Department of Health

Local authority public health grant allocations 2015/16

Government response to public consultation on in-year savings

and

Equality and health inequalities analysis

November 2015

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equality and health inequality analysis

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Contents

Background and context

Since 2013 local authorities (LAs) in England have had a duty to take the steps that they believe are appropriate to improve the health of their populations. The Department of Health (DH) funds LAs for this with a grant. Other than requirements to discharge a limited number of public health functions prescribed in regulations and to comply with certain conditions that DH attaches to the grant, it is for LAs to determine how best to invest these resources.

In 2015/16 the total grant amounted originally to £2.8 billion, supplemented by a further £430 million when responsibility for services for children aged 0 – 5 transferred to LAs from NHS England on 1 October.

On 4 June 2015 the Chancellor of the Exchequer announced a package of savings to be made across government in 2015/16, the current financial year, to reduce public debt. These savings amount to £3 billion across government and include £200 million to be saved from the public health grant.

The distribution of the grant between LAs is informed by a 'fair shares' formula developed by the Advisory Committee on Resource Allocation (ACRA) and intended to reflect relative need for public health services across England. ACRA is an independent committee and its members include public health experts, GPs, NHS managers and academics.

The ACRA formula produces a 'target' share for each LA of the overall national allocation, intended to reflect local needs for public health interventions. In most cases this is higher or lower than the grant that LAs have actually received. This is because LAs' grants were originally based on the previous level of local NHS spending on a given set of public health activities (in order to provide a stable background for the transfer of responsibilities to LAs). All LAs benefitted from growth in their public health grants in 2013/14 and 2014/15, with those below their target allocations gaining the most.

DH is currently consulting separately on proposed adjustments to the ACRA formula designed to reflect variations in need more closely.

Between 31 July and 28 August DH invited views on three questions:

- how best to distribute the £200 million saving between the LAs affected;
- what DH, the NHS and Public Health England (PHE) can do to support LAs through the challenge of implementing the saving; and
- how DH can best assess the impact of the saving.

This document describes the responses to those questions that DH received and sets out how it will take matters forward in the light of those responses. It also analyses the impact of the Department's plans on inequalities in health and on people with characteristics protected by equalities legislation.

Summary of responses

The consultation exercise closed on the 28th August. DH received 219 responses from LAs, stakeholders, third sector organisations and individual members of the health and care workforce. Out of the total of 152 LAs in England with public health duties, 123 (81 per cent) responded.

Question 1

How should DH spread the £200 million saving across the LAs involved?

The consultation document suggested that DH could, for example:

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 applies to individual LAs.

D. Reduce every LA's allocation by a standard percentage unless any 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 document made clear that, subject to the outcome of the consultation, DH's preferred option was C.

Out of the 123 LA responses, two did not respond to this question and one preferred a combination of options A and C. Thirteen LAs and two other respondents

suggested a new option - to use a weighted need based per head of population figure to calculate each LA's saving – and 107 LAs selected one of the options A to D. The table below sets out the response to the different options.

Table 1

Question 1 – Preferred option	Number of LAs and if above or below target allocation	Other respondents	All respondents
A – Take larger sum from LAs above target	54 (52 below target) (2 above target)	14	68
B – Take proportionate to reserves	10 (2 below target) (8 above target)	4	14
C – Take flat rate 6.2%	31 (15 below target) (16 above target)	11	42
D – Flat rate unless hardship	12 (9 below target) (3 above target)	11	23
New option - take per head of population based on weighted need	13 (8 below target) (5 above target)	2	15
Nil or no response	32 (18 below target) (14 above target)	54	86
Total	152	97	249
Notes: Two LAs submitted responses but did not select any of the options and stated that they would prefer no cuts. 30 LAs did not respond to the consultation.			
One other respondent would prefer a combination of option A and C. Not shown in table but included in total number of responses.			

Question 2

How can DH, Public Health England and NHS England help LAs to implement the saving and minimise any possible disruption to services?

