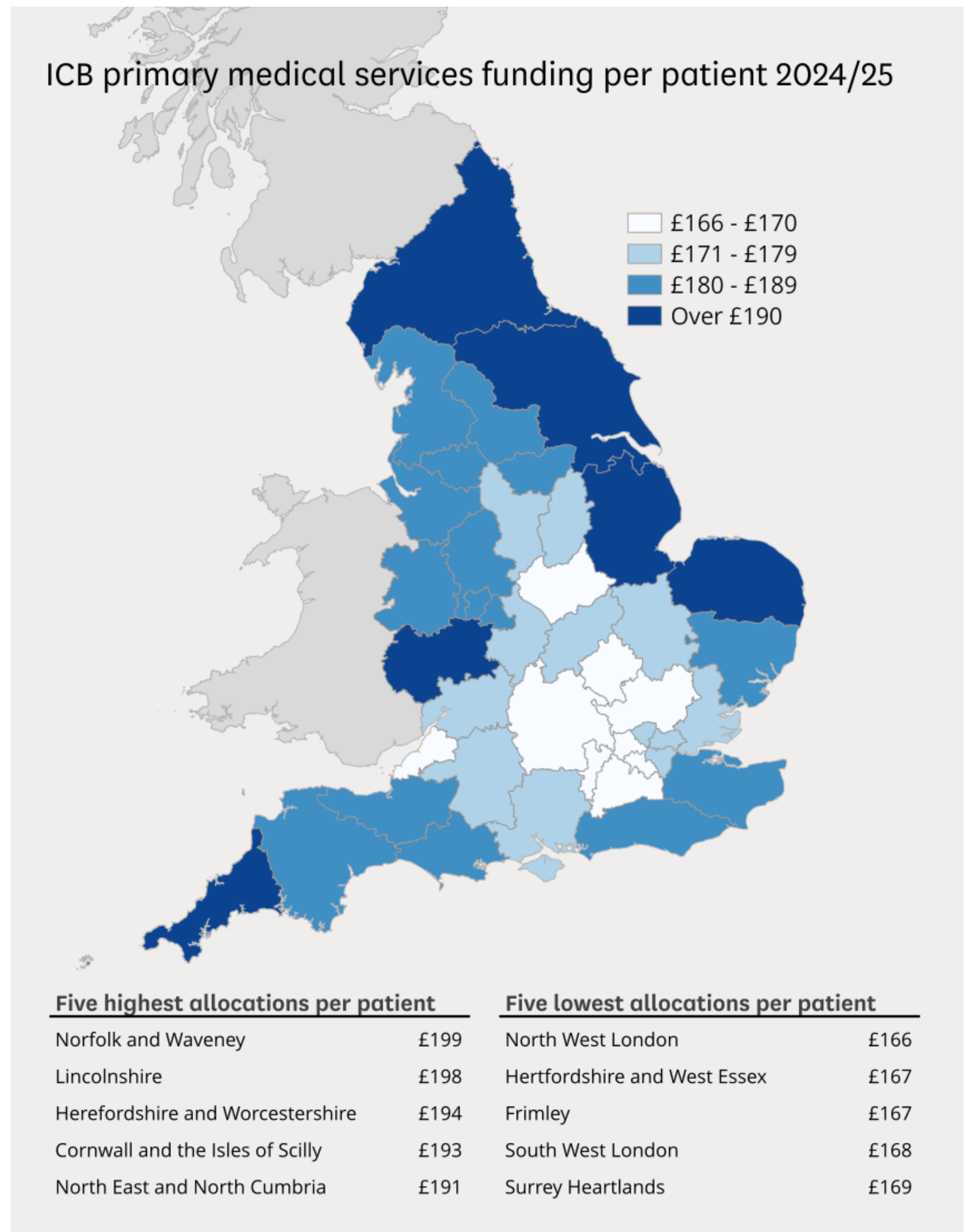
The highest ICB core services allocation per patient in 2024/25 was for NHS Cheshire and Merseyside (£1,986), and the lowest was NHS Buckinghamshire, Oxfordshire and Berkshire (£1,480).



