The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

17 October 2012

Dear Jeremy,

Congratulations on your appointment as Secretary of State for Health, I wish you every success in your new post.

The Advisory Committee on Resource Allocation (ACRA) is an independent expert committee with a long standing history of overseeing the formula used to allocate NHS resources. ACRA's membership comprises senior academics, NHS managers, GPs and public health experts. The Rt Hon Andrew Lansley MP asked ACRA to develop formulae for the allocation of resources to both clinical commissioning groups and to local authorities for their future public health responsibilities.

I set out ACRA's interim recommendations in my letters of September and October last year. In these letters it was recognised that ACRA wished to undertake more work to develop its final recommendations. In this letter I set out ACRA's final recommendations for the formulae for 2013-14 allocations.

Public health allocations to upper tier and unitary local authorities

The interim recommendations on the public health formula from ACRA were published in June in *Healthy Lives, Healthy People: Update on Public Health Funding.* Following publication, your Department undertook an eight week focussed engagement with a full range of stakeholders including public health and local government representatives and the wider NHS community.

This is the first time that ACRA, or the Department, have sought wider views and comments in this way, and it is clear from the feedback we received both formally and informally that the principle of the approach and the openness with which it was carried out were welcomed. We have been keen to engage more widely previously (as proposed in a paper by one of our members, Professor Gwyn Bevan, in recent years). The success of the recent process has confirmed our view that wider engagement should be added to our evidence gathering work.

The response to ACRA's interim public health recommendations has generally been supportive of an approach principally built up from the population size of each local authority and from the standardised mortality ratio (SMR) for those aged under 75 years, as the indicator of relative need.

This approach applies the SMR<75 to small areas with a resident population of around 7,000 which are then aggregated to local authority area. SMR<75 is a measure of how many more or fewer deaths there are in a local area compared with the national average, having adjusted for differences in the age profiles.

Many of the concerns raised were in areas that ACRA was already considering before finalising the recommendations for 2013-14 allocations to local authorities for their new public health responsibilities.

But some new concerns were also raised and we have responded, where appropriate, with some material differences in our final recommendations compared to the interim recommendations.

As we noted in our interim recommendations as planned further work, ACRA has considered:

- An adjustment for age - much of the spend in areas like sexual health meets the needs of young adult populations and public health interventions may be more effective if targeted at younger people – for instance to support a healthy diet initially rather than waiting until an individual is obese. We have also included a non-zero weighting for children aged under five, foreshadowing the expected transition of health visitor and similar services to local authorities from 2015-16.
- A fixed cost adjustment - in which all local authorities receive the same cash amount in absolute terms as part of their allocations because the costs of some services may vary little with population size or need. While there was concern that smaller local authorities would face significant fixed costs, and so may need a higher per capita allocation, we have found no objective evidence of this. Your officials have advised that the policy intention is that smaller authorities should be encouraged to share responsibilities whenever this makes sense and so we are recommending no allowance for fixed costs.
- Non-resident populations – the interim recommendations are based on the number of people resident in each area, but some services, most notably open access sexual health services will be available to anybody who is in an area, whether they are residents or not. Our strong recommendation is that the best way to address this in the medium term is through re-charging of costs back to the areas where the individual is resident. On this basis there would be no requirement for an adjustment to the allocation formula for non-residents. It is for local authorities to agree re-charging or other cost sharing arrangements. In fact, we found that in practice, considering particularly cross border flows of working populations, any such correction would in any case only be material for the City of London.
- Updated to include the latest ONS population projections - we recommend that the latest populations projections, which are based on the 2011 population census are used. This is in line with the population base to be used by DCLG for setting the needs baseline in the new business rates retention scheme. Unfortunately population

information for the smallest areas will not be available in time for the SMR<75 estimates to be updated based on the 2011 census. We recommend using the latest available SMR estimates for 2013-14 allocations, which use the latest information on the number of deaths and are based on population sizes partly derived from the 2001 census to turn the number of deaths into a death rate. This is consistent with our general approach of using the best available data at the time.

- An unavoidable cost adjustment due to location– in its interim recommendations, ACRA proposed using the Area Cost Adjustment (ACA) for unavoidable costs due to location. This was mainly on the grounds of consistency with the local government formula. As local government is moving to a long, multi-year settlement, the ACA is unlikely to be updated for at least another seven years. The Market Forces Factor (MFF) is used in the current PCT allocations formula to adjust for unavoidable costs due to location. As the MFF and ACA are based on similar approaches and the MFF will be updated regularly, ACRA recommend the use of the MFF in the public health allocations formula .

The engagement responses also suggested a very strong view that, compared with the published interim model, we should weight resources more strongly towards areas facing the greatest challenges. ACRA reviewed this issue and found that in practice the weighting in the interim recommendations was not as strong as ACRA had originally intended. Our latest recommendations give a higher weight to the small areas with the greatest challenges, using an exponential distribution – one that sees the rate of growth in resources accelerate as we move towards more challenged areas. The engagement confirmed our earlier findings that there is no firm evidence to guide how much resource the most challenged small areas need compared to the least challenged (the 'gearing'). ACRA had originally settled on a gearing of 3:1, but following a review of engagement responses and spending information, ACRA's consensus view is that the gearing should be increased; we have settled on a gearing of 5 :1. This is a key decision for the model and while this represents our best judgement it will need detailed reappraisal in the medium term.

We also noted some areas of concern where ACRA felt a change to our recommendations was not appropriate. In particular:

- There was concern that the SMR may not be particularly well linked to need for sexual health services. We think the concern is valid, but there is no immediate alternative that appears to work well across the country. As SMR is closely linked to deprivation, and since the engagement we have added an age weighting, we chose not to change our recommendation, but this needs more detailed consideration in the next phase of work.
- There were some who felt that the formula should be linked to a measure of deprivation, not a health outcome. We have previously noted our concern that a health outcome should not be the main driver of the formula in the medium term. This is because a local authority

which improves its health outcomes would be at risk of losing future public health funding and we believe this is a perverse incentive. ACRA will continue to work on a formula based more on the underlying drivers of need. But we believe the SMR is acceptable in the short term and it is strongly linked to deprivation.

- While retaining the activity and outcomes elements of the current formula for adult substance misuse services, we have changed the underlying need component of the current formula to the SMR<75 to be consistent with the wider model. The formula currently used for underlying need was developed in 2000 and is now difficult to update. We therefore believe our proposal offers a pragmatic way forward.
- There was concern that SMR<75 may not be a stable measure of need. This may be true for the smallest local authorities and we recommend that your officials take this in to account when considering the most appropriate pace-of-change policy.

