House of Commons
Health Committee

Public Health

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Volume I: Report, together with formal minutes

Volume II: Oral and written evidence

Additional written evidence is contained in Volume III, available on the Committee website at www.parliament.uk/healthcom

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom.

The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

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1 Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).
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Summary

The Government plans major changes to the public health system in England. These will affect all three domains of public health: health protection (addressing environmental threats to population health); health improvement (tackling health inequalities and lifestyle issues impacting on health and wellbeing); and healthcare public health (applying public health expertise to the provision of healthcare services).

Although the Coalition Government has undertaken to increase NHS spending in real terms, increasing demand for healthcare and slower growth in resources means that the NHS faces an unprecedented financial challenge. An active public health policy represents an opportunity to address this situation by easing the pressures created by rising demand.

Under the Government’s planned public health reforms, the Secretary of State for Health will, for the first time, be under an explicit statutory duty to take appropriate steps to protect the public from dangers to health. We welcome this, but recommend that the Secretary of State should be under a duty to reduce inequalities in relation to public health, as he will be in respect of healthcare under the Health and Social Care Bill.

A Cabinet Sub-Committee on Public Health has been created. We welcome this too, but recommend that it should have a clear remit to scrutinise the public health impact of policies across government.

The Chief Medical Officer (CMO) will become the “professional head of the public health profession”, leaving the NHS Medical Director to provide professional leadership in respect of providing healthcare. We recommend, however, that the CMO should perform both these roles.

A new dedicated public health service, Public Health England (PHE), will become operative from April 2013 as an Executive Agency of the Department of Health (DH), bringing together hitherto disparate public health functions into one national body. Some would prefer PHE to be constituted as a Special Health Authority. The Committee believes that the principle that PHE must be visibly and operationally independent of Ministers is more important than the precise bureaucratic formulation.

The Government has indicated that PHE will have “sub-national hubs”, in some (as yet undefined) alignment with the sub-national structures of the NHS Commissioning Board and the Department for Communities and Local Government. This does not seem to us adequate. The Committee believes that PHE needs a clear structure of regional accountability, along the lines currently provided by the regional structure of the Health Protection Agency.

Major new responsibilities for public health will also be assumed by local authorities, relating to all three domains of public health. The Government argues that local variations in public health call for local solutions; and that local government is ideally suited to address the wider determinants of health, given its existing role in providing a broad range of services that impact on those wider determinants. We broadly welcome the new public health role for local authorities, but take issue with some aspects of the Government’s plans.

We find that the lack of a statutory duty on local authorities to address health inequalities in discharging their public health functions is a serious omission in the Government’s plans.
All Directors of Public Health (DsPH) will by law be jointly appointed by local authorities and the Secretary of State (with this function being exercised through PHE), and located within, and employed by, local authorities. We recommend that these appointments should be subject to a statutory appointments process, involving an Advisory Appointments Committee, and accredited by the Faculty of Public Health, as is currently the case in respect of DsPH within the NHS.

The Committee believes it should be a statutory requirement that DsPH be appointed at chief officer level, reporting directly to the council Chief Executive. Also, any local authority wishing to terminate the appointment of its DPH must be required by statute to have the Secretary of State’s approval.

Councillors will have a “convening role” in respect of public health, NHS and social care, as well as other council services and wider public sector responsibilities. Central to this role will be Health and Wellbeing Boards (HWBs) and the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies that will be formulated through them by local authorities and Clinical Commissioning Groups (CCGs). We recommend there should be a statutory requirement for upper-tier authorities to involve lower-tier authorities in the work of the HWBs.

Instead of the top-down frameworks previously used to drive targets and performance management, progress in public health will be measured through the Public Health Outcomes Framework. We welcome this but are disappointed that the first NHS and Social Care Outcomes Frameworks have been finalised before the Public Health Outcomes Framework. We recommend that outcomes data must be sufficiently localised and detailed to reflect accurately trends and patterns in the health of the public. Datasets must be of an adequate size to be able reliably to detect relevant characteristics of populations at the appropriate level, including at sub-local authority level. Data should also, as far as possible, be capable of disaggregation regarding the full range of protected characteristics under the Equality Act 2010.

The Government has suggested that the current spend on public health services could be over £4 billion, but it has not explained how this figure was arrived at. We believe that this policy confusion is undermining confidence in the Government’s public health strategy and making service planning impossible.

The DH states that 2009–10 will be the historic baseline for future public health allocations. The Department must make clear how the actual level of funding will relate to this baseline. We seek reassurance that, in setting the public health budget both nationally and locally, the DH will take account of objective measures of need.

The DH states that, in the current reduction of NHS management and administration costs, frontline public health services are being protected, but we have heard evidence to the contrary. The Department has also failed to give a convincing account of its distinction between frontline and non-frontline spending in public health services.

Two parts of the ring-fenced PHE grant to local authorities (the recurring fixed “baseline allocation” for health improvement; and funding for mandatory services) will be allocated according to a needs-based formula. We note that the DH has asked the Advisory Committee on Resource Allocation to support the development of this. We are concerned by the government’s decision to reduce the weighting for health inequalities in Primary Care Trust allocations for 2011–12 from 15% to 10%, which seems likely to impact on the future
allocations formula.

The third part of the grant to local authorities will be the proposed “Health Premium”. Authorities will only receive this additional funding for health improvement (over and above their fixed “baseline allocation”) if they make progress in improving the health of their local population. We are concerned about the proposed introduction of the Health Premium. We believe there is a significant risk that, by targeting resources away from the areas with the most significant continuing problems, it will undermine their ability to intervene effectively and thereby further widen health inequalities.

Ring-fencing allocations risks encouraging local authorities to see only spending from the ring-fenced budget as relevant to public health and runs counter to a “place-based” approach. Even with ring-fencing, there is a risk of local authorities “gaming” the system and effectively raiding their public health allocations by “redesignating” services. The Committee therefore proposes that the ring-fenced public health budget should operate for no more than three years.

We welcome the Government’s public commitment to evidence and intelligence as fundamental elements of the public health system. The Government’s plans for PHE do have the potential to improve the public health information and intelligence function, by integrating and streamlining the work currently done by several bodies. However, we have concerns about some aspects of the DH’s approach.

The work of the Public Health Observatories (PHOs) is an extremely valuable part of the public health system. While the Government has promised to continue the work of Observatories, there is a great deal of uncertainty, especially following the substantial cuts to their funding that have been made in the current financial year. We are concerned to hear that three of the Observatories, in London, the North East and the North West, face particular risk of closure. We recommend that Ministers clarify their plans for individual PHOs as a matter of urgency to ensure that this important resource is not lost before PHE is established.

We welcome the intended continuing role of the National Institute for Health and Clinical Excellence (NICE) in evaluating the effectiveness and cost effectiveness of public health interventions. However, the Committee was surprised to learn that NICE’s Public Health Interventions Advisory Committee has yet to meet this year, having previously met on a monthly basis. Ministers should make clear exactly what role NICE will play in future in respect of public health and how that role will be fulfilled.

Healthcare public health is a core part of the public health service. Its role is to bring public health skills and knowledge to bear on the commissioning of healthcare services, helping ensure their quality, safety, efficacy, effectiveness, value for money and accessibility. However, the Government’s initial proposals were widely seen as downgrading the role of public health in the commissioning of healthcare services. It has now been clarified that DsPH and their teams will provide public health expertise, advice and analysis to CCGs, HWBs and the NHS Commissioning Board; and this will be one of the mandated public health services that local authorities must commission or provide. However, this is not enough. The local DPH should be a member of the Board of each CCG. There should be a qualified public health professional on the NHS Commissioning Board; and the Board should routinely take advice from qualified public health professionals when commissioning decisions are being taken.

PHE will secure the provision of public health services: through local authorities; through the Commissioning Board; or by commissioning or providing services itself. We see a danger that this will produce a lack of coordination and cohesion in public health services, compounded by the definition of the mandated services which will be the responsibility of local government.
The Committee recommends that these distinctions be reviewed.

The Government’s plans will make significant changes to arrangements for dealing with public health emergencies, such as major disease outbreaks, at local, regional and national levels. We welcome the updated and enhanced powers that the Bill gives to the Secretary of State in the event of an emergency. We also welcome the clarification given about the role that DsPH will play locally in emergency preparedness, response and resilience; at the same time, PHE will need a clear leadership and coordination role when public health emergencies cross local boundaries. There is an important need for “surge capacity” at the supra-local level in the event of an emergency; the Committee recommends that PHE take responsibility for ensuring that this capacity exists through coordination of local authority structures.

In his report on the arrangements for regulating public health professionals, Dr Gabriel Scally recommended that there should be statutory regulation of the profession, with the Health Professions Council regulating public health specialists as an additional profession, to accommodate specialists who are not members of a regulated healthcare profession. The Government, however, was sceptical, stating that its preferred approach was to ensure effective and independently-assured voluntary regulation. In view of the rising proportion of public health specialists that do not have a medical or dental background, the Committee recommends that the Government review its opposition to Dr Scally’s proposal.

The Government has promised that a detailed Public Health Workforce Strategy will be developed by autumn 2011 to support effective transition to the new system. However, uncertainty has inevitably been created by the transition to new structures; this is undermining morale and causing people with valuable skills to leave the profession. Uncertainty around staffing issues must be resolved as quickly as possible. It is also important that the public health specialty is fully integrated into the Government’s forthcoming proposals for healthcare workforce planning, education and training.

We welcome the Government’s acceptance of the key principles of the Marmot Review on health inequalities. However, we are unclear why the Government only endorsed five of the six policy objectives outlined by Marmot, omitting that of securing a healthy standard of living for all.

As regards the national policy dimension of health improvement, the Government is taking an approach that it says marks a break with the “nannying” of the past. Drawing on the concepts of the “ladder of intervention” and “nudging”, it says that it will aim to make voluntary approaches work before resorting to more intrusive, regulatory measures. A key vehicle for this “escalator” approach is the Public Health Responsibility Deal, based on voluntary agreements with business and other partners. The Committee does not oppose the exploration of innovative techniques such as “nudging”, where it can be shown, following proper evaluation, to be an effective way of delivering policy objectives. The Committee were, however, unconvinced that the new Responsibility Deal will be effective in resolving issues such as obesity and alcohol abuse and expect the Department of Health to set out clearly how progress will be monitored and tougher regulation applied if necessary. Those with a financial interest must not be allowed to set the agenda for health improvement.
1 Introduction

1. Since the publication of the White Paper *Equity and Excellence: Liberating the NHS* in July 2010, the Government has been engaged in the largest reorganisation for many years of the commissioning and provision of healthcare services by the NHS. At the same time, the Government has also been pursuing the most far-reaching reform of the public health system for a generation.

2. This situation is perhaps indicative of the way that public health (the promotion and protection of health, and the prevention of ill health)2 has long tended to be overshadowed in the minds of both the public and politicians by healthcare (the treatment of illness and injury). Yet public health was a priority of governments and local authorities long before the state took responsibility for the provision of universal and comprehensive healthcare services. And, since the creation of the NHS, it has been the policy of successive governments to ensure that, as far as possible, people stay well and so avoid the need to use those healthcare services in the first place. More recently, the combating of health inequalities has also been the explicit policy of successive governments.

3. It is arguably more important now than ever – with a growing and ageing population, continued health inequalities, and constrained public finances – to ensure that public health is accorded the full priority that it deserves. Yet, while the broad outlines of the Government’s proposed changes have been widely welcomed, significant concerns have been raised – not least within the public health field itself – about the risks posed by several key details of implementation.

4. With these considerations in mind, the Health Committee resolved to look at the planned public health reforms. We agreed the following terms of reference for our inquiry on 10 May 2011:

   Public health is a vital, but too often neglected, aspect of the National Health Service. The current constraints on public finances make it more important than ever to limit and reduce the overall demand for NHS services by the public health goals of preventing disease, prolonging life and promoting health. At the same time, the aim of reducing health inequalities becomes ever more pressing as the burden of ill health falls in an increasingly disproportionate way on the poorest, as well as on other disadvantaged social groups.

   It is also particularly important to review this topic at this time given that the Government is proposing major changes to the organisation of public health services, as part of its wider plans for reform of the NHS. These changes, which are being legislated for in the Health and Social Care Bill, were originally welcomed by those in the field but have subsequently become highly contentious. The Committee believes it is important that these plans be effectively scrutinised not least because of

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2 The UK Faculty of Public Health defines public health as “The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society” – www.fph.org.uk/what_is_public_health
the importance of public health in ensuring that health services are commissioned effectively.

In its inquiry, the Committee will consider:

- the creation of Public Health England within the Department of Health;
- the abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse;
- the public health role of the Secretary of State;
- the future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies);
- arrangements for public health involvement in the commissioning of NHS services;
- arrangements for commissioning public health services;
- the future of the Public Health Observatories;
- the structure and purpose of the Public Health Outcomes Framework;
- arrangements for funding public health services (including the Health Premium);
- the future of the public health workforce (including the regulation of public health professionals); and
- how the Government is responding to the Marmot Review on health inequalities.

In addition, our inquiry has touched on the Government’s approach to health improvement at the national level; we have looked particularly at "nudging"; the "ladder of intervention" and the Public Health Responsibility deal (with particular reference to alcohol).

5. During the course of our inquiry, 192 memoranda of written evidence were received and five evidence sessions were held. Oral evidence was taken from: academic experts on public health; the Faculty of Public Health; the UK Public Health Association; the Royal Society for Public Health; the Health Protection Agency; the National Treatment Agency for Substance Misuse; the National Transition Director for Public Health Observatories, Professor Brian Ferguson; the UK Association of Cancer Registries; the Local Government Group; the NHS Confederation; the Association of Directors of Public Health; the British Medical Association; the Marmot Review Team; the Behavioural Insights Team at the Cabinet Office; the Alcohol Health Alliance; Diageo Great Britain Limited; the advertising industry; the Chief Medical Officer, Professor Dame Sally C Davies DBE; officials of the Department of Health; the Chair of the Department of Health Working Group on Information and Intelligence for Public Health, Professor John Newton; the author of the Review of the Regulation of Public Health Professionals, Dr Gabriel Scally; and the Parliamentary Under-Secretary of State for Public Health, Anne Milton MP.
2 The new public health system

Background

The public health system to date

6. The modern public health system in England has its origins in the nineteenth century, when the main challenge to the health of the population was communicable disease. Local authorities had a major impact on public health by carrying out a “sanitary revolution”, in which Medical Officers of Health played a central role. Into the twentieth century, public health further benefited from rising living standards and improved nutrition, as well as advances in medicine.

