Agenda item 11

Health and Wellbeing Board – 7 September 2015

Department of Health consultation on in–year reductions to local authority Public Health allocations

1. Purpose

To inform the Health and Wellbeing Board (HWBB) of the Department of Health's consultation on its proposal to reduce the 2015/16 Public Health allocation.

2. Recommendation

That the Health and Wellbeing Board note the response to the consultation submitted by the Director of Public Health.

That the Health and Wellbeing Board note the implications of the proposed cut for public health programmes in Walsall set out in the response.

3. Report detail

The Department of Health (DH) has published a consultation document setting out options to achieve a £200m in-year reduction in Public Health spending in England. Its preferred option is to apply a standard flat rate percentage reduction of 6.2% for all local authorities. The closing date for the consultation was 28 August 2015.

The consultation called for views on how the saving could be delivered. The DH has stated that money would be taken from the January 2016 instalment of funding provided to local authorities. Its preferred option is to apply a standard flat rate percentage reduction of 6.2% across all local authorities. This would equate to a £1.114M reduction in the 2015/16 Public Health allocation for Walsall. The current Public Health allocation for Walsall is £15.827M

The consultation options were set out as follows:

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 £200 million saving amounts to about 6.2 per cent of the total grant for 2015/16, so that would also be the figure DH applied to individual LAs. Annex C sets out the effect on allocations.

D. Reduce every local authorities allocation by a standard percentage unless an authority can show that this would result in particular hardship, taking account of the following criteria:

- 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;
- 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.

The consultation states that the total savings required under all options would remain at £200m.

The consultation also seeks views on how local authorities can be helped to implement the savings and minimise any disruption to services, and how the DH can assess and understand the impact of the cuts can be assessed.

The response submitted by the Director of Public Health to the Department of Health **(Appendix 1)** describes in detail the likely impact on the health and social care economy in Walsall. It also outlines the preferred option for achieving these savings in Walsall, i.e. that a larger share of the proposed saving should be claimed from authorities that are significantly above their target allocations.

4. Impact on health and wellbeing:

It is anticipated that the proposed cuts will have a negative impact on the ability of Walsall Council to deliver on public health priorities in Walsall. Public Health services in Walsall have invested in innovative and exciting transformation projects in collaboration with partners across the Council.

There is now increasing evidence of the benefits and return on investment of some of these initiatives. The ability of Public Health services in Walsall to continue to invest in such initiatives may now be compromised by the proposed reductions in budget by the Department of Health.

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Date: 7th September 2015

PUBLIC HEALTH

Walsall Council

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Response to Department of Health re: Local Authority public health allocations 2015/16: in year savings

We welcome the opportunity to comment on the Department of Health's proposed approach to reducing the Public Health allocation in-year.

We are extremely disappointed by the Department of Health's lack of recognition of the importance of preventative approaches at a time that demand for public services is outstripping resource. The proposed public health savings are entirely at odds with NHS England's Chief Executive Simon Stevens' vision of "*a radical upgrade in prevention and public health*", as outlined in his Five Year Forward View.

"The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a ***radical upgrade in prevention and public health****. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences".* [i]

Reducing investment in public health programmes is likely to have a significant adverse impact on health services, community safety and community cohesion. The Marmot Review demonstrated that poor health does not happen by chance. Services commissioned through the Public Health grant have a direct impact upon the wider determinants of health and the impact is well documented in the areas of community safety, crime reduction and community cohesion. These services are disproportionately used by vulnerable groups including troubled families and looked after children. Reductions in funding will lead to a reduction in the capacity, scope and quality of these services increasing the vulnerability of individuals, their families and their communities.

We are concerned about the manner in which this consultation is being conducted. The delay in issuing the consultation for what is proposed to be an in-year reduction, the short duration of the consultation requiring submissions within a four week period over the summer holiday season and the lack of supporting information for the options being consulted on, indicate that the consultation exercise falls significantly short of the standards set out in the code of practice for consultation[ii].

The consultation document does not make clear whether the proposed funding reductions are intended to be recurrent. Should the DH intend to impose recurrent reductions using its

preferred option, this will clearly have an even more profound effect in terms of increasing health inequalities across England. A more comprehensive consultation would need to be undertaken should there be plans to reduce Public Health allocations recurrently. This would need to be supported by an analysis of the likely impact on the health and social care economy and an Equality Impact Assessment.

This is important because it is clear that implementation of the preferred option would further increase the inequalities that have been caused by recognised flaws in the original Public Health funding mapping and allocation exercise and the subsequent failure to move local areas to their target allocation.

