Report to :	**HEALTH AND WELLBEING BOARD**
Date :	12 November 2015
Executive Member / Reporting Officer:	Cllr Lynn Travis, Executive Member Health and Neighbourhoods Angela Hardman, Director of Public Health
Subject :	**CONSULTATION RESPONSE ON THE ADIVOSRY COMMITTEE ON RESOURCE ALLOCATION TARGET ALLOCATION FORMULA FOR 2016/17.**
Report Summary :	Advisory Committee on Resource Allocation (ACRA) has reviewed the formula for public health and has made a number of recommended changes for 2016-17 onwards. The paper sets out ACRA's interim recommendations and implications for Tameside MBC. ACRA will make its final recommendations to Ministers this autumn.
Recommendations :	Health and Wellbeing Board are asked to: • Note the launch of the funding formula consultation for 16/17, proposed changes and implications for Tameside; • Endorse and discuss the consultation response; • Agree to receive a further update following the autumn statement at the Health and Wellbeing Board on 21 January 2015.
Links to Sustainable Community Strategy :	Healthy Tameside Prosperous Tameside
Policy Implications :	Local authorities have, since 1 April 2013, been responsible for improving the health of their local population and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse. The Secretary of State continues to have overall responsibility for improving health – with national public health functions delegated to Public Health England.
Financial Implications : **(Authorised by the Section 151 Officer)**	The Council's grant allocation will reduce by £0.340m in 2016/17 following the outcome of this consultation. In addition it is expected that the confirmed 2015/16 in year grant allocation of £0.943m will be a recurrent reduction which will therefore lead to an estimated total grant reduction of £1.283m from 1 April 2016. The Comprehensive Spending Review is due to be announced on 25 November 2015 when the value of grant reduction is expected to be confirmed. Associated proposals to deliver this level of funding reduction will require urgent implementation in advance of 2016/17 financial year on a recurrent basis

Legal Implications : **(Authorised by the Borough Solicitor)**	There are significant risks to loss of funding and subsequent increases in health inequality and it is important the Council responds to the consultation.
Risk Management :	These are set out in the report..
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson  Telephone:0161 342 3358  e-mail: debbie.watson@tameside.gov.uk

1. PURPOSE

1.1 To brief the Health and Wellbeing Board on:

- The ACRA Public health grant proposed target allocation formula for 2016/17 and how it has been developed.
- Implications on our local area.

2. BACKGROUND

2.1 The Advisory Committee on Resource Allocation (ACRA) developed a formula for public health grants for the first time in 2012 which was used to set target allocations for 2013-14 and 2014-15 for public health grants to Local Authorities.

2.2 Between 8 October and 6 November 2015 the Department of Health is consulting, on behalf of ACRA, on interim recommendations for a number of changes to the target formula for the public health grant for 2016-17 onwards.

2.3 The key steps in setting the Public Health allocations are:

- Setting the preferred relative distribution of resources,
- Setting the total resources available,
- Deciding how quickly to move organisations from their baseline position towards the level of resource implied by the preferred distribution (pace of change policy).

