DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		PUBLIC HEALTH GRANT REDUCTIONS		
DATE OF DECISION:		28 JANUARY 2016		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY

BRIEF SUMMARY
This paper sets out the approach that the Council is taking to respond to the 2015/16 in-year Public Health grant cut, and the reduction in grant funding that will continue to 2020/21. A range of options were considered, and proposals for additional in-year savings have been identified. The budget for 2016/17 will include reduced expenditure on commissioned services, and a plan is being developed to respond to what will be a 25% reduction in the purchasing power of the Public Health grant over the next five years.

RECOMMENDATIONS:		
	(i)	HOSP is asked to consider the approach being adopted and contribute views on how the Council and wider system responds to the funding situation described in the report.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Council is the local lead for public health, and has responsibilities to protect local people from threats to their health and to improve the health of the population.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	The Council is continuing to work on longer term plans to meet its public health responsibilities with reduced grant income, and a range of options are still under active consideration.

DETAIL (Including consultation carried out)	
	Background - 2015/16 "in-year" cut
3.	A £200 million cut in the 2015/16 PH grant allocation to local authorities was announced by the Chancellor in June 2015. In the consultation on the cut, the majority of local authorities favoured an option in which more was taken from those currently funded above their target allocation. Despite this, the Government has announced that it is proceeding with its preferred option – an "equal share" cut. This means that the Council's £15.05M 2015/16 Public Health grant has been reduced by £1.06M. £2.10M has been added to cover six months funding for 0-5 year's public health services (health visiting and

Family Nurse Partnership) that transferred to local authority responsibility on 1st October 2015:

Public Health Allocations to local authorities: Total in-year savings in 2015/16 include 0-5 children's budget (£'000s)					
ONS LA Name	Total PH allocation for 15/16 (£'000s)	0-5 allocation transferred in October 15 (£'000s)	Overall PH allocation for 15/16 (£'000s)	LA share of the £200m savings	15/16 allocation after reduction
Southampton	15,048,535	2,103,000	17,151,535	1,061,608	16,089,926

4. In-year savings over a five month period (Quarter 3 and Quarter 4) will be very difficult to find and fully deliver, because the remaining budget controlled by Public Health is almost all in commissioned services that need a 12 month notice period, or in staff costs.

5. The original 2015/16 Public Health (PH) budget headings were:

	2015/16 working budget
Health improvement	£2.77M
Health protection and surveillance	£8.83M
Population healthcare	£3.90M
Public health management, overheads and recharges	£1.98M
Total planned expenditure	**£17.48M**

6. At the start of 2015/16, the PH grant funded £2.26M of services that were provided by the Council prior to it receiving the PH grant. This figure includes an additional £0.40M in 2015/16 following an approved saving in February 2015. This was taken on the assumption of an inflation uplift which was not received, and so has been an additional pressure for the service in the light of the new cut.

Future funding cuts

7. Following the spending review, the CEO of Public Health England sent out on 27th November 2015 the following information to local authority CEOs and Directors of Public Health (DsPH):

"The Chancellor talked about savings in the Public Health grant, which will be an average real terms saving of 3.9% each year to 2020/21. This translates into a further cash reduction of 9.6% in addition to the £200 million of savings that were announced earlier this year. From the baseline of £3,461m (which includes 0-5 commissioning and takes account of the £200m savings) the savings will be phased in at 2.2% in 16/17, 2.5% in 17/18, 2.6% in each of the two following years, and flat cash in 20/21".

8. For Southampton City Council this is an approximate additional cash reduction of £400-500K each year over the next four years which will have a very significant impact on the commissioned public health services (see

below). The impact could be halved if we were moved to be funded according to the target allocation, but the formula is under review and there is no indication of future "pace of change". The current working assumption is that there will be no significant movement towards fairer funding. The confirmed grant allocation will be announced before the end of January 2016.

9. Working estimate of grant reduction as at 30 November 2015:

	£
Baseline indicative 2015/16 PH Grant:	18,194,400

Financial Year	PH Cut %	PH Cut £	Revised PH Grant Allocation £
2016/17	2.20%	400,277	17,794,123
2017/18	2.50%	454,860	17,339,263
2018/19	2.60%	473,054	16,866,209
2019/20	2.60%	473,054	16,393,154
2020/21	0.00%	0	16,393,154
Total	9.90%	1,801,246	

10. The "in-year" grant reduction has largely been mitigated through a range of measures, including holding vacancies, cutting planned public health initiatives and eliminating non-essential expenditure, but there is a residual pressure of £300K for which additional measures are being considered. Most savings have been of a "one off" nature and do not assist the 2016/17 position, for which there is a forecast pressure of £117K before the grant cuts are factored in.

Approach to managing budget reductions

11. When the in-year cut was announced, it was agreed by the Council Management Team (CMT) that this "challenge" would be one for the whole Council to address and could not be met from the residual grant controlled by Public Health alone.

12. The Public Health grant has been re-distributed over the last three years, so that in 2015/16 £2.26M funds existing Council "Internal Services". This does not include any additional services chosen to be purchased from other Council departments by Public Health or the recharges for corporate overheads.