With regard to the three specific questions in the consultation, we offer the following responses:

Q1. Do you agree with DHs preferred option (C) for applying the £200million saving across LAs? If not, which is your preferred option?

We do not support the DH's preferred option (C) - a standard flat rate percentage reduction of 6.2% across all local authorities.

This would exacerbate the recognised financial inequalities that have resulted from the original mapping and allocation of Public Health funding[iii]. Walsall is currently 5.3% below its target public health allocation and has the lowest funding allocation of its statistical neighbours. This equates to Walsall being already **under funded by £800,000 per annum** by the Department of Health's own formula. In addition, Walsall will receive the lowest allocation per head of target population for the commissioning of 0-5 services of all Local Authorities in the Birmingham and Black Country conurbation.

Many local authorities are significantly above their *'fair shares'* public health grant funding formula. It would be entirely unreasonable should this inequity not be taken into account when applying reductions to the Public Health grant.

We do not support Option B - claiming back a larger share of grant from local authorities that carried forward unspent reserves into 2015/16.

In Walsall, as in many parts of the country, monies were purposefully carried forward as part of a strategic plan to support service redesign and recommissioning, with a view to achieving longer term financial savings. The majority has now been committed to contracts.

Since moving from the NHS to local government, Public Health departments across the country have been required to set up a programme to procure public health services through competitive tendering. In Walsall, a commitment was made to achieve this over a three year period and it is now in the final year of this programme. Therefore the Public Health department is in the process of retendering services in year. Funding has been committed to the supporting the implementation of the new integrated service models developed and prescribed in the service specifications. Unforeseen expenditure has also been incurred in year in relation to procurement and recharging for drugs costs for public health commissioned services leaving very little scope to make the in year savings proposed in Option C.

We do not favour Option D – reducing every local authority's allocation by a standard percentage unless an authority can show that this would result in particular hardship - ***but believe it would be more equitable than Option C.*** **NOTE:** Evidence in relation to the criteria set out in paragraph 3.2 of the consultation is presented on page 4 of this response.

Our preferred option is Option A - to devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation.

This is the most equitable option as it goes some way to addressing the historical inequities in the allocation of Public Health funding as described below.

Overall Public Health Allocation
It is important to recognise that Walsall MBC is already underfunded with respect to its overall public health allocation. The public health allocation for Walsall was set at £14.983 million at the point of transition of public health responsibilities to Local authority. Data published by the National Audit Office confirms that the 2014/15 allocation is **5.3% below its target allocation** despite pledges made at the time of transition that future funding mechanisms would be used to bring local areas to their target allocation. 5.3% is equivalent to **a shortfall of more than £800k per annum**; an average of £3 less per head of population in Walsall than the DH methodology calculates it should be.

Walsall's public health allocation per head is lower than that of all local authority areas experiencing similar levels of deprivation[1]. If the average allocation of these statistical neighbours was applied to the Walsall population, Walsall **would receive an additional £4.26 million per annum** (**appendix 1**).

Allocation of funds the commissioning of public health services for 0-5 year olds
The inequities outlined above will be made worse when responsibility for commissioning local public health services for 0-5s is transferred from NHS England to Walsall Council in October 2015. Walsall will receive the lowest allocation per head of target population for the commissioning of these services of all Local Authorities in the Birmingham and Black Country conurbation. It will have one of the lowest allocations of its group of statistical neighbours. If the average cost per head of its statistical neighbours were applied to the Walsall 0-5 population Walsall would receive **an additional £1.6 million per annum** to commission these services.

Guidance published by the department of health indicated that the funding allocation for the commissioning of 0-5 services from 15/16 onwards would be based on a fair shares formula led through ACRA[iv]- in local discussions we have had commitment from NHS England and PHE that they would support Walsall's case for receiving a higher allocation to commission 0-5 services based on levels of need and deprivation in Walsall.

The double hit of a low public health allocation together with a low allocation for the commissioning of services for 0-5s has resulted in a huge gap in funding levels (of **nearly £6 million per annum**), seriously impacting on the health, wellbeing and life chances of children in Walsall.

Proposal for alternative option
In recognition of the challenge being faced and the willingness to participate in the collective response, if the DH were minded to consider a further option **for in year reductions only**, we would propose an alternative 5th option of applying a universal reduction of 2% to all areas, with the remaining 4.2% applied on the more equitable basis as described in Option A. This would ensure that the challenge of achieving in year savings was in part made as a collective effort whilst allowing for some of the inequalities outlined in this response to be mitigated against.

