Department of Health

Public Health England

Health Premium Incentive Scheme 2014/15

and

Public Health Allocations

A Technical Consultation

"Give local communities greater control over public health budgets with payment by the outcomes they achieve in improving the health of local residents"

A Coalition Commitment

May 2010

September 2014

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Health Premium Incentive Scheme Technical Consultation

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Contents

1. Overview

The coalition agreement committed to …"give local communities greater control over public health budgets with payment by the outcomes they achieve in improving the health of local residents."

In 2010 Healthy lives, healthy people: our strategy for public health in England, committed to introducing a health premium that would incentivise local authorities to take action to improve the health of their populations and reduce health inequalities.

1.1 Local authorities are already responsible for improving the health of their local population and are supported in doing so by the ring fenced public health budget. This budget is informed by an estimate of the local need for the relevant public health services (the "target allocation"), although the actual grant is moderated by the historic levels of investment.

1.2 The health premium incentive scheme aims to build on this by offering a financial incentive to local authorities, paid when progress is made in improving the health of the local populations and tackling health inequalities.

1.3 The *Healthy lives, healthy people: public health funding update, published in June 2012*[2] set out the key principles for the incentive. These included:

- *Assessment of the indicators in the Public Health Outcomes Framework for their suitability as an incentive measure;*
- The *incentive is dependent upon the local authority making progress against certain public health indicators*, not the achievement of an arbitrary target;
- The scheme will be *a formula driven model to keep bureaucracy to a minimum and maximise transpa*rency; and
- The scheme will *be designed to reward communities for health improvements or reducing inequality*

1.4 To establish a credible formula-driven scheme it is critical that the design of that scheme is established in an independent way. We therefore asked the Advisory Committee on Resource Allocation (ACRA) to establish the key principles for an incentive scheme, such as criteria for assessing whether or not a particular measure was suitable for inclusion. A sub-group of ACRA, the Health Premium Incentive Advisory Group, was established to report to ACRA, and their report[3], adopted by ACRA.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213684/dh_134580.pdf

[3] https://www.gov.uk/government/groups/health-premium-incentive-advisory-group

1.5 Some parts of the design were outside of ACRA's remit. In particular decisions related to the size of the incentive, how budgetary control over the total amount earned is to be maintained, or the specific choice of indicators was not considered.

1.6 The Health Premium Incentive Scheme is an innovative scheme and we are keen to ensure that the incentive is effective in supporting improvements in health. We are therefore proposing a phased introduction in 2015-16, supported by this technical consultation. Our aim is to shape this scheme in partnership through this consultation with local authorities and public health stakeholders.

1.7 This technical consultation:

- Gives an overview of the proposed plans;
- Sets out the recommendations made by ACRA;
- Asks your views on a number of technical issues;
- Asks local authorities to indicate which public health outcomes indicator from the approved list they would choose as a local indicator for 2014/15 when the scheme is formally rolled out; and
- Sets out public health allocations for 2015/16.

1.8 The scheme we are proposing for payment in 2015-16 is based on only two indicators, supported by a modest available incentive budget of £5 million. This careful roll-out will give us practical experience and the opportunity to gather early feedback from local authorities about the operation of the scheme and its potential impact.

2. Consultation information

To:	Local authorities, local commissioners, directors of Public Health and Finance and representative bodies
Duration:	09 September 2014 to 23 October 2014
Enquires and responses:	You can respond to the questionnaire by completing the electronic form and sending it to the email below or by sending a hard copy to, **Public Health Policy Support Unit,** **Department of Health,** **165 Richmond House,** **79 Whitehall,** **London,** **SW1A 2NS.** General enquiries or requests for Braille, large font or audio format should be addressed to the contact details above or email Healthpremiumincentivescheme@dh.gsi.gov.uk
The consultation:	There are six specific questions regarding the Health Premium Incentive Scheme (HPIS) followed by optional questions about you. The consultation should take approximately an hour to complete. There is no need to answer every question if you do not wish to and we would welcome other wider comments that may not be specifically motivated by the questions.
After the consultation:	Following the close of the consultation we will analyse the responses and publish a summary report on gov.uk. If you would like to receive notification of the published response, please indicate this in the relevant section of the form. Responses will be stored on a secure Government IT system for a maximum of one year from the end date of this survey and then securely destroyed in accordance with the Data Protection Act 1998. All responses to this consultation will be shared between the Department of Health and Public Health England and may be published. Your personal data will not be shared with any third parties without your consent. Any individual responses which are used in the final report will be anonymous. If you are responding on behalf of a local authority or other public body, the local authority will be identified if quoted in the final response document.