7. With the advent of the NHS in 1948, local authorities retained some of their health responsibilities, including all aspects of public health. In 1974, however, major reorganisations of the NHS and local government saw the public health function (with the exception of environmental health) transferred from councils to “community medicine” departments within the new NHS Health Authorities. Following the 1988 Acheson Report, the function was once again called “public health”, now led by NHS Directors of Public Health (DsPH).

8. The public health function currently resides within the NHS in Primary Care Trusts (PCTs), the local bodies that commission (and, until recently, provided some) NHS services; and in Strategic Health Authorities (SHAs), the bodies that performance manage the NHS and effectively act as regional outposts of the Department of Health (DH). Until recently, each PCT has employed a local DPH;\(^3\) and a Regional DPH is located within each SHA.\(^4\) In addition, a number of other public bodies have public health roles.

9. Public health practice is now seen as falling into three distinct domains:

- **Health protection**, covering interventions to address environmental threats to the health of the population.

- **Health improvement** (also referred to as health promotion), embracing a very wide variety of areas, including tackling health inequalities and addressing lifestyle issues that impact on health and wellbeing.

- **Healthcare public health**, which is concerned with the quality, safety, efficacy, effectiveness, value for money and accessibility of healthcare services.

With the current emphasis on “whole system” approaches, public health can also be seen as impinging significantly on social care.

10. While the health of the population has continued to improve in the past generation or so, as communicable disease has been brought increasingly under control, new public health problems have emerged. As people live longer, chronic diseases (which are largely

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\(^3\) “Clustering” arrangements, as part of the NHS reform process, are apparently now changing this – Q 69.

\(^4\) Some Regional DsPH are employed by SHAs as NHS staff; others are employed by the DH as civil servants.
non-communicable) have increased in incidence and prevalence, in both relative and absolute terms. At the same time, non-communicable diseases related to lifestyle (particularly diet, exercise levels, and use of tobacco and alcohol), which are often chronic, have become major causes of illness and disability.

11. In addition, despite major overall improvements in the health of the population, health inequalities have widened, with the poorest and most socially excluded groups in society continuing to have the worst health and the shortest life expectancy. In England, as elsewhere, health inequalities have become a major public health concern, as expressed in the well-known Government reports by Black (1980), Whitehead (1987), Acheson (1998) – and, most recently, Professor Sir Michael Marmot (Fair Society, Healthy Lives, February 2010). These issues have driven an increasing recognition of the “wider determinants” of public health – the whole range of socio-economic and other factors that affect how people live and the impact that has on the health of the population.

12. At the same time, the discipline of public health has evolved in a multidisciplinary direction. The workforce has come increasingly to encompass people from a range of backgrounds other than that of being a doctor or dentist, including other clinicians and healthcare workers, health economists, epidemiologists, statisticians, and people from diverse other backgrounds. The continuation of this trend was identified as a major priority in the report on the public health function published by the Chief Medical Officer (CMO) in 2001. From 2002, applications for senior public health specialist posts (including that of DPH) were no longer restricted to medical and dental professionals.

13. The imperative to deal with the outstanding public health issues in respect of health improvement is now being given a significant added impetus by the constraints that have been imposed on public finances. The NHS received substantial real-terms increases in funding between 2002 and 2010, and the Coalition Government has undertaken to increase spending in real terms. However, the combination of increasing demand for healthcare and slower growth in resources means that the NHS faces an unprecedented financial challenge. In addition to increased productivity an active public health policy represents an opportunity to address this situation by easing the pressures created by rising demand. It is against this background that the Government has brought forward its plans for a major reorganisation of the public health system, to which we now turn.

**The reorganisation plans**

14. In the White Paper on NHS reform, *Equity and Excellence: Liberating the NHS*, published in July 2010, the Government outlined intended major reforms to the public health service. The planned changes were outlined in more detail in a White Paper, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, published in November 2010. In January 2011, the Health and Social Care Bill, which includes provisions to implement the proposed public health reforms, was introduced into the House (it is currently still before Parliament).

15. A consultation on *Healthy Lives, Healthy People*, and on two subsequent documents, published in December 2010, giving further details of the proposed reforms (on the Public
Health Outcomes Framework, whereby performance will be measured; and on public health funding and commissioning routes) ended in March 2011.

16. Following the “listening exercise” conducted during the pause in the progress of the Health and Social Care Bill, the NHS Future Forum considered, and made recommendations on, some aspects of the public health reforms. The Government published its response to the Future Forum soon after, in June 2011.

17. In July 2011, the Government published a Command Paper, Healthy Lives, Healthy People: Update and way forward, responding to the consultation on the public health reforms. A series of “Public Health System Reform Updates to complete the operational design of the public health system” will be produced “through the autumn” of 2011. The Future Forum will continue to have a role advising on the NHS contribution to public health.

18. All elements of the new system will now become operative in April 2013, subject to Parliamentary approval. In the meantime, various transitional arrangements are being put in place, along with “shadow and joint arrangements”.

19. Regional DsPH, located in SHAs, are the leaders of the process of transition to the new system at the regional and local level. SHAs will retain accountability for public health delivery, as well as responsibility for the overall transition process in the regions, until April 2013.

20. In the rest of this chapter, we consider in turn each of the constituent parts of the reforms, relating to:

- the Secretary of State for Health;
- the CMO;
- Public Health England;
- local government and DsPH;
- funding;
- the Public Health Outcomes Framework;
- the Health Premium;

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5 Healthy Lives, Healthy People: Transparency in Outcomes – Proposals for a Public Health Outcomes Framework was published on 20 December 2010.
6 Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health was published on 21 December 2010.
7 Department of Health, Healthy Lives, Healthy People: Update and way forward, Cm 8134, July 2011, p 5 (para 7)
8 Ibid., para 3.5
10 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, p 6 (para 8)
11 Ibid., para 3.15
• public health evidence and intelligence;
• public health and NHS commissioning;
• commissioning public health services;
• emergency preparedness, response and resilience.

The Secretary of State for Health

21. Under the Government’s planned public health reforms, the Secretary of State for Health will, for the first time, be under an explicit statutory duty to take appropriate steps “for the purpose of protecting the public in England from disease or other dangers to health”. He will also have the statutory power to “take such steps as [he] considers appropriate for improving the health of the people of England”.

22. These functions may be delegated to the NHS Commissioning Board – which can in turn delegate them to local Clinical Commissioning Groups (CCGs) – to a CCG, or to a local authority.

23. We heard there is disappointment amongst public health professionals that, while the Bill places the Secretary of State under a new statutory duty 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”, this does not extend to his public health role.

24. Under the planned NHS reforms both PCTs and SHAs, which currently exercise a wide range of public health functions on behalf of the Secretary of State, are to be abolished in April 2013. The Government plans at the same time that a new dedicated public health service, Public Health England (PHE), will become operative as an Executive Agency of the DH; and major new responsibilities for public health will be assumed by local authorities, relating to all three domains of public health.

25. The Secretary of State will be responsible for setting “a ring-fenced budget for public health”, from which all public health activities will be funded. Through a new Public Health Outcomes Framework, he will set “the direction for Public Health England” (for which he will be directly responsible) and “the context for local public health efforts”. He will also be responsible for setting the parameters of the Health Premium, through which local authorities will be subject to an element of “payment by results” in their health improvement role. The Secretary of State will account to Parliament and the public for the Government’s public health activities and spending; and he will be responsible for

12 Health and Social Care Bill, clause 8 [HL Bill 92 (2010–12)]
13 Ibid., cl. 9
14 Ibid., cl. 15, 19
15 Ibid., cl. 3
16 Ev 113; PH 23
17 Department of Health, Healthy Lives, Healthy People: Our Strategy for Public Health in England, Cm 7985, November 2010, para 4.56
18 Loc. cit.
“ensuring that the overall health and care system works coherently to deliver better health and wellbeing, better care and better value for the population and to address health inequalities […]” He will lead “public health work across civil society and with business and brokering partnerships at national level with industry and the voluntary and community sectors to help drive behavioural change”. And he will propose “legislation where this is a necessary and appropriate response” to a public health issue. Healthy Lives, Healthy People: Update and way forward emphasises that “The role of the Secretary of State will be to provide national strategic leadership across all three domains of public health”.

26. Within the Government, the Secretary of State has a new cross-departmental role, “leading public health across central government, through the Cabinet Sub-Committee on Public Health”. The Sub-Committee, which the Secretary of State chairs, has as its remit simply “To consider issues relating to public health.” It is also attended by the Parliamentary Under Secretary of State for Public Health. The King’s Fund told us in evidence that the Sub-Committee “could be a powerful mechanism at the heart of government”, but needed to be: “a more powerful, formal decision-making body, assessing major government decisions that affect health and its determinants through Health Impact Assessments […] and other techniques.” It proposed that “The Secretary of State should set up a mechanism through the Sub-Committee to monitor health inequalities. He should commission and publish a report on the public health impacts of budget changes.” The King’s Fund cited as an example that “recent research suggests that government spending on social welfare (excluding health) has seven times as much impact on mortality rates as changes in GDP”. We heard similarly from the Marmot Review Team about the impact on public health of Government policies such as the abolition of the Warm Front energy efficiency scheme, which helped to tackle fuel poverty and cold housing.

27. At the supra-national level, the Secretary of State participates “in public health work across the UK with the Devolved Administrations and at European and international levels”. The Secretary of State will also, under the proposed reforms, have responsibility for commissioning research for public health; and his powers in the event of an emergency are updated and broadened.

Conclusions and recommendations

28. We welcome the Government’s intention to give greater prominence and priority to public health policy, whilst also emphasizing that “public health is everybody’s

19 Loc. cit.
20 Loc. cit.
21 Loc. cit.
22 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, para 2.4
23 Loc. cit.
24 interim.cabinetoffice.gov.uk/media/425203/cabinet-committees-system.pdf
25 PH 28
26 Ev 154–5
27 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.56
28 Loc. cit.
business”. We also welcome the new emphasis on the public health role of the Secretary of State for Health and the embodiment of this in new statutory duties in relation to health protection and statutory powers in relation to health improvement.

29. We do not understand why the Secretary of State’s new statutory duty to reduce health inequalities under the Bill appears to apply only to the exercise of his functions in relation to the health service. We recommend that the Bill be amended to make it clear that the Secretary of State’s duty to reduce health inequalities applies in the exercise of all his functions, including those applying to public health.

30. The creation of the Cabinet Sub-Committee on Public Health, chaired by the Secretary of State for Health, is a significant step forward in developing a much-needed cross-departmental approach to public health. We recommend that its remit should be defined to include consideration and publication of evidence-based health impact assessments prepared by each department of state on policies within its sphere of responsibility.

The Chief Medical Officer

31. The DH describes the CMO as “the UK Government’s principal medical adviser and the professional head of all medical staff in England”.29 It stated in Healthy Lives, Healthy People that the CMO:

will have a central role in providing independent advice to the Secretary of State for Health and the Government on the population’s health. He or she will be the leading advocate for public health within, across and beyond government, challenging industry, employers, and civil society to take a bigger role in and responsibility for the public’s health.30

32. The present CMO, Professor Dame Sally Davies, told us:

In the job description [for CMO] I have been given a new role, as professional head of the public health profession […] While I am no longer the professional head of the whole medical profession, we take the view that the leaders of the medical profession are collective and multiple and that it does not rest with one person.31

[…]  

Historically, the CMO straddled health care and public health, whereas now I see the NHS Medical Director as playing the lead role for the health care part. As CMO, I will play very much the lead role and be the senior doctor for public health.32

33. In addition, under the public health reforms the CMO will:

29 www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/index.htm
30 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.57
31 Q 289
32 Q 290
• act as “convener and chair of a proposed new public health system advisory board”, which will “bring together key partners to collaborate to improve and protect the public’s health”;

• lead for PHE a “professional network for all those responsible for commissioning or providing public health”;

• attend, subject to invitation, the Cabinet Sub-Committee on Public Health (as the only official to do so);

• publish an independent annual report “On the State of the Public’s Health” and

• “represent the UK internationally on public health issues.”

34. We welcome the continuing role of the Chief Medical Officer (as the Government’s principal medical advisor) in respect of public health, particularly the production of an independent annual report on the nation’s health. However, we have concerns about the devolution of the Chief Medical Officer’s broader duties relating to healthcare to the NHS Medical Director. The NHS Medical Director is a management role within the NHS; the role of the Chief Medical Officer has traditionally been to provide a professional voice on healthcare issues which is independent of NHS management; the Committee regards this as important function which is not recognized in the new arrangements.

Public Health England

35. The DH Executive Agency that is to serve as the new dedicated public health service, PHE, will take on elements of public health activity currently undertaken within the DH and SHAs (notably the work of the Regional DsPH and their teams). In addition, the roles now played by the Health Protection Agency (HPA), the National Treatment Agency (NTA) for Substance Misuse, the Public Health Observatories (PHOs), the Cancer Registries, the National Cancer Intelligence Network, the UK National Screening Committee and screening programmes (both cancer and non-cancer) will all be subsumed within PHE.