Five highest allocations per patient	
Cheshire and Merseyside	£1,986
Lancashire and South Cumbria	£1,979
North East and North Cumbria	£1,958
Cornwall and the Isles of Scilly	£1,873
Greater Manchester	£1,827

Five lowest allocations per patient	
Bucks, Oxfordshire & Berkshire West	£1,480
Leicester, Leicestershire and Rutland	£1,531
Cambridgeshire and Peterborough	£1,534
North West London	£1,535
Frimley	£1,553

The highest primary medical services funding allocation per patient in 2024/25 was observed in NHS Norfolk and Waveney (£199) and the lowest was NHS North West London (£166).



Five highest allocations per patient	
Norfolk and Waveney	£199
Lincolnshire	£198
Herefordshire and Worcestershire	£194
Cornwall and the Isles of Scilly	£193
North East and North Cumbria	£191

Five lowest allocations per patient	
North West London	£166
Hertfordshire and West Essex	£167
Frimley	£167
South West London	£168
Surrey Heartlands	£169

2 ICB funding allocation process

Funding or allocation formulas are a tool for distributing central funding for local health services. They are based on the principle that resources should be distributed with the long-term aim of securing 'equal opportunity of access for people with equal need across the country'.[1]

2.1 Core services allocations

ICB allocations are based on the weighted capitation formulas recommended by the independent Advisory Committee on Resource Allocation (ACRA).[2] The ICB Allocations published by NHS England show details of the actual allocation each ICB receives as well as an indication of its "distance from target" (DFT). The distance from target figure reflects the fact that the target allocation determined by the funding formula is not always what an ICB receives.

The starting point for determining the target allocation is the latest population estimate for the ICB area. If all ICB populations had equal need, and costs didn't vary across the country, the process could end here, with every ICB receiving a target share in proportion to their population size (i.e. an equal per capita allocation). However, health needs and costs do vary, and the population estimates are 'weighted' to reflect this.

The weights used in the formula are discussed in detail in section 2.2.

The effect of the weighting means that, in general, ICBs with a larger proportion of the population in older age groups, those in urban areas or those in more deprived areas will have higher target allocations than they would under a simple population-based formula.

Health resources have been distributed using a 'weighted capitation formula' since 1977/78. Revisions to this funding formula are made each year to reflect such factors as changing population structures, increased understanding/estimation of health needs, and so on.

These alterations in the weighting of allocations—in particular, age and deprivation measures—have coincided with an ongoing wider political debate surrounding funding formulas and which indicators are the stronger

1 Section 13G Health and Social Care Act 2012

2 NHS England, Prescribed specialised services needs-base allocations methodology, 14 August 2024

determinants of 'need'. Because the distribution of areas with older and/or more deprived populations across the country is not even, the weight given to each indicator alters the allocation of resources nationally. The 2008 paper Health care equity, health equity and resource allocation: towards a normative approach to achieving the core principles of the NHS, explains the tension between effectively meeting existing demand and reducing health inequality:

In order to promote 'equal opportunity of access for equal needs', the distribution of funding should reflect the existing burden of disease. In order to promote an 'equal opportunity to be healthy', funding needs to be targeted so as to reduce the health gap between the most advantaged and the least advantaged groups. This implies that resources should not necessarily be directed at populations with the highest absolute burden of ill-health, but at those which have the worst health in terms of age-standardised measures.[3]

If a revised formula results in substantial differences in funding, it may not always be practical to immediately implement the ideal "fair share" according to a revised formula. For example, when the funding formula for 2016/17 to 2020/21 was introduced if CCGs were given their actual target allocations according to the new formula, some CCGs would have benefitted from funding increases of around +10% while others could have lost out by a funding reduction of -30%. To avoid wide swings in year on year allocations, a political decision is taken by the Department of Health and Social Care to constrain change in allocations where ICBs are determined to be under or over target.

Distance from Target (DFT)

ICBs move towards their target allocation over time. Each year all ICBs receive an increase in funding, however, the percentage increase varies depending on their Distance from Target (DFT). ICBs that are above target generally receive less than the national average funding increase while those below target will receive more - the intention being to move towards the target allocation.

The pace at which ICBs move towards their target is set by ministers at the start of each funding round by something known as the 'pace of change'. The pace of change helps to ensure a steady move towards a target year on year. The rules associated with the current formula are intended to guarantee that:

- No ICB is more than 5% below target.
- All ICBs receive a minimum per capita growth that is equivalent to real terms cash growth at the average population growth (in 2024/25 this equated to 2.1%).

