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CITY OF LONDON

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Dear Sir/Madam

City of London Shadow Health and Wellbeing Board

Response to Healthy Lives, Healthy People: Update on Public Health Funding (June 2012)

The City of London's Shadow Health and Wellbeing Board involves representation from the following partners:

- Elected members of the City of London Corporation
- Officers of the City of London Corporation, including the Director of Community and Children's Services and the Director of Environmental Health and Public Protection
- Public Health Consultant for City and Hackney, NHS East London and the City
- City and Hackney Clinical Commissioning Group
- The City Local Involvement Network (City LINk – to be replaced by HealthWatch in April 2013)
- The City of London Police

The Board welcomes the transfer of public health responsibilities to local authorities, and the opportunity that this brings to tackle inequalities and improve population health. It welcomes the opportunity to respond to the recommendations made by ACRA regarding the move to a formula-based public health allocation.

The principle on which the proposed funding changes are based – moving away from the current model of funding, based upon historic spend, towards a needs-based approach grounded in population health, is both welcome and supported by the City's HWB.

The HWB's key concern is whether the actual formula proposed will truly be needs-based, whether it might actually increase health inequalities in certain areas, and whether the proposed measure is suitable for use in an area with a small population, such as the City.

Paragraph 2.12 details that ACRA's interim recommendation is based on the standardised mortality ratio (SMR) for those aged under 75 years (SMR<75).

The rationale for using SMRs over other indicators (e.g. Healthy life expectancy, Disability free life expectancy, IMD, etc.) has not been communicated in detail. In particular it is unclear if the SMR < 75 is a good measure when monitoring progress in reducing health inequalities in the early

years, which has been highlighted as key priority area for public health in the Marmot review. Use of SMR < 75 years also diverges from ACRA proposals for the allocation of funding to NHS health services – which is based on 'Disability-Free Life Expectancy[1]. In the public health outcomes framework the overarching indicator used is healthy life expectancy[2].

When calculating SMRs for a small population such as in the City, the uncertainty around this estimate will be large, and subject to variation year on year. There is a risk therefore that resources allocated on this basis would vary year on year, hindering service planning and development.

Other modifying factors that are relevant to the City include:

- High population churn/ turnover caused by migration into and out of the local authority. This is challenging for population health programmes, including the NHS health checks, and may get worse in another period of recession.
- The pace of change, and the extent to which the resource allocation keeps up with changes in the size and needs of the local population.
- The diverse ethnic profile of the population: leading to a variation in needs and effectiveness of interventions
- The communicable disease profile, and the need for local prevention and response (TB, blood borne viruses, infections acquired overseas) is particularly important for the City, which has the highest daytime population density of any local authority in the UK.

With regards to **paragraph 2.15**, we agree that an Area Cost Adjustment should be included to reflect the very high cost of providing services in the City of London.

With regards to **paragraph 2.16**:

Fixed cost adjustment

Some functions will need to be carried out by all authorities irrespective of size, supporting a fixed minimum allocation; this is very relevant to the City of London as the resources associated with a small resident population may be insufficient to deliver mandatory services. We strongly agree that a minimum fixed allocation will be necessary to deliver services in the City, particularly if we are to deliver the public health functions mandated to us.

Non-resident population

We strongly agree that the non-resident population of the City should be taken account of. With over 360,000 commuters entering the City each day, open access services must cover a population much wider than which we are funded for. There are also unprecedented opportunities to improve the health of workers who spend the majority of their waking hours here, and public health interventions that are applied here have the potential to deliver huge cost-savings to other parts of the NHS, across the south east and beyond. Unlike other authorities the City of London

[1] DH (2011) *Resource Allocation: Weighted Capitation Formula.*
[2] DH (20120) *Improving outcomes and supporting transparency.*

Corporation does not have sufficient public health funding for its resident population to deliver additional services for its non-resident population.

This is also important for the future planning of open access services in London i.e. those for whom access is not restricted to residents, such as sexual health services. In the absence of an effective recharging mechanism it will be challenging for local authorities to commission open access services.

Updates to the ONS population projections based on the 2011 census
We would like to point out that we have been working on allocating our original budget, based upon the government's original assertion that it would not change substantially from the original allocation. A sudden revision of budgets would leave us in an extremely precarious situation with regards to contracting and our arrangements with London Borough of Hackney.

With regards to **paragraph 2.17**, we are unaware of any evidence or rationale for using SMR<75 years to replace the current allocation formula for the pooled treatment budget for drug services, which the national audit office deemed effective. In the absence of the evidence/rational for this proposed change, it is hard to comment on the correlation between SMR< 75 years and the need for drug treatment services in that locality.

Previous work by the Universities of Glasgow and Manchester has focused on triangulation of data from drug treatment services, police, probation and prisons to identify opiate and/or crack users (OCUs)[3]. Resource allocation for substance misuse services should acknowledge poly drug use (including alcohol and stimulants), emerging drugs/legal highs, and the complexity/vulnerability of users (including housing status).

The NTA has acknowledged that the City of London provides drug treatment services to a small group of rough sleepers. The need component will make up 24% of the PTB, so understanding the impact of the shift to SMR <75 years is important.

With regards to **paragraph 2.23**, we would recommend that the pace of change is suitably slow to allow the City to adapt to what might be a 75% cut in public health budget.

The proposed changes in funding would make it extremely challenging to reduce health inequalities in our area. Unlike traditional health services, public health is inextricably linked with non-NHS local and regional funding, as it influences the social determinants of health. Local authorities are experiencing a decline in this funding, so scope for pooled funding may be limited in future. In addition, there is a pressing need to address public health challenges arising from changes to the housing and welfare system[4].

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[3] http://www.nta.nhs.uk/uploads/prevalencestats2009-10fullreport.pdf
[4] Marmot review of Health Inequalities in England

There is a general question as to whether the 4% of the total health budget allocated for public health is adequate given the current and projected burden of ill health and health inequalities. Also whether the circa 42% of the national public health resource being allocated to Local Government is sufficient to enable them to develop the new system and address health inequalities over the medium term.

To conclude, whilst we agree that a formula-based mechanism based on population need is the most fair means of allocating public health funding, we are unclear that the SMR<75 measure is the most appropriate measure on which to base this formula. We think that a formula which combines multiple measures of health and population need would be more suitable. We agree that a *de minimis* allocation will be required to deliver services for a small population such as those resident in the City, and that a further allocation for non-resident populations would be appropriate in this instance.

We look forward to seeing the final recommendations at the end of 2012, and hope that they will take our comments and concerns into account.

Yours sincerely

Joy Hollister
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Chair of Shadow Health & Wellbeing Board, City of London