33 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.57
34 Ibid., p 8 (para 12f)
35 interim.cabinetoffice.gov.uk/media/425203/cabinet-committees-system.pdf
36 Q 289
37 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.58
38 Loc. cit.
39 Ev 106
The case for change

36. The Government argued in Liberating the NHS that there was a need to “integrate and streamline existing health improvement and protection bodies and functions, including an increased emphasis on research, analysis and evaluation.”40

37. The Impact Assessments for Healthy Lives, Healthy People characterised the existing public health system as “fragmented and relatively opaque” and set out the goal of “a co-ordinated and coherent public health service with clear leadership, accountable to Parliament and the electorate, that can respond quickly and flexibly to threats to public health.”41 The Impact Assessments conclude with the precautionary argument that:

[A]lthough there are considerable strengths in the current arrangements, the disjoints in the system could make it more difficult to spot emerging public health problems at the earliest possible opportunity and therefore to respond where necessary as early as could be the case.42

In this regard, Healthy Lives, Healthy People stated, PHE “will bring together a fragmented system”,43 combining “public health functions that are carried out in different parts of the system at present into a new, streamlined whole so as to remove duplication and drive efficiencies and innovation.”44

The role of Public Health England

38. In Liberating the NHS: Legislative framework and next steps (December 2010) the Government summarised PHE’s role as being “responsible for stopping people becoming ill in the first place.”45

39. Healthy Lives, Healthy People said PHE will:

• provide public health advice, evidence and expertise to the Secretary of State and the wider system, including working with partners to gather and disseminate examples of what works;
• deliver effective health protection services;
• commission or provide national-level health improvement services, including appropriate information and behaviour change campaigns;
• jointly appoint DsPH [with local authorities] and supporting them through professional accountability arrangements;

40 Department of Health, Liberating the NHS: Equity and Excellence, Cm 7881, July 2010, para 1.15
42 Ibid., p 18 (para 30)
43 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.3
44 Ibid., para 4.59
45 Department of Health, Liberating the NHS: Legislative framework and next steps, Cm 7993, December 2010, para 3.16
• allocate ring-fenced funding to local government and rewarding them [through the Health Premium] for progress made against elements of the proposed public health outcomes framework;

• commission some public health services from the NHS, for example via the [NHS Commissioning Board]; and

• contribute internationally-leading science to the UK and globally, in areas such as biological standards and control, dangerous pathogens, and incident response.\(^{46}\)

**The status of Public Health England**

40. The Impact Assessments for *Healthy Lives, Healthy People* and the Health and Social Care Bill argued that the existing arrangements risk “confusion as to whether […] HPA are providing independent information or speaking on behalf of Government.”\(^{47}\) The Government’s initial proposal to establish PHE as an integral part of the DH would have compounded this problem, and it was argued in evidence to us that PHE needed to be (and, just as importantly, to be seen to be) independent of the Government – as the HPA in fact currently is.

41. The HPA was established as a Special Health Authority in 2003 (taking over from the Public Health Laboratory Service and other bodies) and became a non-departmental public body in 2005. The Agency was set up as an independent body partly as a solution to the problems that arose in the 1990s regarding trust in relation to Government scientists over the risks posed by variant Creutzfeldt–Jakob disease.\(^{48}\) The President of the Faculty of Public Health (FPH), Professor Lindsey Davies, explained to us that establishing PHE “as one more directorate of the Department of Health” would mean that it would “lose any opportunity to speak influentially and authoritatively to the public about important health matters”. Professor Davies also told us that, as a civil service body, PHE would be unable to generate the income that HPA is currently able to earn by virtue of its independent status.\(^{49}\) (This amounted in 2010–11 to almost £150 million, approximately half of the HPA’s total income.)\(^{50}\) We heard the same arguments from many sources; and we heard that there are similar concerns about the independent status of the PHOs and Cancer Registries, which also generate income from research contracts.\(^{51}\)

42. The FPH’s preference was for PHE to be established as an NHS body – we likewise heard in evidence from others the argument that it should become a Special Health Authority (see Box 1); or, failing that, an Executive Agency (see Box 2).

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46 Department of Health, *Healthy Lives, Healthy People*, November 2010, para 4.64
48 Q 45
49 Q 6
51 Q 87
**Box 1 – Special Health Authority**

A **Special Health Authority** is an NHS health authority which provides a health service to the whole of England rather than to a specific local community. Their staff, being NHS employees, are public servants but not civil servants and, as such, they are not subject to the same rules and restrictions as civil servants. As NHS bodies, Special Health Authorities have non-executive Chairs, Vice Chairs and Board members (alongside executive Board members). Although Special Health Authorities are independent, they are subject to ministerial direction, under section 8 of the NHS Act 2006.

**Box 2 – Executive Agency**

An **Executive Agency** is a part of a government department that is treated as separate for managerial and budgetary purposes in order to carry out some of that department’s executive functions. Their staff are civil servants and, as such, bound by civil service rules and restrictions, including those governing what they may say in public (including before Select Committees) about Government policy. Unlike non-ministerial government departments and non-departmental public bodies, Executive Agencies do not enjoy any actual legal or constitutional separation from ministerial control.

43. On the other hand, we heard a sceptical view about the case for a more independent arrangement from Professor David Hunter, who argued that “hived-off agencies do have problems engaging at the top table and shaping and influencing policy since they tend to be at one remove from these internal systems and processes.” He also pointed out that the National Institute for Health and Clinical Excellence (NICE) was constituted as a Special Health Authority, yet has tended to fight shy of disagreeing with the Government. He thought that “The trouble is there are no rights and wrongs or perfect institutional structures here. There are weaknesses and strengths in all these models and there is no single answer.”

44. Following the Future Forum’s recommendation against placing PHE “fully within the Department of Health”, the Government announced its intention:

> to establish Public Health England as an executive agency of the Department of Health, subject to completing the normal government approval processes for

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52 Under the terms of the Armstrong Memorandum, civil servants are precluded from publicly defending or criticising the policies, decisions and views of the Ministers they serve. The Memorandum also states that civil servants giving evidence to Select Committees do so as the representative of their Minister and subject to that Minister’s instructions. As such, a civil servant may not “seek to frustrate policies or decisions of Ministers by the disclosure outside the Government of information to which he or she has had access as a civil servant”. In giving evidence to Committees, civil servants are further subject to the Osmotherly Rules, which forbid the divulgence of advice given to Ministers by officials or of information on the process whereby decisions have been taken – The Civil Service Code, Standard Note SN/PC/3924, House of Commons Library, February 2006; The Osmotherly Rules, Standard Note SN/PC2671, House of Commons Library, August 2005.

53 Q 5

54 Q 8

55 NHS Future Forum, *Summary report on proposed changes to the NHS*, June 2011, p 23
establishing new bodies. This will ensure that expert and scientific advice is independent, while at the same time integrating policy and action to allow a more joined-up approach to health protection and emergency planning.\footnote{56}  

45. The response to the consultation confirms that PHE will now be constituted as an Executive Agency of the DH, “to provide greater operational independence within a structure that is clearly accountable to the Secretary of State for Health”.\footnote{57}  

46. The Government has given a number of justifications for preferring to make PHE an Executive Agency rather than a Special Health Authority. Anita Marsland, the Transition Managing Director for PHE at the DH, firstly emphasised “the importance of the clear line of sight”.\footnote{58} Secondly, she told us that “Ministers have taken the view across the system that the freedom to set up special health authorities has been overused and that the lifespan of any such body should be strictly time limited and subject to review.”\footnote{59} The DH further explained in a supplementary memorandum of evidence that “The Health and Social Care Bill 2011 provides that any Special Health Authorities established after the relevant provisions of the Bill are in force, are to be established only for a limited period of time.”\footnote{60}  

47. Professor David Harper, Director General of Health Improvement and Protection at the DH, reiterated this point\footnote{61} and provided a third justification, resting on the fact that a Special Health Authority is a type of NHS organisation: “Ministers are very much of the view that this is an opportunity to open up public health to everybody.” He did, though, stress that public health “is not being driven from the National Health Service.”\footnote{62}  

48. The subsequent supplementary memorandum of evidence from the DH deployed a further argument against Special Health Authority status that was not actually put to us in oral evidence (although it was used by a DH spokesperson quoted in media coverage of the Public Health Minister’s evidence session):  

PHE will have UK-wide responsibilities for some highly specialised health protection functions such as radiation protection\footnote{63} and will therefore need an organisational form that can operate across the devolved administrations. An executive agency

\footnote{56}{Department of Health, \textit{Government response to the NHS Future Forum report}, Cm 8113, June 2011, para 4.35}  
\footnote{57}{Department of Health, \textit{Healthy Lives, Healthy People: Update and way forward}, July 2011, p 5 (para 6)}  
\footnote{58}{Q 294}  
\footnote{59}{\textit{Loc. cit.} This policy that Special Health Authorities will henceforth only be created on a time-limited “task and finish” basis appears to stem from the intention that as little as possible of the NHS “system architecture” will in future be under the direction of the Secretary of State (in line with the principle that there will be a general presumption of autonomy in the NHS). Under the 2010 arm’s-length bodies review, several existing Special Health Authorities are to be abolished, with their functions transferring elsewhere, while others are to become non-departmental public bodies. Three bodies (NHS Blood and Transplant, the NHS Business Services Authority and the NHS Litigation Authority) are to continue as Special Health Authorities, but subject to various forms of commercial review – Department of Health, \textit{Liberating the NHS: Report of the Arm’s-Length Bodies Review}, July 2010.}  
\footnote{60}{Ev 168; Health and Social Care Bill, cl. 45}  
\footnote{61}{Q 424}  
\footnote{62}{\textit{Loc. cit.}}  
\footnote{63}{Two of these functions will be inherited from the HPA. The Agency took on the role of the UK National Radiological Protection Board in 2005; and the National Institute for Biological Standards and Control became part of the HPA in 2009. Other UK-wide functions to be subsumed into PHE are those of the UK National Screening Committee and the National Cancer Intelligence Network.}
model allows for this whereas a Special Health Authority is normally established in relation to England only (or occasionally England and Wales only).64

However, a current Special Health Authority, the National Patient Safety Agency, has been responsible since 2005 for the National Clinical Assessment Service, which has a UK-wide remit.65

49. The Secretary of State (Rt Hon Andrew Lansley MP),66 the CMO67 and Professor Harper68 have all indicated to us that the Medicines and Healthcare products Regulatory Agency (the Executive Agency which regulates production of medicines and other healthcare products) can be seen as a model for PHE’s relationship to the DH. This is reiterated in the Department’s supplementary memorandum, which also cites the Met Office (the weather forecasting body, which is an Executive Agency of the Department of Business, Innovation and Skills) as a model.69 How analogous these bodies are to PHE is perhaps somewhat open to question.

50. Ms Marsland also told the Committee that, as an Executive Agency, PHE would still be part of the Department but now with an “operational distinctiveness”.70 The supplementary memorandum further stated that the DH would “engage with the component organisations of PHE, local authorities, the NHS and other government departments to get their views on how we can ensure that PHE develops a strong, distinctive identity.”71

51. The Public Health Minister, Anne Milton MP, told us that she believed Executive Agency status would give PHE staff the freedom to speak out independently of the Government on public health matters:

As to whether a special health authority gives more independence than an executive agency, my understanding is that, as an executive agency, they would be free to voice their views. They are not civil servants in the purest sense, and civil servants are restricted in what they can do.72

52. Subsequently, in its supplementary memorandum, the Department confirmed that “PHE staff will be civil servants.”73

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64 Ev 168; cf. “Public health minister rejects reform threat to independent scientific advice”, G Ponine.com website, 21 July 2011
65 The Service has covered England, Wales and Northern Ireland since 2005 and Scotland since 2008. It provides services outside England through Service Level Agreements with the devolved governments.
66 Oral evidence taken before the Health Committee on 5 July 2011, HC (2010–12) 1248-ii, Q 234
67 Q 295
68 Q 423
69 Ev 167
70 Q 294
71 Ev 167
72 Q 420
73 Ev 167
53. It seems unclear how far PHE will be able to generate income, as the HPA is currently able to, if it is constituted as an Executive Agency, and hence still within the civil service. The Wellcome Trust told us:

The eligibility criteria of external funders, including the Wellcome Trust, will often not be met if the work is to be carried out within a Government department, and this would therefore limit the availability of resources to carry out research.\(^{74}\)

When it was still the Government’s intention to establish PHE as an integral part of the DH, the Department did say (in Healthy Lives, Healthy People) that it would “set up an appropriate mechanism to ensure that the income generation activities of the HPA can be maintained.”\(^{75}\) However, it gave no indication as to how such a mechanism might work.

54. In Healthy Lives, Healthy People, the Department stated that “As is the case today, the NHS Constitution will continue to apply to the whole health service, whether the NHS or Public Health England.”\(^{76}\) This will presumably still be the case if PHE is constituted as an Executive Agency.

**The governance of Public Health England**

55. On arrangements for the governance of PHE, Professor Harper told us: “The intention is not to have a non-executive board. It is absolutely that the Chief Executive will be accountable to the Permanent Secretary of the Department and then to the Secretary of State.”\(^{77}\) The CMO told us that:

As Public Health England will not have a non-executive board, this CMO advisory committee [the proposed public health system advisory board, to be chaired by the CMO] becomes particularly important in its challenge and monitoring functions.\(^{78}\)

She stressed that, in relation to PHE, hers was “not an executive role. There will be a chief executive reporting to the Permanent Secretary. It is a serious advisory and challenge role. It is written down as advisory and I have put in the ‘challenge’ as well.”\(^{79}\)

**The sub-national structure of Public Health England**

56. Regarding the sub-national structure of PHE, Healthy Lives, Healthy People explained that it “will have functions that need to be organised and aggregated at different levels to achieve maximum efficiency rather than the present mandated regional structure [of the HPA].”\(^{80}\) In respect of health protection, though, PHE will “have an important local
presence in the form of Health Protection Units” (HPUs), 25 of which currently exist within the HPA.

57. While PHE will not have a mandated regional structure, the CMO told us that:

we are looking at our sub-national hubs to try to make sure they not only match with the DCLG [Department for Communities and Local Government] resilience stuff but that the Commissioning Board and Public Health England are, ideally, co-located and work very closely together. We are working to make them very close to each other.  

We heard similarly from Professor Harper. The CMO also told us that “Not every office will be co-located, but where significant amounts of activity are going on, if we can, we will. However, that does not mean that at the end, it will be like that.” Ms Marsland further told us: “As far as possible, we will look to the same geography. That may not always be necessary or appropriate, but it will be our starting point.”

Establishing Public Health England

58. A Chief Executive for PHE will be in post from April 2012, with the appointment process beginning in autumn 2011. The assumption by PHE of its full responsibilities (including taking on the functions of the HPA, NTA, PHOs and Cancer Registries) will now take place in April 2013, following a transitional year. This is in alignment with the assumption by local authorities of their new public health responsibilities.