3. Background

3.1 The White Paper, *Equity and Excellence: liberating the NHS* in July 2010[4] stated that '…*a new "health premium" designed to promote action to improve population-wide health and reduce health inequalities'* would be introduced.

3.2 In November 2010 *Healthy lives, healthy people: our strategy for public health in England*[5] expanded on this by committing to introduce '... a new health premium that would reward progress made against elements of the proposed public health outcomes framework, taking into account health inequalities.'

3.3 The public health finance update, *Healthy Lives, Healthy People: Update on Public Health Funding*, published in June 2012[6], included a high-level design summary of the health premium incentive. In summary the premium would be:

- innovative;
- based on Public Health Outcomes Framework (PHOF) indicators;
- have national indicators set by the Government, supplemented by locally chosen indicators;
- be weighted to areas facing the greatest challenges;
- be formula driven to minimise bureaucracy and maximise transparency; and
- be introduced from 2014-15, with the first payments being made in 2015/16, reflecting improvements made in 2014/15.

3.4 It would be inappropriate to pay an incentive if there is clear evidence that a local authority is not meeting the public health ring fenced grant conditions.

3.5 ACRA was commissioned to make detailed recommendations about how the scheme should operate. We believe that independent advice of this kind is critical in providing the basis of a formula driven approach. ACRA established a technical sub group with a broad range of public health and local authority finance expertise, the Health Premium Independent Advisory group (HPIAG), to examine this specific question and they ultimately adopted their report[7].

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4 https://www.gov.uk/government/uploads/system/…/dh_117794.pdf

5 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

6 https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-on-public-health-funding

7 https://www.gov.uk/government/groups/health-premium-incentive-advisory-group

3.6 In summary, HPIAG recommended that:

- Fifty-one PHOF indicators or sub-indicators were deemed suitable for use as part of the incentive scheme, based on a set of criteria;
- Notwithstanding technical difficulties with measuring progress on smoking, alcohol and substance misuse, any credible scheme should have the potential to include indicators relating to these areas;
- Alongside nationally set indicators, local authorities should have the flexibility to select a small number of indicators from those meeting the criteria, different to that selected nationally;
- Local authorities should have further local flexibility to select locally relevant indicators, provided they could demonstrate they were suitably robust;
- The health premium incentive was not the right mechanism for promoting innovation;
- Progress should be considered to have been made if a threshold is met. Ideally this would be set at a statistically significant level, but this might not always be possible;
- Local authorities should seek to incentivise the reduction in health inequalities;
- Indicators chosen should cover the four PHOF domains; and
- Benefits criteria and an evaluation methodology to be developed in conjunction with key stakeholders.

3.7 We have fully accepted ACRA's recommendations. We are now beginning a careful phased roll out supported by this technical consultation.

4. Proposal

4.1 Fifty-one PHOF indicators and sub indicators passed the technical criteria set out in ACRA's recommendations. After discussions with a range of stakeholders we are proposing that for the introductory year (2014/15) we will adopt a more limited approach, measuring against two indicators (excluding indicators from domain 4). These are:

i. **National indicator -** '*Successful completion of drugs treatment*' with combined PHOF data for opiate and non-opiate users; and

ii. **A local indicator** - Selected by Local authorities from the list approved indicators produced by ACRA, see Annex A.

If a LA did not select their own indicator a default indicator '*Smoking prevalence over 18s'* will be assigned.

This limited roll out will give us the opportunity to understand how the scheme operates in practice. However we believe that to make this learning as realistic as possible. We will fund the scheme with a small budget: five million pounds to be distributed across local authorities.

National indicator

4.2 The drugs recovery indicator has been chosen as it provides a litmus test of local authority's capacity to improve the chances of recovery for some of the most vulnerable in our society and showcases local authorities' success in working with a wide range of partners.

