APPENDIX 1. Public Health Grant cut: a response to the government consultation

Introduction

This paper outlines our response to the consultation on the cut to the Public Health Grant as set out by the Department of Health. (Department of health. *Local Authority Circular* LAC(DH)(2014)2. Department of Health. London. 2014) The deadline for response was 28 August 2015 and the actual response can be found in Appendix 1a with additional details of Sloughs Public Health priorities in Appendix A.

Overview

Nationally, the 2015/16 public health grant to local authorities (LAs) will be reduced by £200m. The cut is not negotiable and the consultation concerns the technical options for implementation. DH's preferred option is a flat-rate 6.2% cut to the current grant (including the health visitor 0-5 year old service grant due to transfer on 1 October) across all LAs (Option c) Were there to be a differential cut to LAs (say, options A / B / D) then the cut will be higher for other authorities so that £200m is still saved.

1.1.2 Consultation scope

There are three questions in the consultation:

1. How should DH spread the £200 million saving across the LAs involved?
    A. devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation;
    B. identify LAs that carried forward unspent reserves into 2015/16 and claim a correspondingly larger share of the savings from them;
    C. reduce every LA's allocation by a standard, flat rate percentage. Nationally the £200m saving amounts to about 6.2% of the total grant for 2015/16, so that would also be the figure DH applied to individual LAs; or
    D. reduce every LA's allocation by a standard proportion unless an authority can show that this would result in particular hardship, taking account of:
        - an inability to deliver savings legally due to binding financial commitments;
        - substantial, disproportionate and unavoidable adverse impact on people who share a protected characteristic within the meaning of section 149 of the Equality Act 2010;
        - a high risk that, because of its impact, the decision would be incompatible with the Secretary of State's duties under the NHS Act 2006 (in particular the duty to have regard to the need to reduce inequalities between people with regard to the benefits they can receive from public health services);
        - the availability of funding from public health or general reserves; or
        - any other exceptional factors.
2. How can DH, Public Health England and NHS England help LAs to implement the saving and minimise any possible disruption to services?

    DH says that it welcomes proposals noting that:

    - LAs' duties in primary legislation will remain in place;

- it would not be realistic to amend the existing regulations that require LAs to take particular steps, or the regulations that will mandate the universal aspects of commissioning of public health services for children aged 0-5 years, or any other secondary legislation, in time to influence spending in the current financial year; and
- the conditions attached to the grant will stay in place for the rest of 2015/16.

3. How best can DH assess and understand the impact of the saving?

   Again, DH says that it welcomes proposals especially as it needs to understand the effect of this cut, including its effect on health visitor services. It sees potential ways to do this as being to:

   - undertake a national survey of directors of public health and other key stakeholders;
   - commission Public Health England centre directors to review the local impact and contribute to a national report for DH; or
   - work through representative bodies to gather feedback on local impact.

2. Discussion of context

Whilst, strictly, out of the consultation's scope, it may be worthwhile commenting on the following:

- historically, whilst public health interventions rather than health care have had the greatest beneficial impact on improved life expectancy, and despite a plethora research and policy initiatives, there has been only limited progress in tackling the UK's health inequalities and this is why front line public health services were transferred from the NHS to local authorities;
- to cut the public health grant to local authorities will compromise their ability to reduce health inequalities for which they were given responsibility under the Health and Social Care Act 2012;
- the timing of the cut is counter to the priority given to prevention in the NHS 5 year forward view and this approach will compromise our ability to respond to growing request for prevention from our CCG colleagues
- especially at a time of increasing demand for both health and social care services when budgets for these are being overspent and/or cut, it is counterproductive to reduce funding for prevention which is the cornerstone of public health interventions.

In terms of the consultation questions (see Appendix 1a for the format of the required response), the following is suggested