59. A PHE Operating Model is being developed which:

will set out details of the accountabilities and relationships across the system; the broad structure of Public Health England and how it will drive the delivery of improved health outcomes. Clarity on the role of Public Health England and how it will operate will enable both local bodies, and those bodies whose functions will become part of Public Health England to plan for 2012/13 with confidence that their

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81 Loc. cit.
82 Q 300. The DH has stated that the Commissioning Board will have a sub-national structure, which will initially “reflect the arrangements we have made for PCT and SHA clusters” (transitional arrangements up to the abolition of PCTs and SHAs in April 2013) and that the Department is “seeking to align the organisation of the Board at sub-national level with the regulatory and public health systems” – Department of Health, Developing the NHS Commissioning Board, July 2011, pp 3 and 4.
83 Q 354
84 Q 301
85 Loc. cit.
86 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, para 3.13; Q 428
87 Q 303
88 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, para 3.8. This had originally been scheduled to take place in April 2012 – Department of Health, Healthy Lives, Healthy People, November 2010, p 77 (Table 5.1). It was subsequently postponed, following the “pause” in the progress of the Health and Social Care Bill, to “no earlier than July 2012” – Sir David Nicholson (NHS Chief Executive), Letter to NHS Chief Executives, 13 April 2011, p 6.
actions align with the proposals for implementing Public Health England in April 2013.\textsuperscript{89}

The Operating Model is due to be outlined in a System Reform Update in autumn 2011.\textsuperscript{90}

\textbf{Conclusions and recommendations}

60. The Government’s case for combining within Public Health England a range of public health functions currently carried out by several organisations appears to rest on the perceived need to streamline a system that is currently fragmented. While acknowledging “considerable strengths” in the current system, the Government argues that it can still be made to work better. The Committee does not disagree with this view but sees the main case for change in the need for an independent voice for public health at the heart of government.

61. Public Health England must be – and, just as importantly, must be perceived as being – independent of the Government. Only in this way will it maintain the reputation for independence and evidence-based expertise, as well as the important trading activities, of the Health Protection Agency and some of the other bodies which Public Health England will succeed. We, therefore, welcome the Government’s decision that Public Health England will not, as originally planned, be constituted as an integral part of the Department of Health.

62. It is important that the Government ensures that the arrangements for the new body provide it with sufficient guarantee of its independence. The Committee believes that the principle that Public Health England must be visibly and operationally independent of Ministers is more important than the precise bureaucratic formulation.

63. We are concerned at the lack of clear plans for Public Health England to be established at the regional level. The idea of “sub-national hubs”, in some – as yet undefined – alignment with the sub-national structures of the NHS Commissioning Board and the Department for Communities and Local Government does not seem to us adequate. The Committee believes, in particular in view of the sensitivity of its health protection responsibilities, Public Health England needs a clear structure of regional accountability, along the lines currently provided by the regional structure of the Health Protection Agency.

\textbf{Local government and Directors of Public Health}

64. Under the reforms, local government\textsuperscript{91} will take on a substantial share of the responsibility for public health, alongside PHE. Local authorities will have particular responsibility within their respective areas for health improvement, a function which they will effectively inherit from PCTs. They will also have functions in regard to health protection and healthcare public health (likewise substantially inherited from PCTs).

\textsuperscript{89} Department of Health, \textit{Healthy Lives, Healthy People: Update and way forward}, July 2011, para 3.5

\textsuperscript{90} \textit{Ibid.}, para 3.7

\textsuperscript{91} The specific authorities concerned will be: county councils, unitary authorities, metropolitan boroughs, London boroughs, the Council of the Isles of Scilly and the Common Council of the City of London.
The case for change

65. The Government’s justification for handing this new role to local authorities is essentially twofold. Firstly, it argues that local variations in public health call for local solutions, which are best developed through local authorities. *Healthy Lives, Healthy People* stated that the new public health system would:

put local government in a leadership role as, given the huge variations across the country, local councils are best placed to address the particular issues that their areas face.\(^{92}\)

[...]

Embedding public health within local government will make it easier to create tailored local solutions in order to meet varying local needs.\(^{93}\)

66. Secondly, the Government has argued that local government is ideally suited to address the wider determinants of health, given its existing role in providing a broad range of services that impact on those wider determinants. *Healthy Lives, Healthy People* stated that embedding public health in local government:

will also enable joint approaches to be taken with other areas of local government’s work (such as housing, the environment, transport, planning, children’s services, social care, environmental health and leisure) and with key partners (such as the NHS, police, business, early years services, schools and voluntary organisations).\(^{94}\)

*Healthy Lives, Healthy People: Update and way forward* states that the new public health role of local authorities “opens new opportunities for community engagement and to develop holistic solutions to health and wellbeing embracing the full range of local services (e.g. health, housing, leisure, planning, transport, employment and social care).”\(^{95}\)

67. In making its case for the new system, *Healthy Lives, Healthy People* stated that “top-down initiatives and lectures from central government about the ‘risks’ [of unhealthy lifestyles] are not the answer”\(^{96}\) and that “Centralisation has failed.”\(^{97}\) Instead:

We will end this top-down government. It is time to free up local government and local communities to decide how best to improve the health and wellbeing of their

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92 Department of Health, *Healthy Lives, Healthy People*, November 2010, para 1.46
93 Ibid., para 4.8
94 Loc. cit.; cf. ibid., paras 3.4 (“we will shift power and accountability to local communities and create healthy places to grow up and grow older in, with new partnerships in important areas, such as housing, planning, schools and transport”), 3.59 (“Public health will be better integrated with areas such as social care, transport, leisure, planning and housing”), 4.6 (“Local government, including county, district and parish councils, already plays a significant role in protecting and improving the health of its communities, through, for example, environmental health, air quality, planning, transport and housing.”)
96 Ibid., para 2.2
97 Ibid., para 2.6
citizens, deciding what actions to take locally with the NHS and other key partners, without undue interference from the centre.\textsuperscript{98}

The new system will thus have “localism at its heart”.\textsuperscript{99}

68. On the whole, the new role for local government in public health has been widely welcomed in principle – although the detailed arrangements have proved somewhat contentious, as we will now consider.

\textbf{The role of local government}

69. While the Secretary of State will have powers in respect of health improvement under the Health and Social Care Bill, local government will have a duty to “take such steps as it considers appropriate for improving the health of the people in its area”.\textsuperscript{100} The Bill does set out a list of some of the steps that may be taken by local authorities (and the Secretary of State) to improve the health of the population, but these are not obligatory nor are they the only steps that may be taken.\textsuperscript{101}

70. \textit{Healthy Lives, Healthy People} stated that local authorities would be provided by PHE with a ring-fenced grant to “fund both improving population health and wellbeing, and some non-discretionary services”.\textsuperscript{102} \textit{Healthy Lives, Healthy People: Update and way forward} states that the “non-discretionary services” which local authorities must commission or provide, will be six in number. They include services relating to health protection and healthcare public health, making clear that local government has a role in these respects as well as in relation to health improvement.\textsuperscript{103}

71. The Secretary of State will have the power to make regulations requiring a local authority to exercise any of his public health functions, or requiring the authority to exercise its public health functions by taking prescribed steps.\textsuperscript{104} The Secretary of State may also arrange for a local authority to exercise any of his public health functions.\textsuperscript{105} At the

\textsuperscript{98} Ibid., para 2.7
\textsuperscript{99} Ibid., para 4.99
\textsuperscript{100} Health and Social Care Bill, cl. 9
\textsuperscript{101} The steps (set out in clause 9) are as follows:
\begin{itemize}
\item[(a)] providing information and advice;
\item[(b)] providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way);
\item[(c)] providing services or facilities for the prevention, diagnosis or treatment of illness;
\item[(d)] providing financial incentives to encourage individuals to adopt healthier lifestyles;
\item[(e)] providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment;
\item[(f)] providing or participating in the provision of training for persons working or seeking to work in the field of health improvement;
\item[(g)] making available the services of any person or any facilities.
\end{itemize}
\textsuperscript{102} Department of Health, \textit{Healthy Lives, Healthy People}, November 2010, para 4.31
\textsuperscript{103} Department of Health, \textit{Healthy Lives, Healthy People: Update and way forward}, July 2011, para 2.20
\textsuperscript{104} Health and Social Care Bill, cl. 15
\textsuperscript{105} Ibid., cl. 19
same time, under the Bill, the Secretary of State will be bound by a general “duty as to promoting autonomy” in respect of health services, which will apply to local authorities in the discharge of their public health functions.106

72. Local authorities will be given a new “general power of competence”, as part of allowing them “the freedom to decide what action is needed to take in order to shape their environments”.107 This power, which is to be legislated for under the Localism Bill, supersedes the existing general power of councils, under the Local Government Act 2000, to promote the economic, social and environmental “well-being” of their areas.108 The “general power of competence” will give local authorities the “power to do anything that individuals generally may do”,109 regardless of whether any legislation specifically empowers them to do it (and subject to the condition that the law does not expressly forbid local authorities to do it).

73. Wide-ranging as it sounds, it does not appear that this new power will give councils any more scope to implement interventionist public health policies at the local level, such as setting a local minimum price per unit for alcohol. We heard that, while this particular action would not be as effective as a national intervention of this kind, there does appear to be a case for it.110 Yet councils seeking to take this approach seem to be finding their existing powers inadequate.111

74. We heard there is disappointment that local authorities (like the Secretary of State) will not be under a statutory duty to address health inequalities in discharging their public health functions.112

**Directors of Public Health**

75. The majority of DsPH are now appointed jointly between PCTs (who employ them) and local authorities (to whom they may be seconded).113 Under the new system, all DsPH will by law be jointly appointed by local authorities and the Secretary of State (with this function being exercised through PHE), and located within, and employed by, local authorities.114

76. There will be no stipulations as to how these appointments are carried out. The Association of Directors of Public Health (ADPH) told us that there should be a “statutory appointments process which mirrors the existing Advisory Appointments Committee process for DsPH and Consultants/Specialists in Public Health – and accredited by the

106 Ev 168; Health and Social Care Bill, cl. 4
108 Qq 12, 18, 503
109 Localism Bill, clause 1 [HL Bill 100 (2010–12)]
110 Qq 275, 276 [Dr David Halpern]
111 *A minimum price for alcohol?,* Standard Note SN/HA/5021, House of Commons Library, January 2011
112 Ev 113; PH 28
113 Q 374
114 Health and Social Care Bill, cl. 27
Faculty of Public Health (as is currently the case) [...][115] This was echoed by the FPH itself, which told us that the current statutory system protects the public and employers, works well and parallels that for consultants in other medical specialties. [116] The British Medical Association (BMA) also took this view. [117]

77. DsPH will be accountable to their local authority, as their employer; but they will also be professionally accountable to the CMO (as “professional head of the public health profession”),[118] who “will help to shape the role and expectations of local DsPH”. [119] They will in addition be part of the PHE professional network, which the CMO will lead. [120]

78. The ADPH took the view that it was further necessary for DsPH to “have a formal contractual relationship and role – which could be honorary – with PHE”. [121] We also heard this from other quarters. [122] While there are arguments for this, in terms of national accountability and cohesion in the public health system, there are concerns about lines of accountability cutting across each other. Professor Hunter told us local government would be happy for DsPH to be professionally accountable to the CMO but accountability of a local government officer to the Secretary of State would be “a red line that local government would find it difficult to cross”. [123] Nevertheless, the Local Government Group (LGG) did tell us that:

We recognise that DsPH will have multiple accountabilities, not least to the Secretary of State regarding to health protection. We consider that their primary accountability to the local authority does not preclude DsPH having regional or national responsibilities in the wider public health service and for health protection. [124]

79. Any authority that wishes to dismiss a DPH will be obliged under statute to consult the Secretary of State. [125] However, the Secretary of State will not have a veto over any dismissal (in contrast to the situation up to 1974 in respect of local authority Medical Officers of Health). [126] Bodies such as the BMA [127] and the ADPH [128] thought that such a veto was necessary.

80. We heard concerns about the lack of a statutory requirement for DsPH to be appropriately trained and qualified. This was the case in respect of Medical Officers of
Health up to 1974; and is currently the case within the NHS, which requires DsPH (and public health consultants) to belong to an appropriate professional register. Professor Davies, of the FPH, told us:

the Bill just says “Appoint an individual”. I have heard it mooted that, in these stringent times, a local authority may decide to add these to the responsibilities of a director of social services or even the director of education […] we really do have to have in the Bill that this person needs to be qualified […]

The President of the ADPH, Dr Frank Atherton, told us that he would ideally like to see this achieved by a statutory requirement for all public health specialists to be on an appropriate register.

81. The NHS Future Forum (on which Dr Atherton sat) likewise reported that “Many wanted to ensure that Directors of Public Health are professionally qualified and registered.” The Government’s response has been that the joint appointment process for DsPH, between PHE and local authorities, means that PHE “will be able to ensure that only appropriately qualified individuals are appointed, and will continue to provide them with professional support and advice.”

82. Another major concern we heard was that there will be no requirement for DsPH to be appointed at an appropriately senior level, with direct access to the council Chief Executive, Cabinet and elected members. We heard reports that some local authorities intend their DPH to be subordinate to the Director of Adult Social Services.

83. The Government’s response to this is that:

we would expect the DPH to be of Chief Officer status with direct accountability to the Chief Executive for the delivery of local authority public health functions. We will discuss with local government and public health stakeholders how best to ensure that the Director of Public Health has an appropriate status within the local authority, in line with the position of the Directors of Children’s Services and Adult Social Services.

We have likewise heard from the Secretary of State, and from Ms Marsland of the DH, that the Government “expects” DsPH to be appointed as chief officers, although the

129 Q 366
130 Q 69 [Dr Fiona Sim]
131 Q 12
132 Q 157
133 NHS Future Forum, Clinical advice and leadership, June 2011, para 3.7
134 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, para 2.27
135 Ev 152, 157
136 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, para 2.27
137 Oral evidence taken before the Health Committee on 5 July 2011, HC (2010–12) 1248-ii, Qq 229, 232
138 Q 314
Secretary of State admitted that “To say we have a policy for this is probably overstating it.”