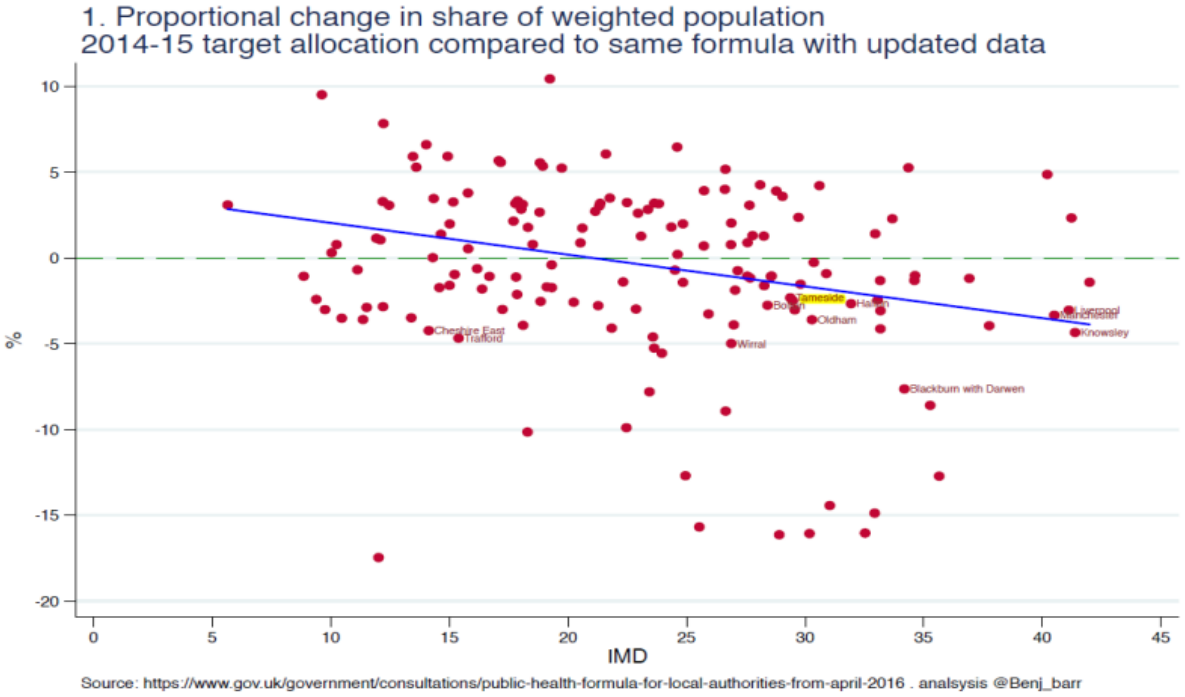
2.4 Pace-of-change is a decision reserved for ministers, as is the total resource available, which will not be known until the outcome of this year's spending review is published. Therefore, this consultation is focused solely on the target formula which determines the preferred relative distribution of resources.

3. KEY ISSUES

3.1 The existing public health grant formula is summarised in **Appendix 1**.

3.2 The proposed changes to the formula, and their impact on Tameside MBC target allocation are summarised below.

3.3 *Routine data updates*. Since the publication of the 2013-14 and 2014-15 allocations a number of the datasets have been updated, in particular the standardised mortality ratios (SMR) have been updated to use population estimates based on the 2011 as opposed to the 2001 census. Deprived areas have tended to see their SMR<75 estimate fall as the denominator (expected number of deaths based on the population size and age structure) rises. This effect is enhanced for the most deprived areas because of the exponential weighting used to weight the SMR<75 and shows the **no change** impact on Tameside target allocation in the graph below.



3.4 *Using a modelled rather than the actual standardised mortality ratio* has a number of benefits, particularly that it can continue to identify underlying drivers of poor health in a local authority that has been successful in meeting those challenges. For Tameside modelled standardised mortality ratios would be advantageous as work already completed re modelled prevalence of disease has shown that the current disease registers have lower rates of disease prevalence than expected.

3.5 However, ACRA's view is that the modelling is not yet robust enough for implementation so recommends the actual SMR<75 continues to be used, while work continues to develop the model. There are no implications for the proposed target allocation formula for 2016-17, but appears a **positive proposal**.

3.6 *Increasing the number of area groupings used for the standardised mortality ratio based component.* During the allocation period concerns were raised by independent analysts around the way small areas of similar mortality were grouped, in particular that this may mean the target was insufficiently sensitive to the most extreme deprivation. ACRA is proposing that finer grouping is used to offset this. The impact of this change is relatively small for the majority of Middle Super Output Areas (MSOAs). However, for the 5% of MSOAs with the worst SMR<75s there is a more marked increase, with some seeing their weighting double. On average, LAs with the most deprived populations benefit from this change. This factor does not change Tameside's share per 100,000 resident population by zero percentage points, so appears the **same.**

3.7 *A new formula component for substance misuse services*. The existing model for drugs misuse uses a combination of recent provision and recent success rates, in line with the approach used in the past for Pooled Treatment Budgets (PTBs). This formulation can be volatile and could be subject to perverse incentives, such as the incentive to treat more people rather than to invest in prevention. ACRA is therefore proposing a new formula, for both drugs and alcohol misuse, based on a utilisation dataset that can be linked to the user's place of residence and controlled for effects that may drive up utilisation, but are not connected to need. Most of the impact is to target more resources at the most deprived areas and this factor decreases Tameside's share per 100,000 resident population by 0.02 percentage points, so appears **negative.**

3.8 *A new formula component for sexual health treatment services.* The existing target formula uses the SMR<75 to indicate areas where deprivation and other factors may be creating a greater health challenge. Some stakeholders were concerned about the suitability of this approach for sexual health services, where the link between mortality and drivers of need for services may be particularly distant. As for substance misuse services, ACRA is now proposing a new formula based on a utilisation dataset that can be linked to a user's place of residence and controlled for effects that may increase utilisation, but are not linked to need.

