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28 August 2015

Dear Public Health Team,

**South East councils' response to the local authority public health allocations 2015/16: in-year savings consultation**

We respond on behalf of South East England Councils (SEEC) and South East Strategic Leaders (SESL). Together we promote the views and interests of all tiers of local government across the South East, representing over 60 local authorities. This response provides a South-East-wide perspective on the Department of Health's (DH) proposed options for calculating and implementing £200 million public health savings. We also refer you to the responses of our member authorities for individual feedback.

## 1. Executive Summary

1.1. SEEC and SESL represent the majority of the County, Unitary and District councils across the South East, with seventeen of our members receiving public health funding directly. Alongside this our districts play an important role, contributing to better public health from housing responsibilities to the provision of leisure facilities. The South East has distinctive funding challenges compared to other areas that often make services more expensive to commission. For example, we are home to the UK's largest population, including the highest elderly population, large numbers of people living in deprivation, and have both a close proximity to London and a large amount of semi-rural and rural areas. Our members would like these to be recognised within their public health allocations.

1.2. This is exacerbated by the low levels of public health funding in the South East. Since receiving public health responsibilities in 2013, our members have been very concerned about an ongoing shortfall in their funding, with the majority receiving far less than their target allocations as defined in 2014-15. No long-term plans have been released by DH on the speed at which they will move towards these targets. It should be a top priority to move quickly towards them, as well as to provide local authorities with long term certainty over their budgets. This would allow them to deliver the successful and sustainable public health services needed to improve their residents' health and wellbeing and reduce the demand for NHS services and social care.

1.3. With a freeze between 2014-15 and 2015-16, followed by this £200 million cut, there is little certainty around public health funding for local government. Our preference would be to avoid cuts altogether. We are disappointed that preventative work to improve public health is not being prioritised, when it could reduce the excessive pressure currently on the NHS and social care services. However, if the £200 million public health savings across local authorities are to be implemented, SEEC and SESL call for DH to:

- Devise a formula to claim a larger share of the saving from those councils significantly above their target allocation (question 1, option A). See our proposal in section 4 below.
- Speed up the pace of change, in order to move faster towards local authorities' target allocations.
- Ensure that councils with unspent reserves are not penalised for being efficient and forward-thinking with their public health budgets.
- Provide local authorities with a long-term plan for public health funding, allowing them the certainty to deliver effective public health services.
- Ensure that local authorities are fully involved in the impact-assessment of the savings.

## 2. South East councils delivering public health services

2.1. The South East has a number of unique characteristics which make it more expensive for councils to deliver the public health services that improve residents' health and quality of life and reduce pressure on the NHS. We want to ensure recognition of the South East's large population size and levels of deprivation, as well as its sparsity and high cost base, when the spread of the £200 million saving is considered.

2.2. Population: at 8.9 million, ours is the largest population in the UK. We are also home to the fastest growing number of elderly people; the number of over 75s in our area is expected to almost double by 2037, from 790,000 to 1.5 million. Adequate investment in preventative public health is vital to reduce the impact on NHS and care services of our growing ageing population. Additionally, with 658,331 children aged 0 to 5 in the South East, second only to London, and the birth rate up by 4% since 2006, there is also growing pressure on 0-5 public health services.

2.3. Deprivation: current local government funding focuses heavily on the percentage of deprivation, which disguises the actual number of people affected and therefore does not reflect the true cost of supporting them. For example, the South East is considered to have the lowest percentage of children in income deprived households in England at 14.8%, while the North East has the second highest percentage at 25%. However, when looking at the absolute numbers, the South East has 235,521 children in this category – more than double the 115,127 children affected in the North East. The South East faces a disadvantage because the previous funding formula focused on deprivation measures without considering absolute numbers needing support. It should be a priority to move quickly towards the new target funding allocations which partly redress this balance.