84. In *Healthy Lives, Healthy People*, the DH set out a “vision” of the DPH role. This is confirmed and added to in *Healthy Lives, Healthy People: Update and way forward*, which summarises that the DPH will be:

- the principal adviser on health to elected members and officials [footnote: “where local authorities have been given new public health functions, the Health and Social Care Bill makes clear that those functions should be exercised by the Director of Public Health.”];
- the officer charged with delivering key new public health functions;
- a statutory member of the health and wellbeing board [under the Health and Social Care Bill];
- the author of an annual report on the health of the population [this is a statutory duty under the Bill, as is the authority’s obligation to publish the report].

The consultation response emphasises that DsPH “will have responsibilities across the three domains of public health, reflecting the responsibilities of local authorities”, and seeks to clarify the role that DsPH will play in respect of health protection and healthcare public health.

85. We heard there are concerns regarding whether DsPH will, within local government, be adequately supported by an independent, expert team. It has been argued in public health circles that the workforce should be employed by PHE and seconded to local government. Dr Keith Reid, Co-Chair of the BMA’s Public Health Medicine Committee, told us that this would “ensure that the status and importance of public health are protected”. The BMA has also argued that public health specialists should have NHS contracts, partly as a way of “ensuring the independence of public health”. Contrastingly, the LGG told us that secondment of staff from PHE would only be acceptable as a short-term transitional measure, for no more than two years. A long-term arrangement of this kind was seen as inimical to the goal of a public health workforce “fully accountable at local level and recognised as a valued part of the local government workforce”. Councillor David Rogers, Chair of the LGG’s Community Wellbeing.

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139 Oral evidence taken before the Health Committee on 5 July 2011, HC (2010–12) 1248-ii, Q 232
141 Department of Health, *Healthy Lives, Healthy People: Update and way forward*, July 2011, para 2.23
142 Health and Social Care Bill, cl. 191
143 *Ibid.*, cl. 28
144 *Ibid.*, cl. 28
145 Q 138
146 Ev 156
147 Ev 137
Programme Board, thought that public health professionals would be as independent as other professionals who already advise “members of local authorities before they make sometimes very difficult decisions”\(^{148}\). It was just such a relationship, though, that the BMA’s Dr Reid feared – being “simply an adviser to the local authority in the same way that the solicitor or the legal expertise within the local authority […] is not seen necessarily as an executive function of a local authority. It is seen as a supporting function”\(^{149}\). Such a political environment, in which specialists advise as officers and elected members actually decide, is clearly a significant contrast to the way public health professionals are used to working within the NHS.

**Health and Wellbeing Boards**

87. Under the planned reforms, councils will have a “convening role”\(^{150}\) in respect of public health, NHS and social care, as well as other council services and wider public sector responsibilities (such as crime and disorder). Central to this role will be HWBs which are new statutory bodies, constituted as local authority committees.\(^{151}\) Forms of HWB already exist in some areas, in consequence of councils exercising their current power to promote local “well-being”.

88. In matters relating to the commissioning functions of the NHS Commissioning Board, an HWB will be able to require the Commissioning Board to send a representative to its meetings.\(^{152}\) HWBs in different areas will be able to work jointly.\(^{153}\) Pan-authority arrangements that are already emerging include a London-wide shadow Health Improvement Board.\(^{154}\) The key role of HWBs will be to promote “integrated working” between NHS, public health and social care commissioners\(^{155}\) (potentially facilitated by means of the HWB taking on other local authority functions).\(^{156}\) The prime means of enabling this will be through the preparation of the Joint Strategic Needs Assessment (JSNA)\(^{157}\) and the Joint Health and Wellbeing Strategy (JHWS).\(^{158}\)

89. It has been a statutory requirement since 2007 for local authorities, along with their local PCTs, to compile JSNAs. These are assessments of the health and wellbeing needs of the local population, intended to establish an evidence-based consensus regarding key local priorities for commissioning health and local authority services so as to improve health and wellbeing outcomes and reduce inequalities. Under the Health and Social Care Bill, putting

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\(^{148}\) Q 139

\(^{149}\) Q 138

\(^{150}\) Department of Health, *Liberating the NHS: Local democratic legitimacy in health – a consultation on proposals, July 2010*, para 11

\(^{151}\) Health and Social Care Bill, cl. 191

\(^{152}\) *Ibid.*, cl. 194

\(^{153}\) *Ibid.*, cl. 195

\(^{154}\) Department of Health, *Healthy Lives, Healthy People*, November 2010, para 4.16

\(^{155}\) Health and Social Care Bill, cl. 192

\(^{156}\) *Ibid.*, cl. 193

\(^{157}\) *Ibid.*, cl. 189. HWBs will also inherit from PCTs the duty to compile a Pharmaceutical Needs Assessment in respect of local pharmacy services – *Ibid.*, cl. 209.

\(^{158}\) *Ibid.*, cl. 190
together the JSNA will be a joint statutory obligation of local authorities and CCGs\textsuperscript{159} (exercised through the HWB).\textsuperscript{160}

90. In addition, under the Bill, local authorities and CCGs will also be obliged to compile a JHWS\textsuperscript{161} (which function is again to be exercised through the HWB).\textsuperscript{162} This is intended to be a “high-level” document “that spans the NHS, social care and public health, and could potentially consider wider health determinants such as housing, or education”,\textsuperscript{163} providing an “overarching framework” within which those areas of commissioning are developed.\textsuperscript{164} Local authorities, CCGs and the NHS Commissioning Board will all be obliged to “have regard” to JSNAs and JHWSs in their activities as commissioners.\textsuperscript{165} HWBs will have certain powers to comment on the congruence of CCGs’ commissioning plans with the JHWS, but they will have no power of veto over these (or any other) commissioning plans.

91. In areas where two-tier local government persists, HWBs will be able to include representation from district councils, although this will not be obligatory.\textsuperscript{166} Also, the existing duty to “consult each relevant district council” in compiling a JSNA will continue,\textsuperscript{167} although there will be no such duty in respect of JHWSs. Further, the Minister foresaw “some devolution of [the public health] budget down to the second tier, without a doubt.”\textsuperscript{168} Nevertheless, we heard there are concerns that lower-tier authorities,\textsuperscript{169} as well as parish or town councils,\textsuperscript{170} should be better recognised in attempts to join up local commissioning for health and wellbeing. District councils have responsibility for services with important public health implications, including environmental health, trading standards, housing and leisure services. Until 1974, a lower-tier Medical Officer of Health role existed and until 1988 these authorities employed Medical Officers of Environmental Health. They still retain the statutory local authority “proper officer” function in relation to monitoring and reporting cases of notifiable diseases, and will continue to do so under the reforms.\textsuperscript{171} Parish and town councils also have responsibilities relevant to public health, such as footpaths, allotments and parks.

\textsuperscript{159} Ibid., cl. 189
\textsuperscript{160} Ibid., cl. 193
\textsuperscript{161} Ibid., cl. 190
\textsuperscript{162} Ibid., cl. 193
\textsuperscript{163} Department of Health, Liberating the NHS: Legislative framework and next steps, December 2010, para 5.22
\textsuperscript{164} Ibid., para 5.23
\textsuperscript{165} Health and Social Care Bill, cl. 190
\textsuperscript{166} Department of Health, Liberating the NHS: Legislative framework and next steps, December 2010, para 5.8
\textsuperscript{167} Health and Social Care Bill, cl. 189
\textsuperscript{168} Q 446
\textsuperscript{169} PH 12, PH 53, PH 60, PH 82, PH 160
\textsuperscript{170} PH 15, PH 23, PH 60, PH 173
\textsuperscript{171} Q 441; Department of Health, Healthy Lives, Healthy People, November 2010, para 4.6, Annex A, para 7 (p 84). Medical Officers of Environmental Health (in single-tier and lower-tier authorities) were replaced by Consultants in Communicable Disease Control within the NHS, acting as local authority “proper officers” on a delegated basis.
Conclusions and recommendations

92. We welcome the new public health role planned for local authorities, leading in health improvement, and the emphasis that this places on tackling the wider determinants of health. We also welcome the new role envisaged for Directors of Public Health, as public health leaders in local communities, located within local authorities. However, several concerns have been raised with us about the details of implementation.

93. The lack of a statutory duty on local authorities to address health inequalities in discharging their public health functions is a serious omission in the Government’s plans. We recommend that the Health and Social Care Bill be amended to rectify this.

94. Some witnesses have argued that local authorities need additional regulatory powers to allow them to achieve public health improvements in their area, including, for example the ability to extend the scope of the ban on smoking in enclosed public places or set a minimum price per unit for alcohol. The Committee recommends that these proposals be the subject of further public consultation.

95. We endorse the joint appointment of Directors of Public Health by local authorities and the Secretary of State (through Public Health England). We recommend that, in addition, these appointments should be subject to a statutory appointments process, involving an Advisory Appointments Committee, and accredited by the Faculty of Public Health, as is currently the case in respect of Directors of Public Health within the NHS.

96. The Government argues that the involvement of Public Health England in the appointment of Directors of Public Health will be sufficient to ensure that those appointed are appropriately qualified and trained. The Committee does not agree; it believes that there should be a statutory requirement for Directors of Public Health to be a member of an appropriate professional register.

97. The Committee believes that Directors of Public Health should be appointed at chief officer level, reporting directly to the council Chief Executive. The Government says that it “expects” Directors of Public Health will be appointed at this level, but there will be no sanctions that can be applied if they are not. We recommend that this be laid down as a statutory requirement in the Health and Social Care Bill.

98. We endorse the plan for Directors of Public Health to be, under statute, mandatory members of their local Health and Wellbeing Boards. We also welcome the proposed statutory obligation on Directors of Public Health to prepare an annual report, which the local authority must publish.

99. We are concerned that, in fulfilling their role, Directors of Public Health should be free to speak out, if necessary to criticize their local authority, without inhibition or restriction. We, therefore, recommend that any local authority wishing to terminate the appointment of its Director of Public Health must be required by statute to have the Secretary of State’s approval.
100. We are concerned that too little attention is paid in the Government’s plans to the role of lower-tier authorities. Given their areas of responsibility, in particular in the commissioning and provision of social housing, there should be a statutory requirement for upper-tier authorities to involve them in the work of the Health and Wellbeing Boards.

The Public Health Outcomes Framework

101. The DH consultation on the Public Health Outcomes Framework stated that it had three purposes:

- to set out the Government’s goals for improving and protecting the nation’s health, and for narrowing health inequalities through improving the health of the poorest, fastest;

- to provide a mechanism for transparency and accountability across the public health system at the national and local level for health improvement and protection and inequality reduction; and

- to provide the mechanism to incentivise local health improvement and inequality reduction against specific public health outcomes through the ‘health premium’.  

The DH argues that the Framework will mark a change from previous policy:

This will be different to old style top down frameworks used to drive targets and performance management – rather it will set out the outcomes for public health across public services and at all levels of responsibility – national to local.  

The local accountability which the Outcomes Framework is intended to facilitate is envisaged as including the holding to account by voters of elected local authority members. The Minister told us:

locally, you have an elected body so you can vote them in and vote them out, and there are going to be outcomes frameworks against which the local council will be judged. In my dreams, I imagine local councillors in the council chamber fighting about the fact that Councillor A’s residents live less long than Councillor B’s instead of whether Mrs Smith has a porch on her house.  

102. Initial plans for the Outcomes Framework have been the subject of consultation and the finished Outcomes Framework will be published in a System Reform Update in the autumn of 2011. The DH told us that, in its consultation, it had been apparent that there was general support in principle for the Outcomes Framework as a way of measuring

173 Ibid., para 7
174 Q 434; cf. Q 448
175 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, para 3.5
performance. We found this too, but there were also several major concerns about the implementation of the Framework.

**The structure of the Public Health Outcomes Framework**

103. The Framework will sit alongside, and, to an extent, overlap with, the NHS Outcomes Framework (against which NHS commissioners, both CCGs and the Commissioning Board, will be judged) and the Adult Social Care Outcomes Framework (against which local authority commissioning will be judged). As with the other Frameworks, the one for public health will be supported by Quality Standards which NICE has been tasked with developing (as required by commissioners).\(^{176}\) In the forthcoming System Reform Update, the DH will “bring further clarity to the alignment across the NHS, public health and adult social care outcome frameworks, whilst recognising the different governance and funding issues that relate to these.”\(^{177}\)

104. The LGG told us that, rather than there being multiple Outcomes Frameworks for public health, the NHS and adult social care, there should just be one single overarching Framework, because:

- it recognises the interdependence of outcomes across adult social care, health care and public health: this should be extended to include children’s services;
- it would lessen the reporting burdens on councils and the NHS;
- it would ensure that all local partners are working together on the same priorities; and
- it would allow local priorities to drive strategies for health improvement.\(^{178}\)

105. Others supported at least the idea of maximum linkage and integration across the three Outcomes Frameworks;\(^{179}\) the Department told us that it too had heard concerns that there should be close alignment with the NHS and social care Outcomes Frameworks.\(^{180}\) We also heard, though, disquiet that the first NHS and Adult Social Care Outcomes Frameworks have both already been finalised, ahead of the first Public Health Outcomes Framework.\(^{181}\)

106. It is proposed that the Outcomes Framework be structured around five “domains”, under each of which a series of specific outcome indicators will be developed (see Box 3). These domains represent the high-level goals through which the Government aims to achieve its overarching vision. The domains are “sequenced” to reflect the entire spectrum of public health.