Some LAs were keen to look at what can be achieved with the remaining budget and asked for support in identifying innovative interventions that offer value for money. Others felt that there was little that DH, PHE or NHS England can do to ease this process. They expressed concerns on the timing of the budget reduction and the

challenges this poses in planning public health services. Some LAs felt legal support would be helpful in looking at how services could be decommissioned.

LAs felt that the decision to make the saving was inconsistent with the emphasis of the NHS Five Year Forward View on prevention. Some highlighted the fact that between 40 per cent and 80 per cent of their public health budgets go to NHS providers.

This table lists suggestions from all respondents and the numbers making them.

Table 2

Early funding announcement for better planning.	25
Tools to help commissioners identify interventions that offer greatest VFM.	24
Appropriate time and legal support required to renegotiate contracts and give notice.	15
Be more aware of the impact of the saving on NHS services.	14
Saving should not be recurrent.	13
Savings should be shared with PHE.	10
Act a focal point or broker for discussions about economies of scale and other efficiencies. To help address fall out from staffing, contractual issues, etc.	9
Keep ring-fence around the grant for clarity.	9
Work with CCGs to minimise impact.	6
NHS commissioners/trusts to supplement health programmes to ease the challenges.	6
Clarity on health visitor target numbers.	5
Permit a targeted approach to NHS Health Checks and support with more national marketing campaigns.	5

Remove prescription in regulations of steps that all LAs must take.	5
Redirect Health Premium Incentive Scheme budget to reduce the saving.	4
PHE, DH, LGA and NHS England could model the saving's impact.	3
Carry out equality analysis to review the impact.	3
Implement payment by results, using data which are currently available, in order to drive change.	1
NHS could be asked to reduce waste.	1
Clarify performance assessment.	1

Question 3

How best can DH assess and understand the impact of the saving?

The three options that DH suggested were:

- to undertake a national survey of directors of public health and other key stakeholders;
- commission PHE centre directors to review the local impact and contribute to a national report for DH; and
- work through representative bodies to gather feedback on local impact.

All were favoured by some LAs and other respondents, and the table below lists further suggestions from respondents and the numbers making them.

Table 3

A national survey of directors of public health and other key stakeholders and PHE centre directors to review Local impact.	60
Conduct a health impact assessment on the social and economic impact of the budget reductions for each local authority.	35
Link the assessment or survey to the Public Health Outcomes Framework to evaluate the potential impact.	31

Ask how each LA made up its share of savings in the planning phase.	21
Discuss this with CCGs and NHS service providers to identify the impact on all services and third sector providers.	19
Request evidence from LGA, DCLG, ADPH and Faculty of Public Health regarding the impact as well as undertake benchmark studies to understand impact on savings (including on the NHS).	12 12
Speak to service user groups who have direct experience.	2
Ensure the assessment is not burdensome for LAs.	2
Improve data sharing between the various agencies involved in the commissioning and delivery of public health services.	1
Seek specific information through the annual Public Health Grant Statement of Assurance.	1

Government position

DH is grateful for the helpful and constructive responses to its questions. It has made its decisions after considering them carefully in the light of the three underpinning principles that it set out in the consultation document:

- the need to save £200 million from this year's grant as an important contribution to reducing the national deficit;
- the need to do so in a way that is consistent with the Department's public sector equality duty and the Secretary of State's health inequalities duty; and
- the need to do so in a way that minimises any disruption to public health services.

Equality and health inequality analysis

Section 149 of the Equalities Act 2010 sets out the public sector equality duty (PSED) which requires public authorities, including the Secretary of State for Health and LAs, to (among other things):

"… have due regard to the need to -

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

Section 1C of the NHS Act 2006 requires the Secretary of State to:

"… have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service."

A condition that DH attaches to the public health grant confers the same requirement on LAs in the way that they use the money.

From the outset of this exercise the Department's priority has been to make the saving in a way that:

minimises disruption by preserving as far as possible the important public health services used by vulnerable people, including those with characteristics protected by equalities legislation or who experience inequalities in their health; and
complies with all its policies and statutory duties on equality.