In summary, ACRA's recommendations for the public health formula to determine 2013-14 allocations to local authorities are:

- the measure of population health should be the standardised mortality ratio for those aged under 75 years of age (SMR<75). SMR<75 is being proposed as an indicator of the whole population's health status, and hence need for public health services; it should not be interpreted as meaning that the allocation should not reflect the needs of those aged over 75 or that morbidity is not important;
- the formula should be applied to small areas to take account of localised health inequalities within local authority areas;
- the gradient of the formula across small areas should be exponentially weighted at a ratio of 5:1 targeting funding towards areas with the poorest health outcomes;
- an unavoidable cost adjustment should be used in the formula and this should be the Market Forces Factor as this will be updated regularly
- ONS population projections should be the main basis of the public health formula and these should be updated in line with the 2011 population census;
- age-gender adjustments should be incorporated in to the formula to weight for relative needs between different groups due to age and gender.
- an adjustment for non-resident populations for sexual health services should not be used to encourage the development of a recharging approach between authorities.
- the component to support drug treatment services currently funded through the pooled treatment budget should continue to broadly follow the approach used to allocate that budget. This is currently based on a need component, an activity component and an outcome component. ACRA recommends the need component is replaced with SMR<75 as recommended for the rest of the public health formula.

Further details on ACRA's recommendations on the public health formula are provided at annex A.

Longer term development of a more evidence-based formula
ACRA has already expressed a desire to develop a more evidenced based formula for the distribution of public health resources in the longer term based on the underlying drivers of need for public health services, including supporting reductions in health inequalities. ACRA has considered potential approaches and has identified those worth more detailed consideration:

- utilisation, for instance how does service usage vary with the type of population served;
- a bottom-up costing, based on a model of what services might be offered to populations with different needs;
- exploring how deprivation and other measures, such as ethnicity, link to the need for public health services; and
- exploring relevant longitudinal data.

ACRA recommend continuing to explore these approaches as part of their longer term work programme. It may be the case that different approaches are best suited to different public health roles.

CCG Allocations

General and Acute
As per my letters to Mr Lansley of 2 September and 18 October 2011, ACRA has already recommended that the formula developed by the Nuffield Trust for ACRA should be used for the general and acute components of the formula, with the exception of mental health, to determine allocations to clinical commissioning groups (CCGs) from 2013-14. This formula is built up from individual patient data and includes weights for age and additional need (over and above that due to age). Previous conditions for patients registered with each GP practice is a major factor in the estimate of additional need. ACRA confirms its interim recommendation that the formula developed by Nuffield is used for CCG allocations.

Testing of the Nuffield formula at GP practice level against the current PCT formula gave plausible results and was more accurate than the current PCT formula in predicting expenditure at this level.

Mental Health
Work to develop the mental health component of the CCG formula based on the person based approach has been commissioned from a team led by Professor Matt Sutton of Manchester University. The formula provides robust estimates for relevant mental health expenditure. The approach is closely linked to the general and acute methodology discussed above and exploits the Mental Health Minimum Data Set. We recommend this approach is adopted.

Unregistered Populations

The weighted population in the CCG formula will be based on registered lists, as in the Nuffield Trust and University of Manchester methodologies. In the allocation formula, registered lists will not be scaled to equal ONS population figures as has been the case for PCT allocations, and therefore an adjustment for the unregistered population needs to be considered. Unregistered populations for allocation purposes include those without a valid GP registration which includes unregistered travellers and the unregistered homeless, but excludes those registered with a GP in the private sector and visitors from overseas.

Asylum seekers who are eligible for free NHS services are not included as they are eligible to register and there should be an incentive to primary care to ensure they are registered.

We have explored a number of data sources, most notably the Hospital Episode Statistics, and have been unable to identify a robust source of information about the use of services by people who are not registered with a GP. We therefore recommend that funding for these services is handled through a post hoc adjustment that ensures that all CCGs make a fair contribution to these services. This is similar to the approach taken for PCTs in respect of charge exempt overseas visitors, but it does have some serious disadvantages. It creates no incentive for registration of what may be a particularly vulnerable group and CCGs may be unwilling to invest in services when the funding stream is uncertain. Further work to improve the identification of unregistered individuals is therefore urgently needed and ACRA recommends that the NHS Commissioning Board is pro active in taking this work forward.

As registered lists will no longer be scaled to equal ONS population figures in the formula, ACRA has previously recommended that a greater emphasis is placed on work already in hand to ensure the quality and robustness of GP registered lists and that these improvements continue to be maintained to ensure the accuracy of CCG allocations. ACRA emphasises again the importance of work to ensure registered lists are accurate and up-to-date.

Rurality

In Mr Lansley's letter of 27 September 2011, he asked ACRA to review the impact of rurality on unavoidable differences on costs of providing services once data from the Community Services Minimum Data Set (CSMDS) becomes available. As these data will not be available in 2012, this work will need to be considered as part of ACRA's future work programme. In the meantime, as requested, ACRA will share its knowledge on the impact of rurality with Monitor once it is in a position to take this work forward.

Unmet Need

As part of its longer term work programme, ACRA was also asked to consider unmet need as part of our future recommendations on the CCG formula. ACRA believe that rather than 'unmet need' the problem is one of 'sub-optimal access' where an individual's care costs more or less than it would if it had been accessed at the most beneficial point. We believe that the best way

forward is to focus future research on a selection of specific diseases/conditions with sufficient coverage to be representative.

ACRA also recommends that increasing patient registration should be considered as an important method to reduce unmet need; a focus on increasing registration will also allow utilisation to better, but not necessarily completely, capture need.

ACRA agreed that a formula adjustment alone will not tackle unmet need completely, as the way in which resources are deployed locally is also important. Policy complements are therefore likely to be needed, such as local performance management and incentive measures.

ACRA's future work will continue to determine a specification for research building on the approach set out above.

On many occasions, ACRA discussed the need to ensure coherence across all approaches to the allocation of resources for health services, and in particular the interaction between the distribution of resources at local level for each of the three separate budgets for primary care, CCGs and public health.

The recommendations set out in my previous letters on the population base for allocations to CCGs, and the prescribing and maternity elements of the CCG formula remain unchanged. Copies of these letters are attached at annex B for reference.

I would be happy to explain further ACRA's recommendations if this would be helpful. I am copying this letter to the Chief Executive of the NHS Commissioning Board to inform his work on allocations to CCGs.