3.9 Outside London the effect is predominantly to target more resources in more affluent areas and away from more deprived areas. This is consistent with the criticism of the existing approach: SMR<75 (which is highly correlated with deprivation) is not a good predictor of sexual health services utilisation, and so the most deprived areas tended to see their target share reduce as this is corrected. This factor reduces Tameside's share per 100,000 resident population by 0.04 percentage points, so appears **negative.**

3.10 In contrast, London is a net beneficiary of this change, with just two boroughs seeing a reduction of their target share, even when they are in the most deprived groups. This is consistent with the view of the London Boroughs in particular who felt the existing formula underestimates need for these services in their areas.

3.11 *A new component for children's 0-5 services* takes account of the transfer of resources from NHS England to LAs for responsibility for commissioning public health services for children aged under five years. From October 2015 to March 2016 the budgets are primarily on the basis of 'lift and shift.'

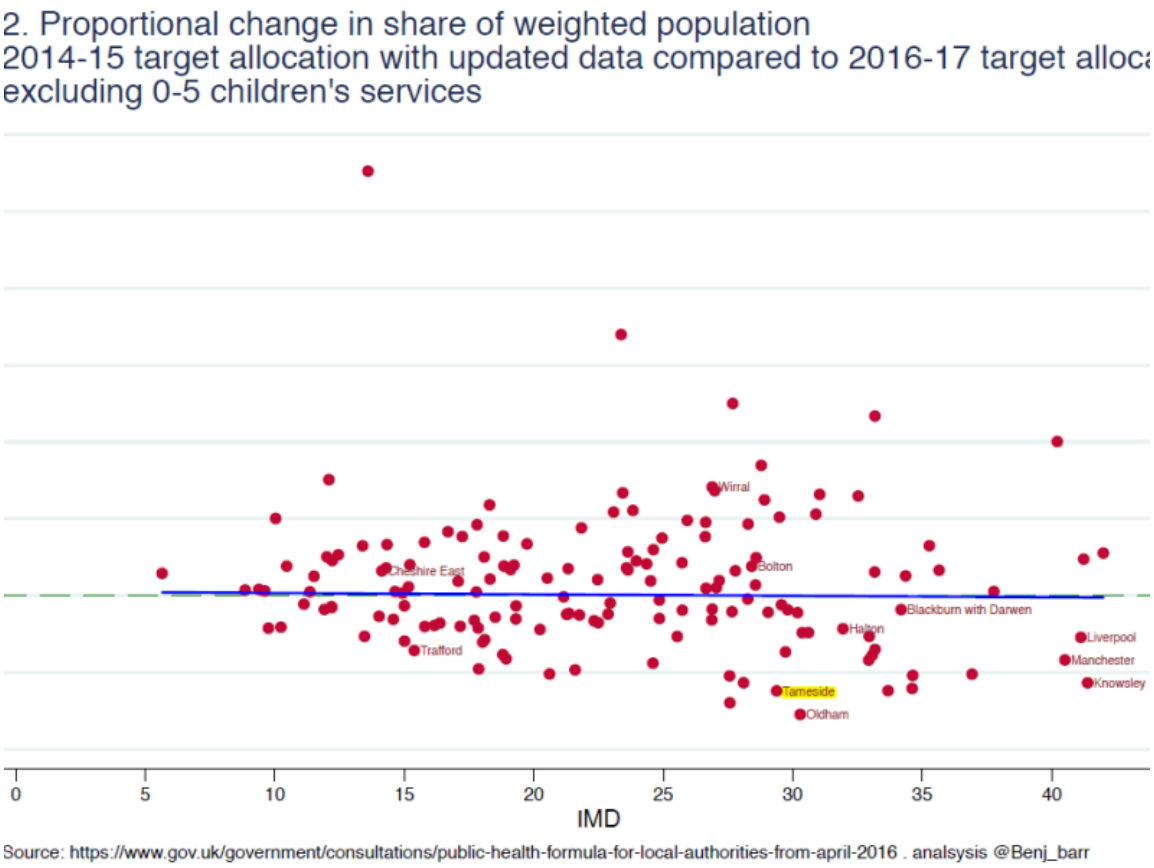
3.12 The formula proposed by ACRA has three elements:

