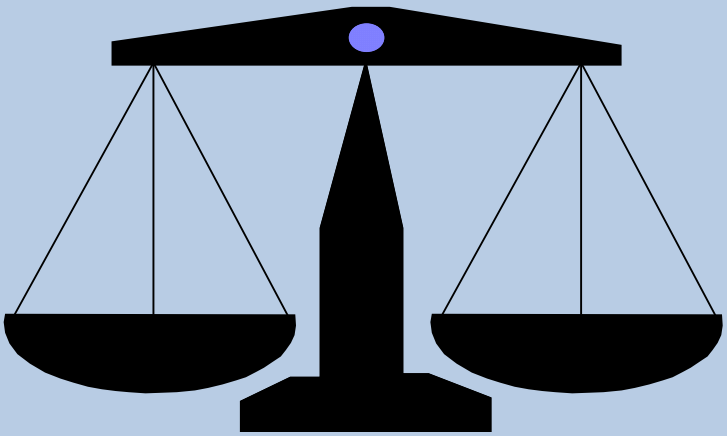
Health and Social Care Board

PROPOSED CHANGES TO THE NORTHERN IRELAND WEIGHTED CAPITATION FORMULA

SIXTH REVIEW

CONSULTATION DOCUMENT AND RESPONSE FORM



DECEMBER 2015

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CONTENTS

A – Consultation Summary Document

1 CAPITATION FORMULA OVERVIEW

Introduction

1.1 The Health & Social Care Board (HSCB) is currently responsible for the commissioning of Health and Social Care services for the population of Northern Ireland. The HSCB must ensure funding addresses health needs across localities. A complex statistical tool known as the Capitation Formula has been used to assist commissioners in this process since 1994.

1.2 Health and Social Care services are commissioned across five Local Commissioning Group (LCG) areas. Each Local Commissioning Groups' fair share of available resources is determined by the formula, based on its population size, age/gender mix and the additional needs profile of the population.

1.3 The demands for Health and Social Care are be greater than the resources available. Therefore, the formula cannot guarantee that all Health and Social care needs are met but helps to ensure that all populations have fair access to the resources that exist.

1.4 The Capitation Formula does not determine the level of investment required at Programme of Care level; rather it provides the equitable distribution of that Programmes' funding by LCG.

1.5 Responsibility for the Capitation Formula was delegated to the HSCB by the DHSSPS following the Review of Public Administration (RPA).

1.6 The formula is maintained and updated by the Capitation Formula Review Group (CFRG). CFRG is a multidisciplinary group with representatives from the

Department of Health, Social Services and Public Safety (DHSSPS), the Health and Social Care Board (HSCB) and the Public Health Agency (PHA).

The Current Formula

1.7 The primary purpose of the Capitation Formula is identifying fair shares to inform resource allocation by locality. Each year additional commissioning investment is identified to LCG through the use of Capitation shares. An equity review is carried out on an annual basis comparing planned and actual expenditure on baseline investments with fair shares from the Capitation Formula, together with an assessment of variances in quality and performance across LCGs. The Capitation Formula also provides a direction of travel for strategic investment decisions.

1.8 The formula is based on a Programme of Care (PoC) approach. There are nine PoCs as listed below:

- PoC 1 – Acute Services
- PoC 2 – Maternity & Child Health
- PoC 3 – Family & Childcare
- PoC 4 – Older People
- PoC 5 – Mental Health
- PoC 6 – Learning Disability
- PoC 7 – Physical Disability
- PoC 8 – Health Promotion
- PoC 9 – Primary Health & Adult Community

1.9 Each PoC has an associated formula, most of which comprise of three elements:

- Relevant Population – The client group on which the PoC is based;
- Age/ Gender weighting – Compensating for the effects of Age/Gender structure on the Health and Social Care needs of a population;
- Additional Needs Weighting – Differential needs for services are likely to be due to socio economic factors e.g. deprivation. The relevant factors are chosen for each PoC.

