

# How-to: Supporting Integrated Care Boards (ICBs) to allocate extra funding to General Practices based on socio-economic deprivation and local needs.

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## Aim

To provide a practical tool for ICBs in England to allocate extra funding to general practices based on socio-economic inequalities and local needs by using the 'extra Funding allocation Inequality Tool (eFIT)' software.

## Summary

The allocation of general practice funding is well established nationally, but there is currently no national guidance on how to allocate discretionary additional funds in an equitable manner. Often ICBs resort to allocating funding per head of population, rather than considering inequalities and population need.

This user-friendly tool (eFIT) allows ICB managers to easily calculate various scenarios of how to split this funding by taking into consideration the health data associated with the intervention they are aiming to roll out.

## Background

While the allocation of core NHS general practice funding is well established nationally (with a variant of the Carr-Hill formula)<sup>1</sup>, there is currently no national guidance on how to allocate additional discretionary fundings. In many cases Integrated Care Boards may not take into consideration available data and might simply split the money equally by population size and may, unknowingly, widening inequalities.

In many cases, the teams receiving the extra funding might ask the ICB Finance team to calculate the split. ICB Finance directors have a training package available on the *NHSFuture* website by HFMA around inequalities but it lacks detail. As a result, different ICBs may find it simpler to split the money based on 'weighted population'. Weighted population does somewhat take into account inequalities, but it can be seen as a '*one size fits all*' approach which might not be ideal when extra funding would provide greater benefit if proportionately allocated to disadvantaged communities. .

## The app

In order to support ICBs in England to allocate funding based on local needs and inequalities, we have developed the 'extra Funding allocation Inequality Tool (eFIT)'<sup>2</sup>. This software is available free of charge at <https://efit-tool.streamlit.app/>.

The methodology behind eFIT derives from a modification of the equation taken from 'Health Inequality strategy for Cambridgeshire and Peterborough (2020)'<sup>3</sup>. With this equation (see methodology below), funding can be split proportionally based on population size of a general practice and up-to-date health indicators for many disease areas. For example, if an ICB cancer team receives extra funding to boost their cervical cancer screening uptake among young women, it can calculate the allocation for each general practice based on their female registered population and based on a combination of cervical cancer screening uptake data and deprivation scores for those practices. This results in proportionally

higher funding going towards general practices that have a lower screening uptake and higher deprivation (and therefore highest need). Ultimately it will be patients that will benefit the most, since this would result in those practices being able to roll out a better, more tailored screening programme e.g. extra admin time to phone unresponsive invited patients; translating messages for patients who do not speak English; contracting extra locum doctors and nurses to carry out screening work, etc.

### **How does it work?**

The user (e.g. ICB managers across England), select their ICB, specify the amount of funding, the target demographics, the health indicators and the weights (e.g. to give more based-on disease prevalence or inequality). By hitting the 'Calculate' button, the results are instantaneous. A variety of publicly available health indicators are listed, however, alternative datasets can be uploaded.

The funding allocation is specified for each general practice in a table which can be downloaded (and opened in excel). This tool can also be used as a screening aid to find the best compromise between health indicators and their weights in a stakeholder meeting, since results can be visualised in a chart and be easily tweaked. Should you wish to see exactly how each indicator contributes to the final allocation, there is a 'Show more detail' functionality.

To see the impact of the tool, you can view the difference between using eFIT and a standard approach such as the 'weighted population' formula.

We strongly encourage the users though, to engage with a wide range of stakeholders to agree on the health indicators and the weight to use for the calculation, before finalising. The following stage would usually include agreement by the Local Medical Committees (LMC) and the Primary Care Commissioning Sub Committee before funds are released to practices/Primary Care Networks (PCNs).

### **Is there any evidence that using this type of approach would reduce inequalities?**

Barr *et al* have shown that needs-based target allocations can improve the equity of outcomes for individuals ("*additional healthcare spend reduced mortality rates, and that this effect was greater in more deprived areas*")<sup>4</sup>; in addition, the Advisory Committee on Resource Allocation (ACRA) stated that '*needs-based allocation methodology can help not only to achieve equity but also to reveal opportunities for increasing the efficiency of services*'<sup>5</sup>.

This approach has been used for various programmes in many ICBs already, including Cambridgeshire and Peterborough ICS where it was well received by the various stakeholders. With this app, all ICBs in England can apply this method by taking advantage of its straight-forward set up.

### **Conclusion**

In conclusion, we can facilitate the calculation extra funding to primary care by implementing this free tool. By making it available to all ICBs, we can share best practice in allocating discretionary funding proportionate to need. If adopted, this tool has the potential to help reduce inequalities by giving more to general practices that need more.

## Methodology

For each indicator selected we have applied the following formula:

$$a = \frac{b_z \times c_z}{\sum(b_{all} \times c_{all})} \times d$$

Hence, given that you can assign different weights to each indicator, the resulting equation is the following:

$$a = \frac{\sum \left( \frac{b_z \times c_z}{\sum(b_{all} \times c_{all})} \times W \right)}{\sum W} \times d$$

where:

a = allocation for GP practice 'z'

b<sub>z</sub> = population for GP practice 'z'

c<sub>z</sub> = indicators for GP practice 'z'

∑(b<sub>all</sub> × c<sub>all</sub>) = sum of all GP practice population multiplied by their indicator scores

W = weight for indicator

∑W = sum of all weights for all indicators

d = total funding available

Where weights do not add up to 100%, the remaining percentage will be based in registered population size.

## Data sources

Indicators data for 2022/23, including IMD scores (2019)\* and prevalence (QOF) data, was extracted on 26/3/2024 from fingertips<sup>6</sup>.

\*Where new GP practices opened or merged/demerged (e.g. Cambridgeshire and Peterborough ICB and Nottingham and Nottinghamshire ICB), we have calculated their new IMD.

Weighted population data is for 2024/25 and was extracted from: *J-Overall weighted populations by ICB and GP practice 2023/24 to 2024/25 at NHS England >> Supporting spreadsheets for allocations 2023/24 to 2024/25*<sup>7</sup>.

General practice population size data is as of April 2024 and were extracted from NHS Digital<sup>8</sup>.

## References

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