13. The grant from the Department of Health is to enable the Council to deliver the responsibilities that transferred in April 2013. These include a set of "mandated" services, reflecting the fact that local authorities are part of the national public health service for England:

- Appropriate access to sexual health services
- Steps to be taken to protect the health of the population, in particular, giving the Director of Public Health a duty to ensure there are plans in place to protect the health of the population
- Ensuring NHS commissioners receive the public health advice they need

	• The National Child Measurement Programme • NHS Health Check assessment • Elements of the Healthy Child Programme.
14.	The other responsibilities are: • Tobacco control • Alcohol and drug misuse services • Obesity and community nutrition initiatives • Increasing levels of physical activity in the local population • Assessment and lifestyle interventions as part of the NHS Health Check Programme • Public mental health services • Dental public health services • Accidental injury prevention • Population level interventions to reduce and prevent birth defects • Behavioural and lifestyle campaigns to prevent cancer and long term conditions • Local initiatives on workplace health • Supporting, reviewing and challenging delivery of key Public Health funded and NHS delivered services such as immunisation programmes • Comprehensive sexual health services • Local initiatives to reduce excess deaths as a result of seasonal mortality • Role in dealing with health protection incidents and emergencies • Promotion of community safety, violence prevention and response • Local initiatives to tackle social exclusion.
15.	Included amongst these are “demand-led” services, largely commissioned from NHS providers. The Council is responsible for ensuring these service are provided and meet national quality standards. These include sexual health services (and the treatment of sexually acquired infections), drugs and alcohol treatment, school nursing and health visiting.
16.	It will be challenging to reduce the cost of meeting these needs as the number of service users will increase, and the scope for delivering the service at lower costs will be limited. This means that all aspects of the Council’s funded public health programmes are now under review in order to propose a balanced budget for 2016/17 and a realistic plan for the subsequent four years of cuts.
	Process and progress
17.	All non-essential expenditure ceased after the announcement in June 2015, and other central controls have applied. The Public Health team is now a third the size it was at the point of transfer three years ago. All public health contracts have been moved to the management of the Integrated Commissioning Unit (ICU) and are under review so that the appropriate level of investment can be achieved in 2016/17, balancing protecting the public’s health with achieving better health outcomes through prioritised, high value interventions. At the same time, the public health programmes will need to be geared to supporting the delivery of the Council’s priorities. This will involve

	doing things differently and doing different things.
18.	If the reduction in grant is translated into an “equal shares” cut to all services there is likely to be a greater impact on health outcomes and future costs than if a more targeted programme of cuts is developed. The Public Health team and the Integrated Commissioning Unit are using the available evidence on return on investment (ROI) from public health preventative measures to refine the approach to delivering savings. All recommissioning will look at delivering the maximum return on investment and net savings to the Council, while improving health outcomes. Principles and priorities for achieving this are summarised in Appendix 1.
19.	The level of corporate overheads charged to Public Health is being reviewed, and other directorates benefitting from the re-allocation of the Public Health grant are considering ways of profiling their future spend with reduced grant support.
20.	The running costs of the small in-house Public Health team will continue to be kept as low as possible while ensuring that the Council is able to meet all its statutory responsibilities. Working as part of a Hampshire and Isle of Wight network has enabled some joint initiatives and avoided duplication of efforts. As plans for a devolved authority progress there will be further opportunities to develop cost-efficient ways of delivering the public health function and commissioning services.
21.	The major opportunities for contract saving lie with Solent NHS Trust, who have contracts for most of the major public health services. Discussions have begun to identify potential contract variations that would allow savings to SCC and avoid redundancy costs and other costs passed on by the provider. Anything agreed by the Council will have implications for the rest of the block contract that the CCG has with Solent NHS Trust, and all three organisations will need to work together to ensure sustainability of the provider’s services.
22.	For the longer term, major service re-commissioning exercises will look to take out costs to the Council, and will be brought forward if possible in the ICU work programme so that these are achieved sooner rather than later. These have the potential to contribute to the delivery of a sustainable financial plan.
23.	The details of the changes to services in 2016/17 are still to be finalised and agreed. Options under consideration include suspending the NHS Health Check programme and chlamydia screening as these services are considered to be less cost-effective than other PH programmes, but the contractual implications are significant, and the cost is likely to be more than the saving in both 2015/16 and 2016/17, based on experience elsewhere.
	Conclusion
24.	The huge cuts to the Public Health grant will present a major challenge to the Council over the next five years. However, these are not the only resources available to the Council, as it has previously delivered a wide range of services that have a positive impact on the public’s health. The NHS, other partners and wider society will have contributions and assets to bring as the prevention and Public Health “offer” to the City is redesigned. The role of the Health and Wellbeing Board will be crucial in ensuring that a sustainable system is built, that progress in improving health outcomes does not stagnate (or reverse) and that longstanding and unacceptable inequalities are reduced.

	Engagement of citizens and communities will be equally important, enabling people to have a voice and to get involved in making change happen at both an individual and community level.
RESOURCE IMPLICATIONS	
Capital/Revenue	
25.	The reduced Public Health Grant income will result in a reduction in the Health and Adult Social Care budget that without corresponding savings will create a pressure.
26.	Information within this report outlines the approach being taken to meet this challenge to reduce the recurring spend on public health services both in year, (2015/16) and on an ongoing basis.
Property/Other	
27.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
28.	Public Health responsibilities of the Authority are set out in the Health and Social Care Act 2012.
Other Legal Implications:	
29.	N/A
POLICY FRAMEWORK IMPLICATIONS	
30.	The City's Health and Well-being Strategy is being reviewed and re-written, and its plans to improve health outcomes and reduce health inequalities will need to recognise the Council's reduced grant income

KEY DECISION?	Yes/No
WARDS/COMMUNITIES AFFECTED:	
SUPPORTING DOCUMENTATION	
Appendices	
1.	Return on Public Health Investment Summary
Documents In Members' Rooms	
1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	Yes
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	No

Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	