GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

# Arrangements for funding public health functions through a pilot of retained business rates in Greater Manchester from April 2017

## Introduction

1. Greater Manchester (GM) will continue to commit to deliver national mandation and this paper outlines the approach to doing that through the Business Rates Pilot.

## Business rate pilot

2. Arrangements for the business rate pilot in 2017/18 in the ten local authorities in the Greater Manchester area will be:
    - Individual local authorities would retain business rates, funding would not be at the GM level.
    - GM local authorities would still qualify for the top up and tariff system.
    - Funding would mirror the SR 2015 settlement.
    - Local authorities would continue to comply with CIPFA/SERCOPS guidance so financial reporting would continue.
    - Local authorities would continue to report against PHOF outcomes.

## Grant conditions

3. Current grant conditions include the primary aim of spending to improve the public's health, to have regard to reducing health inequalities and to have regard to improve the take up of and outcomes from drug and alcohol services.

4. Whilst these grant conditions would no longer apply to the ten GM LAs, there would be a continued focus on delivering public health outcomes and reducing health inequalities and a focus on drug and alcohol services which are a priority in the GM wide STP (Taking Charge).

## Accountability

5. GM did not think it was appropriate to remove the grant and the grant conditions but then create something that looked like the old system. However, it was acknowledged that there needs to be a system of assurance, particularly as the GM pilot could potentially set a precedent for others to follow. It will be important to achieving a balance between allowing GM the freedom to innovate whilst providing reassurance to Ministers. GM suggested the STP assurance process – led by NHSE but involving PHE – could be one way of ensuring that prevention and public health were being given sufficient priority and resources. It would also provide a way of testing whether this could be an assurance mechanism that might work nationally.

6. Transparency will be important to the pilot and locality plans could also provide useful information about LAs' intentions on both priorities and resources. Local authorities have two main objectives for the business rates pilot:
    - Growth (and connecting people to growth through employment etc)
    - Improving public services

7. This reflects the commitments agreed in the GM Population Health Plan (January 2017) and which set out GMs approach to delivering a radical upgrade in population health. The plan is aligned with the broader approach to reform across GM which is predicated on a new relationship between people and public services; connecting people to the opportunities of growth and reform; place based integration of services and early intervention and prevention to achieve clear population health outcomes. The priorities for change in the plan, inclusive of the commitment for improving outcomes for drug and alcohol services, have been chosen to add value to local delivery described in each of the ten locality plans. We see that LCOs, are central to our programme of reform to support the delivery of those outcomes, along with public health within localities working with all sectors.

**Governance & Assurance**

8. Building on system wide discussions across GM and specifically with LA CEO's, we have secured commitment to a set of proposals and an overall approach for creating a unified population health system to support the delivery of the GM Population Health plan. Sitting alongside current national mandation, we intend to introduce a set of GM Commons Standards for core priority areas that we would ask that all localities to work to. This supports GM's desire to use the business rates pilot to see a wholescale upgrade in prevention. As a minimum we would expect the initial focus to be on existing mandated programmes as well as introducing other thematic areas: substance misuse (drugs and alcohol); tobacco control; mental health and ageing well. It is the expectation that these will be added to over time as we need to balance LA's statutory responsibilities with additional 'asks' of the system.

9. At GM level, overall governance for assurance in meeting national mandation and GM commons standards will be through the wider existing arrangements for the whole of the health and care devolution programme (including the GM Population Health Programme Board, GM Health & Social Care Partnership Board and the GM Reform Board under the Combined Authority), as well as through existing LA governance arrangements. Progress against common population health goals and outcomes, and the ambitions in locality plans would be reviewed at existing GM quarterly assurance meetings with localities.