1.10 The PoC formulae are consolidated to produce LCG shares. Two adjustments are then made to compensate the LCGs for the differing cost of service provision to their population;

- Rurality – The additional cost of providing services in urban/rural areas
- Economies of Scale adjustment – The effect hospital and community infrastructure size has on costs.

1.11 The resulting formula establishes the fair share of available resources which each LCG should receive based on relative, not absolute, need. Further information on the population and need index information for each PoC can be found in Appendix 3 of the report 'Proposed Changes to the Northern Ireland Weighted Capitation Formula'.

Work Programme

1.12 Since its inception in 1994, in addition to annual updates of demographic and financial information, CFRG has carried out periodic reviews of individual elements of the formula. As such, the current sixth review of the formula, has focussed on the review or investigation into following areas of work:

- The update of the Rurality adjustment
- The production of a new formula for Mental Health
- A review of Alternative Resource Allocation Methodologies
- A scoping exercise on the Family & Childcare formula

1.13 The purpose of this report is to provide an overview of the main topics of the sixth Capitation Formula review. It is not designed to be a technical discussion paper and those wishing a fuller analysis should refer to the document titled "Proposed Changes to the Northern Ireland Weighted Capitation Formula".

1.14 The update of the Rurality adjustment has taken place resulting in new Rurality shares by LCG. It is proposed that these be incorporated into the 2016/17 Capitation Formula.

1.15 The review of the Mental Health formula has produced new needs variables and a different modelling approach. The approach has had collaborative peer review and has been shared with Mental Health professionals who accept this methodology. However, a limited consultation will still take place with Health and Social Care

Trusts (HSCTs) and Mental Health Community & Voluntary sector. The consultation will also be available on the HSCB website to ensure any other interested parties are given an opportunity to respond to the proposed changes.

2 RURALITY

2.1 The Rurality cost adjustment was introduced to the Capitation Formula as part of the third review, published in 2001. The adjustment is designed to compensate areas for unavoidable costs associated with delivering services in rural areas. This can be the cost of unproductive time spent by staff travelling to the clients' home as well as the cost of this travel and is dependent on the geographical spread of the population.

2.2 The Rurality adjustment to the model became a priority for update in light of the changing pattern of service delivery, the changing HSCT structures following the Review of Public Administration and the age of the data on which the adjustment was originally modelled. .

2.3 The review of the Rurality adjustment has taken place in a number of stages:

- A review by the Health and Social Care Trusts of the existing services contained within the formula;
- Detailed data collection exercise of the services Trusts identified as relevant;
- Modelling of the data collected;
- Review of the annual uplift methodology.

2.4 The Health and Social Care Trusts (HSCTs) have reviewed the relevance of the services on which the current formula is based and have had the opportunity to identify additional services for inclusion. Based on this review, no additional services are proposed, however a number of services such as those now provided on a regional basis e.g. non-emergency ambulance services, are no longer included.

2.5 An extensive data collection exercise has been carried out in each Trust for the activity data of Community and Personal Social Services remaining in the Rurality formula.

2.6 The data collected includes the age-gender profile of service users, service delivery location and contains a significant volume of information, for example, the district nursing service includes over 1.1 million client contacts. Information on the staff grade, cost and the health service location of those who delivered the services has been collected.

2.7 After a quality assurance exercise covering both volumes and service delivery location by the HSCTs and the HSCB, the services as listed in Table 1 have been modelled.

TABLE 1: SERVICES FOR INCLUSION IN RURALITY FORMULA

Services for inclusion in Rurality Formula
District Nursing
Community Psychiatric Nursing
Health Visiting
Podiatry
Occupational Therapy
Community Midwifery
Community Social Work
Physiotherapy
Speech Therapy
Learning Disability Nursing
Community Dentistry, Med. Services & Specialist Nursing
Domiciliary Services
Mental Health Day Centres
Learning Disability Day Centres

2.8 The update to the rurality adjustment has followed the previous methodology as closely as possible, with only minor changes made to accommodate updates to geographies used in the model. This incorporates moving from the old four Health and Social Service Boards to the current five LCG configurations.