Q2. How can DH, PHE and NHS England help LAs to implement the saving and minimise any possible disruption to services?
The proposed reductions will have a direct impact upon local services and disruption to these services is inevitable if in-year Public Health grant reductions are made.

Q3. How best can the DH assess and understand the impact of the saving?
A national survey of Directors of Public Health and other key stakeholders, particularly CCGs would be the best of the proposed options.

[1] IMD 2nd decile group of Local Authorities

Evidence submitted for Walsall in relation to the criteria set out in paragraph 3.2 of the consultation

1. Inability to deliver savings legally due to binding financial commitments;

Walsall Public Health services are delivered mainly through contracts with providers. This means that almost the entire public health budget has already been committed through contractual agreements with providers. Attempting to reduce contract values in-year will result in financial penalties being levied on Walsall Council, increasing financial pressures and endangering commissioner-provider relationships. It may result in provider agencies terminating contracts early where financial viability becomes an issue. This could have a profound effect on Walsall residents leaving them without crucial services and resulting in the Council incurring additional costs to run competitive tender processes for new service contracts.

Since moving from the NHS to local government, Public Health departments across the country have been required to set up a programme to procure public health services through competitive tendering. In Walsall, a commitment was made to achieve this over a three year period and it is now in the final year of this programme. Therefore the Public Health department is in the process of retendering services in year. Funding has been committed to the supporting the implementation of the new integrated service models developed and prescribed in the service specifications. Unforeseen expenditure has also been incurred in year in relation to procurement and recharging for drugs costs for public health commissioned services leaving very little scope to make the in year savings proposed in Option C.

2. Substantial, disproportionate and unavoidable adverse impact on people who share a protected characteristic within the meaning of section 149 of the Equality Act 2010;
3. 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);

Health Challenges in Walsall

Health indicators show that Walsall residents experience far poorer health and wellbeing than is the case in most other parts of the country. Life expectancy for both men and women is well below the England average and the infant mortality rate is one of the worst in the country. Deprivation levels are high and nearly one in three children lives in poverty. It is well documented that deprivation drives greater use of health and social care services. Walsall Council has reached the point of crisis in funding levels for social care and other services and the proposed DH reductions will lead to the loss of preventative services at a time that they are needed most.

The most recent **health profile for Walsall 2015 (see appendix 2)** showed that:

- The rate of alcohol-related harm admissions was 730 per 100,000 population, worse than the average for England. This represents 1,864 stays per year
- The rate of smoking-related deaths was 320 per 100,000 population, worse than the average for England. This represents 463 deaths per year

- Estimated levels of adult excess weight and physical activity are worse than the England average
- Rates of sexually transmitted infections and TB are worse than the England average

The **health and wellbeing of children in Walsall (see appendix 3)** is worse than the England average:

- The infant mortality rate is one of the worst in the country
- The level of child poverty is worse than the England average with 28% of children aged less than 16 years living in poverty.
- Childhood obesity rates are worse: one in four children aged 10-11 years are obese
- The number of children in care is spiralling (90.4/10,000 10-18 year olds on 31st March 2015) and child school readiness is below than the England average.

4. The availability of funding from public health or general reserves; or

5. Any other exceptional factors.

Overall Public Health Allocation

It is important to recognise that Walsall MBC is already underfunded with respect to its overall public health allocation. The public health allocation for Walsall was set at £14.983 million at the point of transition of public health responsibilities to Local authority. Data published by the National Audit Office confirms that the 2014/15 allocation is **5.3% below its target allocation** despite pledges made at the time of transition that future funding mechanisms would be used to bring local areas to their target allocation. 5.3% is equivalent to **a shortfall of more than £800k per annum**; an average of £3 less per head of population in Walsall than the DH methodology calculates it should be.

Walsall's public health allocation per head is lower than that of all local authority areas experiencing similar levels of deprivation[2]. If the average allocation of its statistical neighbours was applied to the Walsall population, Walsall **would receive an additional £4.26 million per annum** (**appendix 1**).

Allocation of funds the commissioning of public health services for 0-5 year olds

The inequities outlined above will be made worse when responsibility for commissioning local public health services for 0-5s is transferred from NHS England to Walsall Council in October 2015.