Yours sincerely

David Fillingham
Chief Executive Advancing Quality Alliance (AQuA) North West
& Chair of ACRA

Copy: Sir David Nicholson, Chief Executive of the NHS Commissioning Board

The ring-fenced public health grant to local authorities –final recommendations for 2013-14

Background

ACRA was asked to develop a formula for the preferred relative distribution of public health resources between local authorities based on relative population health need. The approach developed should enable action to improve population wide health and reduce health inequalities.

ACRA's interim recommendations were published in June 2012 in *Healthy Lives, Healthy People: Update on Public Heath Funding.* Following publication, the Department of Health undertook an eight week focussed engagement with a full range of stakeholders including public health and local government representatives.

Standardised Mortality Ratio (SMR)

ACRA's recommendation for the weights per head for need, is based principally on a measure of population health, namely the standardised mortality ratio for those aged under 75 years of age (SMR<75). This is a measure of how many more or fewer deaths there are in a local area compared with the national average, having adjusted for differences between the age profile of local areas compared with the national average. SMR<75 is being proposed as an indicator of the whole population's health status, and hence need for public health services; it should not be interpreted as meaning that the allocation should not reflect the needs of those aged over 75 or that morbidity is unimportant.

ACRA considered a wide range of possible indicators of need. The SMR for those aged under 75 years was preferred to the other leading options of disability free life expectancy (DFLE) and healthy life expectancy (HLE) because the data are more up to date, especially for small areas such as Middle-Layer Super Output Areas (MSOAs). MSOAs are small, geographical areas defined by the Office for National Statistics, used for statistical analysis and typically cover a population of around 7,000. DFLE and HLE data for small areas are only available from the Census so may quickly become dated and will not be available from the 2011 Census in time for 2013-14 allocations. While DFLE and HLE capture morbidity as well as mortality, the SMR is highly correlated with both DFLE and HLE, so it appeared DFLE or HLE has little advantage in terms of capturing morbidity. Furthermore, the morbidity measure in DFLE and HLE are fairly basic - a simple yes/no categorisation of whether a person self-reports they have a long term illness, health problem or disability (DFLE) or are in good health or not (HLE).

Gearing

ACRA recommend that resources should be weighted more strongly towards small areas facing the greatest challenges. Following publication of its interim recommendations, ACRA reviewed this issue and found that in practice the

weighting in the interim recommendations was not as strong as ACRA had originally intended. Our latest recommendations give a higher weight to the small areas with the greatest challenges, using an exponential distribution – one that sees the rate of growth in resources accelerate as we move towards more challenged areas. The engagement confirmed our earlier findings that there is no firm evidence to guide how much resource the most challenged small areas need compared to the least challenged (the 'gearing'). ACRA had originally settled on a gearing of 3:1, but following a review of engagement responses and spending information, ACRA's consensus view is that the gearing should be increased; we have settled on a gearing of 5 :1. This is a key decision for the model and while this represents our best judgement it will need detailed reappraisal in the medium term.

Market Forces Factor

ACRA's interim recommendations proposed that an unavoidable cost adjustment should be used in the public health formula and this should be the Area Cost Adjustment (ACA) to provide consistency with the Department for Communities and Local Government's local authority formula. The preference for the ACA over the NHS market forces factor (MFF) was on the pragmatic grounds of coherence with other local authority funding streams. However, since publication of the interim recommendations we have learned that local government is moving to a long, multi-year settlement, and therefore the ACA is unlikely to be updated for at least another seven years. The Market Forces Factor (MFF) is used in the current PCT allocations formula to adjust for unavoidable costs due to location. As the MFF and ACA are based on similar approaches and the MFF will be updated regularly, ACRA recommend the use of the MFF in the public health allocations formula .

Age-Gender Adjustment

Some public health functions are clearly directed at certain age groups and ACRA agreed this should be taken into account in the formula.

ACRA agreed there should be an age-gender adjustment using the indicators set out in the table below. Indicators of lifestyle risks were generally preferred to rates of service use as prevention rather than cure seemed closer to the spirit of a public health service (eg indicators of heavy drinking in preference to alcohol related hospital admissions). These indicators cover a high proportion of current spend on functions which will become the responsibility of local authorities from April 2013. In some cases the indicators are different for those aged under 16 years due to data availability.

Indicators for age-gender weights

Function	Indicator for those aged 16 and over	Indicator for 5 to 15 year olds	Indicator for children aged under 5 years[1]

[1] The age-gender adjustment is applied in the formula by multiplying the total population by an overall index for age-gender. This ensures where there is zero weight for some age groups, the size of this population group still contributes to the area's target allocations.

Function	Indicator for those aged 16 and over	Indicator for 5 to 15 year olds	Indicator for children aged under 5 years[1]
Sexual health	Health Protection Agency (HPA) data on the rates of new episodes of diagnoses at GUMs for gonorrhoea, syphilis, herpes and warts in 2010 per 100,000 population for those aged 15 and over. HPA no longer collect comparable data for chlamydia. The rates of new episodes for these four have simply been added together, giving equal weight to each.	No weight for under 15s	Not applicable
Children 5-19	A weight of one for each member of the population aged 5-19, and zero for all other population age groups.	Same for those aged 16+	Not applicable
Nutrition, obesity and physical activity	Percentage in each age-gender group who eat fewer than 5 portions of fruit and vegetables per day as recorded in the 2010 Health Survey for England (HSE).	Same for those aged 16+	Average weights for parental age groups.
Alcohol misuse	Percentage of each age-gender group binge drinking as recorded in the 2010 HSE. Defined as more than 8 units for men and more than 6 units for women in the heaviest drinking day last week.	Percentage of 14-15 year olds who reported they had an alcoholic drink or alcopop in the last 4 weeks. Used as weight for all 5-15 year olds.	Average weights for parental age groups.
Tobacco	The percentage in each age-gender group who are current smokers from the 2010 HSE.	Percentage of 14-15 year olds who reported they had smoked in the last week or that they smoked sometime or more often or are often near people who smoke at home. Used as weight for all 5-15 year olds.	Average weights for parental age groups.
Drugs misuse	Treatment rates by age group	Treatment rates by age group	Zero (LAs are responsible from the ring-fenced budget for treatment only, Children's education and prevention services are funded by the separate education/children's services budgets,

Function	Indicator for those aged 16 and over	Indicator for 5 to 15 year olds	Indicator for children aged under 5 years[1]
			for which DfE is the policy lead.)