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\(^{176}\) Health and Social Care Bill, cl. 231; PH 139; Q 45  
\(^{177}\) Department of Health, *Healthy Lives, Healthy People: Update and way forward, July 2011*, paras 2.11 and 2.12  
\(^{178}\) Ev 138; cf. PH 15  
\(^{179}\) PH 167  
\(^{180}\) Q 338  
\(^{181}\) PH 165, PH 166. The first NHS Outcomes Framework (for 2011–12) was published on 20 December 2010. The first Social Care Outcomes Framework (for 2011–12) was published on 31 March 2011.
Box 3 – Domains of the Public Health Outcomes Framework

<table>
<thead>
<tr>
<th>Domain 1: Health Protection and Resilience</th>
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<tbody>
<tr>
<td>Protect the population’s health from major emergencies and remain resilient to harm</td>
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<tr>
<th>Domain 2: Tackling the Wider Determinants of Health</th>
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<tr>
<td>Tackling factors which affect health and wellbeing and health inequalities</td>
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<tr>
<th>Domain 3: Health Improvement</th>
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<tr>
<td>Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities</td>
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<th>Domain 4: Prevention of Ill Health</th>
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<tbody>
<tr>
<td>Reducing the number of people living with preventable ill health and reduce health inequalities</td>
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</table>

<table>
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<tr>
<th>Domain 5: Healthy Life Expectancy and Preventable Mortality</th>
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<tbody>
<tr>
<td>Preventing people from dying prematurely and reduce health inequalities</td>
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</tbody>
</table>

**Outcome indicators**

107. The Government states that the Outcomes Framework will:

- use indicators which are meaningful to people and communities;
- focus on major causes and impacts of health inequality, disease, and premature mortality;
- take account of [the Government’s] legal duties in particular under equalities legislation and regulations [including the Equality Act 2010];
- take a life course approach [i.e. taking account of how social determinants of health operate at each stage of a person’s life, such that disadvantage can accumulate over the course of a person’s lifetime]; and
- as far as possible, use data collated and analysed nationally to reduce the burden on local authorities.

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182 The Act places a duty on public bodies to have due regard, in respect of nine “protected characteristics”, to the need to:

- (a) eliminate unlawful discrimination, harassment, and victimisation;
- (b) to advance equality of opportunity; and
- (c) foster good relations between people who share a relevant protected characteristic and those people who do not.

108. We heard that some thought there were too many proposed indicators, and we were told about the risk of “a plethora of confusing outcomes and indicators”. Some anticipated that a heavy burden of data collection and processing could be imposed on local authorities. More fundamentally, the Royal Society for Public Health (RSPH) was concerned that, while many candidate indicators were good, being “evidence-based and likely to be achievable with focussed, coordinated, local interagency effort”, many others were “at best aspirational and at worst either impossible to measure or to achieve, or both”.

109. The DH told us it had heard particular support for focusing in the Outcomes Framework on combating health inequalities. However, we heard that the policy objectives identified by the Marmot Review were not adequately reflected in the Outcomes Framework as currently proposed. The RSPH told us that, although the Framework was based on the life-course approach (which Marmot advocated), it “found the framework to be weak in relation to some important groups within the population, including older people, people with disabilities and people of working age (health in the workplace) […]”

110. The relationship between the Outcomes Framework indicators and local priorities set out in JSNAs and JHWSs was a cause of some concern. There was a fear that the national imperatives set out in the Outcomes Framework could, contrary to the principle of localism, override those set locally. One suggested approach, which would also help cope with the large number of proposed indicators, was to allow authorities “to prioritise a smaller set of indicators based on the issues identified through the JSNA process”.

**Measuring outcomes**

111. It was pointed out to us that some outcomes were short-term (such as reducing delayed discharge from hospital), whereas others were long-term (such as reducing mortality and morbidity rates, and increasing life expectancy). Outcomes of the latter kind could not, by definition, be measured using short-term data and it was therefore necessary to use some kind of proxy measure or process (as opposed to outcome) indicator – which some of the candidate indicators effectively are. The Minister told us she thought that proxy measures could be used in these instances:

184 PH 11
185 PH 09
186 Ev 158
187 Loc. cit.
188 Q 338
189 Qq 45, 213; PH 151
190 Ev 146
191 PH 41, PH 125, PH 167
192 PH 135
193 Ev 138, 144
194 Q 150
195 Ev 144; Q 46
On things like smoking, you could look at quit attempts, you could survey populations to see how much they are drinking and you could weigh people to see how fat they are. You cannot, however, go to the ultimate outcome which is to reduce the incidence of coronary heart disease, which are much longer timelines.\textsuperscript{196}

An additional complicating factor in this regard is the effect of screening interventions, such as for sexually transmitted infections (STIs), as the Minister admitted. Where successful, these will, in the short term, produce what appears to be an increase in rates of illness, as hitherto undetected cases are uncovered. In the long term, however, the net result will be an improvement in the health of the population.\textsuperscript{197}

112. Another concern, raised by the BMA, was that outcome measures “must reflect the number of people whose health has been improved, as well as the extent of the improvement”\textsuperscript{198}

113. A problem in measuring outcomes that we heard about from several sources, and which the Minister acknowledged, was the phenomenon of population “churn”. The BMA explained that this “describes the movement of a people to a neighbouring, more affluent region, as they themselves become richer and healthier [and their replacement] by a poorer and unhealthier population.” In consequence, “it could be that a local authority which is consistently doing excellent work goes unrewarded, while an already affluent neighbour would reap the financial benefits”.\textsuperscript{199} Given, though, that health status tends to be a function of socio-economic status it is arguable how far a council could legitimately take credit for the improved health of upwardly mobile outward migrants. The significance of population churn for health outcomes is arguably that churn helps to keep poor areas poor – and poor areas tend to be where the worst health is found

114. The quality of the actual data used to measure outcomes proved to be a significant issue. Action on Smoking and Health told us that “Current data sources do not afford the statistical power required to assess differences in local smoking prevalence by socio economic group and current proposals to gather these data are inadequate.” It warned that, for “areas the size of Local Authorities, the proposed method of collecting the data will not be adequate”, due to the “completely inadequate” sample size at that level.\textsuperscript{200}

115. Another issue raised in relation to the “granularity” of outcomes data was the need for data at an even more localised level than that of local authorities, in order to show a full picture of geographical inequalities. Professor Peter Goldblatt, of the Marmot Review Team, told us: “At the moment, very few of the outcomes are available to measure individual inequalities or inequalities between neighbourhoods. To be successful, a greater proportion needs to be.”\textsuperscript{201} We heard from the LGG that:

\textsuperscript{196} Q 463
\textsuperscript{197} Loc. cit.
\textsuperscript{198} Ev 159; \textit{cf.} Q 151
\textsuperscript{199} Ev 159; \textit{cf.} Qq 52, 152, 458, 462, Ev 138, 142
\textsuperscript{200} PH 53
\textsuperscript{201} Q 213
Even in affluent areas there are considerable geographical inequalities in health, often at a very local level. Outcomes data will need to be able to be broken down for individual neighbourhoods that are meaningful to local people, providers and commissioners.\(^{202}\)

The Minister acknowledged this phenomenon in reference to her own constituency (Guildford).\(^{203}\)

116. The Association of Cancer Registries commented on issues that might affect the quality of data relating to healthcare outcomes which feature in the Framework. Outcome indicators relating to mortality or morbidity could be made less reliable where poor or incomplete data is received from healthcare providers, as sometimes experienced by the Registries (a problem that might be exacerbated by the development of a more diverse provider market).\(^{204}\) Registries have had a particular problem with staging data (regarding how advanced a cancer is at the time of diagnosis). A target has been set for this to be collected in all areas by 2012 at the rate achieved in the best performing areas, but that rate only amounts to 70% of cases – which (for a number of technical reasons) is the optimum achievable rate.\(^{205}\)

117. We also heard concerns about the need for data to reflect the full range of inequalities, not just those manifested geographically. For this purpose, data would need to be disaggregated according to all the “protected characteristics” under the Equality Act 2010.\(^{206}\)

118. We were told there is a particular issue in respect of recording health outcomes among homeless people, a very small and extremely disadvantaged population which can easily fall under the radar in terms of data collection.\(^{207}\) There are likely to be other groups in a similar position, notably gypsy and traveller communities.

119. We were told that, if outcomes data are to be of an appropriate standard, it is crucial to preserve analytical capacity within the public health intelligence function. However, it is feared that a significant part of this capacity is being lost in the transition to the new system.\(^{208}\) The need for adequate capacity within local authorities to collect data was also raised with us.\(^{209}\)

120. Another complicating factor raised with us was the potential lack of coterminosity between the Boards and their local NHS commissioners.\(^{210}\) The Government does, though,
now seem to have addressed this by prescribing that there will be a presumption of coterminosity between CCGs and local authorities.211

**Attributing outcomes**

121. While the DH says that the Framework will enable “the public health system at the national and local level” to be held to account for health outcomes,212 it also acknowledges that all public services, locally and nationally, contribute to health outcomes.213 It does not, however, say how, in order to hold the public health service to account, its specific contributions to health outcomes will be disentangled from those of other public services. This is hardly surprising, given the extreme difficulty of doing so.

122. The DH does not either indicate how the contribution of the public health system to health outcomes will be disentangled from the effects of all the other wider determinants of health. This too is not surprising, given that it would be even more difficult. Yet there are numerous powerful wider determinants (possibly mediated through public policy) whose impact the public health system can only qualify (for good or ill), including demographic trends, the economic fortunes of people, areas, industries and the nation and socio-cultural factors.

**Conclusions and recommendations**

123. We welcome the Government’s intention to measure progress in improving the health of the population by reference to outcomes rather than process targets; and we endorse the overall Outcomes Framework that has been outlined for public health.

124. There is a good case for having a single, integrated Outcomes Framework for public health, the NHS and adult social care. It is disappointing in this regard that the first NHS and Social Care Outcomes Frameworks have been finalised before the Public Health Outcomes Framework.

125. We recognise the need to minimise data collecting burdens. However, outcomes data must be sufficiently localised and detailed to reflect accurately trends and patterns in the health of the public. Datasets must be of an adequate size to be able reliably to detect relevant characteristics of populations at the appropriate level. This must include levels below those of local authorities, so that inequalities within authorities’ areas are detected. Data should also, as far as possible, be capable of disaggregation regarding the full range of protected characteristics under the Equality Act 2010.

**The overall public health budget**

126. The Government has noted that the current system, in which public health funding for PCTs is not ring-fenced, PCTs have sometimes “raided”, public health budgets to fund healthcare services when budgets are under pressure. This has confirmed the status of

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public health as a lesser priority within the NHS.\textsuperscript{214} We heard in evidence about the then CMO’s criticism of the raiding of public health budgets during the financial turbulence experienced by the NHS in 2005–6.\textsuperscript{215}

127. To ensure that the public health budget is in future spent on the purpose for which it is meant, the Government intends that it should be ring-fenced. At the national level, there will be a budget allocated to PHE, set by the Secretary of State, which will be intended to pay for all public health services. This will come “from within the overall NHS budget”,\textsuperscript{216} of which it will apparently constitute not more than 10% (although the actual level has yet to be fixed).\textsuperscript{217} Out of it, PHE will disburse the planned grant to local authorities; the grant will be ring-fenced within each authority.

128. \textit{Healthy Lives, Healthy People} stated that:

> The first step in determining budgets for public health will be to establish the baseline health spend on those services for which Public Health England will take responsibility in the future. Local PCT spending on such services during 2009/10 will be used as the baseline to reflect recent historic spending rather than spending during a transition year.\textsuperscript{218}

129. Despite the fact that the baseline figure had not been determined, \textit{Healthy Lives, Healthy People} stated that:

> Early estimates suggest that current spend on areas that are likely to be the responsibility of Public Health England could be over £4 billion [per annum]. This estimate will be revised as the detailed design of Public Health England develops and we gather more information about existing services and spend.\textsuperscript{219}

No indication was given as to how this figure had been arrived at. Professor Davies, of the FPH, told us that she had “no idea” whether it would be enough, as there was no indication of “what the boundaries of that budget are”.\textsuperscript{220} It does, though, appear that the figure applies to the totality of public health functions to be encompassed by the new system. The Marmot Review Team thought £4 billion was close to the value of the current public health share of the NHS budget, which they put at 4% (though they thought it ought to rise to 7%).\textsuperscript{221} However, by the BMA’s calculations, a figure of £5 billion would be a more accurate reflection of current spending.\textsuperscript{222}

\begin{flushleft}
\textsuperscript{214} Department of Health, \textit{Healthy Lives, Healthy People}, November 2010, paras 1.3, 2.10
\textsuperscript{215} Qq 18, 148
\textsuperscript{216} Department of Health, \textit{Healthy Lives, Healthy People}, November 2010, para 4.56
\textsuperscript{217} Oral evidence taken before the Health Committee on 15 December 2010, HC (2010–12) 513-ii, Q 560
\textsuperscript{218} Department of Health, \textit{Healthy Lives, Healthy People}, November 2010, para 5.6; cf. ibid., para 4.30
\textsuperscript{219} Department of Health, \textit{Healthy Lives, Healthy People: Update and way forward}, July 2011, para 4.29
\textsuperscript{220} Q 47
\textsuperscript{221} Ev 153
\textsuperscript{222} Q 140
\end{flushleft}
130. We heard from academic experts that the £4 billion figure actually appeared to derive specifically from “an estimate of prevention expenditure in England in 2006-2007” (which would be at odds with the DH’s statement that it is actually using 2009–10 as its baseline year). Professor Steve Morris, of University College London (UCL), told us that, if so, this was concerning on three grounds. Firstly: “This is money that is spent on prevention activities. It is not anything to do with the health promotion bit and the partnership between the NHS and communities.” Secondly, the current level of spending on prevention provides an inadequate baseline, since it includes figures for services such as the national Bowel Cancer Screening Programme, with a disappointing level of uptake; were the uptake optimal, expenditure would be higher. Thirdly, 2006–07 is not a suitable baseline year, since spending on prevention services will have increased since then, judging by previous trends (this area of spending “at least doubled” between 2000 and 2006).

131. Witnesses from the DH were not able to enlighten us greatly as to the basis of the £4 billion figure. Professor Harper of the DH told us:

"The figure was taken from a number of sources, not least from money that is currently spent in national programmes and budgets from those arm’s length bodies that would be coming together—or the functions of those bodies that would be coming together—to form Public Health England. The part that we have found most difficult is to tease out the local spend on public health because, of course, different parts of the system currently classify spend in different ways. That is a part of what we are still working on. Those three elements, essentially, went together to form the over £4 billion." According to Healthy Lives, Healthy People: Update and way forward, the definitive “baseline public health spend” will now be published in a System Reform Update “by the end of the year [2011]."