Walsall will receive the lowest allocation per head of target population for the commissioning of these services of all Local Authorities in the Birmingham and Black Country conurbation. It will have one of the lowest allocations of its group of statistical neighbours (appendix 1). If the average cost per head of its statistical neighbours were applied to the Walsall 0-5 population Walsall would receive **an additional £1.6 million per annum** to commission these services.

Guidance published by the department of health indicated that the funding allocation for the commissioning of 0-5 services from 15/16 onwards would be based on a fair shares formula led through ACRA[v]- in local discussions we have had commitment from NHS England and PHE that they would support Walsall's case for receiving a higher allocation to commission 0-5 services based on levels of need and deprivation in Walsall.

The double hit of a low public health allocation together with a low allocation for the commissioning of services for 0-5s will result in a huge gap in funding levels (of **nearly £6 million per annum**), impacting on the health, wellbeing and life chances of children in Walsall.

[2] IMD 2nd decile group of Local Authorities

Financial Challenges across health and social care in Walsall

Given target reductions in the overall Walsall Council budget (c£82 million reduction over 4 years[3]) as a consequence of reduced central government funding and a local Healthcare Trust under extreme financial pressure, it is clear that the scale of financial challenge for the health and social care economy in Walsall is immense. The extent of financial pressures in Walsall have meant that there has already been a significant scaling back of the limited resources that partners in the health and social care economy have been able to invest in prevention strategies and upstream intervention.

The transfer of public health services from the NHS to the Local Authority has provided the Council with an opportunity to commission more effective and seamless services which improve the health and wellbeing of the local community and reduce demand on public services (see Table 1 below).

Table 1 Examples of Transformation Projects funded through the Walsall Public Health allocation to reduce demand on services

Parenting

Walsall Public Health is working with the Children's Directorate to transform parenting support across Walsall and has invested £137k in parenting programmes as part of the Public Health Transformation. There is evidence to show that parenting programmes to reduce conduct disorder pays back £8 over 6 years for every £1 invested; in Walsall this should translate to savings of £1,096,000.

Teenage Pregnancy

Walsall Public Health is working with the Children's Directorate to transform teenage pregnancy prevention programmes in Walsall. Every pound spent on preventing teenage pregnancy saves £11 in healthcare costs. Walsall Public Health has invested £150k in teenage pregnancy services, a potential saving of £1,650,000 in health care costs in Walsall.

We request that the DH give careful consideration of the comments and arguments raised above and thus review their approach to the allocation of the proposed reductions to public health budgets.

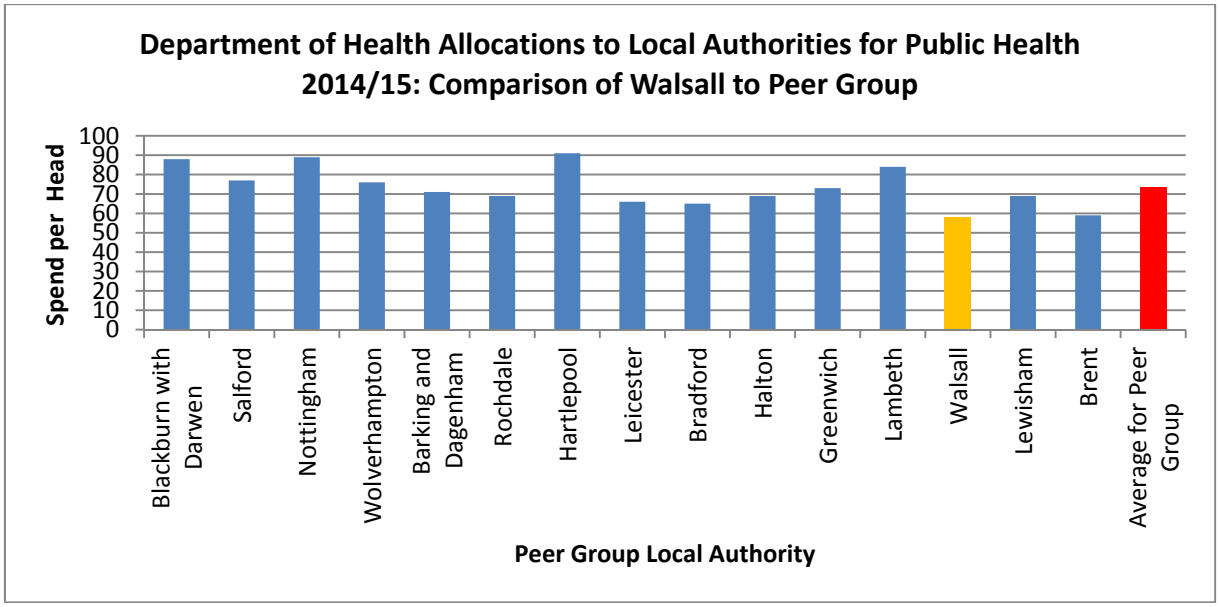
Dr Barbara Watt
Director of Public Health
Walsall Council