For three functions, the average weights for the parental age groups have been recommended for children aged under 5 years. ACRA recognised that local authorities will not be formally responsible for this age group initially, but felt in line with Marmot's recommendations, account should be taken of the very early development years for their future health, influenced by their parents, and also that the precise division of responsibility by age group may be less relevant on the ground as local authorities are expected to prioritise their spend in line with the local priorities they identify.

ACRA also considered whether there should be different age-gender adjustments by ethnic group as these may be different. However, the data are not sufficiently robust due to small sample sizes for different ethnic groups by age and gender. ACRA therefore recommended the age-gender adjustments should not vary by ethnic group.

Drugs Treatment- Pooled Treatment Budget

Drug treatment services are currently commissioned by Drug Action Teams (DATs) which are multi-agency partnerships created as part of the UK national drug strategy and are responsible for delivering the drug strategy at a local level. DATs in England receive various funding streams including the pooled treatment budget via the DH funded National Treatment Agency for Substance Misuse.

ACRA recommends that there should be a specific component in the overall formula for services currently funded by the pooled treatment budget, and this component should continue to follow the current PTB formula which has been praised as effective by the National Audit Office. The current formula is based on a need component, an activity component and an outcome component dependant in part on the number of people successfully completing treatment. This should continue to be followed in the public health formula except for replacing the need component with the SMR<75, as recommended for the rest of the public health formula. The formula currently used for underlying need was developed in 2000 and is now difficult to update.

ONS population projections

ACRA has already recommended the use of the 2011 Census population based projections from the Office for National Statistics (ONS) as the population base for the public health allocations to local authorities. ONS have now issued the sub-national population projections for local authorities and these will be included in the formula for 2013-14 allocations.

The SMR<75 measure in the public health formula is used at Middle-Level Super Output Area (MSOA) level. A key part of the calculation of the SMR<75 is the death rate by age group for which the population by age group is required for each MSOA. This is normally calculated over five years and the

SMR<75 proposed for use in the formula uses deaths between 2006-10 and MSOA populations for these years partly derived from the 2001 Census. ACRA investigated whether it would be possible to calculate SMRs using the population by age group for MSOAs based on the 2011 Census. The MSOA populations from the 2011 Census, however, will not be available in time for use in the formula, and ACRA therefore recommend the use of current SMRs based on the pre-2011 Census MSOA populations. This allows consistency with both the allocations from the Department for Communities and Local Government (DCLG) and future allocations to clinical commissioning groups (CCGs). The use of 5 year SMRs is also consistent with the 5 year SMR<75 values that local authority and public health colleagues are already familiar with.

Non-resident populations

ACRA recommend that the population base for public health allocations is to be the resident population projections produced by ONS. As part of their work programme, ACRA considered whether there should be an adjustment for people who live outside a local authority's area but use services within that local authority's area, such as commuters to work. ACRA considered whether there should be an adjustment for non-resident populations for sexual health services only, as policy advice suggested that local authorities should have discretion to determine how best to discharge their new public health responsibilities. With the emphasis on localism, it should not be for DH to imply whether local authorities should or should not provide certain services for non-residents, with the exception of sexual health services which are mandated as open access.

ACRA acknowledge that re-charging by local authorities for non-resident use of mandatory open access sexual health services is preferable to an adjustment to the formula. While PCTs currently recharge for GUM services using a mandatory tariff they do not recharge for contraceptive services which are funded by a host PCT. It is for local authorities to decide whether they introduce re-charging: if this is not the anticipated system a correction has been estimated. However, this is material for the City of London only.

The current data sources available to support the development of an adjustment do not currently provide a firm enough basis for an adjustment for cross-border flows; they do not cover all sexual health services and as they are based on PCT boundaries they can not provide cross-border flow data for the significant number of local authorities which are not coterminous with PCTs. An adjustment based on the number of people who work in each local authority area relative to the number of people who live in the area was also considered; however, this approach would provide a material adjustment for the City of London only, of around 15%. It is not significant for other areas.

Our strong recommendation is that the best way to address this in the medium term is through re-charging of costs back to the areas where the individual is resident. On this basis, there would be no requirement for an adjustment to the allocation formula for non-residents.

Fixed Cost Adjustment

ACRA considered the option of including a fixed cost component in the formula, in which all local authorities receive the same cash amount in absolute terms (not per head). This would be in recognition that there may be some costs they have to incur which do not vary materially with the size of their local population and the level of health need. Public health leadership and information and intelligence were considered as possible examples of this. However, the reported spend by PCTs as part of last year's baseline spending exercise showed a wide variation in spend on these functions between PCTs.

ACRA noted that one issue is whether small local authorities should be funded to perform these types of functions by themselves, or alternatively be encouraged to undertake these functions jointly with other areas in order to increase overall cost-efficiency.

Although a fixed cost component may have a potentially significant effect on those areas with very small populations, it was found not likely to be significant for other local authority areas. As ACRA could not find a technical basis to advise on whether the formula should include a fixed component, primarily related to limited data availability, ACRA recommended that the final decision should be a DH policy decision on whether each area should be required to provide certain functions itself. DH's current view is that there should not be a fixed cost adjustment as it should be for local authorities themselves to determine how best to discharge their new duties and they have the option of joint commissioning with other local authorities to gain economies of scale.

Perverse Incentives

ACRA was concerned that a health outcome should not be the main driver of the formula in the medium term. This is because an area which improves its health outcomes would be at risk of losing future public health funding and we believe this is a perverse incentive. ACRA will continue to work on a formula based more on the underlying drivers of need for use in the medium term.

Allocations to Clinical Commissioning Groups – final recommendations for 2013-14

ACRA was asked to develop a formula for CCG allocations that supports equal opportunity of access to NHS services, relative to the prospective burden of disease and disability.

General and Acute Formula

As described in last year's letter setting out ACRA's interim proposals substantial programme of research was commissioned from a team led by Dr Jennifer Dixon of the Nuffield Trust to develop the person based resource allocation approach for use in allocating funds for HCHS to CCGs. This methodology is currently used in the Practice Based Commissioning Fair

Shares Toolkit and so will not be entirely new to the service. ACRA has confirmed its interim recommendation that the Nuffield models should be used in the formula for CCG allocations.

The researchers used data routinely collected on each individual using the NHS (the data were anonymised to protect patient confidentiality), on the accessibility of health services for the individual, and on the characteristics of the community in which the individual lives. Statistical models were developed using these data that predict the cost of hospital care of each age/gender group by GP practice in the next financial year.