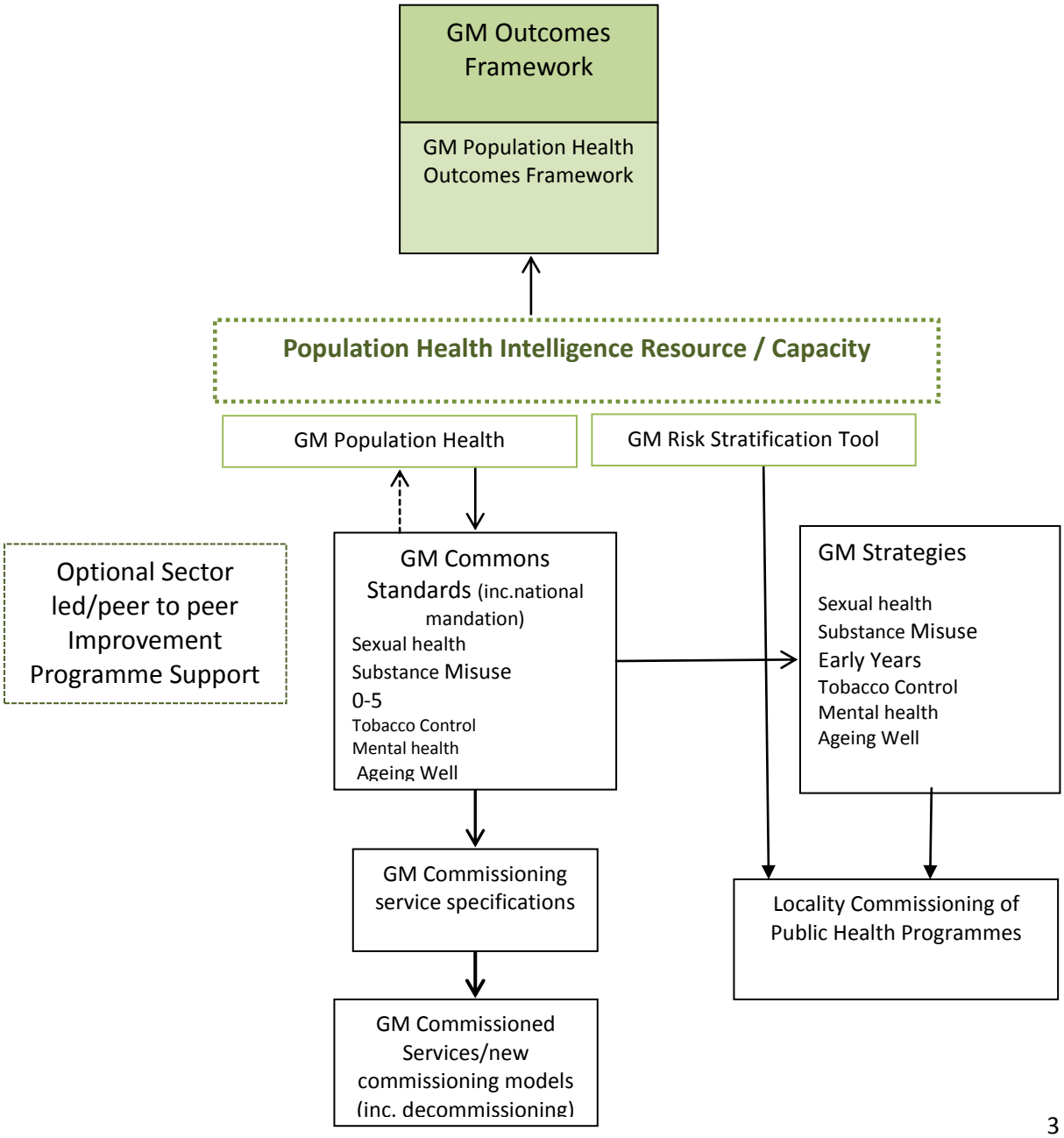
10. We do not wish to create an additional layer of assurance of top of national mandation. As LAs are accountable for improving population health it will be for localities to self-assure with respect to compliance with agreed standards, with the GM Partnership only raising issues where additional support may be required to facilitate delivery of the improved outcomes. At the locality level, oversight therefore will be integrated into the wider governance arrangements overseeing the delivery of the Locality Plan under Taking Charge Together. This reflects the overall stewardship of local population health sitting with the Health and Wellbeing Board, and the DPH, in their statutory role, continuing to have overall accountability for public health leadership.

11. At GM level we will work collaboratively with the wider system to co-produce a population health dashboard and metrics which will give a system wide view of progress against target outputs and outcomes and also provide localities with a means of comparing and

benchmarking their outcomes with other localities across GM. We intend to make data about programme and system performance readily available, including how money is spent, and openly tracking progress against target outcomes and impact on narrowing the health inequalities gap.

12. We also intend to agree a programme of sector led improvement around agreed priority themes to support any localities which may require additional support. Over the next year, there will be an initial in-depth review to baseline localities' current strengths and weaknesses to understand therefore where a sector led/peer-to-peer improvement programme may add value.

13. The following illustrates the relationship between the various proposals.



**Monitoring and evaluation**

14. There are no plans for a formal academic evaluation of the pilot and it would be difficult, in any case, to judge the precise impact of the move to BRR on public health outcomes. However the pilot provides the opportunity to test the mechanism for how BRR will work and learn from how GM approaches transparency - both financial and outcomes. GM would be willing to actively be part of any formalised learning and sharing opportunities, such as facilitated learning workshops. The ongoing relationship between GM, Local Government and PHE will be key to this.

**Reserves**

15. It should be noted that DH legal advice is that the ten local authorities will need to comply with the grant conditions when spending any reserves post-April 2017.