[3] Source: Walsall MBC Medium Term Strategy

Appendix 1: Comparison of Walsall allocation and spend per head across Birmingham and the Black Country and statistical neighbours

TABLE 1: Comparison of overall Public Health allocation per head of population and distance from target for Walsall and local authority areas experiencing similar levels of deprivation[4]

Rank	IMD Score	Local Authority	2014/15	Distance from Target	
			Allocation per person (£)	(£) Per Person	%
1	35.23	Blackburn with Darwen	88	6	7.80%
2	34.74	Salford	77	-5	-6.20%
3	34.42	Nottingham	89	3	3.90%
4	34.41	Wolverhampton	76	9	13.30%
5	34.20	Barking and Dagenham	71	-5	-6.70%
6	33.85	Rochdale	69	-4	-5%
7	33.68	Hartlepool	91	17	22.20%
8	33.65	Leicester	66	-12	-15.70%
9	32.58	Bradford	65	-5	-6.50%
10	32.54	Halton	69	-2	-3.4
11	31.94	Greenwich	73	-4	-5.10%
12	31.24	Lambeth	84	-4	-5%
13	31.23	Walsall	58	-3	-5.30%
14	30.97	Lewisham	69	-1	-1.30%
15	30.50	Brent	59	0	0.00%
	33.01	Average for Peer Group	73.6	-0.67	



[4] IMD 2nd decile group of Local Authorities

Health summary for Walsall

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average* | England Average | England Worst | 25th Percentile | 75th Percentile | England Best | England Range

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	124,940	45.9	20.4	83.8	0.0
	2	Children in poverty (under 16s)	15,490	27.9	19.2	37.9	5.8
	3	Statutory homelessness	332	3.1	2.3	12.5	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	1,534	48.5	56.8	35.4	79.9
	5	Violent crime (violence offences)	2,902	10.7	11.1	27.8	2.8
	6	Long term unemployment	2,363	14.1	7.1	23.5	0.9
Children's and young people's health	7	Smoking status at time of delivery	487	13.7	12.0	27.5	1.9
	8	Breastfeeding initiation	2,291	63.4	73.9		
	9	Obese children (Year 6)	772	24.4	19.1	27.1	9.4
	10	Alcohol-specific hospital stays (under 18)†	31.7	48.6	40.1	105.8	11.2
	11	Under 18 conceptions	192	36.8	24.3	44.0	7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	20.5	18.4	30.0	9.0
	13	Percentage of physically active adults	244	50.7	56.0	43.5	69.7
	14	Obese adults	n/a	30.4	23.0	35.2	11.2
	15	Excess weight in adults	463	68.9	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma†	26.3	11.7	18.4	38.0	4.8
	17	Hospital stays for self-harm	537	196.0	203.2	682.7	60.9
	18	Hospital stays for alcohol related harm†	1,864	730	645	1231	366
	19	Prevalence of opiate and/or crack use	2,186	12.8	8.4	25.0	1.4
	20	Recorded diabetes	18,579	8.6	6.2	9.0	3.4
	21	Incidence of TB†	56.7	20.9	14.8	113.7	0.0
	22	New STI (exc Chlamydia aged under 25)	1,753	1026	832	3269	172
	23	Hip fractures in people aged 65 and over	283	550	580	838	354
Life expectancy and causes of death	24	Excess winter deaths (three year)	169.3	22.3	17.4	34.3	3.9
	25	Life expectancy at birth (Male)	n/a	78.1	79.4	74.3	83.0
	26	Life expectancy at birth (Female)	n/a	82.8	83.1	80.0	86.4
	27	Infant mortality	26	6.8	4.0	7.6	1.1
	28	Smoking related deaths	463	319.6	288.7	471.6	167.4
	29	Suicide rate	17	6.5	8.8		
	30	Under 75 mortality rate: cardiovascular	209	95.1	78.2	137.0	37.1
	31	Under 75 mortality rate: cancer	355	161.5	144.4	202.9	104.0
	32	Killed and seriously injured on roads	71	26.1	39.7	119.6	7.8

Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. * "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