This approach offers a number of advantages for CCG allocations over the approach currently used for allocations to PCTs. These include:

- information about the diagnoses made during past hospital episodes is used, which has been shown to be a good indicator of need;
- the approach is more robust in estimating relative need for individual GP practices, as it uses individual level data. It is therefore more flexible to changes in the membership of each CCG;
- it is built on registered populations and so is well suited to funding CCGs' primary responsibility, for the combined registered population of their member practices.

The models will be used to calculate the fair share of each CCG of the available budget, weighted for age and additional need over and above that due to age. Previous diagnoses of patients registered with each GP practice is a major factor in the estimate of additional need over and above that due to age. As noted above, the models provide fair shares for individual GP practices which are then combined to provide fair shares for CCGs.

<u>Mental Health</u>

The Nuffield led work did not cover the mental health component of the HCHS formula. Work has been commissioned on the mental health component from a team led by Manchester University which has pioneered the use of the new Mental Health Minimum Data Set (MHMDS). Their approach closely follows that used by the Nuffield Trust, and is person based (using anonymised data).

The researchers have developed models for three gender and age groups (males aged 16-64, females aged 16-64 and persons aged 65+). For these three gender and age groups, the models with the highest explanatory power contain the following needs variables:

Males aged 16-64 years	**Females aged 16-64 years**	**Persons aged 65+**
Five-year age bands	Five-year age bands	Five-year age bands
QOF SMI prevalence	QOF SMI prevalence	QOF dementia prevalence
IB/SDA for a mental health condition	IB/SDA for a mental health condition	SMR for mental illness
Student practice	Student practice	Single person pension credit
Proportion of population widowed	Proportion of population widowed	Rate of long-term health problems
Proportion of population single	Proportion of population single	

	Proportion of population divorced	
Prevalence rates in previous 2 years: • Viral hepatitis • Poisonings by drugs	Prevalence rates in previous 2 years: • Cognition/perception symptoms • Poisonings by drugs	
43 types of psychiatric diagnosis in previous two years	43 types of psychiatric diagnosis in previous two years	43 types of psychiatric diagnosis in previous two years
8 categories of condition severity and mental health care patterns in previous two years	8 categories of condition severity and mental health care patterns in previous two years	8 categories of condition severity and mental health care patterns in previous two years
For service users only: ethnicity, marital status, employment status, accommodation status and year first received psychiatric care	*For service users only*: ethnicity, marital status, employment status, accommodation status and year first received psychiatric care	*For service users only*: ethnicity, marital status, employment status, accommodation status and year first received psychiatric care

A two-part approach, which first models the proportion of people using mental health services, and then as the second stage, the costs of services used, was found to provide the most robust methodology. As with the Nuffield work, the formula predicts the cost of care by each age/gender group by GP practice in the next financial year.

ACRA recommends the two part model based on the three gender and age groups set out above for the mental health component of the CCG allocations formula.

Population

Any allocation methodology depends critically on high quality population data. A move towards GP registered lists as the basis for allocations was recommended by ACRA for CCG allocations. As registered lists will no longer be scaled to equal ONS population figures in the formula, ACRA has previously recommended that a greater emphasis is placed on work already in hand to ensure the quality and robustness of GP registered lists and that these improvements continue to be maintained to ensure the accuracy of CCG allocations. ACRA emphasises again the importance of work to ensure registered lists are accurate and up-to-date.

Unmet need

As part of its longer term work programme, ACRA was asked to consider unmet need in relation to the CCG formula. ACRA recognises that any formula that uses utilisation as an indicator of need may fail to reflect fully the needs of those who do not use healthcare services efficaciously for a wide range of reasons. ACRA believe that rather than 'unmet need' the problem is one of 'sub-optimal access' where an individual's care costs more or less than it would if it had been accessed at the most beneficial point.

ACRA has previously reviewed the available evidence and found there is a lack of quantified research of sufficient scope and scale to allow us to understand the overall impact of any sub-optimal access to services. ACRA believes that the best way forward is to focus future research on a selection of specific diseases/conditions with sufficient coverage to be representative.

Rurality

Currently there is no specific adjustment in the PCT resource allocation funding formula for rural areas, other than an adjustment to reflect the higher costs of providing emergency ambulance services. ACRA continues to believe that there is no evidence that the impact of rurality on either need or the cost of providing hospital services is not adequately captured in the current approach. For instance, it is commonly claimed that rural areas have greater need because they have older populations. The age of an individual is the main driver of need for healthcare. This is fully captured in the model and so there is no need for an additional correction for the tendency of rural areas to have older populations.

However, there is a plausible case for higher costs in delivering community and outreach services in sparsely populated areas. For instance, staff travel costs may be higher or services may need to be provided from a greater number of smaller centres. Data to examine this are not currently available, but as the Community Services Minimum Data Set becomes available this should be revisited. Future work on unmet need should also consider how it is driven by rurality, deprivation etc.

Market Forces Factor (MFF)

The MFF is an adjustment to allocations due to unavoidable differences in the costs of providing services due to location alone (and not due to differences in the population's need for health services). ACRA have undertaken many reviews of the MFF over time and continue to recommend the current approach, which is largely based on pay rates in the private sector. There is clear evidence that differences in private sector pay rates are associated with higher indirect staff costs in the NHS, such as vacancy rates, staff turnover and use of agency staff.

ACRA therefore continues to recommend the current MFF is used for allocations to CCGs.

Prescribing

The formula for the costs of medicines prescribed in primary care for PCT allocations was re-estimated to be based on GP practices rather than small geographical areas.

ACRA confirms its interim recommendation that the practice list based version of the prescribing formula is used for allocations to CCGs.

Maternity

The Nuffield person based research does not cover maternity. The current (CARAN) maternity formula for PCT allocations is based on a model of the cost per birth and the number of births in each area.

ACRA confirms its interim recommendation that the CARAN formula for maternity is used for allocations to CCGs.

Letter from the Rt Hon Andrew Lansley MP to David Fillingham

11 October 2010

Dear David

Thank you for your letter of 27 September setting out ACRA's proposals for the weighted capitation formula post 2010-11. I would like to express my gratitude to you and ACRA members for all the work undertaken to develop your recommendations.

I am pleased to inform you that I accept all of ACRA's recent recommendations in full, except for those on the devolved budgets, to which I will need to give further consideration as these will align differently within the proposed new funding streams. I also welcome your proposal to move to GP registrations as the basis of allocations. In the interests of transparency, I would like to publish your letter to me setting out the findings of your work and final independent research reports alongside the 2011-12 Primary Care Trust allocations later this year.

I am a firm believer in the importance of the fair and efficient allocation of resources, which is why I gave it such a high profile in my recent White Paper, *Equity and Excellence: Liberating the NHS*. The changes described there will allow the NHS to deliver healthcare services more effectively to the communities it serves.