4.3 However, this measure is not straightforward to use. As ACRA highlighted, the absolute numbers of people going through drug treatment is low, meaning that due to small population numbers there is a high level of natural variation in the measured success rate.

4.4 To reduce this effect, we are proposing to use a combined success rate for opiate and non-opiate treatments. But even then a practically realistic improvement can only be robustly measured for the largest authorities.

4.5 ACRA suggested that one way to address this would be to use a multi-year average to further reduce the natural variability. But they recognised that this may not send a sufficient signal of the importance of a measure as the incentive could not be offered on year-on-year basis. They therefore recommended that the threshold should be informed by the statistical properties of the measure, but not determined by it.

4.6 LAs will be required to demonstrate an improvement of 2.0 percentage points (lower quartile) from the set baseline to trigger a payment. Given the variation across the local authorities we need to balance statistical robustness against achievability and consistency. An improvement that is robust in one place would not be practical in another.

The most recent historical data for the drugs indicator suggest the following local authority wide improvement thresholds for statistical robustness:

Drugs indicator	Improvement required
Lower Quartile	2.0 percentage points
Median	2.5 percentage points
Upper Quartile	3.2 percentage points

4.7 Access to drug treatment services will be monitored to ensure that current service provision does not deteriorate. Whilst some variation in access is inevitable, local areas shall continue to focus on supporting complex clients, including opiate and crack users, and not unintentionally incentivise treatment provision on low complexity substance users in order to boost successful completion figures. Data on the complexity levels of users accessing and completing treatment is collected and monitored.

4.8 Note that the populations of the Isles of Scilly and City of London are so small that it is all but impossible to detect their progress or otherwise. For health premium purposes they are therefore assumed to have fully achieved their threshold.

Question 1

Do you agree that successful completion of **drug** treatment should be used as the pilot national incentive measure?

☐Yes

☐ No

If you have answered no, please explain why

Question 2

What threshold should we adopt for demonstrating progress, balancing statistical significance with robustness for successful completion of **drug** treatment?

Local indicator

4.9 In the 2014/15 pilot year, local authorities are asked to select one indicator from those passing ACRA's technical criteria. Given that local authorities have taken on responsibility for public health relatively recently we have excluded measures that use a multi-year rolling average from this list, such as mortality rate measures mainly from domain 4 of the PHOF.

4.10 Subject to this pilot year, we expect to roll this scheme out in the coming years, expanding the scheme to cover all domains of the Public Health Outcomes Framework and also seeking to accommodate locally developed health inequalities indicator that meet ACRA's technical criteria.

4.11 PHOF Indicators that attract incentives from other government departments have also been excluded. For 2014/15,the exclusions are:

- First time entrants to the youth justice system (1.04i) - Local authorities are paid on a reduction in youth reoffending rates of 33% per child yearly. Payments are made by Department of Communities and Local Government.
- Re-offending levels (1.13i&ii) - In transforming rehabilitation for adult offenders, Ministry of Justice will pay the new Community Rehabilitation Companies, whose contracts are due to start towards the end of this year for the management of all medium and low risk offenders for improvements made. This excludes high risk offenders which will be managed by the new National Probation Service.

4.12 There are 34 total indicators available for the pilot year, this excludes domain 4 indicators (14) and the 3 indicators listed in 4.10 above.

4.13 Where a choice of local indicator is not made we will set a default local indicator 'smoking prevalence adults over 18s'. An improvement of 2.3 percentage points (lower quartile) from the set baseline will be required to trigger a payment.

4.14 Given the variation across the local authorities we need to balance statistical robustness against achievability and consistency. An improvement that is robust in one place would not be practical in another.

The most recent historical data for the smoking prevalence adults over 18s' indicator suggest the following local authority wide improvement thresholds:

Smoking indicator	**Reduction required**
Lower Quartile	2.3 percentage points
Median	2.6 percentage points
Upper Quartile	2.8 percentage points

Question 3 (LAs only)

Which PHOF measure from the list at Annex A, would you be likely to select for a local measure of attainment when the scheme is formally launched, or would you accept the default adult smoking prevalence?

Question 4 (LAs only)

Do you agree that smoking prevalence adults over 18s' should be used as the default indicator where no choice has been made from the list of approved indicators?

☐ Yes

☐ No

What threshold would balance attainability and robustness?