Walsall Child Health Profile — June 2015

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

● Significantly worse than England average ● Not significantly different ○ Significance not tested
● Significantly better than England average ◆ Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	1 Infant mortality	27	7.1	4.1	7.5	1.7
	2 Child mortality rate (1-17 years)	9	14.6	11.9	22.6	3.0
Health protection	3 MMR vaccination for one dose (2 years)	3,387	97.0	92.7	78.3	98.3
	4 Dtap / IPV / Hib vaccination (2 years)	3,438	98.5	96.1	81.6	99.1
	5 Children in care immunisations	415	92.2	87.1	27.3	100.0
	6 New sexually transmitted infections (including chlamydia)	1,489	4,262.0	3,432.7	8,098.4	1,899.8
Wider determinants of ill health	7 Children achieving a good level of development at the end of reception	1,944	53.3	60.4	41.2	75.3
	8 GCSEs achieved (5 A*-C inc. English and maths)	1,654	48.7	56.8	35.4	73.8
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	10 16-18 year olds not in education, employment or training	580	5.8	5.3	9.8	1.8
	11 First time entrants to the youth justice system	140	509.1	440.9	846.5	171.0
	12 Children in poverty (under 16 years)	15,490	27.9	19.2	37.9	6.6
	13 Family homelessness	203	1.9	1.7	10.8	0.1
	14 Children in care	625	98	60	153	20
	15 Children killed or seriously injured in road traffic accidents	16	28.9	19.1	48.3	8.2
Health improvement	16 Low birthweight of all babies	374	10.1	7.4	10.4	4.6
	17 Obese children (4-5 years)	386	11.0	9.5	14.2	5.5
	18 Obese children (10-11 years)	767	24.4	19.1	26.8	10.5
	19 Children with one or more decayed, missing or filled teeth	-	28.3	27.9	53.2	12.5
	20 Under 18 conceptions	192	36.8	24.3	43.9	9.2
	21 Teenage mothers	83	2.3	1.1	2.5	0.2
	22 Hospital admissions due to alcohol specific conditions	32	48.8	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	24	68.7	81.3	264.1	22.8
Prevention of ill health	24 Smoking status at time of delivery	487	13.7	12.0	27.5	1.9
	25 Breastfeeding initiation	2,291	63.4	73.9	36.6	93.0
	26 Breastfeeding prevalence at 6-8 weeks after birth	1,273	35.3	-	19.4	77.4
	27 A&E attendances (0-4 years)	9,923	530.0	525.6	1,684.5	252.7
	28 Hospital admissions caused by injuries in children (0-14 years)	482	90.4	112.2	214.1	64.4
	29 Hospital admissions caused by injuries in young people (15-24 years)	383	110.4	136.7	291.8	69.6
	30 Hospital admissions for asthma (under 19 years)	152	225.5	197.1	509.1	54.6
	31 Hospital admissions for mental health conditions	54	84.5	87.2	391.6	25.6
	32 Hospital admissions as a result of self-harm (10-24 years)	187	359.7	412.1	1,246.6	119.1

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2011-2013
2 Directly standardised rate per 100,000 children age 1-17 years, 2011-2013
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2013/14
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2013/14
5 % children in care with up-to-date immunisations, 2014
6 New STI diagnoses per 100,000 population aged 15-24 years, 2013
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2013/14
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2013/14
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2014 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2013
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2013
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2012
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2013/14
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2014
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2011-2013
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2013
17 % school children in Reception year classified as obese, 2013/14
18 % school children in Year 6 classified as obese, 2013/14
19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
20 Under 18 conception rate per 1,000 females age 15-17 years, 2013
21 % of delivery episodes where the mother is aged less than 18 years, 2013/14
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2011/12-2013/14
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2011/12-2013/14
24 % of mothers smoking at time of delivery, 2013/14
25 % of mothers initiating breastfeeding, 2013/14
26 % of mothers breastfeeding at 6-8 weeks, 2013/14
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2013/14
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2013/14
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2013/14
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2013/14
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2013/14
32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2013/14

[i] NHS England 5 year forward view https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[ii] Consultation Principles: Guidance July 2012 https://www.gov.uk/government/publications/consultation-principles-guidance

[iii] *Cutting public health funds – implications for health inequalities? June 16, 2015 by Policy team, FPH*

[iv] Transfer of 0-5 children's public health commissioning to Local Authorities Baseline Agreement Exercise Department of Health December 2014

[v] Transfer of 0-5 children's public health commissioning to Local Authorities Baseline Agreement Exercise Department of Health December 2014