2.9 The updated model has resulted in a smaller Rurality pot for redistribution across localities than predicted using the current model. This is due to a number of factors e.g. services now provided regionally being excluded, the travel cost element not increasing as much as predicted and changing community service delivery patterns.

2.10 Table 2 sets out the updated Rurality shares by LCG.

TABLE 2: REFRESHED RURALITY SHARES BY LCG

Local Commissioning Group	Belfast	Northern	South Eastern	Southern	Western	Total
Rurality Shares	12.07%	26.14%	14.90%	26.79%	20.09%	100.00%

2.11 The proposed new shares offer an improved Rurality adjustment to the Capitation Formula. The activity data is a more up to date reflection of community service delivery across LCGs, reflecting service investments since the current formula was developed and changes to travel patterns.

2.12 It is recommended that the new shares are incorporated in the Capitation Formula from 2016/17 and used in future equity reviews.

2.13 It is also recommended that going forward, the time between the reviews of this adjustment should be reduced to no more than 5 years. This is in light of, both the current Transforming Your Care agenda and the potential for changes in distribution of resources as these services are changed.

3 THE REVIEW OF THE MENTAL HEALTH FORMULA

3.1 A review of the Mental Health formula has been prioritised in the current work programme. The current formula was produced for the fourth report using needs variables from the 1991 population census and utilisation data dating back to 1997/98 from former Eastern, Northern and Western Board areas, with none then available from the Southern.

3.2 The Mental Health formula does not determine the level of investment required for the Programme of Care; rather, how the existing funds should be allocated by LCG to best reflect the needs of the population.

3.3 The Mental Health formula comprises all personal social services and community services where the primary reason for the service is due to a Mental Illness, as well as hospital inpatient activity where the consultant is a specialist in one of the following areas:

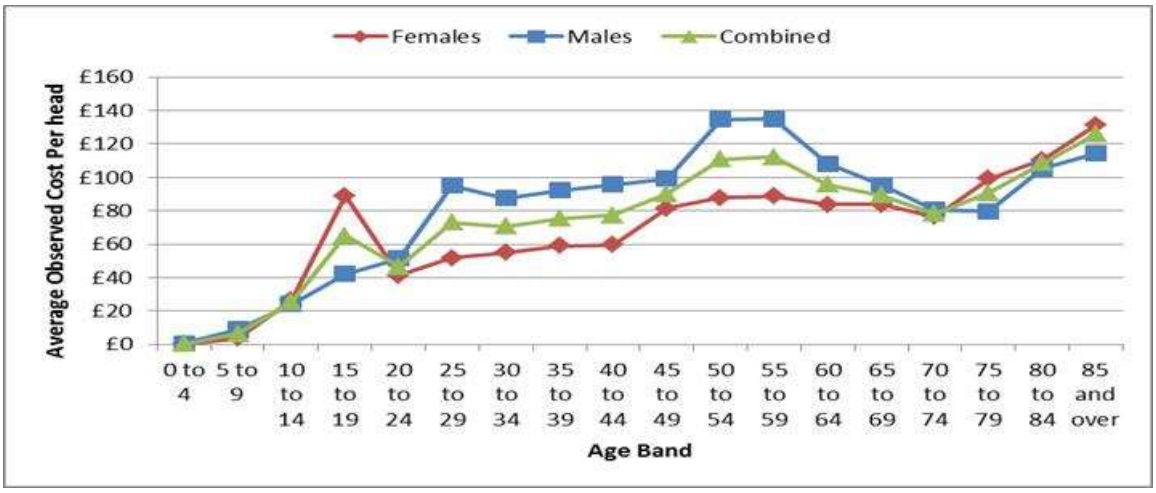
- Mental Illness
- Child & Adolescent Psychiatry
- Forensic Psychiatry
- Psychotherapy

3.4 As with the Rurality review, the update of the Mental Health formula has required an extensive data collection exercise from HSCTs. In excess of 243,000 hospital bed days and 360,000 community contacts data has been collected by age, gender, postcode and Mental Health service.