2.4. Cost of service provision: many parts of the South East face higher service delivery costs than other areas outside London. This affects premises, procurement and staff costs, where salaries need to reflect the high living costs. Ease of commuting means that South East employers must often compete for staff with higher-paying London-based organisations. Economies of scale are also lower in semi-rural and rural areas, which make up much of the South East, meaning that many South East councils face higher costs than urban areas for the provision of public health. All of these factors force up costs for South East authorities and we would like to see this recognised when the cuts are implemented.

## 3. Speeding up the pace of change

3.1. In 2014, DH accepted ACRA defined targets for local authority public health allocations. Although some progress was made to bring allocations closer to these targets in 2014-15, the following year allocations were frozen. There have not been any long-term plans announced for the speed at which DH will move towards the targets. A lack of certainty over funding does not provide local authorities with the optimal environment to deliver services and improve public health in their area. The current lack of progress towards the targets undermines the new and agreed allocations, at the same time as exacerbating the South East funding deficit. We feel that the £200 million savings provide a timely opportunity for DH to bring public health allocations closer to their accepted targets.

3.2. Figure 1 shows that out of 152 councils who receive public health funding in England, not one of the original 2015-16 allocations for the age 6+ population was on target. Out of the 95 authorities who received less funding than their target, 14 were underfunded by between 20% to 43%. This is compared to 57 councils who received more than their target, 7 of which received 45% more. After accepting the targets, it should now be a priority for DH to move as quickly as possible towards them.

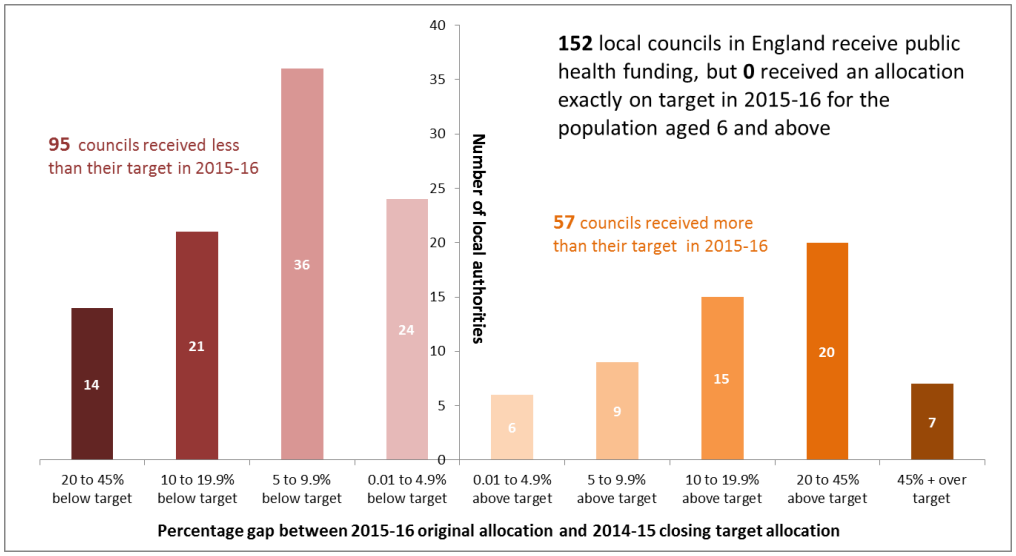



*Figure 1. Distance of original 2015-16 public health allocations from 2014-15 defined target allocations (for the population aged 6 and above).*

3.3. Out of the 17 SEEC and SESL member authorities who receive public health funding, 16 received a significantly smaller 2015-16 grant than their target funding allocation; for example Slough received 43% less and Windsor and Maidenhead 38% less. A standard 6.2% cut would pull these authorities even further from their target, whilst other areas would still be receiving well over theirs.

3.4. The charts below (figures 2 and 3) show how far SEEC and SESL members' original 2015-16 allocations are from their targets, and how much larger this gap would be if all local authorities received a standard 6.2% cut. The charts also allow for comparison with Kensington & Chelsea and Durham, who are at the other end of the scale, both receiving far more than their target allocation, even when a 6.2% cut is calculated.