To support this objective, its consultation document stated specifically that:

“Views on the questions from all will be carefully considered and are equally welcome, particularly in relation to any people sharing a protected characteristic as defined in the Equality Act 2010. Please include in responses any views about ways to minimise possible disruption to services and adverse impacts on public health.”

As well as the responses to the consultation, and to set the issue in the appropriate context, DH has considered other existing evidence on the effect on inequalities in health and between people with protected characteristics of the distribution of available resources between LAs.

Distribution

DH undertook an equality analysis when allocating the grant between LAs for 2013/4 and 2014/15 (a two-year settlement). The settlement for 2015/16 was the same in cash terms as in 2014/15 and was distributed on the same basis (with minor adjustments to correct some local anomalies).

The table below summarises the factors related to health inequalities and protected characteristics that ACRA took into account when it considered the impact of the allocation formula. ACRA uses standardised mortality ratio for people aged under 75 years of age (SMR<75) as a robust indicator of the whole population’s health status, and hence need for public health services. It should not be interpreted as meaning that the allocation should not reflect the needs of those aged over 75, or that morbidity is not important. ACRA’s analysis showed that the SMR<75 is highly correlated with other measures of population health, such as disability free life expectancy and healthy life expectancy.

More details are available at https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15.

Summary of equality analysis of the public health grant distribution:

Characteristic	Considerations in the ACRA formula
Age	For younger people aged 19 or under, substance misuse and sexual health services have a formula component adjustment.
Sex	Adjustments, or weights, for sex are applied to the same functions as age.
Race	Race may be correlated with the SMR<75. ACRA explored the Health Survey for England data on smoking, alcohol, and fruit and vegetable consumption by ethnicity and age, but the sample numbers were too small to provide robust data by ethnicity for allocations purposes.
Disability	ACRA considered using Disability Free Life Expectancy (DFLE), and the Healthy Life Expectancy (HLE) which more explicitly measure morbidity and disability than the SMR<75. However, SMR<75, DFLE and HLE are very highly correlated so the use of the SMR<75 does capture morbidity.
Gender reassignment	Gender reassignment data within the healthcare context is complex and incomplete. There was a lack of data on the group's public health needs suitable for use in an allocations formula.
Sexual orientation	The 2007 Citizenship Survey showed no difference in self-reported good health between heterosexual and gay/lesbian people. The Lesbian and Gay Foundation highlighted that LGB&T people are more likely than heterosexual people to smoke and drink alcohol and so could potentially have a higher need for public health services. Due to the lack of robust data available on sexual orientation within LA areas that are suitable for allocations purposes no adjustment was made for this factor.
Religion and belief	There is a lack of robust data suitable for allocations purposes on the public health needs of groups with different

	beliefs. No adjustment was made.
Pregnancy and maternity	Care through pregnancy and the early years impacts upon health and healthcare needs throughout life, but LAs are not directly responsible for pregnancy and maternity services. ACRA recognised that a good start in life can influence future health, educational and social outcomes, and recommended an age weight for children under five years old. The weight is approximated from the behaviour of the parental age group, as an indicator of likely future public health need.
Carers	Carers play a vital role in supporting the healthcare system, but often have poorer health outcomes. Allocations indirectly account for carers through the SMR as this is correlated with, for example, DFLE.
Other identified groups	<u>Seasonal workers</u> ACRA considered seasonal workers, who may be at risk of inequity of opportunity to access public health services. ACRA considered data from the ONS on the estimates of short-term migrants which were mapped to administrative sources provided by other government departments in order to accurately allocate short-term migrants to local authorities. In the majority of LAs the number of short-term residents is very small in comparison with the usually resident population (less than 0.5%). Those with a proportion higher than 0.5% are predominantly in London but without data on the intention of length of stay we cannot predict their pattern of public health demand. For this reason no adjustment is made. <u>Deprived populations within affluent areas</u> Deprivation impacts heavily upon public health need and more affluent areas, all else being equal, are less likely to need the same level of public health services. The SMR is highly correlated with deprivation and as the SMR is applied at ward level it takes account of the relative deprivation between and within LAs. Higher deprivation is therefore associated with higher allocations per head. <u>Travellers</u> Travellers may not have full access to public health services because of their non-permanent status. Public health allocations can help promote equity of access by ensuring LAs with relatively higher populations of travellers receive a higher share of available resources. Analysis was undertaken to calculate the traveller population as a proportion of each LA's total population. This was shown to be very low, as was