Question 5 (LAs only)

For future years LAs will have additional flexibilities to develop their own local indicator. Would you have developed your own local indicator and progress measure this year, had this flexibility been available?

☐ Yes

☐ No

If yes, what sort of indicator would you have developed?

4.15 All LA baselines data sets can be found on the Public Health Outcomes Framework interactive web tool www.phoutcomes.info

5 Measuring success and Payment

5.1 The health premium will reward progress, rather than the attainment of a set target.

5.2 A key design feature of the health premium incentive is that it is a payment for progress, not meeting an arbitrary target. There will not be any need for local authorities to submit any additional data. All data will be collected via the normal Public Health Outcomes Framework data collection route and any additional statistical analysis will be done centrally within PHE with support from the technical sub group of ACRA.

5.3 When it comes to rewarding payment, all indicators both national and those chosen locally will be weighted the same. For 2015/16 this would mean,

- If a local authority made progress on both indicators they would receive the maximum reward for that authority;
- If they made progress on only one out of the two indicators, they would only receive payment for one indicator only (ie half of the available reward); and
- If they did not make progress on any of the indicators, they would not receive any payment.

5.4 In line with the long term aim of low bureaucracy, we expect this approach to the equal weighting of indicators to continue for the foreseeable future.

5.5 For each measure, where a local authority demonstrates it has made an improvement by the end of March 2015 they will receive a share of the total available incentive. The share will be proportional to their target allocation, as recommended by ACRA. When all the shares are known, the incentive will be fully distributed among the LAs based on the allocation formula for 2014/15.

Question 6

Do you agree that we should adopt an approach based on point shares from a fixed pot, maximising the amount we can pay for progress, even though this means a lack of certainty on exactly how much the incentive for progress will be for each local authority?

☐ Yes

☐ No

If no, what other methodology do you suggest

5.6 Payment will be made in 2015/16 as soon as possible after necessary data become publicly available.

5.7 As noted above, £5m has been allocated for this first year of the incentive. Each authority's share of the £5m will be proportional to its 2014-15 target allocation, and also dependent on the authority passing their threshold for payment. So, an authority demonstrating progress on both measures can expect provisionally to receive a minimum of around £1.79k per 2014-15 £1m target allocation. The exact amount will depend on the number of local authorities passing the thresholds for payment of the incentive.

6 Core allocation

6.1 Colleagues in local government have been clear about the benefits of announcing allocations as early as possible. We have therefore chosen to announce the 2015/16 core allocation earlier than was usual practice for Primary Care Trust allocations.

6.2 The public health allocations for 2015/16 have been maintained at the current cash levels. While it would be possible to redistribute funding to move those areas that are below target further towards their target allocations**,** we have made considerable progress on distance from target over the last two years. We therefore intend to protect the allocations of individual local authorities in cash-terms to promote stability.

6.3 Transfer of funding for children 0-5 for the year 2015/16 is being handled separately to the core allocations.

7 Next steps

7.1 Respond to the consultation by 23 October 2014.

7.2 Once responses to the consultation have been received and considered, PHE will write to local authorities with details of:

- The agreed national indicator;
- Baselines for each of the 34 indicators offered for 2014/15 HPIS (using the most recent PHOF derived data);
- The level of improvement to be demonstrated for each potential indicator;
- The process for informing PHE of the locally chosen indicator and details of how payments will be made; and
- A summary of the responses to the consultation to be published.

8. Question Summary

Question 1

Do you agree that successful completion of drug treatment should be used as the pilot national incentive measure?

☐Yes

☐ No

If you have answered no, please explain why

Question 2

What threshold should we adopt for demonstrating progress, balancing statistical significance with robustness for successful completion of drug treatment?

Question 3 (LAs only)

Which PHOF measure from the list at Annex A, would you be likely to select for a local measure of attainment when the scheme is formally launched, or would you accept the default adult smoking prevalence?

Question 4 (LAs only)

Do you agree that smoking prevalence adults over 18s' should be used as the default indicator where no choice has been made from the list of approved indicators?

☐ Yes

☐ No

What threshold would balance attainability and robustness?

Question 5 (LAs only)

For future years LAs will have additional flexibilities to develop their own local indicator. Would you have developed your own local indicator and progress measure this year, had this flexibility been available?