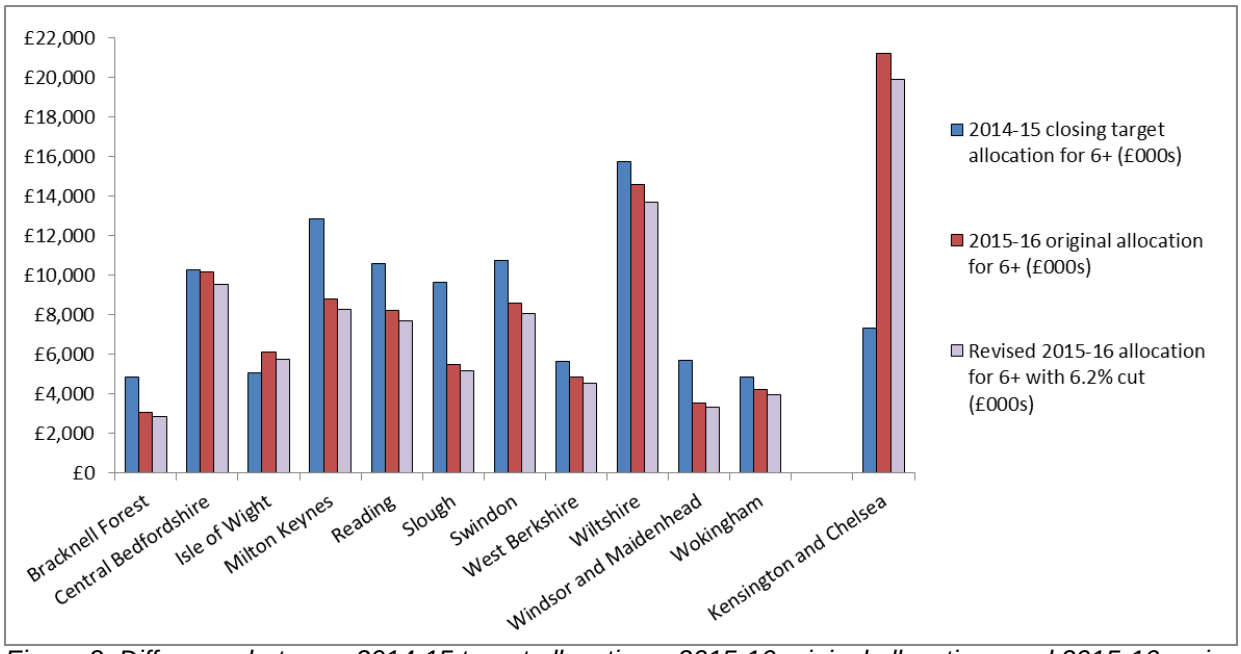



*Figure 2. Difference between 2014-15 target allocations, 2015-16 original allocations and 2015-16 revised allocations with 6.2% standard cut; for SEEC-SESL Unitary authorities compared to the Royal Borough of Kensington and Chelsea (for age 6+ population only).*