3.5 Costs were applied to this data using NI average direct costs from both hospital specialty and community indicators. This costed data has been compared to reported figures in Trust Financial Returns to ensure consistency.

3.6 Relative population average costs for each gender and age band have been calculated and are shown in figure 1 overleaf:

FIGURE 1: AGE COST CURVE FOR MENTAL HEALTH ACTIVITY IN NORTHERN IRELAND



3.5 Statistical modelling of the data took place using a number of approaches:

- *Model 1 - Informed Model Approach* – The opinion of a relevant group of professionals was sought to identify what variables they feel best explains the need for Mental Health services.
- *Model 2 - Full Set of Needs Variables* – Statistical modelling approach based on modelling a large selection of all available variables from sources such as 2011 census.
- *Model 3 - Needs Variables with Outliers Removed* – Modelling on full set of needs variables BUT removing 35 Super Output Areas (SOA)[1] which display untypical costs

3.6 A collaborative Peer Review of the model development has been carried out by an academic expert in this field from the University of Manchester[2].

3.7 Each of the three modelled approaches represents an improvement on the current model used for Mental Health. The utilisation data is more up to date and has a greater geographical coverage. The models reflect the reform and modernisation of mental health services which has taken place since the fourth report e.g. resettlement of clients into the community from long stay hospital facilities.

[1] For the purpose of reporting statistical information such as the results of the Northern Ireland census, the country is split into 890 Super Output Areas (SOAs). These SOAs were designed to be homogenous and of equal population size with approximately 2,000 residents in each.
[2] William Whittaker, Research Fellow in Health Economics, University of Manchester

3.8 The model which explains the most variation in the health needs of the population is consistent with the Peer Reviewer recommendation and is the model 'Need variables with Outliers Removed'. This model excludes the impact of the outlying SOAs which was considered to have distorted the results. Table 3 below sets out the needs variables as well as the statistical measures of modelling fit. It is proposed that this model is taken forward for new Mental Health allocations

TABLE 3: PROPOSED MODEL FOR MENTAL HEALTH FORMULA

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	.024	.096		.245	.807
Belfast	-.127	.053	-.088	-2.400	.017
South Eastern	-.064	.047	-.045	-1.363	.173
Southern	-.066	.047	-.046	-1.415	.157
Western	.027	.050	.018	.543	.587
Supported Living present in area	.684	.077	.241	8.857	.000
GP Supply 2	-.001	.001	-.041	-1.191	.234
supported supply (dist)	.005	.003	.050	1.607	.108
inpatient supply (dist)	.015	.008	.051	1.807	.071
GP Supply 1	.007	.009	.021	.758	.449
Alcohol and Drug Related Admissions	.001	.000	.104	2.319	.021
Living rent free: HRP aged 65+ years	.029	.007	.128	4.234	.000
Unshared dwelling: Flat, maisonette or apartment: Total	.011	.003	.132	3.375	.001
Economically inactive: Long-term sick or disabled: Aged 16-74 years (%)	.040	.006	.279	6.650	.000
Emergency Admissions: 65+yrs	.002	.001	.084	2.963	.003
Rented from: Private landlord or letting agency (%)	.007	.002	.105	3.131	.002

4 ALTERNATIVE RESOURCE ALLOCATION METHODOLOGIES

4.1 Different methodologies for resource allocation in other parts of the United Kingdom have been reviewed and compared to assess the continued relevance of the NI formula and identify any potential evidence-based improvements in the approach used. .

4.2 Each country in the United Kingdom has developed its own resource allocation formula, tailored to local commissioning structures and informed by available population and utilisation data. The various steering groups overseeing the development of each countries model comprise of a senior membership base with a wide range of expertise in the area of resource allocation, Health and Social Care and academia. Regular and lengthy consideration of developments is deemed essential to ensure the complex and challenging issues surrounding formula development are fully considered.