- The under 5 years child population;
- An adjustment for relative need per head of the population base;
  - ACRA also considered the proportion of live births at term that are low birth weight and the number of births to women aged under 20 years. However, data on these were felt to be too volatile at LA level due to small numbers and not broad enough to capture all children with higher need.
  - The IMD2010 indices, which are based on data for around 2008, were felt to be too dated. The date of publication of the IMD2015 indices had not yet been finalised.
  - Children in need of support from social services and children in need of safeguarding and subject to a child protection plan were also considered, but not recommended due to concerns over the variability between LA in the interpretation of the definition of, and routes to identify, children in need and in need of a child protection plan.
  - ACRA favours, and has used in the proposed formula, the measure 'Children in Low Income Households'
  - The measure also needs to be scaled – how much higher should be the weight per head for children in poverty compared with children not in poverty. ACRA has found little evidence to support a particular weighting and an element of judgement is required, so are proposing a ratio of 4:1 as reflecting a central position given the advice they have received.
  - Sparsity; may create unavoidable differences in the costs of providing some 0-5 children's public health services between LAs, in particular where health visitors travel for home visits. A model has been developed which suggests that health visitors in the most sparsely populated areas require 4% more resources than the least sparsely populated.

3.13 With these three elements combined, the new component for children's 0-5 services tends to benefit areas with higher birth rates. It also has a tendency to reduce the target share for more deprived areas. Although counter intuitive at first sight, this is because core health

visiting is a universal service and so, the net effect of the weighting for deprivation in this part of the formula is less than for other parts of the formula.

3.14 **Tameside's share per 100,000 resident population reduces by 0.04 percentage points, so appears negative.**

