Response to DH Update on PH Funding

Key concerns

There are a number of key concerns for DsPH summarised as follows.

- Final figures need to be published as soon as is practicable to enable planning for the final transfer of PH to LAs in April 2013.
- An interim statement would be helpful assuring a minimum level of funding over the next few years based on the higher of the published baseline and the newer figures sent to DH.
- Assurance that the final ACRA formula will be progressive and will continue the support to those areas with the greatest need.
- Clarification on the pace of change providing protection for those PH departments that have spent appropriately in the past whilst being fast enough to provide sufficient funding for those who have not.

Baseline – There are still some issues around increases after 10/11 (eg new burdens - health checks etc) and decreases before 10/11 due to QIPP savings applied across PCTs.

Some areas have discovered significant errors in the collections including:

- miscoding of SH spend to NHSCB rather than Public Health;
- inability to disaggregate block contracts;
- inadequate determination of overheads;
- inability to identify costs for use of properties now transferring to PropCo.

There is also concern that the DH 5.8% growth (as published in Feb 2012) has been netted off in the more recent collections by some Finance Departments. ADPH can provide further detail on this if required.

There is a perception in many Councils that the baseline amounts already published may not be reflected in the final allocations (despite DH assurances) or if they are then the guarantee will only be for one year after which there will be a reduction. This is resulting in some Councils looking to reduce programmes and staff before PH transfers. ADPH is asking for as much explicit assurance from DH as possible that funding will not be cut in the short and medium term.

ADPH is also concerned that assumptions around staffing levels are being made in advance of clarity on what functions will be part of the PH service in LA. We would welcome further clarification of roles and responsibilities particularly in Health Protection services.

Formula – ADPH welcomes the use of SMR<75 and aggregated MSOAs. However we caution that this approach has an element of self-referral given that improvements in PH bring improvements in SMR and this could lead to perverse incentives (ie poor outcomes in PH may be 'rewarded' by an increase in the allocation).

We are also concerned that the weighting of 3X the SMR has a less steep gradient than historic spend and is therefore regressive

We would like to see consideration being given to adding an explicit element in the formula for SH services. We recognise that service parameters may be unhelpful since areas with fewer services may well reflect under-provision and we recommend exploring the use of a composite indicator such as that used by HPA.

We also see the sense in there being a fixed element intended to cover the fixed costs of a PH department – without which a smaller LA could struggle to deliver a full PH programme of services.

Non-resident populations (such as found in eg high tourist areas; or summer festivals) increase take up of some PH services and indeed require some specific services and we welcome consideration of this as an element in the final formula.

Quantum – ADPH continues to argue for an increase in the total amount of funding both in short and longer term to be shared between the LAs. We accept that the BMA figure of an extra £1 - 2bn for PH would make a significant difference to PH activity and in particular would allow those areas that have historically under-invested to be given a fair allocation whilst not reducing the allocation for those who have invested more in PH. This amount whilst being significant for PH would have a marginal effect if taken from the overall comprehensive health service budget. It would also represent a reasonable proportion of the QIPP savings that we understand are to be re-invested in front-line services including PH.

Longer term we would advocate a continuing shift of in the proportion of the comprehensive budget to prevention spend in order to achieve sustainable improvements in health outcomes.

Pace of change – We recognise that to invest in PH across the country the pace of change to a needs-based formula should be as fast as possible. However, this should not disadvantage those areas that have historically invested appropriately in PH and these levels of spend should be protected. Extra funds should be made available (as above) to ensure that it will be a 'pace of growth' to the highest.

The ADPH finance group is modelling function to funding for several areas of PH and we are sharing early iterations with DH and other stakeholders. This should provide a strong business case for appropriate funding.

Health Premium – ADPH welcomes the proposal for an outcome-based formula for the health premium whilst cautioning against one which is regressive by rewarding those areas of least need. A reward for a reduction in health inequalities could incentivise effort but this should reflect the local complexities and not reward improvements easily gained.

We welcome the proposal of a few core indicators along with some locally defined areas for action. However we would caution against creating unintended consequences and suggest learning the lessons from Local Area Agreements.

Grant conditions – whilst we approve the general move towards local determination of priorities and services we would ask for a tighter definition for the mandated functions. For instance the term 'open access' for SH services can be interpreted in many ways differing in both effectiveness and cost.

We understand that the grant will be signed off by the LA CEO. We would like consideration to be given to the requirement that the forward projections and outturns should be jointly signed off with the DPH which would ensure strong planning.

Contingency – we are aware given the complexities of mapping spend across PH that there will be some significant budgetary risks in the first few years after April 2013. These will be within a relatively small budget and ADPH recommends that consideration be given to enabling a contingency fund to cover these risks.

ADPH

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