4.3 Population size, age, gender and additional needs factors are taken account of in each model. Table 4 below compares the differing approaches across the UK:

TABLE 4: ALLOCATION METHODOLOGIES IN UK COUNTRIES

	NI	England	Scotland	Wales
Coverage	9 PoCs*	Hospital and Community Health Services	Acute	Hospital and Community Health Services
			Mental Health & Learning Disability	
		Prescribing	Maternity	Prescribing
		Primary Medical	Community	Primary Medical
		Dental	GP Prescribing	Dental
			Care of the Elderly	
Population	MYE	GP list	MYE	MYE
	* GP list		GP Pop	GP Pop
Age Weight	Yes	Yes	Yes	
Additional Needs Weighting	Yes	Yes	Yes	
Unavoidable cost adjustment	Yes	Yes	Yes	
Unmet need adjustment	No		Yes - limited	
Inequality adjustment	No	Yes		
* Separate formulas existing for FHS - Prescribing, General Medical, Dental				

4.4 The different approaches reflect the commissioning structures within each country. The approach in Northern Ireland reflects many of the core elements in used in other countries, such as age and additional needs weightings whilst having the benefit of being built around our local commissioning structures. Moving forward it will be important to reflect any future availability of accurate local data at postcode level.

4.5 Following the announcement on the restructuring of Health & Social Care commissioning in NI, the current approach will have to be revisited after new structures are established.

5 CONCLUSION

5.1 This latest review of the capitation formula has provided an opportunity to update and review some core elements of the Capitation Formula. The results follow significant data collection and analysis from a range of organisations across the HSC. The areas reviewed are more reflective of the pattern of service delivery and provide a wider data coverage than that contained in the current models. .

5.2 The recommendations are that the HSCB:

- **Introduces the updated Rurality model into the 2016/17 Capitation Formula**
- **Incorporates Model 3 as the new Mental Health formula in the 2016/17 Capitation Formula. This reflects current modelled needs at small geographical level.**
- **Continues to use the current approach to formula development including the PoC approach set out in the proposed work programme (subject to the commissioning review and information availability) .**
- **Undertakes an 18 month limited review of the Family & Childcare PoC and the Acute PoC models. The work programme and membership of CFRG will be kept under review as the DHSSPS Commissioning Review November 2015 is rolled out.**

GLOSSARY OF TERMS

Additional Needs Weighting - Two populations of the same size and structure can have a different need for services due to a differing underlying morbidity i.e. such as that caused by deprivation levels. A statistical model is used to calculate this additional needs weighting which is then combined with an age/gender weighting to produce a single composite weighted population share.

Adjusted R^2 - This is a modification of the R^2 test and is again used to determine the quality of a fit of a model (See R^2 in this Annex). The addition within the adjusted R^2 is that it takes into account the number of variables included with the model, when evaluating the quality of the fit**.**

Bamford – the Review of Mental Health and Learning Disability. This independent review, set up in 2002, looked at the law, policy and provisions which affected people with mental health needs or a learning disability in Northern Ireland. The review completed its task on 16th August 2007 with the publication of its report on legislative reform.

Capitation Formula Review Group (CFRG) - The CFRG is a multi-disciplinary group drawn from both the Department of Health Social Services and Public Safety (DHSSPS) and Health and Social Care Board (HSCB) which has been tasked with responsibility for the Northern Ireland Weighted Capitation Formula.

Commissioners – A term used to describe organisations or groups who have been given responsibility for the commissioning of Health and Social Care. Commissioning involves identifying local Health and Social Care needs, making agreements with service providers to deliver services, and monitoring outcomes.

Confidence Intervals - Confidence intervals can be used to indicate the reliability of an estimate. Instead of estimating a parameter by a single value, a confidence interval gives an estimated range of values which is likely to include a known population parameter (an interval of 90% has been used as this was the standard level used in English work). The smaller the interval is the more reliable the estimate will be. This provides a means of assessing how accurate an area's allocation will be.

Day Care - Day care is provided by a health care provider for the clinical treatment, assessment and maintenance of function of patients, in particular, though not exclusively, those who are elderly, mentally ill or have learning disabilities. They may be called Day Hospitals, Centres or Units, staffing is by Health Service employees. The facilities specifically do not have hospital beds and function separately from any ward.