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

- All ICBs receive a minimum cash growth equal to real terms growth plus specific non-routine policy pressures (predominantly relating to pensions and 7 day services); unless the ICB is more than 10% above target, when its cash growth is limited to the specific policy pressures.

The table below gives an example of large distances from target according to the 2022/23 – 2024/25 ICB allocations.

Birmingham and Solihull ICB funding allocation was under target by 3.4% in 2022/23 so I the next two years they received above average allocation increases, thereby reducing their distance from target. Conversely, Surrey Heartlands received below average funding increase in 2023/24 and 2024/25 as their funding was over target by 8.9% in 2022/23.

ICB distance from target (DFT) and allocation increases

	Birmingham and Solihull		Surrey Heartlands		England average % change
	DFT	% change in allocation	DFT	% change in allocation	
2022/23	-3.4%		+8.9%		
2023/24	-3.2%	+5.5%	+8.1%	+4.3%	4.6%
2024/25	-3.0%	+3.4%	+6.6%	+1.6%	2.1%

Source: NHS England Allocations data

2.2 Core services weights and adjustments

The basic approach in calculating need-weighted populations is to multiply the population for each age-sex group for each GP practice by the relative need per head estimated by academic researchers. The products for each age-sex group are summed to give the relative need weighted population for each GP practice. The weighted populations for GP practices are summed to calculate the need-weighted populations for each ICB.

The weighted population for each ICB is based on:

- the size of each ICB's registered population
- a weight per head for health care need for health care services related to age and sex and for need (for example, areas with poorer health have a higher need per head)
- an adjustment per head for unmet need and health inequalities
- an adjustment per head for unavoidably higher costs of delivering health care due to location alone (the market forces factor)
- adjustments for the higher cost of providing ambulance and A&E services in remote areas

- an adjustment for the unavoidable costs of the private finance initiative (PFI)

Variation in need

Age and sex are the primary factors that drive differences in need. The very young and the elderly, whose populations are not evenly distributed across the country, have a higher need for health services than the rest of the population. Therefore, the weighted capitation formula takes the relative need per head of local populations into account. However, age and sex are not the only factors determining need. Therefore, the formula takes into account other predictors of need (see below).

Unmet need and health inequalities adjustment

NHS England has the legal duty to reduce health inequalities. In order to fulfil this duty, an adjustment to the allocation formula is made. ACRA have recommended that a measure of avoidable mortality is the best available indicator on which to base the adjustment. The adjustment is based on populations of small areas within each ICB and then aggregated in order to take into account inequalities between as well as within ICBs. The share of funding redistributed through this adjustment is 5% for the specialised services formula and 15% for primary medical care. These different weightings reflect the relative importance of these services in addressing unmet need and health inequalities.

In 2022/23, an additional £200m health inequalities funding was released across systems using this adjustment which has been absorbed into the 2023/24 ICB programme baseline.

Market Forces Factor (MFF)

The MFF adjusts for the unavoidable cost differences between areas due to their geographical location alone. For example, it typically costs more to run a hospital in a city centre than in other areas due to higher staff, buildings and land costs. This adjustment is for higher, unavoidable input costs alone, not due to higher costs due to higher need.

There are four components to the MFF, unavoidable differences in cost across the country due to each of: medical and dental staff; other staff; land; and buildings.

In the NHS, pay rates are determined by national pay structures and therefore differences across the country are relatively small. However, indirect pay costs faced by providers differ significantly across the country, such as vacancy rates, staff turnover rates and use of agency staff. The HERU research report (PDF) used differences in pay rates across the country in the private sector, which were found to be highly correlated with these indirect staff costs faced by NHS providers.

Private sector pay rates are adjusted for differences across the country in age and sex of employees, occupation, industry and level of responsibility of the job. Indirect staff costs for medical and dental staff were found not to differ across the country as they do for other staff. Instead, the medical and dental component was based on the direct, higher costs of employing medical and dental staff in London as a consequence of the London pay weighting.

The building component is based on relative location factors calculated by the Building Cost Information Service (BCIS) from an analysis of tender prices for public and private contracts at local authority level. The land component is based on the land value per hectare calculated for each NHS Trust.