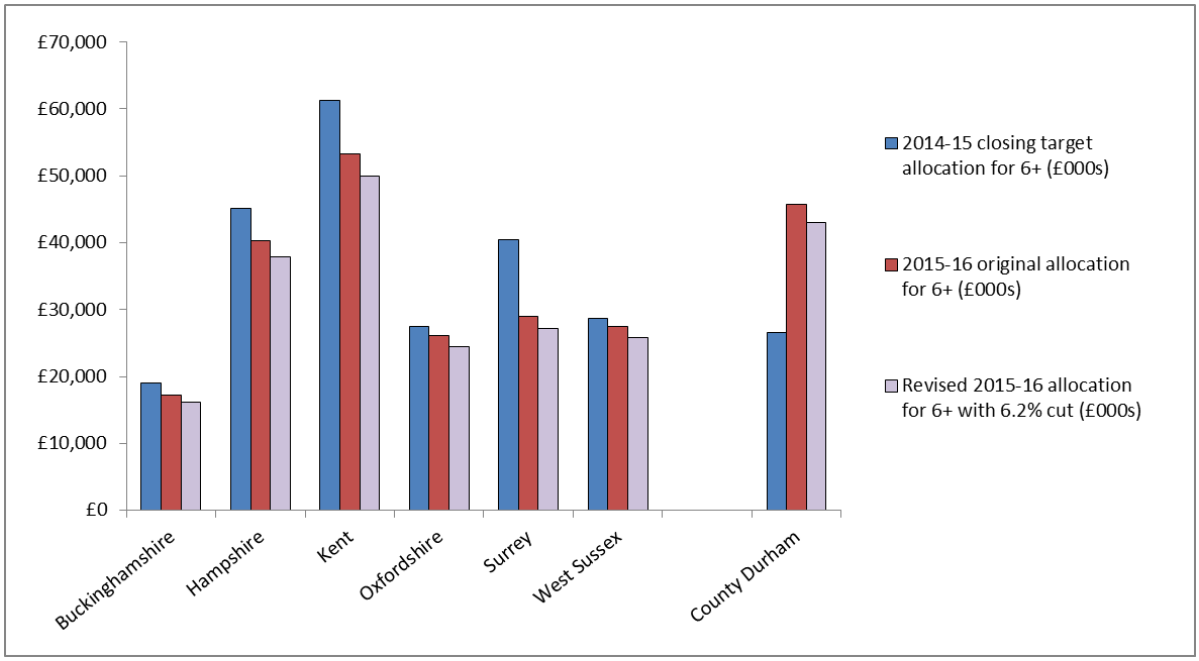



*Figure 3. Differences between 2014-15 target allocations, 2015-16 original allocations and 2015-16 revised allocations with 6.2% standard cut; for SEEC-SESL County authorities compared to Durham County Council (for age 6+ population only).*

3.5. It is not sustainable for South East authorities to receive so much less than their target allocation, when they have already been providing public health services with an ongoing deficit since the commissioning transfer from the NHS in 2013. With resource already put into evaluating the funding formula and publishing fairer targets, SEEC and SESL are calling for DH to now begin moving towards them more quickly.

## 4. Question 1: How should DH spread the £200 million saving across local authorities?

4.1. SEEC and SESL support option A; to devise a formula that claims a larger share of the saving from local authorities that are significantly above their target allocation, rather than a uniform 6.2% cut across all councils. As we demonstrate below it is possible to find the same savings with differential cuts to local authorities, based on their distance from their funding target. The evidence below presents a high-level proposal for how the cuts could be spread across local authorities, finding the required amount of savings at the same time as speeding up the pace of change. DH has proposed that £200 million could be saved

through a 6.2% cut to total funding allocations, reducing the £2.8bn granted for the 6+ population by £174m, with the remaining £26m cut from funding for children aged 0-5.

| | | Government proposal to cut 6.2% across all councils | | Our proposals to make same savings with differential cuts across councils | |
|---|---|---|---|---|---|
| ***All figures in £000s & for 6+ population*** | **A) Total 2015-16 original allocations** | **B) 2015-16 allocation with 6.2% cut (6.2% of A)** | **C) Savings to find (A minus B)** | **D) Total of our proposed revised allocation with differential cuts** | **E) Total cuts (A minus D)** |
| **England** | £2,801,472 | £2,627,780 | £173,691 | £2,626,777 | £174,694 |

4.2. The table above shows the same savings of £174 million on the aged 6+ population funding can be found using differential cuts rather than a standard 6.2% cut. This is based on:

- Cutting 12.4% from those 15 authorities 30% or more above their target allocation.
- Cutting 6.2% from the 102 authorities closer to their target allocation, between 29% above and 9% below.
- Cutting 3.1% from those 35 authorities 10% or more below their target allocation.

4.3. Cutting differential amounts based on an authority's funding gap would speed up the pace of change by bringing many overfunded authorities closer to their target than a standard 6.2% cut would. It would also reduce the burden of these cuts on already underfunded authorities. Figure 4 shows how these differential cuts could affect allocations for a sample of local authorities. Slough, Windsor and Maidenhead and Bracknell Forest are the three authorities whose original 2015-16 allocations were furthest below their targets. Although any reduction will increase the gap between their allocation and target, a 6.2% cut would expand this gap more than a 3.1% cut.

