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Public Health Grant Consultation Response

Overview:

Herefordshire Council objects to the decision made by the Chancellor of the Exchequer to make a significant in year reduction to the public health grant. In its rationale for establishing a ring fenced public health grant within local authorities rather than the NHS, the former Secretary of State for Health, Andrew Lansley stated that the government wished to prevent public health resources being raided as had happened within the NHS. Whilst the current Secretary of State has emphasised the importance of prevention, this in year cut in public health resources will adversely affect local authorities' ability to commission accessible and effective services for their local populations. An in year reduction at such short notice also does not take into account the contracts that are already in place or the severe funding pressures already placed on local government. Reluctantly Herefordshire Council has identified Option C as the least, worst option for our local population of the choices available.

Preferred Option: C Flat Rate reduction for every Local Authority

Rationale:

The Department of Health has stated that its preferred option for implementing the £200m cut in the national Public Health grant is a universal 6.2% reduction. Whilst this may have the advantage of ease of administration for the Department of Health, it ignores the fundamental inequalities in the current allocations and does nothing towards moving towards the Department of Health's stated ambition of achieving a fair funding formula. Rural Authorities such as Herefordshire have the costs of providing services that are not adequately taken into account by the current funding formula.

Rural Health Inequalities:

As was made clear in the presentations to the Public Health England Board in January 2015, rural councils have the same responsibilities to commission public health programmes as their urban counterparts, however given the nature of their dispersed communities, there is a significant challenge to make such programmes accessible. Whereas urban authorities can achieve economies of scale and concentrate services in a small number of centres that are relatively well served by public transport, rural authorities cannot do so. Public Health England has now commenced a programme of work to review the data available as the current deprivation profiles do not adequately take into account rural factors compared to urban indices.

The current funding formula used by the Department of Health takes into account the cost pressures of funding services in major urban centres such as London, but fails to take into account the costs of delivering services in rural communities, including the travel time of staff; the need to utilise multiple sites in order to provide appropriate access to patients, the cost of fuel and the difficulties of achieving economies of scale. The current Market Forces Factor (MFF) that is used to take into account these cost variations gives a significant weighting to London boroughs such as Westminster at the expense of rural counties such as Herefordshire, e.g. MFF of 1.21 compared to Herefordshire's MFF of 0.94. The use of such a weighting adds to the inequalities in funding rather than reducing them.

The Rural Affairs Select Committee, the All Party Parliamentary Group on County Councils, the Rural Services Network and the County Councils' Network have in the last 18 months highlighted their concerns that the current national funding formulae being used do not adequately recognise the needs of rural communities compared to their urban counterparts.

Prof. Rod Thomson, Director of Public Health for Herefordshire

Option A: Devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation.

There are merits in this proposal as several local authorities are significantly over their target allocations by more the total public health grant for Herefordshire. For rural counties such as Hereford there are some fixed costs that it must incur in order to meet the legislative requirements such the employment of appropriately qualified staff. As highlighted above the current funding formula for the grant does not adequately reflect the challenges of commissioning public health services in rural areas. Therefore though Herefordshire is identified as being as being over its target allocation this is by a comparatively small amount compared to many other Councils.

Option B: Targeting of Local Authority Reserves

Option B proposes the targeting of the unspent reserves of Local Authorities that were carried forward into 2015/16. Whilst this may be appropriate for those Local Authorities that are significantly over their target allocations, this could adversely affect the plans of those authorities that have tried to use their resources prudently. For example there have been protracted negotiations with NHS England regarding the transfer of commissioning responsibility for health visiting services. For many local authorities there has been uncertainty regarding whether NHS England was transferring sufficient funds to meet the current service and future service. In view of this uncertainty Herefordshire has had to be cautious in committing resources for local programmes until appropriate assurances have been given by NHS England regarding Health Visitor funding. In addition Herefordshire Council is facing pressures from changes in health services in Wales with increasing numbers of people resident in the principality choosing to attend sexual health clinics in Herefordshire.

As we approach our third year of local public health teams being based in local authorities several major contracts are now in the process of being tendered, including substance misuse, sexual health and some health promotion services. Experience has taught that even in the most well conducted procurement exercises there is often the need to incur one off costs as a service transfers from one provider to another, to ensure continuity of care for particular groups of patients.

Option C: **Flat Rate reduction for every Local Authority**

A flat reduction may at first glance appear to be the fairest way of making the national £200m one off reduction in the grant however it does not address the fundamental inequalities in the current allocations that have been recognised by Public Health England. A flat rate reduction perpetuates these inequalities rather than moving each local authority towards its own target. The purpose of the increased allocation to underfunded local authorities in 2013/14 and 2014/15 was to move towards a fairer funding settlement therefore a flat rate reduction to every council undermines that policy. As the attached appendix 1 show there are eight local authorities that are currently over funded (based on Department of Health figures) by more than the total public health grant that Herefordshire Council receives, i.e. by more than £7.8m. (Prior to the inclusion of the Health Visiting budget.)