132. We have heard there are fears that the difficulty of establishing this baseline could lead to inadequate funding. The NHS Confederation told us: “we emphasise that it is not easy to define ‘public health’ and therefore to identify public health activity and spend accordingly.” The Acting DPH for Derbyshire, Dr Bruce Laurence, warned that identifying current public health spending was an “almost unfathomably complex” task. There is “a very mixed funding model”, involving numerous NHS and non-NHS pots of money, with “a vast array of providers”, across many sectors – and probably “great

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224 Q 202

225 Loc. cit.

226 Q 327

227 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, p 5 (para 7)

228 Ibid., para 3.5. The methodology for identifying baseline spending is reportedly being trialled in the north west – Q 141.

229 Ev 127
variances in what is actually spent between different areas”.

The DPH for Gateshead, Dr Alyson Learmonth, told us there were “multiple ‘stocktaking’ exercises going on, with poor definitions leading to fears of ‘double counting’ of scarce resources.”

133. It does not yet appear to be clear how the actual public health budget will be derived from the baseline figure, once it has been established. Although raiding of public health budgets by some PCTs has been acknowledged as a problem (indeed it is a problem that the reforms are intended to resolve), no indication has been given as to whether there will be some sort of adjustment to the baseline to take account of this.

134. A further complicating factor is that public health spending is “subject to the planned reduction of one-third of non-frontline administration costs across the whole system, while protecting frontline services”. This is intended to form part of the £20 billion “Nicholson Challenge” efficiency savings the NHS needs to make by 2015.

135. Although Professor Harper affirmed to us that “front-line services, as far as possible, are protected”, we have heard in evidence that the actual capacity of public health services is being significantly diminished. Professor Davies, of the FPH, told us:

We know that the cuts are having an impact. For example, [DsPH, and public health consultants and specialists] have lost a lot of the support that they were getting from the regional teams, which have gone, and the national support teams [based at the DH, working with PCTs and local authorities on delivering ten key public health priorities] have gone. That is causing them, across the country, to have to do more on their own than they did, and a lot of them do not have the resource or the energy anymore to do it.

136. We further heard from Dr Fiona Sim, Vice Chair of the Royal Society for Public Health, that budget cuts were causing low morale, with DsPH jobs disappearing as PCTs formed “clusters” (in the transition to the new NHS “system architecture”). In addition:

There has also been a loss of the front-line troops who are not protected in terms of their job titles, although they work full time in public health—for example, people who are providing smoking cessation services. Some of those have disappeared completely as part of the budgetary reductions, and that is another thing affecting the morale of the specialists because they have no front-line colleagues to deliver health-improving interventions. It is also clearly going to have an impact on the health of

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230 PH 12
231 PH 55. See also “Council chiefs rebel over public health funding sign-off”, Health Service Journal website, 6 October 2011.
232 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.62; cf. ibid., p 8 (para 12c), paras 1.3, 2.11, 4.28, 4.38
233 Q 336
234 Q 68; cf. PH 53, PH 62, PH 74, PH 84, PH 112. Richard Douglas, Director General of Policy, Strategy and Finance at the DH, has told the Committee in evidence that a lot of national support teams “were set up originally as task-and-finish type programmes but they tended not to finish”; they were supposed to transfer learning “across to local organisations for them to take forward themselves” – Oral evidence taken before the Health Committee on 11 October 2011, HC (2010–12) 1499-ii, Qq 109, 110.
235 It should, though, be noted that under the new system there should be roughly the same number of DPH posts as originally existed within PCTs, given the number of local authorities that will be taking on public health responsibilities.
the population because those interventions are no longer being delivered by those people who have been doing so […] They have already cut quite deep in many places […]\textsuperscript{236}

137. When we asked how the DH distinguished between frontline and other aspects of public health services, Professor Harper told us that there was a spectrum. A Consultant in Communicable Disease Control\textsuperscript{237} was clearly providing a frontline service, whereas “people involved in the management of public health” were clearly not frontline staff. In addition:

There will also be a group in the middle providing essential support to front-line services, and it could be laboratory diagnostic work. As the operating model for Public Health England and for the system is developed over the next few months, some of that will become much clearer. However, there will inevitably, on this spectrum, be the bit in the middle […]\textsuperscript{238}

The Minister confessed that she did not entirely understand this distinction and that “the bit in the middle and providing support to front-line services is the more tricky area”.\textsuperscript{239}

Conclusions and recommendations

138. \textit{Healthy Lives, Healthy People} stated that early estimates suggested that the current spend on services for which Public Health England will be responsible could be over £4 billion. More than 12 months later the Government has been unable to provide any detailed explanation as to how this figure was arrived at, or – more fundamentally – which services will in future be the responsibility of Public Health England. The Committee believes that this policy confusion is undermining confidence in the Government’s public health strategy and making service planning impossible.

139. The Department of Health is currently compiling its definitive baseline public health expenditure, with the intention of publishing it later this year. When it does so, it must show in detail exactly how this figure has been arrived at. The Department must clarify whether it intends to make any adjustments to the baseline, relating to factors such as localised underspending and the impact of the reduction in management and administration costs occurring since the baseline year.

140. The Department of Health must also make clear how the actual level of funding for public health will relate to the historic baseline. We seek reassurance from the Department that, in setting the public health budget, it will take account of objective measures of need. This must apply in respect of both the national budget and allocations to local authorities.

\textsuperscript{236} Q 69

\textsuperscript{237} Consultants in Communicable Disease Control, now located in the HPA, still act as local authority “proper officers” on a delegated basis. They will presumably transfer to PHE under the reforms.

\textsuperscript{238} Q 441

\textsuperscript{239} Q 442
141. Although the Department of Health states that, in the current reduction of NHS management and administration costs, frontline public health services are being protected, we have heard evidence to the contrary. Furthermore, the Department has failed to give a convincing account of its distinction between frontline and non-frontline spending in public health services. Unless it can do so, the suspicion will remain that it is an arbitrary distinction and that public health services are suffering, and will suffer, in consequence of the cuts that are being made.

Local public health budgets

142. The ring-fenced PHE grant to local authorities will have three components – two relating to health improvement and one to mandatory services. The first part of the element relating to health improvement will be a recurring fixed "baseline allocation". This will be “weighted towards areas with the worst health outcomes and most need” at the baseline point but will not thereafter be adjusted to take account of changes in health outcomes and need. The formula for this allocation will thus “be based on a ‘one-shot’ strategy” (as the King’s Fund put it to us), using a single “snapshot” of population health as it stands at the inception of the new system. (There will presumably be annual uprating of baseline allocations to allow for inflation, although the DH has not said so.) The second element relating to health improvement will be the performance-related Health Premium payment, determined by how far each council succeeds in improving population health. The element relating to mandatory services will be need-based and simply “grow in line with the estimated relative need of the population”.

143. It has not yet been indicated what proportion of the overall public health budget will be passed on to local authorities, but it is likely to be a very sizeable one. Their new public health responsibilities are substantial and they are supposed to be fully funded, “in line with the Government’s New Burdens Doctrine”, whereby no new burdens are imposed on local government without the allocation of concomitant additional funding.

The allocations formula

144. Healthy Lives, Healthy People stated that the DH would “ask the independent Advisory Committee on Resource Allocation (ACRA) to support the detailed development of its approach to allocating resources to local authorities.” ACRA currently advises the Government on the “weighted capitation” formula used to determine each PCT’s target “unified allocation”. The formula seeks, through a complex set of weightings, to ensure target allocations that would provide “equal access to healthcare for people at equal need”;

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240 PH 28
241 Loc. cit.
242 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.32
243 Department of Health, Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, December 2010, para 5.8
245 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.36
and “contribute to the reduction in avoidable health inequalities”. Where actual allocations are above or below the target, the former are moved towards the latter by the differential allocation of growth in funding, according to a “pace of change” policy (governing how “distance from target” is resolved over time).

145. The consultation response reports that ACRA “continues to consider what it will recommend as an appropriate allocations formula for the local authority grant.” It is now planned that “details of the allocation methodology […] and shadow allocations [for 2012–13 – the first actual allocations will be made in 2013–14, when local authorities assume their new roles]” will be published in the System Reform Update on public health funding which will be issued by the end of 2011. However, some outline information on the formula has been given; and issues raised by it have become apparent.

146. The formula will, like the weighted capitation formula, yield target allocations; and, where actual allocations do not concur with them, there will likewise be a “pace of change” policy. In the funding consultation document, the DH stated that there were “three general approaches to consider when establishing the formula”:

- “utilisation” – based on modelling the statistical relationship between current patterns of public health activity and need across the country. This is based on the premise that higher or lower expenditure in small areas provides information on relative need;
- “cost-effectiveness” – based on potential gains in health outcomes across the country using available information about the cost-effectiveness of public health interventions, that is gains in health outcomes relative to spend; and
- “population health measures” – based on measures of health outcomes, such as Standardised Mortality Ratios, or Disability-Free Life Expectancy. Allocations would be higher to areas with poorer health taking into account health inequalities. The measures would link to the Outcomes Framework.

147. The Department thought that, given the lack of data necessary for the first two approaches, “it may be that the third is the most pragmatic, at least in the short term”. This appeared to be reflected in statements in Healthy Lives, Healthy People that allocations would be “weighted for inequalities” and “weighted towards areas with the worst health outcomes and most need”. In our second commissioning inquiry, we heard from Professor Margaret Whitehead (a member of the Technical Advisory Group of ACRA, ...
although not speaking on behalf of either) that the third approach “is the only sensible choice from a conceptual and practical perspective.”

148. It was explained to us in evidence that a change made to the weighted capitation formula in the current year is likely to have implications for the local authority public health allocations formula. In recent years, a weighting for health inequalities (now called the Disability-Free Life Expectancy formula) has been applied to PCT allocations, in order better to meet the objective of contributing to the reduction in avoidable health inequalities. Given the correlation of ill health with socio-economic factors, this tends to favour less well-off areas. Professor Morris, who has researched this element of the formula for ACRA, told us that the additional funding was to fund prevention activity, health promotion and treatment of unmet need for healthcare (although, being part of the unified allocation, it is not ring-fenced for these purposes). In 2009–10 and 2010–11, this adjustment was applied to 15% of allocations, but in 2011–12 it is being applied to 10%. ACRA recommended only that the adjustment be fixed somewhere between 10% and 20%; it has been a ministerial decision where exactly to fix it.

149. Mr Lansley explained this to us in December 2010:

> We are very clear that we are moving in due course towards separate allocations for NHS services and for public health. It is clear that the public health allocation will not exceed 10%, although we have not determined what it will be. So we as Ministers have said to the ACRA that we will set the allocation for relative health outcomes at 10% and allow, consequently, additional weight to be given to the factors, such as age and deprivation, that directly relate to health care need.

As Public Health Manchester have pointed out to us, there is an apparent assumption here that the weighting is solely intended to pay for public health activity – yet, as ACRA (and Professor Morris) have stated, it is actually also intended to fund healthcare services where there is unmet need.

**The Health Premium**

**How the Health Premium will operate**

150. The intended operation of the Health Premium was outlined in *Healthy Lives, Healthy People* and the consultation document on public health funding. It was explained that whether local authorities received any additional funding over and above their fixed…
“baseline allocation” for health improvement services would be dependent upon “progress made in improving the health of the local population.” The Department: aims to pay local authorities for the progress they make and to ensure that they do not automatically receive additional funding if the health of the local population deteriorates. Nor should they be punished by seeing their funding reduce if they are successful in improving the health of their population.

This would mean that:

Potentially, an area that makes no progress might receive no growth in funding for these services, but, other than losing the opportunity of the incentive payment, which would be a legitimate local decision, there would be no automatic financial detriment to not making progress on the indicators.

151. The policy that baseline allocations will not be annually altered to take account of changes in health outcomes or need is apparently based on the assumption that this would constitute a perverse incentive to spend money ineffectively. It would supposedly “reward” those councils presiding over worsening health and “punish” those which succeed in making their populations healthier. Although health outcomes are also partly determined by local authority spending on areas other than health improvement (such as on social care or housing), there will apparently be no application of any element of health outcomes-related “payment by results” to the allocations for these purposes (which are mostly not ring-fenced).

152. Progress in local population health will be measured using selected indicators in the Outcomes Framework. The DH states the Premium will not be “an all-or-nothing payment. There would be a sliding scale depending on the size and extent of a local authority’s progress and relative to the authority’s position in terms of relative health outcomes.” Nor will it be “a target regime. Central Government will not be dictating detailed targets”. This might be taken to mean that no maximum level of Premium payment will be set (so the sliding scale is open-ended), but it is unclear whether this is the case.

153. The DH states that the Premium will be “simple and driven by a formula developed with key partners”. In recognition that disadvantaged areas “face the greatest challenges”

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259 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.32
260 Department of Health, Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, December 2010, para 5.4
261 Ibid., para 5.5
262 The fact that baseline allocations are fixed in this way clearly rules out the possibility of Premium payments being offset by a falling baseline, where population health improves; or the lack of a Premium payment being offset by a rising baseline, where health worsens. According to the NHS Confederation, “areas that succeed in reducing health inequalities” and “are rewarded by the health premium […] may be simultaneously penalised by a reduction in their overall public health funding allocation due to the improvement in their deprivation indicators”. However, this is predicated on the assumption that “the current approach to funding allocations continues” – Ev 131.
263 Department of Health, Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, December 2010, para 5.5
264 Ibid., para 5.6
265 Ibid., para 5.2
in health improvement, they “will see a greater premium if they make progress”. 266 This envisaged “formulæ based approach” will minimise administrative burdens and be fair, “with payments reflecting achievement, not the ability to negotiate a less stretching target”. 267

154. The DH says that the chosen subset of indicators from the Outcomes Framework will need to:

- have a balance of short-term and long-term indicators;
- be “comprehensive” or “complete” enough not to distort priorities at the local level; and
- incentivise interventions that reduce health inequalities while improving health overall. 268

155. The sums available through the Premium will be “clear and significant”. 269 It “will be funded from within the funding available for public health” and the DH “will look for opportunities to reprioritise discretionary central public health funding to ensure [local authorities] get the incentive payments they deserve and as part of a progressive rebalancing of central and local budgets.” 270 However, no indication has been given as to what proportion of the funding for health improvement will be constituted by the Premium.