4.4. The savings lost by giving some councils a smaller cut could be made up by cutting a larger amount from authorities receiving well over their target allocations. Kensington & Chelsea, Westminster and Durham are the three authorities whose original 2015-16 allocations were furthest over target. By cutting more from overfunded areas and less from underfunded areas, it provides the opportunity for DH to use these cuts to speed up the pace of change.

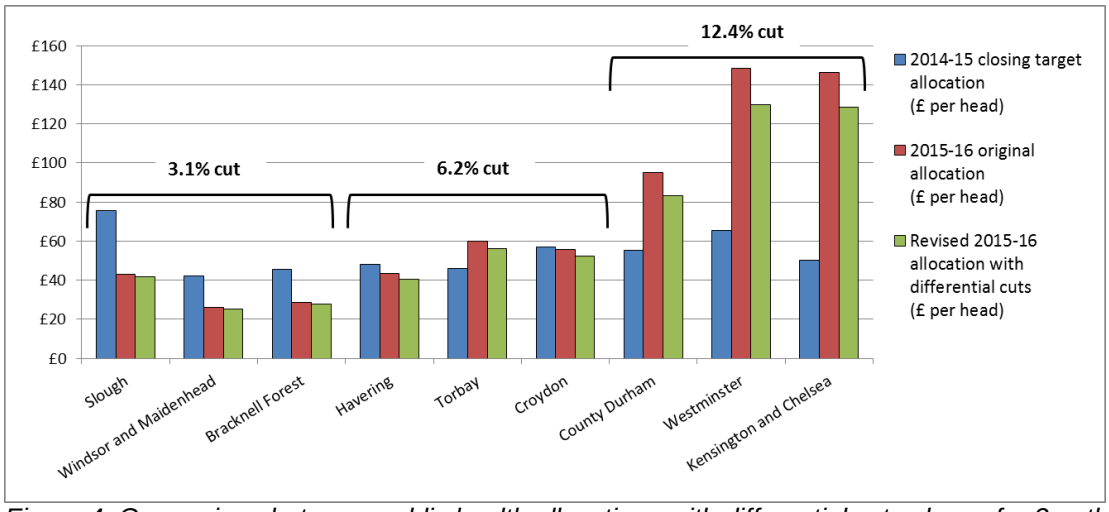



*Figure 4. Comparison between public health allocations with differential cuts shown for 3 authorities furthest below target (3.1% cut), 3 furthest above target (12.4% cuts) and 3 in the group closest to their target (6.2%).*

4.5. Option B: we do not feel that it is fair to claim more from councils that carried forward unspent reserves into 2015-15. This option does not align with the DH Public Health Ring-Fenced Grant Conditions for 2015/16, which state that DH reserves the right to reduce allocations in future years where there are large underspends but indicates any reductions based on unspent grant would only take place from 2016-17 onwards. Authorities with underspends should not be penalised for being efficient and resourceful with their funding allocations. If a larger share of the savings was claimed from these councils, it could threaten important projects planned by forward-thinking authorities.

4.6. Option C: this option would be our second preference; to share the savings by cutting 6.2% from every local authority without exception. This is explained below in our response to Option D.

4.7. Option D: it is unclear how this option to adapt cuts to avoid 'particular hardship' would work in practice. We feel it is unrealistic to expect councils to put appropriate resource in the given timescale towards evidencing hardship. Additionally, with so many South East authorities receiving less than their target and a lot of public

health work based on prevention, it would be difficult to define 'particular hardship' in a fair and transparent manner. Please also see individual responses submitted by our members.

**5. Question 2: How can DH, PHE and NHS England help local authorities to implement the saving and minimise any possible disruption to services?**

5.1. For many authorities in the South East, the major level of under-funding makes providing public health services challenging. Per person, the South East receives the lowest grant in England for both the 0-5 population (£189) and the rest of the population (£40). We feel strongly that differences of up to 100% - between the South East at £40 per person and the North East at £81 per person - need to be addressed. Although a superficial analysis by broad area shows the South East has the third highest amount of total Public Health funding for 2015-16, this does not take into account our very high population.