The most pertinent change for ACRA will be the establishment of an independent NHS Commissioning Board, which will allocate resources to GP consortia and provide commissioning guidelines. This will place the financial power to change health services in the hands of the NHS professionals.

In addition, Local Directors of Public Health will be given control over ring-fenced public health budgets, to provide a strong local strategy and leadership for improving the health of their populations and provide dedicated finance to reduce avoidable ill health and health inequality.

So, instead of one allocation to Primary Care Trusts, I envisage two local funding streams: one for public health, allocated to Directors of Public Health at Local Authority level; and one to GP consortia for commissioning the majority of healthcare services.

No doubt ACRA's role and membership will continue to evolve as the NHS Commissioning Board becomes established and defines its needs and the Public Health Service is set in place. Future decisions on ACRA will fall to the Board in respect of NHS allocations. However, I am mindful of the calibre of advice offered by ACRA, and while I still hold responsibility for resource allocation, I would like for ACRA to continue to advise on the allocation of NHS revenue resources, at least during the transition period.

This advice should be given in light of new objectives:

"To develop a formula for allocations to GP consortia to secure equal opportunity of access to NHS services relative to the burden of disease and disability."

"To develop a formula for the allocation of the public health budget to Local Authorities relative to population health need, to include a "health premium" to enable action to improve population-wide health and reduce health inequalities."

Our aim is to publish shadow allocations for 2012-13 in late 2011, as well as PCT allocations, and the first operational allocations for 2013-14 in late 2012. I would particularly welcome your advice on:

- moving to GP registrations as the population base for allocations within two years;
- how unmet healthcare need is captured in allocations to GP consortia;
- the impact of rurality on unavoidable differences on costs; and
- how labour market conditions impact on NHS costs of providing services and how this can be captured in allocations to GP consortia from 2012-13.

In relation to the new public health budget, the intention is for a public health White Paper to be published towards the end of this year, setting out further detail on the Public Health Service. Work has already commenced to determine the scope of this allocation, and I will ask officials to keep ACRA informed as appropriate.

I would expect in due course to ask ACRA to advise on the baseline allocations to local authorities to reflect relative levels of health outcomes and health inequalities; but not at this stage to advise on the Health Premium, further details of which will be published in the Public Health White Paper for consultation.

To allow shadow allocations to be made in late 2011, I will require ACRA to report by June 2011. To support this I would like you to consider, alongside officials, how the current membership of ACRA might be augmented, in particular by extending the representation of GPs and public health experts and introducing a patient representative.

I look forward to receiving your recommendations on the future allocation of funding to the NHS.

Yours sincerely

Andrew Lansley
Secretary of State for Health

Letter from David Fillingham to the Rt Hon Andrew Lansley MP

2nd September 2011

Dear Andrew,

RESOURCE ALLOCATION FORMULAE

In October last year, you wrote to the Advisory Committee on Resource Allocation (ACRA) requesting advice on potential formulae for allocations to clinical commissioning groups (CCGs) and grants to Local Authorities for public health. This letter advises you of our recommendations to date for the formulae for 2012-13 shadow allocations, due to be announced later this year.

The new formulae recommended by ACRA support the major changes in the way NHS revenue resources are to be allocated. Given the extent of this change, and the timescales in which it has to be delivered, ACRA has focused its attention on the major elements of the formulae. We have used the best available research and technical advice to come to our recommendations, through our partners and our Technical Advisory Group (TAG). We have also set out areas of further work that would be of benefit for any successor bodies.

The detail of ACRA's recent work programme and a description of our recommendations are set out at the annex.

Your officials will, no doubt, provide further advice on the impact of the proposals. I have highlighted the key findings from our work programme below.

<u>Allocations to Clinical Commissioning Groups</u>
You asked ACRA to develop a formula for Hospital and Community Health Services (HCHS) allocations to CCGs that supports equal opportunity of access to NHS services, relative to the prospective burden of disease and disability.

A substantial programme of research was commissioned from a team led by Dr Jennifer Dixon of the Nuffield Trust to develop the person based resource allocation approach for use in allocating funds for HCHS to CCGs. This methodology is currently used in the Practice Based Commissioning Fair Shares Toolkit and so will not be entirely new to the service.

This approach offers a number of advantages for CCG allocations over the approach currently used for allocations to PCTs. In particular it is built on the registered population and so is well suited to funding CCGs' primary responsibility, for the combined registered population of the member practices.

The research team could not get access to some key datasets as quickly as hoped and we do not expect to see the final research report until September. The Technical Advisory group have been working closely with the researchers

and ACRA have been well briefed. Subject to further analysis and sense checking over the summer, ACRA feels confident in recommending the approach for the 2012-13 shadow allocations to CCGs.

The Nuffield led work did not cover the mental health component of the HCHS formula. Work has been commissioned on the mental health component from a team led by Manchester University which has pioneered the use of the new Mental Health Minimum data set. Preliminary results suggest this will also benefit from adopting a person based approach, but work to develop this will not be complete until July 2012.

ACRA therefore recommends that the 2012-13 shadow allocations adopt the current PCT mental health formula, adapted for use with GP registrations and at GP practice level.

Population

Any allocation methodology depends critically on high quality population data. A move towards GP lists as the basis for allocations was recommended by ACRA last year, subject to issues being resolved; such as unexplained differences of up to 20 per cent between GP registrations and Office for National Statistics (ONS) population projections. As a shift to CCGs puts the focus on registered populations, it is vital that registration data are thoroughly assessed, improved and then maintained. Our recommendations on the use of GP registered lists for 2012-13 shadow CCG allocations are made in the context of this being achieved.

I have previously reported to you the work of the Population Steering Group (PSG), a sub-group of ACRA, and we heard since then about the work in your Primary Care policy team to improve current lists. It is vital that this work to improve the current situation is seen through by PCT clusters (I am copying this letter to Jim Easton and Dame Barbara Hakin to consider in their work with PCT clusters) and that the Commissioning Board introduces robust measures to ensure quality is maintained. We recommend that the NHS Commissioning Board considers building into its regular annual assessment via the authorisation process of CCGs, a requirement to provide evidence to demonstrate that registered patient lists held by all member practices are regularly maintained and kept up-to-date, and that the CCG has a mechanism to ensure this is the case.