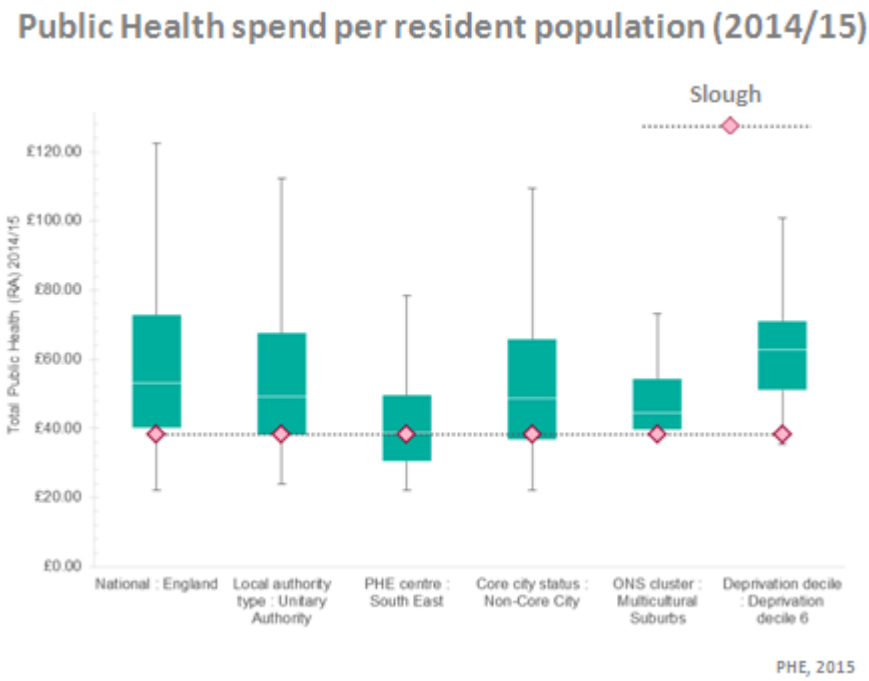
Question 1

A – that is, DH should devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation.

The rationale for this suggestion is that:

- this council is below its fair share allocation of the PH grant - *the distance from target in 2014-15 in percentage terms was 43% equal to an absolute amount of £37 per head compared to £48 for our ONS cluster, £57 per head nationally and £63 for our deprivation decile as shown in the 2014-5 Public Health Spend and Outcomes tool see Figure 1 overleaf*

Figure 1 public health spend per resident population



- *Discussions have already been undertaken and agreed with ACRA to resolve a fair share for the health visiting allocation and the results of that consultation should inform the whole grant as the principles remain the same*

To apply a flat-rate cut across all LAs irrespective of position against their fair allocation will

- (i) disadvantage the people of *Slough still further*
- ii) tend to perpetuate rather than help to redress persisting health inequalities (the main reason that public health responsibilities were transferred from the NHS to LAs), and
- (iii) be inequitable (it is treating people with unequal needs equally, which is unethical),
- (iv) runs counter to the NHS approach to growth which has been to focus on areas which are below their fare share allocation
- To make any in-year budget cut is, in any case, counter to the government's commitment that Public Health Grant underspends can be carried over, as part of a public health reserve, into the next financial year and that only if there are repeated large underspends would DH consider whether allocations should be reduced in future years[i] – the £200m cut is based on a national underspend in the first year of the public health transfer to LAs and is being effected in-year and not 'in future years
- Locally the transfer of PH into local government was complicated with resources moving from two PCTs into 6 unitary authorities and so the first year was planned against an unknown baseline. A prudent position was taken to ensure all existing commitment could be honoured. This prudency would be penalised if option B was taken e.g Slough has not underspent in either of the first two years and has had to absorb much higher sexual health costs than planned at transfer from the PCT to the UA in addition to adoption of a risk share approach across Berkshire until accurate activity and costs could be achieved.
- We also believe that option D would be unworkable and that it would be possible in this financial climate for every PH department to construct arguments that would demonstrate that the

decision would be incompatible with the Secretary of State's duties under the NHS Act 2006 (in particular the duty to have regard to the need to reduce inequalities between people with regard to the benefits they can receive from public health services) Moreover this approach would introduce further delay regarding the announcement the consultation results and make the in year savings even more difficult.

Question 2

Any cut to the grant in-year will disrupt services and it is difficult to see how DH, Public Health England or NHS England could help to ameliorate this.

Health visitor services are to be transferred in October 2015 and a requirement for the safe transfer was that local government was required to sign contracts from the service in April for the October transfer . Thus making an in-year cut impossible for those services because contracts are already in place and there will be insufficient time to negotiate with providers. However it would help a review of this service if there was absolute clarity that upon transfer the target number of health visitors was no longer key but that the focus was on the outcomes and delivery of the mandated services.

Clarity on the performance assessment or management for the PHOF and assurance concerning the PH grant would also be useful .

Question 3

DH will probably best be able to understand the impact of this in-year cut by both undertaking a national survey of directors of public health and other key and commissioning Public Health England centre directors to review the local impact and contribute to a national report for DH. Liking this knowledge to any changes in the PHOF framework would be useful in the longer term to assess the impact on outcomes

It is inevitable that an in-year cut of this magnitude, because it will not be possible to apportion it equally across all public health-commissioned services, will focus on services without legal running contacts or where activity can be varied e.g :

- fewer people beneficially changing their lifestyles (for example, quitting smoking) and thus experiencing poorer health;
- more people developing avoidable ill-health and disability;
- greater operational and financial pressures on both health and social care services; and
- some smaller providers, especially in the voluntary sector, ceasing to provide services and possibly going bankrupt.

Appendix 1a: Actual response to the consultation questions

Question: 1

Do you agree with DH's preferred option (C) for applying the £200 million saving across LAs? If not, which is your preferred option?

Please tick your preferred option or describe an alternative :

A This is Slough's preferred option as Slough has the biggest gap in spend per head of the population compared to target and because long term outcomes such as early deaths from cardiovascular disease; which require a higher expenditure on health improvement remain significantly higher than the England average.