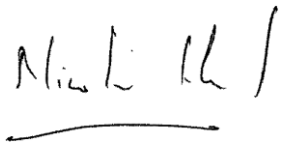
5.2. Bringing councils closer to their target allocations would minimise disruption to public health services, not only by relieving the challenges of being underfunded, but also by providing areas with more certainty over long-term funding. This would allow them to plan and deliver efficient, effective and sustainable public health services, which in turn could release cost and service pressures from the NHS and social care through successful prevention work. The negative impact of the cuts could also be mitigated by implementing the savings over more than one year.

5.3. Once the £200 million saving has been implemented, it is vital that DH provides long-term plans for public health funding. The importance of prevention is clear as both local and central government continue to work hard to reduce spending. In order to deliver successful preventative public health services, local authorities must have certainty over their budgets from year to year.

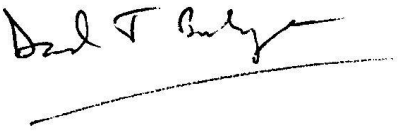
**6. Question 3: How best can DH assess and understand the impact of the saving?**

6.1. DH should fully involve local authorities in their impact-assessments of the saving. In particular Directors of Public Health should have direct involvement in order to provide the local knowledge needed for a meaningful investigation. With full responsibility for commissioning local public health services, local authorities are best placed to inform the process and predict the potential effects of the savings. Their complete knowledge of public health budgets and structures within their own authority must be taken into account when the DH is analysing the savings and planning for 2016-17. As part of this analysis, it would be useful to look at the impact on different public health service areas by gathering information on what has been transformed, reduced or discontinued as a result of the cuts. Additionally, DH should look at the impact on areas where large amounts of funding are already committed within legally binding contracts. In the long-term, DH should look at the effect of reducing public health budgets aimed at prevention on NHS and social care demand. Please also refer to individual responses by our members.

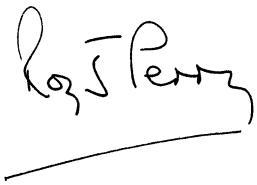
Yours sincerely



**Cllr Nicolas Heslop**
**Chairman, South East England Councils**
**Leader, Tonbridge & Malling District Council**



**Cllr David Burbage MBE**
**Chairman of South East Strategic Leaders**
**Leader, Royal Borough of Windsor & Maidenhead**



**Cllr Roy Perry**
**Deputy Chairman, South East England Councils**
**Leader, Hampshire County Council**

**Cllr Martin Tett**
**Deputy Chairman of South East Strategic Leaders**
**Leader, Buckinghamshire County Council**

## ABOUT US

**South East Strategic Leaders** (SESL) is a partnership of upper tier authorities committed to nurturing the engine room of the UK economy and promoting public service excellence. SESL supports its members to create the conditions within which individuals, communities and businesses thrive. We aim to:

- **Influence** – speaking with a stronger, united voice for South East strategic councils.
- **Inform** – producing robust evidence relevant to practice.
- **Inspire** – connecting people, sharing ideas, sparking innovation.

SESL is chaired by Cllr David Burbage MBE, Leader of Royal Borough of Windsor and Maidenhead.
**Contact:** Sarah Momber, Policy Officer - **admin@secouncils.gov.uk - 020 8541 7555** - **www.sesl.org.uk**

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**South East England Councils** (SEEC) was established in 2009. It is a membership organisation representing all tiers of local authority. The SEEC area covers Berkshire, Buckinghamshire, East and West Sussex, Hampshire, Isle of Wight, Kent, Oxfordshire and Surrey. SEEC's objectives are:

- To strive for a fair funding deal for the South East
- To promote the South East's position as a leading global economy
- To act as single democratic voice for South East interests
- To monitor the pulse of the South East.

SEEC is chaired by Nicolas Heslop, Leader of Tonbridge & Malling Borough Council.
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