Unmet need

Building on previous research, we have looked at options for including a correction for unmet need as appropriate. ACRA recognises that any formula that uses utilisation as an indicator of need may fail to reflect fully the needs of those who do not use healthcare services. However, there is a lack of quantified research of sufficient scope and scale to allow us to understand the overall impact of any potential unmet need and to develop any necessary correction at this point. More detail is at the annex. Therefore, due to the lack of quantified evidence, ACRA does not at this time recommend the inclusion of a correction for unmet need in the formula for allocations to CCGs. ACRA

recommends that new research is commissioned that directly addresses the need for and size of any appropriate correction.

The Market Forces Factor and Rurality

You asked us to review our approaches to the Market Forces Factor (MFF) and rurality. While we believe that our current approaches are appropriate, within the limitations of available data, we have prepared short reports outlining the current position and highlighting where further research would be appropriate in the short or medium term.

Currently there is no specific adjustment in the resource allocation funding formula for rural areas, other than an adjustment to reflect the higher costs of providing emergency ambulance services. ACRA continues to believe that there is no evidence that the impact of rurality on either need or the cost of providing hospital services is not adequately captured in the current approach. For instance, it is commonly claimed that rural areas have greater need because they have older populations. The age of an individual is the main driver of need for healthcare. This is fully captured in the model and so there is no need for an additional correction for the tendency of rural areas to have older populations.

However, there is a plausible case for higher costs in delivering community and outreach services in sparsely populated areas. For instance, staff travel costs may be higher or services may need to be provided from a greater number of smaller centres. Data to examine this are not currently available, but as the Community Services Minimum Data Set becomes available this should be revisited. Future work on unmet need should also consider how it is driven by rurality, deprivation etc.

ACRA commissioned an extensive review of the MFF in 2008 from independent researchers. The review confirmed the staff MFF is the most appropriate mechanism for adjusting for unavoidable cost differences and should continue to be based on private sector wages. ACRA has reviewed its findings and believes the current approach to the staff MFF is appropriate and the most suitable currently available. ACRA recommends the current MFF is used for allocations to CCGs, based on the going rate of pay in the local labour market, except for medical and dental staff which should be based on the London pay weighting.

Any further research work will need to be played into the appropriate mechanism in the new system. Corrections for unavoidable cost differences, we understand, would be mainly matters for Monitor or its successor.

Public Health

In addition, ACRA was also tasked with developing a formula for the allocation of the public health budget to Local Authorities relative to population health need.

In developing the formula, ACRA has considered the measure to be used for the allocation, the issue of within area inequality, scaling, demography of local areas and an adjustment for unavoidable costs in health service provision.

In line with the comments received in response to the consultation on funding for public health, ACRA recommends that the allocation is based principally on a measure of population health. A range of approaches were considered by TAG and this option best met the criteria by which ACRA chooses formulae. Within the approach, several population health measures were considered, which were found to be closely correlated. Our preference would be to use the Standardised Mortality Ratio for those aged under 75 years. This would be applied on a small area basis, to take account of localised health inequalities, and aggregated up to the local authority.

However, ACRA understands that data on local variations in public health spend will not be available before 16 September. ACRA would want to revisit this work when these data are available for further sense checking and refinement before finalising our recommendations.

This is an area where future research may also be required. ACRA has used the best information available within the timescales and limitations of the evidence base. I have highlighted areas of further research at the annex.

Other topics for consideration

ACRA discussed a number of areas where further work was needed, which are described in detail at the annex. There are two areas I would particularly draw you attention to.

Our work so far has focussed on GPs' registered populations as these are likely to drive the majority of the funding. However, the Government response to the Future Forum emphasised the responsibility of CCGs for their whole population, not just those registered. Further work will be needed to make recommendations on allocations for unregistered populations.

ACRA often discussed the need to ensure that there is coherence across all of the allocation approaches ie, the interaction of the distribution of resources used to fund other health services, such as primary care, and those allocated to CCGs. Your officials will, no doubt, be advising you accordingly.

Future Governance

The recommendations made here are for the formulae for the 2012-13 shadow allocations, and there are a number of issues that need further consideration before the actual allocations for 2013-14 are made. We have put in place a small number of meetings to finalise this work.

ACRA would welcome your view as to how you see the role of ACRA going forward and the requirements for any advisory group in the new system architecture.

Reporting

As previously, ACRA feel it would be helpful to publish ACRA's recommendations alongside, or before, the allocations they support to improve the understanding of the proposed changes and to aid transparency of our decision making process.

I would be happy to explain further ACRA's recommendations if needed.

I look forward to hearing from you, in particular in relation to future governance procedures for resource allocation.

Yours sincerely

David Fillingham

Letter from the Rt Hon Andrew Lansley MP to David Fillingham

Date: 21 September 2011

Dear David,

Thank you for your letter of 2 September setting out ACRA's recommendations to date for the formulae for shadow allocations to clinical commissioning groups (CCGs) and grants to Local Authorities for public health. I would like to thank you and ACRA members for all the hard work undertaken to develop your recommendations, particularly given the relatively short timescales involved.

I am pleased to inform you that I accept all of ACRA's recommendations in full, pending formal confirmation of the recommendations on the allocations to CCGs once the final report from the researchers is available later in September and on public health once the results from the data collection exercise have been analysed.

I am also pleased to confirm that I have discussed ACRA with Sir David Nicholson and we agreed that ACRA should, subject to Parliament's approval of the Health and Social Care Bill, in the future provide both advice on allocations to the NHS Commissioning Board and on public health allocations to the Department.

ACRA may need to evolve in terms of membership to be suitably equipped to provide the independent advice required and to continue to be responsive to emerging issues going forward. I would welcome your proposals in due course on how ACRA should be structured to best meet these two roles. Subject to the passage of the Bill, detailed work will of course be required with the NHS Commissioning Board to ensure ACRA can best meet its needs.

I would like to ask ACRA to consider feedback from local organisations and others on the shadow allocations to CCGs and shadow public health allocations once they have been issued, and to consider what further development of these formulae is required before 2013-14 allocations are issued. I am aware also that research, overseen by ACRA, is continuing to develop a person based formula for mental health in time for 2013-14 allocations.

Through its recent work programme, ACRA has reviewed the approach to the issue of rurality and determined that the needs and costs of rural areas are adequately captured within the current approach. ACRA did however, find evidence that providing community and outreach services in sparsely populated areas may lead to higher costs but I understand that the current evidence is not sufficient to assess the materiality of potential adjustments and form an adjustment to the formula. I understand that further analysis is currently hampered by the quality of community services data, but I welcome

ACRA's recommendation that rurality should be revisited once data from the Community Services Minimum Data Set becomes available.