	the variation across local authorities. In addition, the Office for National Statistics undertook a special exercise to ensure that the 2011 population census included travellers, who are therefore included in the population base for public health grants. For these reasons, no adjustment was recommended by ACRA.

Consultation responses

Twenty-seven LAs and other respondents commented directly on the potential impact of the saving on health inequalities or on people with protected characteristics. All believed that removing £200 million from the grant in 2015/16 by any of the four options that DH suggested would have some level of negative impact on inequalities in health. Some suggested that the saving would have a substantial, disproportionate and unavoidable adverse impact on people who share a protected characteristic under the Equality Act 2010. Several argued that implementing the reduction at all is incompatible with the Secretary of State's duties under both the NHS Act 2006 and the Equality Act 2010 (DH does not accept these arguments, for the reasons described below). Others were disappointed that DH had not completed an equality analysis before publishing the consultation document.

A number of respondents made points about the impact on health inequalities or protected characteristics of the four specific options for making the saving suggested in the consultation document. Others suggested a different option. These responses are summarised below.

Option	**Responses**
A. Take a larger proportion of the saving from LAs that are significantly above their ACRA target allocation.	ACRA allocations do not take into account cost pressures in commissioning service in rural areas, creating disadvantages in the way allocations are calculated that option A would exacerbate. Fairer, creates equality.
B. Take a larger proportion of the saving from LAs that carried forward unspent reserves into 2015/16.	Reserves are earmarked for programmes that would reduce inequalities in health.

C. Take a standard rate of 6.2% from every LA's allocation.	There are difficulties in cancelling contracts which will affect front line services, leading to increased health inequalities in key areas.
D. Take a standard rate unless any LA can demonstrate that doing so would cause it particular hardship or would contravene DH's PSED or its health inequalities duty.	The saving will have an unavoidable adverse impact on people who share a protected characteristic within the meaning of Section 149 of the Equality Act 2010. Aging population or levels of child poverty are greater in some LAs; other significant health inequalities within others.
New option – a standard, cash per capita reduction from every LA.	This was suggested by LAs who argued that it would have the least detrimental impact on areas with the highest levels of economic deprivation. .

Analysis

The Government believes that taking action to reduce the deficit is vital to the long-term health of our economy and to all of the public services that it supports. A reduction (or, indeed, increase) in the size of the available national budget for the public health grant need not in itself affect relative inequalities. Far more influential are the formula by which resources are divided between LAs and the decisions that LAs themselves make on how to use their grants. This applies now, to the decision on how to implement savings, as much as it does to the original distribution of the grant. For these reasons, DH does not accept that the decision to make the saving is inconsistent with its equality duties and has taken account of the impact on health inequalities.

Each of the five options for making the saving that this analysis considers has merits and drawbacks in terms of their impact on health equalities and the PSED.

Option A would accelerate the pace of change of LAs towards the 'fair share' target allocations determined by the ACRA formula. It would, though, do so in a negative way, without increasing any LA's grant and by decreasing others' by a larger amount than they might be planning for, with consequent disruption to services used by people with protected characteristics or who experience health inequalities (especially when the time available to implement savings is so limited). It would also

pre-empt the current review of the ACRA formula. This review will make the formula more reflective of local need and is highly likely to affect the distance from target of many LAs, possibly moving some from above target to below and vice versa.

Option B might seem to minimise the impact on services by simply collecting unspent money. However DH does not have accurate figures for all LAs' carry-forward into 2015/16, nor does it have any quick or reliable way to obtain that information. As the responses to the consultation show, 'unspent' is not the same as 'uncommitted' – LAs carry forward resources for good reasons, and some intend the reserves to be used in ways that address inequalities in health or for long term projects.