☐ Yes

☐ No

If yes, what sort of indicator would you have developed?

Question 6

Do you agree that we should adopt an approach based on point shares from a fixed pot, maximising the amount we can pay for progress, even though this means a lack of certainty on exactly how much the incentive for progress will be for each local authority?

☐ Yes

☐ No

If no, what other methodology do you suggest

Optional
Your name :
Local Authority / Organisation
Email address
Contact Number :
Would you like notification of publication? Yes / No

Thank you for answering this technical consultation - your time and views are appreciated.

We will publish feedback of the technical consultation. In the meantime you have any queries, please do not hesitate to contact us via the health premium incentive scheme mailbox Healthpremiumincentivescheme@dh.gsi.gov.uk

Annex A

Health premium Incentive selected indicators

PHOF Indicator ref:	Indicator description
0.1 ii	Life Expectancy at Birth
1.01	Children in poverty - Percentage of children in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)
1.03	Pupil absence - Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence)
~~*1.04 i*~~	~~*First-time entrants to the youth justice system - Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population*~~ ***This indicator attracts incentives from DCLG 'green for Troubled Families' with payments to local authorities.*** **Excluded**
1.05	Percentage of 16-18 year olds not in education, employment or training (NEET)
1.06 i	Percentage of all adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family
1.12 i	Age-standardised rate of emergency hospital admissions for violence per 100,000 population
1.12 ii	Rate of violence against the person offences based on police recorded crime data, per 1,000 population
~~*1.13 i*~~	~~*Re-offending - % of offenders who reoffend from a rolling 12 months cohort*~~ ***This indicator attracts incentives from MoJ, with payments to providers of probation services - the new Community Rehabilitation Companies.*** **Excluded**
~~*1.13 ii*~~	~~*Re-offending - Average no of re-offenders committed per offender from a rolling 12 month cohort .*~~ ***This indicator attracts incentives from MoJ, with payments to providers of probation services - the new Community Rehabilitation Companies.*** **Excluded**
1.15 ii	Statutory homelessness / Household in temporary accommodation
2.01	Percentage of all live births at term with low birth weight
2.04	Under 18 conception rate per 1,000 population
2.06	Excess weight in 4-5 and 10-11 year olds

2.07i	Hospital admissions for unintentional and deliberate injuries in children age 0-14
2.07ii	Hospital admissions for unintentional and deliberate injuries in young people age 15-24
2.13i	Physically active adults
2.13ii	Physically inactive adults
2.14	***Smoking prevalence –Adults aged 18 and over (Default local indicator)***
2.15	***Successful completion of drug treatment (National indicator)***
2.20 ii	The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period
2.22 i	Percentage of eligible population aged 40-74 offered an NHS Health Check in the financial year
2.22 ii	Percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the financial year
2.24 i	Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population
3.03 i	Hepatitis B vaccination coverage (1 and 2 year olds)
3.03 iii	DTaP/IPV/Hib vaccination coverage (1, 2 and 5 year olds)
3.03 iv	MenC vaccination coverage (1 year olds)
3.03 v	PCV vaccination coverage (1 year olds)
3.03 vi	Hib/MenC booster vaccination coverage (2 and 5 year olds)
3.03 vii	PCV booster vaccination coverage (2 year olds)
3.03 viii	MMR vaccination coverage for one dose (2 year olds)
3.03 ix	MMR vaccination coverage for one dose (5 year olds)
3.03 x	MMR vaccination coverage for two doses (5 year olds)
3.03 xii	HPV vaccination coverage (females 12-13 year olds)
3.03 xiii	PPV vaccination coverage (aged 65 and over)
3.03 xiv	Flu vaccination coverage (aged 65 and over)