Subject to the passage of the Bill, adjustments for unavoidable cost differences through payment by results tariffs are likely to be primarily the responsibility of Monitor under the new commissioning arrangements. I should be grateful if ACRA would share its knowledge on rurality and the market forces factor with Monitor once they are in a position to take forward this work.

In addition, I understand it has not been possible, due to the absence of robust data, at this stage, for ACRA to make a recommendation for the inclusion in the formula for allocations to CCGs of an element of unmet need to meet the objective of equal opportunity of access to NHS services relative to the burden of disease and disability. I agree that further research may be required with sufficient scope to establish the scale of sub-optimal access and how it varies between different parts of the country and social groups and the costs involved in addressing sub-optimal access. I agree that as part of ACRA's future work programme, they should develop the scope and specification for such research.

In developing the formula for actual allocations to CCGs for 2013-14, I agree ACRA should also, as part of their next work cycle, test out approaches for allocations for unregistered populations.

I welcome ACRA's recommendation to move to GP registrations as the population base for future allocations as this is particularly well suited to the formula for CCG allocations. As you point out in your letter, any allocation methodology is dependent upon the availability of accurate population data and I understand significant steps are underway to improve the accuracy of GP lists and ensuring they are up-to-date. I have asked my officials to ensure this work remains a priority moving forward.

I agree that ACRA's recommendations should be published to aid transparency. I will ask my officials to discuss with you the appropriate timing.

I look forward to receiving final confirmation of ACRA's recommendations after its meeting on 28 September.

ANDREW LANSLEY CBE

Letter from David Filligham to the Rt Hon Andrew Lansley MP

Date 18 October 2011

Dear Andrew,

I wrote to you in September to advise you of the provisional recommendations of the Advisory Committee on Resource Allocation (ACRA) in relation to the formulae for 2012-13 shadow allocations to clinical commissioning groups (CCGs) and shadow grants to Local Authorities for public health. Thank you for your response in which you accepted all of ACRA's recommendations. ACRA members were pleased to be informed also that, subject to passage of the Bill, ACRA will continue to provide advice both on allocations to the NHS Commissioning Board and to the Department.

As my letter set out, ACRA wished to undertake some further analysis and sense checking before making its final recommendations on the general and acute and public health formulae for shadow 2012-13 allocations. The need for this further reflection arose mainly because of the late availability of access to some key datasets.

I am now pleased to be able to provide you with ACRA's final recommendations for the general and acute and public health shadow formulae. ACRA's advice on other aspects of the formulae is unchanged from my earlier letter. ACRA has also suggested a number of areas for further work on these two formulae, which I set out below and that we believe need to be explored before these formulae are used in setting actual allocations for 2013-14.

CCG Shadow Allocations

Research to develop the general and acute component of the formula for target allocations for CCGs was commissioned from a team led by the Nuffield Trust. The proposed formula is built up from individual patient data and includes weights for age and additional need (over and above that due to age). Previous conditions for patients registered with each GP practice is a major factor in the estimate of additional need.

ACRA has now considered in some depth the final formula recommended by the Nuffield team. We have compared this with the current PCT formula by attributing it to the formula at GP practice level. The Nuffield formula gave plausible results and was superior to the current PCT formula at GP practice level in terms of its accuracy in predicting expenditure.

ACRA therefore confirms its earlier recommendation that the Nuffield formula is used for shadow 2012-13 target allocations to CCGs.

ACRA would like to reinforce that these shadow allocations will differ from PCT allocations. We recommend that a communications and handling strategy be developed that incorporates the following:

- Differences in the population basis for the formula
- Technical improvements for the formula
- Further work to be conducted

ACRA recommends also that this formula forms the basis for the formula for 2013-14 actual CCG allocations. However, ACRA agree with the comments in your reply to my previous letter, that we need to consider further development of this formula before 2013-14 allocations are issued, following feedback on the shadow allocations formula.

Public Health Service Grants to Local Authorities

I previously set out ACRA's recommendations that the formula for target allocations for the ring-fenced public health grant to upper tier and unitary local authorities be based on a population health measure, the standardised mortality ratio (SMR) for those aged under 75 years. ACRA recommended that this should be applied on a small area basis, to take account of localised health inequalities, and aggregated up to the local authority. ACRA recommended also that there should be an adjustment for unavoidable differences in costs due to geographical location, using the same adjustment as in the local government funding formula.

Since my previous letter, ACRA has confirmed its view on how the SMR for those aged under 75 should be incorporated into the target formula. Based on advice from a number of public health experts on the differential costs of providing services, and in order to help reduce health inequalities, ACRA recommends that the decile of small areas with the highest SMRs should receive a target allocation per head three times greater than the decile of small areas with the lowest SMRs. Other small areas would receive an allocation per head proportionate to their SMRs. This variation will be reduced when small areas are aggregated to local authorities. The range will be less than 3:1 between authorities, reflecting differences in population health between local authorities. We have defined small areas as ONS's determined MSOAs, of which there are just under 7,000 in England.

ACRA has also recently considered whether the formula should include a fixed cost element in recognition that the cost of some public health functions vary little by population size or health need. ACRA felt that the shadow allocations should not include a fixed cost element due to the lack of a current evidence base; and a possible lack of incentive for small areas to pool their resources to avoid high overheads. ACRA looked at the case for an age adjustment in the formula, as some public health functions are focused on specific age groups. ACRA could not find an evidence base for an age adjustment, so does not recommend an adjustment for age in the shadow formula.

ACRA does recommend that further consideration be given to the evidence base for inclusion of a fixed cost component and an age adjustment in the public health allocations to local authorities in 2013-14 and that this item should be included on ACRA's 2012 work programme.

ACRA recommends that the population base for 2012-13 shadow allocations for the public health grant to local authorities should be the Office for National Statistics (ONS) resident population, and specifically the projections for 2012. This is the same approach followed in the local government funding formula. ACRA considered whether account should also be taken of temporary residents or daytime populations, such as commuters, in the formula. This may be important for services to be defined in regulations as “open access”. Further research is required on the likely use of services by non-residents of public health services and the ability of local authorities to recharge each other. ACRA understands that an initial project on these issues is being undertaken by one of the regional public health teams. ACRA is also aware that data on non-resident populations are limited and dated. ACRA recommends that no adjustment for non-resident populations is included in the formula for shadow allocations, and that ACRA re-visits this issue as part of its work programme next year.

I would be happy to explain further ACRA’s recommendations if this would be helpful.

Yours sincerely

David Fillingham
Chief Executive Advancing Quality Alliance (AQuA) North West
& Chair of ACRA