Option C – the Department's initial preference – was seen by some respondents as a blunt instrument that does not adequately reflect local health inequalities or other circumstances. Nevertheless, as other respondents acknowledged, it remains the quickest and simplest option to implement, giving LAs the maximum clarity as quickly as possible about what is required and so minimising disruption to services (a priority for DH from the outset). The importance of rapid clarity was emphasised by a number of respondents, including the Local Government Association (LGA). Reducing each LA's grant by the same percentage is consistent with the ACRA formula and the approach taken to distribute the original allocations (itself based on an equality analysis and reflecting health inequalities through using standardised mortality ratio as a proxy for need) in that it leaves unchanged LAs' funding relative to each other.

Option D offers a mechanism for adjusting some LAs' required savings to mitigate potential adverse impact on equalities or on health inequalities, but that could only work at the expense of other LAs – the imperative to save a total of £200 million nationally would remain. The evidence that 20 LAs submitted would not allow DH to calculate adjustments that were demonstrably fair to the large majority of LAs that chose not to submit evidence. Nor does the evidence enable us to determine with confidence that the impacts these LAs cited are significantly different from those described by a number of other respondents who neither favoured this option nor submitted evidence.

The respondents putting forward the **new option** of a fixed per capita cash reduction argue that it would be fairer by taking less from areas of higher deprivation – and deprivation is associated with health inequalities. The savings required from LAs under this option would range from 1.7 per cent to 12.2 per cent. It would be inconsistent with the ACRA formula, which is designed to reflect local public health needs and has broad support. Just as with options A, B and D, the option would mean that some LAs would have to make larger savings within the current financial year (up to double the average of 6.2 per cent) and at very short notice. Again, as with options A, B and D, DH believes that there is a high risk that the effects of the

disruption that this would cause, to health inequalities and services in those areas for people with protected characteristics or who experience health inequalities, would outweigh the potential benefits for other areas.

In conclusion, DH has considered carefully both the existing evidence and the responses to its consultation document. In the light of this, and while it accepts that the decision is not straightforward, it believes that option C remains preferable to any other identified option and is fully consistent with its duties under section 1C of the NHS Act 2006 and section 149 of the Equalities Act 2010.

Impact on services

The factors that DH has taken into account when considering impact on services are very similar to those it considered in relation to equalities and health inequalities, and lead to the same conclusion: that option C remains the most viable and overall the least disruptive way of delivering this saving. The arguments that respondents expressed in favour of options A, B and D reflected points that the Department had considered before publishing its consultation document and expressing a preference.

Given that **option A** was the preference of the largest number of respondents, the Department gave it very careful consideration. While it understands the arguments in the option's favour, DH remains concerned about the likely impact on the planning of services of the uncertainty that would inevitably continue while DH arrived at an appropriate formula. For option A to produce a materially different outcome to option C it would also require some LAs to find savings significantly greater than 6.2 per cent, and with significantly less time to manage the effects. Finally, the review of the ACRA formula is very likely to change many LAs' target allocations for 2016/17 and beyond, meaning that making adjustments now on the basis of the current targets would risk producing avoidable anomalies.

Option B received the least support and DH believes it is the least practical, for the reasons it describes in the equality analysis. It too would prolong the uncertainty for LAs to an unacceptable degree.

DH has considered the evidence of hardship submitted by 20 LAs under **option D** but is not satisfied that the evidence described exceptional hardship or could support a robustly calculated adjustment that would be fair to the LAs whose contribution would have to increase. The Equality Analysis section of this document sets out why DH believes its preferred option C complies with the PSED and its health inequality duty.