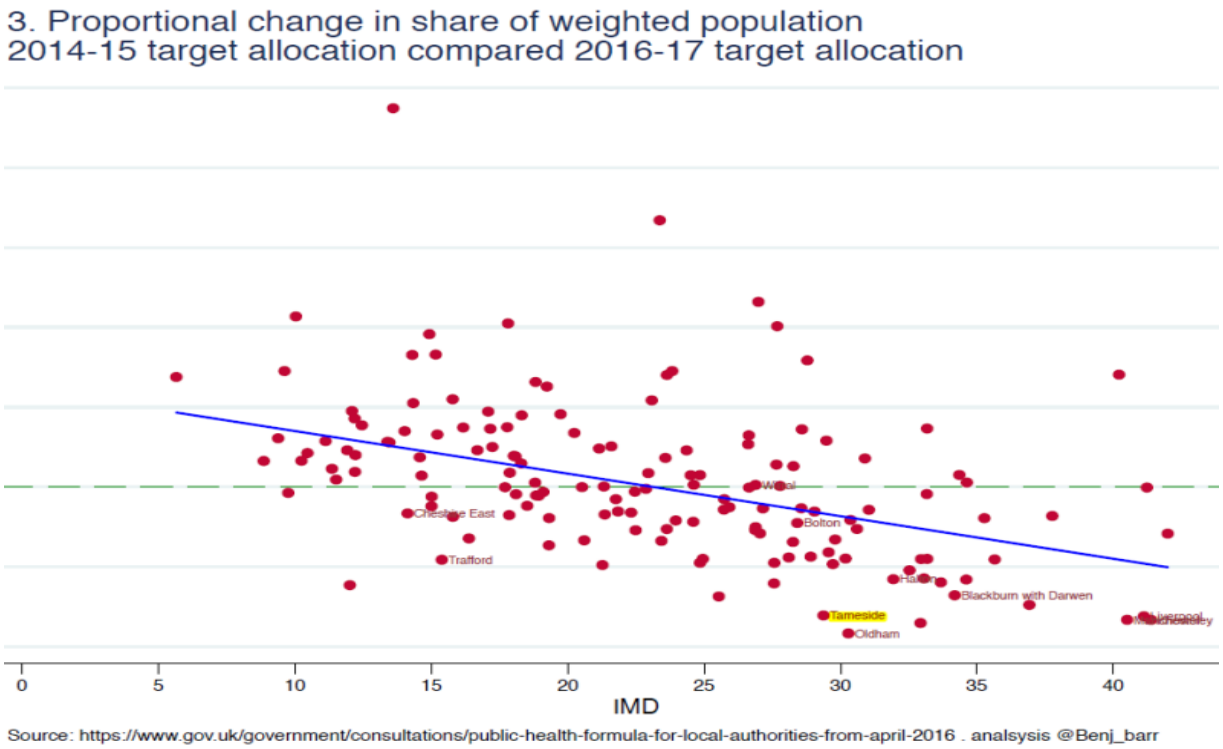


3.15 In our consultation response we would want to highlight the following:

- That the impact of deprivation on the need for 0-5 years children's public health services is under estimated
- Similarly, the formula ignores safeguarding, which has a massive impact on Health Visitor workload in deprived areas

3.16 **<u>Overall impact</u>**

3.17 **The overall impact on Tameside of the proposed target allocation formula for 2016/17 is shown below, which represents a 0.1% reduction of relative share.**



3.18 Timetable

3.19 The tentative timetable for the 2016/17 Public Health allocations is as follows,

i. Response to consultation closes 6 November 2015
ii. Analysis and review by ACRA and Final Recommendation to Ministers Mid November 2015
iii. Allocation finalised subject to Spending Review settlement End November 2015
iv. Allocations announcement December 2015/January 2016

4. FINANCIAL IMPLICATIONS

4.1 The public health grant in 2015/16

	£'000
Public Health Baseline Grant	13,463
0-5 Health Visiting	3,454
Total	16,917

4.2 The 1% decrease in the Tameside MBC allocated share will decrease from 0.25% to 0.24%, which in financial terms is equivalent to a reduction of £340k in grant allocation for Tameside. Based on the 2015/16 baseline grant allocation this would mean the Tameside allocation reducing from £13,463m to £13,123m.

5. LEGAL IMPLICATIONS

5.1 The local authority decides how best to spend the public health grant, having regard to the needs of the population, its statutory responsibilities and the grant conditions.

6. RESOURCE IMPLICATIONS

6.1 The formula for public health grants is on a weighted capitation basis. The consultation suggests that the proposed target allocation for each Local Authority area can be summarised as either % share of overall weighted population or % share of weighted population per 100,000.

6.2 For Tameside, the target allocation for 2014/15 using the current formula is 0.25% of overall weighted population. The proposed target allocation for 2016/17 using the fully updated formula and data is 0.24% of overall weighted population, a 0.1% reduction of relative share.

7. CONSULTATIONS:

7.1 Between 8 October and 6 November 2015 the Department of Health is consulting, on behalf of the Advisory Committee on Resource Allocation (ACRA), on interim recommendations for a number of changes to the target formula for the public health grant for 2016-17 onwards. See **Appendix 2** for copy of the consultation response from Tameside Council.

THE CURRENT FORMULA, USED TO SET TARGET ALLOCATIONS FOR 2013-14 AND 2014-15 FOR PUBLIC HEALTH GRANTS TO LOCAL AUTHORITIES

A summary of the current formula is as follows:

The formula is principally based on a population health measure, the standardised mortality ratio for those aged under 75 years (SMR<75). Many of the mortality and morbidity measures are highly correlated, and are in turn highly correlated with deprivation. The SMR<75 is used as an indicator of the whole population's health status and should not be interpreted as meaning that the allocation should not reflect the needs of those aged over 75 years or that morbidity is unimportant.

The SMR<75 is applied at middle layer super output areas (MSOA) level to take account of inequality within LAs as well as between LAs;

The gradient of the formula across small areas is exponentially weighted at a ratio of 5:1 to target funding per head towards areas with the poorest health outcomes; obesity and physical activity, alcohol misuse, tobacco misuse, sexual health services, children's 5-19 services, and drugs misuse.

An age-gender adjustment is applied for those services with the highest proportion of public health spend which are also directed at specific age-gender groups, to weight for relative needs between different age-gender groups;

A component to support drug treatment services funded through the pooled treatment budget (PTB) up to 2012-13 which broadly follows the approach used to allocate that budget. This is based on a need component, an activity component and an outcome component. The need component in the PTB formula was replaced with the SMR<75;

An unavoidable cost adjustment, the Market Forces Factor (MFF); the MFF is that used in NHS allocations to Clinical Commissioning Groups (CCG), mapped to LAs.

