Department of Health

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

Proforma for responses to consultation exercise

November 2015

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Summary of consultation questions

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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.

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or

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