The **new option** that a number of respondents proposed attempts to relate individual authorities' contribution to the overall saving more closely to the local need for public health interventions. Although some LAs mentioned disadvantages in the current

ACRA formula, it is the established and broadly accepted mechanism for bringing target resources into line with need. Adopting a per capita approach now would be inconsistent with that, and would produce a wide disparity in the proportion of their grant that LAs were required to save – from 1.7 percent to 12.2 per cent. DH is currently consulting on proposed refinements to the ACRA formula that should make it more reflective of local circumstances.

On balance, **option C** – a flat rate reduction of 6.2 per cent – remains DH's preference. It is the option most consistent with the underpinning principles for managing the saving that the Department has set out: it delivers the £200 million, it is the least disruptive to services and it is compliant with the PSED and the health inequality duty. The Annex (A) sets out revised 2015/16 allocations, subject to final technical checks.

Questions 2 and 3

The responses to questions 2 and 3 in the consultation will help DH to facilitate the saving and understand its consequences.

The government will address questions about the 2016/17 grant and the future of the ring-fence later this autumn, at the conclusion of the current spending review. DH will also consider the prescription in regulations of certain functions and the future of the Health Premium Incentive Scheme in the same light.

To assist LAs in managing the saving in the current year DH will bring forward the January instalment of the grant and make it available to LAs shortly, net of the £200 million saving.

PHE will continue to develop the advice it can offer to LAs on the cost effectiveness of specific public health interventions. PHE will also work with the LGA, the Association of Directors of Public Health, individual LAs and clinical commissioning groups to both mitigate and monitor the effect of the saving on public health outcomes. DH fully accepts the need for a process that makes optimum use of existing sources of information and does not place additional burdens on LAs.

Conclusion

The Department will save £200 million from the 2015/16 public health grant by reducing each LA's grant by an equal percentage – option C in its consultation document. The saving will be implemented through a reduction in the fourth quarterly instalment of the grant, which will be brought forward from January 2016. DH will continue working with its partners in PHE, NHS England, and the local government and public health sectors to support LAs and monitor the impact of the saving.

Annex A

Public Health Allocations to local authorities: total in-year savings for each LA in 2015/16 including 0-5 children's budget (£'000s)

ONS LA Name	Total PH allocation for 2015/16	0-5 allocation transferred in October 2015	Overall PH allocation for 2015-16	LA share of £200m savings	2015-16 allocation after reduction
Barking and Dagenham	14,213	2,512	16,725	1,035	15,690
Barnet	14,335	2,592	16,927	1,048	15,879
Barnsley	14,243	2,549	16,792	1,039	15,752
Bath and North East Somerset	7,384	1,387	8,771	543	8,228
Bedford	7,343	1,291	8,634	534	8,100
Bexley	7,574	1,720	9,294	575	8,719
Birmingham	80,838	11,210	92,048	5,697	86,351
Blackburn with Darwen	13,134	1,880	15,014	929	14,084
Blackpool	17,946	1,551	19,497	1,207	18,290
Bolton	18,790	2,835	21,625	1,339	20,287
Bournemouth	8,296	1,818	10,114	626	9,488
Bracknell Forest	3,049	774	3,823	237	3,586
Bradford	35,333	6,133	41,466	2,567	38,900
Brent	18,848	2,763	21,611	1,338	20,274
Brighton and Hove	18,695	2,111	20,806	1,288	19,518
Bristol, City of	29,122	3,799	32,921	2,038	30,884
Bromley	12,954	1,901	14,855	919	13,935
Buckinghamshire	17,249	3,061	20,310	1,257	19,053
Bury	9,619	1,806	11,425	707	10,718
Calderdale	10,679	2,190	12,869	797	12,072
Cambridgeshire	22,155	3,861	26,016	1,610	24,405
Camden	26,368	2,121	28,489	1,763	26,725
Central Bedfordshire	10,149	1,902	12,051	746	11,306
Cheshire East	14,274	2,353	16,627	1,029	15,598
Cheshire West and Chester	13,889	2,107	15,996	990	15,006
City of London	1,698	75	1,773	110	1,663
Cornwall	20,749	3,673	24,422	1,512	22,910
County Durham	45,780	4,894	50,674	3,137	47,538
Coventry	19,415	2,807	22,222	1,375	20,846
Croydon	18,825	2,748	21,573	1,335	20,237
Cumbria	15,594	2,599	18,193	1,126	17,067
Darlington	7,184	1,215	8,399	520	7,879
Derby	15,710	3,094	18,804	1,164	17,640
Derbyshire	35,562	5,140	40,702	2,519	38,183