Option D: Special Need

As indicated above, rural local authorities face significant challenges in commissioning the range of accessible services that their populations need. Programmes such as sexual health and substance misuse treatment need to meet national quality standards and be accessible to populations that are dispersed over a wide area. In Herefordshire's case connectivity is a

big issue, we have five market towns and the public transport links between them and the county town of Hereford are limited. The public transport links from the surrounding villages and hamlets are even more restricted. These include a number of isolated hill villages and hamlets with poor infrastructure. In view of that the option open to urban areas of commissioning a single specialist centre close to the public transport routes is not an option. For services such as school nursing, the travel times for staff between the schools that they serve are significant, particularly during the winter months. As Herefordshire shares its long western border with Wales our services are accessed by the residents of Welsh towns such as Hay on Wye. With changes in service provision in Wales, our sexual health services are seeing an increase in the number of patients that we are seeing who prefer to access provision in Herefordshire rather than in Powys. Several factors influence such choices including perceived anonymity of the Herefordshire service, employment in Herefordshire makes our services more accessible relatively speaking and clinic visits are combined with other activity such as a major shopping trip to Hereford.

As Herefordshire CCG will confirm over many years the cost of running acute hospital services within the county have been and are a major drain on NHS resources. The former Herefordshire PCT was therefore force to prioritise acute care over prevention whilst dealing with the financial deficit that it faced. This has meant that spend on public health programmes was lower than it should have been for a population of 186,000 people.

Healthier Lives

According to Public Health England's Healthier Lives report Herefordshire rates 30th out of 150 local authorities in terms of its premature mortality rates. This compares to Kensington and Chelsea's rating of 2nd out of 150 local authorities, yet this London borough currently receives in its public health grant £21.9m compared to Herefordshire's £7.8m. The population of Kensington and Chelsea is 155,600 compared to Herefordshire 186,000 people. For the ten Healthier Lives categories, Kensington & Chelsea's rating is higher than Herefordshire's on six of them. This London borough also benefits from access to higher levels of grants and business rates than Herefordshire as well as having a smaller geographic area to serve. Kensington and Chelsea's public transport links includes access to an extensive rail and bus service that makes the service that it commissions readily accessible to its population.

Conclusion

The Health and Social Care Act 2012 and its supporting guidance recognised the importance of a strong focus on prevention and the need to invest in a range of health promotion programmes to reduce the prevalence of long term conditions. The proposed in year reduction in the public health grant to local authorities undermines this government commitment. For rural authorities such as Herefordshire, the challenge of making these public health programmes accessible to its dispersed population is not fully acknowledged within the funding formula used by the Department of Health. The attached supporting information commissioned by Public Health England highlights the case for a fairer funding settlement for rural councils. In addition the significant in year reduction in the public health grant that is proposed will undermine local programmes to promote the health and wellbeing of our population.

Appendix1: Briefing Note: Public Health Funding Cuts
July 2015
Prof Rod Thomson, Director of Public Health

Local Authority	Allocation per head	Total 15/16 Budget	Funding in Addition to Target Grant (approx.)	
Blackpool	£126	£17.9m	51.5%	£9.2m
Camden	£112	£26.3m	42%	£11.m
County Durham	£88	£45.7m	72.5%	£33.1m
Darlington	£67	£7.1m	11.7%	£0.83m
Derbyshire	£46	£35.6m	11.4%	£4m
Doncaster	£66	£20.1m	9.1%	£1.8m
Dudley	£60	£18.9m	28.9%	£5.46m
East Sussex	£46	£24.5m	27.6%	£6.7m
Gateshead	£78	£15.8m	23%	£3.63m
Hackney	£117	£29.8m	29.4%	£8.7m.
Hammersmith	£114	£20.8m	72.4%	£15m
Hartlepool	£91	£8.4m	22.3%	£1.87m
Herefordshire	£42	£7.9m	16.2%	£1.27m
Hull	£87	£22.5m	10%	£2.2m
Islington	£116	£25.4m	22.3%	£5.6m
Kensington & Chelsea	£133	£21.2m	90.3%	£19.1m
Kingston	£54	£9.3m	30.6%	£2.84m
Knowsley	£111	£16.3m	44.1%	£7.2m
Middlesbrough	£117	£16.3m	35.7%	£5.8m
Nottingham	£89	£27.8m	4%	£1.1m
Portsmouth	£77	£16.1m	13.7%	£2.2m
Redcar	£81	£10.9m	46%	£5m
Richmond	£40	£7.8m	18.1%	£1.4m
Sefton	£73	£19.9m	33%	£6.6m
South Tyneside	£86	£12.9m	44.4%	£5.7m
St Helens	£74	£13m	22.2%	£2.8m
Stockton	£67	£13m	9.3%	£1.2m
Stoke	£80	£20.2m	11.1%	£2.2m
Sunderland	£76	£21.2m	24.5%	£5.2m
Telford	£64	£10.9m	21.9%	£2.38m
Torbay	£55	£7.3m	29.2%	£2.1m
Tower Hamlets	£116	£32.2m	16.2%	£5.2m
Wakefield	£62	£20.7m	3.7%	£0.76m
Wandsworth	£80	£25.4m	42%	£10.6m
Westminster	£133	£31.2m	27%	£8.4m
Wigan	£73	£23.6m	18.9%	£4.6m
Wirral	£82	£26.4m	28%	£7.4m
Wolverhampton	£76	£19.2m	13.3%	£2.5m
Worcestershire	£46	£26.5m	23%	£6.1m