Day Case – A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be classed as an ordinary admission.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Differential Need - Different populations may have a different need for Health and Social Care services, due to need-related factors. This can be caused by factors including deprivation and travelling times in rural areas.

Economies/ Diseconomies of Scale - Costs for organisations change as they increase or decrease in size. Although there are additional costs for larger operations, scale benefits in productivity occur as efficiency increases forcing unit costs down. Similarly smaller organisations can have higher costs associated with their operations as their costs of production are spread across a lower output.

Elderly Care – Refers to Health and Social Care services provided to people who are aged 65 years or more that are not included in any of the other programmes of care.

Elective – A procedure that the patient/physician has decided should be undertaken.

Fair Share - The aim of the regional allocation formula is to determine each commissioner's fair share of the available resources that are available. This is based upon population size, age/gender and additional needs profile of that population.

Health and Social Services Board - Organisation responsible for commissioning Health and Social Care services for the resident population.

Health and Social Care Trusts – Organisations responsible for providing Health and Social Care services. Five Health and Social Care Trusts replaced eighteen Health Social Services Trusts in April 2007. The Ambulance Service Trust remained.

HRG – Health Resource Grouper -Standard groupings of clinically similar treatments which use common levels of healthcare resource. They enable comparison within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time.

Inpatient – A non-elective patient (i.e. emergencies and transfers), and any elective patient from a waiting list who remains in hospital for at least one night.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional Health and Social Care staff and community and elected representatives. Their role is to help the Board arrange or commission Health and Social Care services at local level.

Mid-Year Estimates (MYEs) - These are estimates of the size, age and sex of the population of Northern Ireland. The MYE has an integral role in ensuring that the Department's Capitation Formula is reflective of the most up to date estimate of the population base.

Northern Ireland Statistics and Research Agency (NISRA) - The official statistics organisation in Northern Ireland, which provides a considerable amount of the information used in the Capitation Formula. This includes Census figures, data on births and deaths, and information relating to demographic trends.

Non Elective Admission- A patient who is admitted as an emergency. This does not include maternity.

Outpatient – An appointment and/or an attendance to enable a patient to see a consultant, a member of his firm or locum for such a member, in respect of one referral. A patient attending a clinic will always be given an appointment (even when arriving with no prior notice, where this facility is available), but appointments will not always result in an attendance. An attendance may involve more than one person e.g. a family. The number of attendances to be recorded should be the number of patients for whom the particular consultant has identifiable individual records and which will be maintained as a result of the appointment/attendance.

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker

Rurality - This term is a measure of the rural nature of an area. Using this term allows a correction to be made to account for any extra costs incurred in delivering services to that area

R^2 - The coefficient of determination, this is a statistic which can be used to determine the quality of the fit of a model to the data being modelled. Where a value of $R^2=1$ indicates that the fit is perfect.

Review of Public Administration (RPA) – A wide ranging review of the delivery of Public Services across Northern Ireland. In the field of Health 5 HSC Trusts were set up April 2007. Further recommendations included that the 4 HSS Boards are replaced by a single Regional Health and Social Care Board which was established in 2010.

Standardised Mortality Rate (SMR) – The standardised mortality rate is used to compare the mortality of a particular sub-group of the population relative to a standard, adjusting for differences in population age structures. It is calculated by applying the age-sex specific rates from the standard population to the sub-group to obtain the “expected” number of deaths and comparing the actual number of deaths in the latter with the expected number.

Super Output Areas (SOAs) – Northern Ireland is split into 890 of these. Each of these areas has population sizes of between 1,300 and 2,800. They were described by NISRA for the 2001 census and are used in statistical analysis on a wide range of government and academic studies.

Unmet Need - This is a concept that there may be an under-utilisation of services in certain areas which can lead to underfunding issues for the areas in question. This is a key idea in resource allocation and of prime importance when targeting resources at those who need them most.

Transforming Your Care – this is a strategic assessment across all aspects of Health and Social Care services examining the present quality and accessibility of services.