3.03 xv	Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding pregnant women)
~~*4.01*~~	~~*Crude rate of infant deaths (persons aged < 1 year) per 1,000 live births*~~
~~*4.03*~~	~~*Age-standardised rate of mortality from causes considered preventable per 100,000 population*~~
~~*4.04 i*~~	~~*Age-standard rate of mortality cardiovascular diseases (including heart disease and stroke) < 75 years of age per 100,000 population*~~
~~*4.04 ii*~~	~~*Age-standard rate of mortality preventable cardiovascular disease (including heart disease and stroke) < 75 years of age per 100,000 population*~~
~~*4.05 i*~~	~~*Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population*~~
~~*4.05 ii*~~	~~*Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population*~~
~~*4.06 i*~~	~~*Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population*~~
~~*4.06 ii*~~	~~*Age-standardised rate of mortality that is considered preventable from liver disease in persons less than 75 years of age per 100,000 population*~~
~~*4.07 i*~~	~~*Age-standardised rate of mortality from respiratory diseases in persons less than 75 years of age per 100,000 population*~~
~~*4.07 ii*~~	~~*Age-standardised rate of mortality that is considered preventable from respiratory diseases in persons < 75 years of age per 100,000 population*~~
~~*4.08*~~	~~*Age-standardised mortality rate from certain infectious and parasitic diseases per 100,000 population*~~
~~*4.10*~~	~~*Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population*~~
~~*4.11*~~	~~*Indirectly standardised percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission*~~
~~*4.14 i*~~	~~*Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 and over per 100,000 population*~~

To note: *Indicators listed in domain four are not available for local selection in the pilot year.*

Annex B

Core Allocations

ONS LA Name	2014-15 Allocation £000	Net Baseline Adjustments £000	2015-16 Allocation £000
Barking and Dagenham	14,213	0	14,213
Barnet	14,335	0	14,335
Barnsley	14,243	0	14,243
Bath and North East Somerset	7,384	0	7,384
Bedford	7,343	0	7,343
Bexley	7,574	0	7,574
Birmingham	80,838	0	80,838
Blackburn with Darwen	13,134	0	13,134
Blackpool	17,946	0	17,946
Bolton	18,906	(116)	18,790
Bournemouth	8,296	0	8,296
Bracknell Forest	3,049	0	3,049
Bradford	34,699	634	35,333
Brent	18,848	0	18,848
Brighton and Hove	18,695	0	18,695
Bristol, City of	29,122	0	29,122
Bromley	12,954	0	12,954
Buckinghamshire	17,249	0	17,249
Bury	9,619	0	9,619
Calderdale	10,679	0	10,679
Cambridgeshire	22,299	(144)	22,155
Camden	26,368	0	26,368
Central Bedfordshire	10,149	0	10,149
Cheshire East	14,274	0	14,274
Cheshire West and Chester	13,889	0	13,889
City of London		0	

ONS LA Name	2014-15 Allocation £000	Net Baseline Adjustments £000	2015-16 Allocation £000
	1,698		1,698
Cornwall	18,339	2,410	20,749
County Durham	45,780	0	45,780
Coventry	19,615	(200)	19,415
Croydon	18,825	0	18,825
Cumbria	15,594	0	15,594
Darlington	7,184	0	7,184
Derby	14,484	0	14,484
Derbyshire	35,651	0	35,651
Devon	22,060	0	22,060
Doncaster	20,198	0	20,198
Dorset	12,889	0	12,889
Dudley	18,974	0	18,974
Ealing	21,974	0	21,974
East Riding of Yorkshire	9,175	0	9,175
East Sussex	24,507	(440)	24,067
Enfield	14,257	0	14,257
Essex	…	…	…
Gateshead	15,832	(1,892)	13,939
Gloucestershire	21,793	0	21,793
Greenwich	19,061	0	19,061
Hackney	29,818	0	29,818
Halton	8,749	28	8,776
Hammersmith and Fulham	20,855	0	20,855
Hampshire	40,428	(65)	40,363
Haringey	18,189	0	18,189
Harrow	9,146	0	9,146
Hartlepool	8,486	0	8,486
Havering	9,717	0	9,717