Devon	22,060	4,513	26,573	1,645	24,928
Doncaster	20,198	3,450	23,648	1,464	22,184

ONS LA Name	Total PH allocation for 2015/16	0-5 allocation transferred in October 2015	Overall PH allocation for 2015-16	LA share of £200m savings	2015-16 allocation after reduction
Dorset	12,889	2,267	15,156	938	14,218
Dudley	18,974	2,453	21,427	1,326	20,100
Ealing	21,974	2,863	24,837	1,537	23,300
Essex	48,192	10,981	59,173	3,663	55,511
Gateshead	14,850	1,987	16,837	1,042	15,795
Gloucestershire	21,793	3,141	24,934	1,543	23,391
Greenwich	19,061	3,574	22,635	1,401	21,234
Hackney	29,818	4,009	33,827	2,094	31,733
Halton	8,776	1,410	10,186	630	9,556
Hammersmith and Fulham	20,855	1,996	22,851	1,414	21,437
Hampshire	40,363	8,843	49,206	3,046	46,160
Haringey	18,189	2,422	20,611	1,276	19,336
Harrow	9,146	1,577	10,723	664	10,059
Hartlepool	8,486	761	9,247	572	8,675
Havering	9,717	1,372	11,089	686	10,402
Herefordshire, County of	7,970	1,266	9,236	572	8,664
Hertfordshire	37,642	8,200	45,842	2,837	43,004
Hillingdon	15,709	2,137	17,846	1,105	16,742
Hounslow	14,084	1,935	16,019	992	15,028
Isle of Wight	6,088	1,226	7,314	453	6,861
Isles of Scilly	73	37	110	7	103
Islington	25,429	2,092	27,521	1,703	25,818
Kensington and Chelsea	21,214	1,342	22,556	1,396	21,160
Kent	53,264	11,894	65,158	4,033	61,125
Kingston upon Hull, City of	22,559	2,682	25,241	1,562	23,679
Kingston upon Thames	9,302	1,112	10,414	645	9,770
Kirklees	23,527	3,049	26,576	1,645	24,931
Knowsley	16,419	1,593	18,012	1,115	16,897
Lambeth	26,437	4,652	31,089	1,924	29,165
Lancashire	59,801	9,034	68,835	4,261	64,574
Leeds	40,540	4,993	45,533	2,818	42,715
Leicester	21,912	4,288	26,200	1,622	24,578
Leicestershire	21,930	3,202	25,132	1,556	23,576
Lewisham	20,088	3,790	23,878	1,478	22,400
Lincolnshire	28,506	4,166	32,672	2,022	30,650
Liverpool	41,436	4,845	46,281	2,865	43,417