Variables – Within this modelling a variable is a measureable characteristic or feature that will vary from one SOA to the next, allowing the differences between each to be studied**.**

Weighted Capitation Formula - The formula used to calculate the fair share of resources for each of the Health and Social Care commissioners within Northern Ireland. This is based on population size, the age gender profile of that population the additional needs profile and other factors such as the Rurality of the area

B - Responding to this Consultation

The purpose of this document is to consider the proposed changes to the Northern Ireland weighted Capitation Formula. This consultation process offers an opportunity for all stakeholders to consider and comment on the proposed changes. You can respond to this consultation by e-mail or letter.

Before you submit your response, please read Appendix 1 about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises. If you require the documents in another format or language please use the contact details below.

Responses should be sent to:

E-mail: capitationformula@hscni.net

Written:

Consultation on proposed changes to Northern Ireland Weighted Capitation Formula
Finance Directorate
Health and Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

Telephone: 0300 555 0115

Responses must be received no later than 5.00pm on Friday 19th February 2016.

C - YOUR VIEWS - THE CONSULTATION RESPONSE QUESTIONNAIRE

The questionnaire can be completed by an individual, health or social care professional, stakeholder or member of the public; or it can be completed on behalf of a group or organisation.

Please tell us if you are responding on your own behalf or for an organisation by placing a tick in the appropriate box:

I am responding:

- As an individual ☐
- As a health and social care professional ☐
- On behalf of an organisation ☐

(please tick one option)

Name:	
Job Title:	
Organisation:	
Address:	
Telephone:	
Textphone:	
E-mail:	

May we contact you should clarification be required on your response?

Yes ☐ or No ☐ (please tick a box)

1. **Do you agree that in resource allocation, it is important to continue to recognise the unavoidable travel costs associated with delivering services in the clients' home?**

Agree ☐ Disagree ☐ Unsure ☐

If 'no' please comment below

2. **Do you agree that the changes to the Mental Health Formula make it more reflective of the health and social care needs of those requiring Mental Health services in Northern Ireland?**

Agree ☐ Disagree ☐ Unsure ☐

Please comment below:

3. **Do you agree that it is important to reflect the different age cost profiles of Mental Health service user as shown in Figure 1?**

Agree ☐ Disagree ☐ Unsure ☐

4. **Table 7 sets out the variables which explain the need for Mental Health services. e.g.** Economically inactive: Long-term sick or disabled: Aged 16-74 years (%)**. Do you agree that it is important to reflect these factors in the Mental Health Capitation Formula?**

Agree ☐ Disagree ☐ Unsure ☐

5. **The Acute and Family & Childcare Formula will be reviewed as part of a limited 18 month review, are there any areas of priority you would like to see taken forward in the Capitation work programme in the future?**

Yes ☐ No ☐

6. **Are there any other comments you would wish to make?**

Yes ☐ No ☐

Equality implications

The screening for equality implications as required by Section 75 of the Northern Ireland Act 1998 and for compliance with human rights and disability legislation has been limited to the new formula for Mental Health as all other elements of the formula have been previously subject to screening including Rurality.
Documentation to evidence the screening has been produced and is publicly available http://www.hscboard.hscni.net/consult/Consultation

Please let us know if you are satisfied with the content of the screening exercise and if all relevant equality issues have been identified. If not we would be interested in your reasons for this.

Yes ☐ No ☐

Comments:

Thank you for your comments.

APPENDIX 1

Freedom of Information Act 2000 – confidentiality of consultations

The Health and Social Care Board will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Health and Social Care Board can only refuse to disclose information in exceptional circumstances. Before you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Health and Social Care Board in this case. This right of access to information includes information provided in response to a consultation. The Health and Social Care Board cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

- the Health and Social care Board should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Health and Social care Board functions and it would not otherwise be provided;
- the Health and Social Care Board should not agree to hold information received from third parties "in confidence" which is not confidential in nature;
- acceptance by the Health and Social Care Board of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact the Information Commissioner's Office (or see web site at: http://www.informationcommissioner.gov.uk/).