ONS LA Name	2014-15 Allocation £000	Net Baseline Adjustments £000	2015-16 Allocation £000
Herefordshire, County of	7,970	0	7,970
Hertfordshire	37,642	0	37,642
Hillingdon	15,709	0	15,709
Hounslow	14,084	0	14,084
Isle of Wight	6,088	0	6,088
Isles of Scilly	73	0	73
Islington	25,429	0	25,429
Kensington and Chelsea	21,214	0	21,214
Kent	54,827	(1,563)	53,264
Kingston upon Hull, City of	22,559	0	22,559
Kingston upon Thames	9,302	0	9,302
Kirklees	23,527	0	23,527
Knowsley	16,375	45	16,419
Lambeth	26,437	0	26,437
Lancashire	59,801	0	59,801
Leeds	40,540	0	40,540
Leicester	21,995	(16)	21,979
Leicestershire	21,863	0	21,863
Lewisham	20,088	0	20,088
Lincolnshire	28,506	0	28,506
Liverpool	41,436	0	41,436
Luton	13,065	0	13,065
Manchester	44,116	4,188	48,303
Medway	14,280	0	14,280
Merton	9,236	0	9,236
Middlesbrough	16,378	0	16,378
Milton Keynes	8,788	0	8,788
Newcastle upon Tyne		0	

ONS LA Name	2014-15 Allocation £000	Net Baseline Adjustments £000	2015-16 Allocation £000
	21,301		21,301
Newham	26,112	0	26,112
Norfolk	30,633	(42)	30,590
North East Lincolnshire	9,971	0	9,971
North Lincolnshire	8,464	0	8,464
North Somerset	7,593	0	7,593
North Tyneside	10,807	0	10,807
North Yorkshire	19,732	0	19,732
Northamptonshire	29,523	0	29,523
Northumberland	13,408	(47)	13,361
Nottingham	27,839	0	27,839
Nottinghamshire	36,119	0	36,119
Oldham	14,915	0	14,915
Oxfordshire	26,086	0	26,086
Peterborough	9,291	0	9,291
Plymouth	12,276	0	12,276
Poole	6,057	0	6,057
Portsmouth	16,178	0	16,178
Reading	8,212	0	8,212
Redbridge	11,411	0	11,411
Redcar and Cleveland	10,917	0	10,917
Richmond upon Thames	7,891	0	7,891
Rochdale	14,777	0	14,777
Rotherham	14,176	0	14,176
Rutland	1,073	7	1,080
Salford	18,777	0	18,777
Sandwell	21,805	0	21,805
Sefton	19,952	0	19,952
Sheffield	30,748	0	30,748

ONS LA Name	2014-15 Allocation £000	Net Baseline Adjustments £000	2015-16 Allocation £000
Shropshire	9,843	0	9,843
Slough	5,487	0	5,487
Solihull	9,905	(262)	9,644
Somerset	15,513	0	15,513
South Gloucestershire	7,345	0	7,345
South Tyneside	12,917	0	12,917
Southampton	15,050	(2)	15,049
Southend-on-Sea	8,060	0	8,060
Southwark	22,946	0	22,946
St. Helens	13,035	64	13,099
Staffordshire	33,313	0	33,313
Stockport	12,834	355	13,189
Stockton-on-Tees	13,067	0	13,067
Stoke-on-Trent	20,242	0	20,242
Suffolk	26,289	0	26,289
Sunderland	21,234	(685)	20,549
Surrey	25,561	3,416	28,977
Sutton	8,619	0	8,619
Swindon	8,680	(122)	8,558
Tameside	12,600	863	13,463
Telford and Wrekin	10,913	0	10,913
Thurrock	…	…	…
Torbay	7,351	45	7,396
Tower Hamlets	32,261	0	32,261
Trafford	10,456	373	10,829
Wakefield	20,797	308	21,105
Walsall	15,827	0	15,827
Waltham Forest	12,277	0	12,277

ONS LA Name	2014-15 Allocation £000	Net Baseline Adjustments £000	2015-16 Allocation £000
Wandsworth	25,431	0	25,431
Warrington	10,439	0	10,439
Warwickshire	21,810	(2,333)	19,477
West Berkshire	4,819	0	4,819
West Sussex	27,445	0	27,445
Westminster	31,235	0	31,235
Wigan	23,665	0	23,665
Wiltshire	14,587	0	14,587
Windsor and Maidenhead	3,511	0	3,511
Wirral	26,440	1,724	28,164
Wokingham	4,223	0	4,223
Wolverhampton	19,296	0	19,296
Worcestershire	26,528	0	26,528
York	7,305	0	7,305
England	2,793,775	5,487	2,799,263

Note:

"…" Essex and Thurrock's allocations will be published after the 9th October due to the by-election in Clacton.

The total allocation for England does not equal the sum of LA allocation published.