Emergency Ambulance Cost Adjustment

The Emergency Ambulance Cost Adjustment (EACA) adjusts for unavoidable variations in the cost of providing emergency ambulance services in different geographical areas, in particular sparsely populated areas and metropolitan areas.

The current EACA is based on modelling the time taken by ambulances to reach incidents, provide treatment and convey patients to hospitals, across a combined data set from four of the 10 Ambulance Trusts.

This adjustment is only applied to ICB core allocations.

Rurality

This adjustment provides funding to ICBs to meet the unavoidably higher costs of remote hospital sites, where the costs are higher because the level of activity is too low for the hospital to operate at an efficient scale.

The package of Advisory Committee on Resource Allocation (ACRA) recommendations has three key elements:

- the criteria for considering an NHS site remote;
- the unavoidable impact of scale on efficiency; and
- the reference point for deriving a cost adjustment.

There are three criteria that a hospital providing A&E services must meet for its commissioning ICB to be considered eligible for the uplift to its target:

- There must be 200,000 or fewer population within a one-hour travel time. A population served of 200,000 is the estimated scale at which a hospital can achieve close to national efficiency levels. This ensures that a large provider that is geographically remote but operating at efficient scale does not receive extra support;
- The next nearest provider must be one hour or more by normal road travel times (including ferry times where relevant). This is a measure of whether consolidation of services to fewer sites is feasible.

- For at least 10% of the population in the hospital's catchment area, this must be the closest provider, with the next nearest provider over an hour away. An adjustment to target allocations for the relevant ICB is only made when this percentage is 10% or higher. This avoids giving very small adjustments to a large number of providers.

A relevant cost curve was created by analysing the costs of all hospital sites relative to their size as measured by activity levels. The estimated relative costs were adjusted to remove the impact of differences in case mix, and in costs that are already compensated through the market forces factor (e.g. differential staff and premises costs across the country).

The national average costs were used as a reference for average sized hospitals. The cost curve gives the estimated higher costs above national average costs for each of the hospitals with low activity levels (population catchment areas of under 200,000 people). The sparsity adjustment therefore reflects the expected cost premium based on national scale/cost relationships rather than the actual cost of the individual site, which may be affected by a number of factors unrelated to its scale.

Excess finance costs of the private finance initiative (PFI)

This adjustment was introduced in 2022/23 due to the excess financial costs of historical PFI contracts. Previously, trusts with PFI obligations received direct payments based on historical analysis undertaken by the Department for Health and Social Care (DHSC) in 2011. Instead, now a consistent methodology is applied which is focussed on the additional costs some trusts pay in PFI contracts compared to public sector financing.

Utilisation approach

A statistical model is used to reflect the relationship between the utilisation of health services and the characteristics of individual patients and the areas where they live. These models produce combined estimates of need based on age and sex as well as additional need rather than separate estimates. This is because additional need varies by age group.

Supply side variables

Supply variables take into account the fact that health service availability generally leads to higher use despite similar levels of need. Since utilisation driven by high availability is not a good measure of need, supply variables are set to the national average when weighted populations are calculated. This way, areas with lower utilisation due to lower accessibility or capacity are not penalised.

2.3 Primary Medical Care allocations

The formula for allocating funding for primary medical care (GP services) is based upon general practice workload and how the attributes of practices and their patients influence that workload.

The formula uses data from the Clinical Practice Research Datalink (CPRD), a primary care database of around 2 million anonymised medical records from a large number of general practitioners. The CPRD data is broadly representative of the UK general population in terms of age, sex and ethnicity.

Estimates of workload are based on the number of minutes electronic files for patients were open, weighted by staff group. A model is then applied to this data to estimate the effect of patient and practice characteristics on GP workload. Factors reflected in the formula include patient age, sex, and length of time at the practice. Typically, elderly patients use more minutes of GP practice time than younger age groups. In addition, being newly registered with a practice was found to be associated with higher workload.

The formula also uses the Index of Multiple Deprivation (IMD) as a proxy for higher need in more deprived areas.

Rurality is not included in the Primary Medical Care allocation weightings. This was because of uncertainty over whether it genuinely reflected additional workload or was a consequence of differences in behaviour in rural practices not arising from workload.

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