The weights per head from the above are applied to Office for National Statistics resident population projections for LAs to give weighted populations for each LA. Each LA's share of the total weighted population gives its target share of the national budget (once known).

Department of Health

Public health grant: proposed target allocation formula for 2016/17

Proforma for responses to consultation exercise

November 2015

Public health grant: proposed target allocation formula for 2016/17

Summary of consultation questions

Name : Angela Hardman

Position : Director of Public Health

Organisation : Tameside Council

Email : angela.hardman@tameside.gov.uk

Q1 : Do you agree that a modelled SMR<75 should be developed for use in the longer term?

Response :

Yes, Tameside Council are in favour of the development of a modelled SMR<75 that reduces volatility in allocation over time.

Q2 : Do you agree that the sixteen groups outlined above provide a sensible balance between sensitivity to the most extreme mortality rates and protection against volatility of measurement?

Response :

Yes, overall Tameside Council supports to move to the use of 16 groups as this increases the weighting for the most deprived areas and achieves a more progressive allocation. However, some moderation of the beneficial impact for the most affluent LAs would need to added in to prevent this approach also increasing inequality.

Q3: Do you agree that the proposed new substance misuse formula component should be introduced?

Response :

No, Tameside Council does not support this change as although most of the impact is to target more resources at the most deprived areas, this change would reduce the local allocation. This approach fails to provide sufficient continuing support to those LAs that have invested in effective preventive programmes that reduce demand, seeming to reward those that haven't invested in effective prevention and encouraging them to maintain service usage. This approach also discourages more deprived areas from developing local access to services to reduce drift to urban centres for treatment.

The existing model for drugs misuse uses a combination of recent provision and recent success rates, in line with the approach used in the past for Pooled Treatment Budgets (PTBs). Whilst this formulation can be volatile and could be subject to perverse incentives, such as the incentive to treat more people rather than to invest in prevention and the formula change proposed by ACRA will help to control for effects that may drive up utilisation, but are not connected to need; however, more work is needed to make this component more robust.

Q4 : Do you agree that the proposed new sexual health services formula component should be introduced?

Response :

No, Tameside Council do not support this change, in line with the Consultation Document statement: "Outside London the effect is predominantly to target more resources in more affluent areas and away from more deprived areas". As for substance misuse services, this approach fails to provide sufficient continuing support to those LAs that have invested in effective preventive programmes that reduce demand, seeming to reward those that haven't invested in effective prevention and encouraging them to maintain service usage. This approach also discourages more deprived areas from developing local access to services to reduce drift to urban centres for treatment.

We do not feel that any of the models are appropriate for implementation at this time, primarily because none of the models include the use of SHRAD. In 2013/14, SHRAD was not mandatory and was a transition period between KT 31 and SHRAD for the collection of contraception activity. None of the outlined models reflect need for preventative services rather than need for treatment services.

Q5 : Do you agree that the proposed new services for children under five years formula component should be introduced?

Response :

No, Tameside Council would not support this change. Whilst accepting that birth rate is an important factor in need for 0-5 years services, deprivation and safeguarding account for such a significant amount of the variation in need that a factor that reduces the share to more deprived areas is regressive. Travel times are higher in

more affluent County LAs, where need associated with deprivation and safeguarding makes up a smaller proportion of the total service demand.

The deprivation element based on an arbitrary weighting of the percentage of children in poverty is the least distributive of all the deprivation formulae in the proposal. This doesn't make sense in view of the importance of early years' health in influencing health in later years, which is a key underlying driver for the Greater Manchester Early Years New Delivery model. Therefore we suggest that it be replaced either by the SMR<75 weight or that the weighting ratio of 1:4 be increased significantly, certainly 1:5 as a minimum.

The formula for services for children under 5 should include an age weight. This is because:

a. Spend is skewed to births and the earlier ages of years 0 to 4.

b. The fractions of the England population at ages 0-1,1-2,2-3,3-4 and 4-5 vary within local authorities. This variation appears systematic in that in general urban areas have higher fractions for the earlier years (and for births) while rural and some suburban areas in general have the opposite - higher fractions in the later years of 0-5. This pattern reflects migration of families with very young children who migrate from urban to suburban or rural areas. Urban areas often have a greater burden of births and very early years high costs while many suburban and rural areas have a greater 0-5 population at the higher ages where costs are less.

Thank you for your response to the consultation.

Email to: PHformula2016/17@dh.gsi.gov.uk

or

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