Luton	13,286	2,114	15,400	953	14,447
Manchester	48,303	5,441	53,744	3,327	50,418

ONS LA Name	Total PH allocation for 2015/16	0-5 allocation transferred in October 2015	Overall PH allocation for 2015-16	LA share of £200m savings	2015-16 allocation after reduction
Medway	14,280	2,522	16,802	1,040	15,762
Merton	9,236	1,476	10,712	663	10,049
Middlesbrough	16,378	1,398	17,776	1,100	16,676
Norfolk	30,590	6,893	37,483	2,320	35,163
North East Lincolnshire	9,971	1,299	11,270	698	10,573
North Lincolnshire	8,464	1,078	9,542	591	8,951
North Somerset	7,593	1,636	9,229	571	8,658
North Tyneside	10,807	1,674	12,481	773	11,709
North Yorkshire	19,732	2,535	22,267	1,378	20,889
Northamptonshire	29,523	5,033	34,556	2,139	32,417
Northumberland	13,361	2,547	15,908	985	14,923
Nottingham	27,839	5,319	33,158	2,052	31,106
Nottinghamshire	36,119	5,815	41,934	2,596	39,338
Oldham	14,915	2,164	17,079	1,057	16,022
Oxfordshire	26,086	4,333	30,419	1,883	28,536
Peterborough	9,291	1,563	10,854	672	10,182
Plymouth	12,276	2,575	14,851	919	13,932
Poole	6,057	1,287	7,344	455	6,889
Portsmouth	16,178	2,013	18,191	1,126	17,065
Reading	8,212	1,446	9,658	598	9,060
Redbridge	11,411	2,112	13,523	837	12,686
Redcar and Cleveland	10,917	1,117	12,034	745	11,289
Richmond upon Thames	7,891	1,334	9,225	571	8,654
Rochdale	14,777	2,299	17,076	1,057	16,019
Rotherham	14,176	2,150	16,326	1,011	15,316
Rutland	1,080	195	1,275	79	1,196
Salford	18,777	2,444	21,221	1,313	19,907
Sandwell	21,805	3,175	24,980	1,546	23,433
Sefton	19,952	2,216	22,168	1,372	20,796
Sheffield	30,748	3,724	34,472	2,134	32,338
Shropshire	9,843	1,474	11,317	700	10,617
Slough	5,487	1,546	7,033	435	6,597
Solihull	9,644	1,407	11,051	684	10,367
Somerset	15,513	3,843	19,356	1,198	18,158
South Gloucestershire	7,345	1,655	9,000	557	8,443
South Tyneside	12,917	1,392	14,309	886	13,424

Southampton	15,049	2,103	17,152	1,062	16,090
Southend-on-Sea	8,060	1,355	9,415	583	8,832

ONS LA Name	Total PH allocation for 2015/16	0-5 allocation transferred in October 2015	Overall PH allocation for 2015-16	LA share of £200m savings	2015-16 allocation after reduction
Southwark	22,946	3,464	26,410	1,635	24,775
St. Helens	13,099	1,582	14,681	909	13,773
Staffordshire	33,313	5,330	38,643	2,392	36,251
Suffolk	25,742	4,206	29,948	1,854	28,095
Sunderland	21,036	2,750	23,786	1,472	22,314
Surrey	28,977	6,528	35,505	2,198	33,307
Sutton	8,619	1,280	9,899	613	9,286
Swindon	8,558	1,472	10,030	621	9,409
Tameside	13,463	1,771	15,234	943	14,291
Telford and Wrekin	10,913	1,572	12,485	773	11,712
Thurrock	8,631	1,956	10,587	655	9,932
Torbay	7,396	1,494	8,890	550	8,339
Tower Hamlets	32,261	3,855	36,116	2,235	33,881
Trafford	10,829	1,642	12,471	772	11,699
Wakefield	21,105	3,267	24,372	1,509	22,863
Walsall	15,827	2,146	17,973	1,112	16,861
Waltham Forest	12,277	2,908	15,185	940	14,245
Wandsworth	25,431	2,871	28,302	1,752	26,550
Warrington	10,439	1,467	11,906	737	11,170
Warwickshire	19,477	3,326	22,803	1,411	21,392
West Berkshire	4,819	919	5,738	355	5,383
West Sussex	27,445	5,582	33,027	2,044	30,983
Westminster	31,235	2,242	33,477	2,072	31,405
Wigan	23,665	2,761	26,426	1,636	24,790
Wiltshire	14,587	2,584	17,171	1,063	16,108
Windsor and Maidenhead	3,511	957	4,468	277	4,191
Wirral	28,164	2,522	30,686	1,899	28,787
Wokingham	4,223	930	5,153	319	4,834
Wolverhampton	19,296	2,198	21,494	1,330	20,164
Worcestershire	26,528	3,342	29,870	1,849	28,021
York	7,305	916	8,221	509	7,712
England	**2,801,473**	**429,763**	**3,231,236**	**200,000**	**3,031,236**