ASSOCIATION OF NORTH EAST COUNCILS

LOCAL AUTHORITY PUBLIC HEALTH ALLOCATIONS 2015/16: IN-YEAR SAVINGS

RESPONSE TO CONSULTATION

Introduction

The Association of North East Councils is the representative voice for local government in the North East. It represents all 12 councils in the North East, throughout Northumberland, Tyne and Wear, Durham and the Tees Valley on issues of concern to them and the communities they serve. It is a cross-party organisation, with all of its members democratically elected and accountable councillors.

We welcome the opportunity to comment on this consultation. However, we have to record at the outset our member authorities' disappointment and concern at the Government's decision to impose an in-year reduction of £200m in local authorities' public health allocation. Since assuming responsibility for public health functions in 2013, councils in the North East have placed public health at the centre of their agendas, undertaking many valuable initiatives in areas such as tobacco control, alcohol harm reduction, sexual health, obesity and diabetes prevention and a range of other issues. These initiatives have addressed the factors that so often lead to ill health – as well as underpinning much of the prevailing health inequality that the North East faces – and have helped to release pressure on expensive primary and acute health services. Our councils have taken a planned approach to public health service development across several years and have been reviewing, reworking and driving change in a planned way. This is something that the ring-fenced budget and funding levels announced for a number of years was aimed at encouraging.

Our member authorities are committed to sustaining and developing their work, but the 6.2% reduction in the public health budget will seriously undermine their ability to plan, manage and sustain services going forward. It calls into question the commitment, in the *NHS Five Year Forward View*, to a "*radical upgrade in prevention and public health*". Ultimately, looking at the health system as a whole rather than just a part of it, the reduction in the public health allocation is unlikely to produce any real saving as any scaling down of preventative measures will simply increase costs downstream. Judged against the goals of improving the nation's health and reducing health inequalities, reducing the public health budget is simply, we believe, counter-productive.

The issue of health inequalities is a critical one for the North East. In February 2014, Public Health England commissioned an independent inquiry to examine health inequalities affecting the North of England. The inquiry report, published in August 2014 as "*Due North*", found that the North of England has persistently had poorer health than the rest of England and that the gap has continued to widen over four decades,

equating to 1.5 million excess premature deaths in the North since 1965 compared with the rest of the country. The report drew attention to the reasons why the North of England is particularly adversely affected by the socio-economic drivers of poor health:

- whilst the North represents 30% of the population of England it includes 50% of the poorest neighbourhoods;
- poor neighbourhoods in the North tend to have worse health even than places with similar levels of poverty in the rest of England; and
- there is a steeper social gradient in health in the North than in the rest of England, resulting in an even greater gap in health between disadvantaged and prosperous socio-economic groups in the North than in the rest of the country.

Any reduction in the public health allocation is likely to damage our member authorities' continuing efforts to redress these inequalities. This is exacerbated by the fact that North East councils have suffered disproportionate cuts in Government funding for core services, which also tend to impact on disadvantaged groups. Indeed we do not believe that cutting the grant to North East councils in this way is compatible with the Secretary of State's statutory duty to reduce health inequalities.

The lateness of the announcement of the reduction, and the delay in publishing the consultation paper, are also regrettable. Such delays reduce local authorities' already limited room for manoeuvre given that much of the current year's expenditure will already be committed, contractually or otherwise. The Government may wish to re-consider the wisdom and indeed practicality of imposing this cut. At the very least, Government should consider deferring the reduction until 2016/17 to allow time for proper service planning and renegotiation of contracts where necessary. It would also be helpful to have confirmation that this in-year reduction relates only to 2015/16 and will not impact on the level of grant for future years.

Within this context, we wish to comment as follows on the three specific questions in the consultation paper.

Q1. How should DH spread the £200 million saving across the LAs involved?
We would argue strongly that the cut should not be made.

Q2. How can DH, PHE and NHS England help LAs to implement the saving and minimise any possible disruption to services?
If the Government proceeds, it will be for individual authorities in the first instance to consider how they could implement the required saving in a way that causes the least disruption and damage to services. There could be scope for discussion, at local and/or regional level, with NHS Area Teams and PHE regional centres as to how they can support this process, should it be required.

It would not be appropriate to amend local authorities' public health duties as set out in primary and secondary legislation.

Q3. How best can DH assess and understand the impact of the saving?
It would be vital that the impact of any reduction in the public health allocation is properly assessed and understood as a basis for future policy-making in this area.

The real costs of this approach, including the additional costs imposed on the NHS as a result of reduced spend on prevention, need to be accurately identified.

We agree that it would be useful for DH to work through representative bodies to gather feedback on local impact. ANEC would be willing to participate in such an exercise on behalf of its member authorities.

There would also be merit in commissioning PHE centre directors to review the local impact and contribute to a national report.