B not preferred

C not preferred

D (LAs are invited to include any such evidence in responses to this consultation. Should the Department opt to implement option D, it will rely on this evidence in making decisions on its application and will not mount a separate consultation to gather this evidence.)

This is Slough's second preference. Factors which make Slough more deserving than others are shown in Appendix A and below

i. it is in the fifth most deprived group in England on the PHOF profiles

ii. it has the fifth highest birth rate in England placing continuing demands on the whole early years, housing and education sectors

iii. it has the highest population churn exacerbated by the now common practice of London boroughs and other areas to export families with complex needs to the poorest accommodation in the private rented sector within the borough

iv. the ethnic diversity of the population is equivalent to many London boroughs who are receiving far higher rates per head of the population

v. employment rates whilst low are in the lowest paid sectors

vi. violent crime is reducing but remains the highest in the Thames Valley

vii. our population has one of the highest recorded rates of diabetes in primary care and the poorest outcomes for cardiovascular disease for which funding cuts to key lifestyle interventions would further increase demand on the health care system

Question: 2

How can DH, PHE and NHS England help LAs to implement the saving and minimise any possible disruption to services?

Allow the LAs to offset the reductions through the health visiting grant in 2016-17 to fund more integrated services within the Slough Childrens Trust

Question: 3

How best can DH assess and understand the impact of the saving?

Through the spend and outcome tool and PHOF results

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APPENDIX A

Data in support of Slough's position being more deserving than comparators

Demography

- Total population: 149,145 (ONS projected 2015)
- Slough is in the fifth most deprived quintile with a deprivation ranking of 93 out of 326 local authority areas (Based on 2010 IMD). 10 LSOAs fall below the 20th percentile & 1, Slough 013B, below the 10th (IMD 48.79). 60 of the 78 LSOAs fall below the average for England
- Around 65.5% of residents are from BME backgrounds, the largest group being Asian/Asian British at 39.7% (55, 767). Black/Black British make up 8.6% (12, 115).
- Some 1,682 people are over the age of 85, this is 1.2% of the population, significantly below the SE and England averages (Census 2011)
- Slough has over 19,000 children aged 0-7 (13.6%). This is the second highest proportion of 0-7 year olds in England
- Relates to outer London rather than Berkshire and has a similar profile to statistical neighbours in Bradford and Luton.

Key Public Health Challenges for Slough

The key challenges are
Slough has one of the highest recorded rates of diabetes (8.2% in 2013-14 compared to 6.2% in England) in persons aged 17+ primary care and preventable early deaths from cardiovascular disease, for which funding cuts to key lifestyle interventions would further increase demand on the health care system

- The under 75 mortality rate (2011-13) from cardiovascular diseases considered preventable (71.7) is significantly higher than England average (50.2)
- 31.4% of adults are inactive compared to 27.7% England average
- Smoking prevalence is 22% compared to 18.6% England (2013)
- 10.5% of the population have diabetic eye disease (in persons aged 12+) compared to 3.5% in England 2013/14
- Self reported wellbeing; the percentage of people with a low satisfaction score was 7.1% compared to 5.6% in England (2013-14)
- Injuries (2013-14) due to falls in people aged 65 and over were 2435 per 100000 compared to 2064
- The fraction of mortality attributable to air pollution was 6.4% compared to 5.1% (2012)
- Infant mortality (2011-13) 5.9% compared to 4.0% in England
- In 2013, there were over 99 conceptions per 1,000 females in Slough, much higher than the national average of 78 per 1000 females.
- Low birth weight of term babies was 4% compared to 2.8% England (2012)
- The level of child poverty is worse than the England average with 19.1% of children aged under 16 years living in poverty (South East: 13.6%. England 18.6%)
- Tooth decay rates in three year olds are the highest in the Southeast (2013)
- 36% of children aged 10-11 years are classified in the excess weight category in 2013/14, this is above the national average of 33.5%

- Uptake of preventative screening is lower than the England average; e.g
- Breast cancer screening: 68.3% screened adequately in 2014 compared to 75.9% England
- Cervical cancer screening: 68.8% of eligible women screened adequately in 2014 compared to 74.2% England
- Population vaccine coverage (2014/15) remains below the recommended levels on all indicators
- TB incidence is higher than the UK average at 58.3:100,000 compared to 14,8:100,000 – 2011/13
- Slough has above England rates of late diagnoses for HIV at 49.2% compared to 45% nationally

Other determinants of health

- Slough has the fifth highest birth rate in England placing continuing demands on the early years, housing and education sectors
- Slough has double the regional average of private rented sector housing (23% compared to 11% regionally) with the highest occupancy rates among the poorest and most transient populations
- Slough has high rates of population churn exacerbated by the now common practice of London boroughs and other areas to export families with complex needs to the poorest accommodation in the private rented sector within the borough.
- the ethnic diversity of the population is equivalent to many London boroughs who are receiving far higher rates per head of the population
- employment rates whilst average are in the lowest paid sectors
- violent crime is reducing but remains the highest in the Thames Valley
- there are four air quality zones in the area two of which are impacted by proximity to the M4.