156. The Department says it “will only be able to set out a detailed model when we have established the baseline and potential scale of the premium clearly, and have agreement about how the Public Health Outcomes Framework will be used.” 271 The DH now plans that details of the Health Premium will be published by the end of 2011, in the System Reform Update on the public health funding regime. This will also contain shadow baseline allocations for local authorities for 2012–13. The first Premium payments will be made as part of the first actual budgets, in 2013–14, based on performance during the shadow year. 272 The Minister told us that 2012–13:

will be when we start to see where we can tick a box if [the Premium] has worked well. I think any gaming that might be in the system will bubble to the surface at that point. It is going to be important and critical to inform so that we get it absolutely right when we kick off with the real allocations. 273

266 Loc. cit.
267 Loc. cit.
268 Ibid., para 5.3; Ev 110
269 Department of Health, Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, December 2010, para 5.5
270 Ibid., para 5.4
271 Ibid., para 5.7
272 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, p 5 (para 7), paras 2.62, 3.5; Qq 335, 346, 348, 444, 459; Ev 110
273 Q 460
157. We found that, while not everyone was necessarily hostile to the Premium in principle, very serious concerns were raised about how workable it would be in practice. The particular danger highlighted was that, as Professor Goldblatt told us: “The health premium being implemented in a very crude way risks being regressive rather than progressive, with more money going to the most affluent areas and less to the least well-off areas.”

The RSPH told us “the payment of a premium only to those who succeed is likely to widen the health inequalities gap and exacerbate the impact of the ‘inverse care law’.”

The Chartered Institute of Environmental Health feared that the Premium could “make the overall distribution of funding for the new services obtuse, perverse and unfair.”

The King’s Fund thought that the operation of the Premium as currently conceived was “far too crude” and risked “consigning parts of the country to a vicious spiral of chronic underfunding.”

Professor Hunter told us that the Health Premium would simply “prove unworkable […] I am not sure it is a mechanism that is going to survive, to be honest, or have real impact.”

158. Fears have been heightened by the lack of detail at this stage on how the Premium will be formulated. Despite asking, we have been unable to obtain any information from the DH on the policy options that are being considered or developed in this regard. The Minister could only tell us that the Premium was “a work in progress”, that advice was being taken (including from the King’s Fund) and that reducing health inequalities was the prime concern:

I can give you my political assurance. I do not have the expert knowledge to say how that is best done, but I am very clear, and the Secretary of State is very clear, about the outcome he wants to achieve.

Practical problems with the Health Premium

159. One possible problem with the Premium is its propensity to compound disadvantage stemming from shortcomings in historical PCT allocations (such as defects in the formula or underfunding due to “distance from target”) – or indeed in the baseline allocation. UCL’s Division of Population Health told us: “some areas may have insufficient funding to start making progress in the first place. This approach may widen health inequalities if progress is more likely to be made in more affluent areas.”

160. Given that Premium payments will be determined by performance against a subset of Outcomes Framework indicators, any defects in the Framework (of which, as we have seen, there could be a number) will potentially frustrate the aims of the Premium.

274 Q 220


276 PH 09

277 PH 28

278 Q 51

279 Q 458; cf. Q 462

280 PH 70
161. There are potential pitfalls in the choice of specific outcomes indicators for the subset according to which the Premium will be paid. As the DH acknowledges, these will need to be balanced between short-term and long-term indicators. If there is too much focus on short-term outcomes, this will tend to favour wealthier areas over more deprived ones, since the worst population health problems take the longest to solve. A similar effect will certainly occur if the indicators chosen do not adequately meet the DH’s criterion of incentivising reductions in health inequalities. If the subset fails to meet the other DH criterion of being sufficiently “comprehensive” to avoid distorting local priorities this too might have a regressive effect.

162. As we have noted, the Outcomes Framework will apparently not distinguish between the trends in health outcomes attributable to health improvement activity and those that are down to other public services or other wider determinants of health. This necessarily makes the Framework a flawed basis for making performance-related payments. The Government appears tacitly to acknowledge this by acknowledging the need to: calibrate “the sensitivity of indicators and outcomes to public health interventions”; and factor out “changes in indicators and outcomes for reasons unconnected with public health interventions”. Yet it gives no indication as to how this might actually be achieved.

163. Given all the different issues that need to be addressed in framing the Premium, it is, as the BMA’s Dr Reid indicated to us, hard to “see how a simple formula [as the DH promises] can lead to such an important element [of public health funding] being devised”. The UK Public Health Association argued that an effective Premium would entail “subtleties of approach”, requiring “sophisticated and responsive management” to allow health inequalities to be tackled. The CMO admitted bluntly to us that “It is complex”. Furthermore, it seems that those with the unenviable task of putting together the Premium will have the added disadvantage of there being no relevant research base.

**Objections to the Health Premium in Principle**

164. It can further be objected that, even if the Premium turns out not to be “unworkable in practice”, it is still “flawed in principle”. The Premium is predicated on the theory that withholding increases in funding (even where need is increasing), as a punishment for underperformance in health improvement, is bound to motivate optimal performance. Yet the DH has furnished no evidence of any kind that such a mechanism would actually work; and there seem to be sound reasons for doubting it will work.

165. Public health authorities that succeed in improving health outcomes are unlikely to do so as a result of threats or incentives. Success is more likely to be the result of their

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281 Department of Health, Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, December 2010, para 5.7
282 Q 151
283 PH 181
284 Q 346
285 Q 221
286 PH 46
professional and political commitment to improving health and reducing inequalities. There is a danger, on the other hand, that the effect on underperforming authorities could be one of demoralisation and demotivation, leading to a downward spiral of mutually reinforcing poor performance and underfunding. A compounding factor in this would be that withholding funding increases in order to punish past underperformance means there is less money to support new, potentially successful, initiatives in the future. As the BMA told us, on this basis “it is difficult to see how [the Premium] will support innovation and development in public health approaches.”

**Ring-fencing**

166. While there is widespread disapproval of the way that the current system allows PCTs to raid public health budgets, there is some controversy about the virtues of the proposed ring-fencing arrangements for local authority budgets. Dr Atherton expressed the view, which we also heard from others, that there is a role for ring-fencing in the short term, but: “In the longer term, the real challenge is for the whole—the totality—of the local authority budget to be geared towards public health improvement and public health protection.”

Ring-fencing could encourage the view that only spending from the ring-fenced budget is relevant to public health. Professor Davies told us she was:

> concerned about the risk of it being seen that that is all that anybody has to do for public health, given that the whole point of these changes, I hope, is to get many more people engaged in doing what they can from their own budget’s point of view.

Angela Mawle, Chief Executive of the UK Public Health Association, made the point that the Public Health Outcomes Framework covers all the wider determinants of health, to which a whole range of local authority budgets, are relevant, not just the proposed public health budget.

167. The LGG supported ring-fencing only as a transitional measure (for no more than two years). It argued that, if public health were to be integrated with other local authority services, the budget should likewise be integrated. This related to:

> a much wider view that is held by the Local Government Group about all taxpayer-funded spending, that there should be a sense of place that is brought to bear upon it and that is the most effective way of using the taxpayers’ pound.

We likewise heard from Professor Hunter that ring-fencing, which “is not the norm in local government”, “flies in the face” of the Government’s support for “community-based

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288 Ev 159; cf. Q 151
289 Q 141
290 Q 47
291 Loc. cit.
292 Ev 138
293 Q 144
Public Health

budgets or place-based budgets”. However, simply allocating budgets to local authorities without ring-fencing would risk allowing local authorities (which now face severe financial constraints) free rein to raid public health funds, just as PCTs currently can.

168. At the same time, there is a fear that, even with ring-fencing, local authorities will be effectively able to raid public health budgets to fund areas of spending for which they are already responsible by “redesignating” them as public health functions. The DH stated in the consultation document on public health funding that this new (ring-fenced) budget is intended to pay for new public health functions, not for existing areas of spending that relate to public health: “For the purposes of funding, the Department is treating these existing functions as separate from the public health ringfence, as they are already funded through the existing funding settlement […]” It cites both “wider responsibilities that bear on public health such as leisure, housing, education and social care” and local authority health protection activity, which “is funded as part of existing local authority funding for health protection”. (The latter case is somewhat confusing, given that it appears local authorities will inherit additional health protection functions from PCTs.) However, Dr Atherton told us “It is quite easy to see a pothole filling as a public health intervention”, but councils “should not be raiding sexual health budgets or immunisation budgets to pay for potholes”.

169. The consultation response confirms that, in spite of objections, the Government still intends to ring-fence the public health funding allocation for local authorities. At the same time:

- to maximise flexibility we will place only a limited number of conditions on the use of the grant. The core conditions will centre on defining clearly the purpose of the grant, to ensure it is spent on the public health functions for which it has been given, and ensuring a transparent accounting process. We will work with stakeholders to consider if any possible additional conditions might be necessary, although in considering any possible additional conditions we will need to be mindful of the need to maintain local flexibility.

170. Professor Harper told us that, to address the potential issue of redesignating existing local authority services, the DH was working with local government and others:

- to identify areas within local authority remits that are legitimately public health. There will be areas of transport—not [filling potholes], which is, I think, a very clear example—where we would not expect the ring-fenced budget to be paid. However, you might well find that there are areas on housing, on redevelopment and on other areas of transport, such as cycling and walking, that could legitimately be funded using some of that ring-fenced money.

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294 Q 47
295 Department of Health, Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, December 2010, para 2.5
296 Q 143
297 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, para 2.16
298 Q 330
171. The Minister told us the DH was not so naive as to deny the possibility of “what is commonly referred to as ‘gaming the system’”, but: “The meaningfulness and measurableness of these outcomes is going to be very important and this money is being given to local authorities on the back of compliance with the local outcomes framework.” She admitted the system was still a “work in progress” and emphasised that “working through DCLG, the Local Government Association, and up-skilling councillors” would be essential in making it work. She was also simply sceptical that public health budgets would be siphoned off, given that local authorities were already, under their current well-being powers, voluntarily funding “what we would consider to be public health interventions and the provision of many services. They are not compelled or obliged, but they do it because that is what they believe their local residents want.” This does, though, beg the question of where these services would sit in respect of the ring-fenced budget and what the impact would be on the overall level of public health funding were this activity to be paid for (whether appropriately or not) from that budget.

172. At the same time, the Minister seemed relaxed about the possibility of local authorities taking a somewhat elastic approach in spending their ring-fenced health improvement allocations. She pointed out that some PCTs were already making public health funding available to local authorities for purposes that stretched the definition of public health: “some of the PCTs will give money to improve, say, cycle lanes and you could argue that improving the potholes encourages more cycling.” We similarly heard about Durham and Darlington PCT paying its local authority £1 million towards preventing winter slips, trips, falls and accidents. However, we note that this proved controversial, with accusations that it amounted to the raiding of NHS funds to pay for core local government functions.

Conclusions and recommendations

173. We are concerned by the government’s decision to reduce the weighting for health inequalities in Primary Care Trust allocations for 2011–12 from 15% to 10%.

174. We are concerned about the proposed introduction of the Health Premium. We believe there is a significant risk that, by targeting resources away from the areas with the most significant continuing problems, it will undermine their ability to intervene effectively and thereby further widen health inequalities.

175. Although many witnesses welcomed the proposed ring-fencing of public health budgets transferred to local authorities, and the Committee understands the short-term attractions of this approach, it does not believe it represents a desirable long term development. Ring-fencing risks encouraging local authorities to see only spending
from the ring-fenced budget as relevant to public health and runs counter to a “place-based” approach, which would allow the wider determinants of health to be more effectively addressed. Furthermore, even with ring-fencing, there is a risk of local authorities “gaming” the system and effectively raiding their public health allocations by “redesignating” as public health spending services that they are already providing from other budgets.

176. The Committee therefore proposes that the ring-fenced public health budget should operate for no more than three years. During that period it should be a statutory duty of Directors of Public Health to certify that the ring-fenced budget is used appropriately for public health purposes.

Public health evidence and intelligence

177. All three domains of public health practice, in order to be truly effective, must be informed by sound public health evidence and intelligence. These functions are given particular importance in the new public health system by the intention to measure progress in health protection and health improvement through the Public Health Outcomes Framework, using various streams of data relating to health outcomes. Also, the Government has stated that an underlying value of the new public health system will be to “do what works, on the basis of evaluation and evidence, focussed on outcomes”, affirming the importance of intelligence relating to the effectiveness of particular public health interventions.

178. The Government plans that a number of information and intelligence functions currently performed by different organisations will be subsumed into PHE. The DH intends that “PHE will promote information-led, knowledge-driven public health interventions – supporting both national and local efforts”. The creation of PHE will also allow public health information and intelligence to be aligned with NHS healthcare information systems (as part of the planned NHS “information revolution”). This will build on existing links (especially in healthcare commissioning) to better allow public health information to be used to improve healthcare outcomes and healthcare information to be used in public health. At the same time, those functions relating to public health research and the evaluation of public health interventions will sit outside PHE, resting with the National Institute for Health Research (NIHR) and NICE.

179. While plans for these arrangements are taking shape, a number of important questions remain unanswered. There are concerns that the reforms are causing significant disruption to public health information and intelligence, with the loss of vital capacity and, according to the Health Statistics Users Group, the risk of valuable data being lost in the transition. In what follows we examine what is known regarding the fate of the different threads of public health evidence and intelligence.

305 Ev 106
306 Ev 109
307 Department of Health, An Information Revolution – a consultation on proposals, October 2010, paras 2.34–5
308 PH 153
Functions being subsumed into Public Health England

180. The creation of PHE is seen by the Government as addressing the perceived problem of fragmentation in the public health information and intelligence function, whereby “a very rich range of bodies producing intelligence, information and analysis […] has grown up in a piecemeal fashion, resulting in a lack of overall coherence with duplication and gaps within the system.”\(^{309}\) According to the DH, while the current system:

has delivered rich sources of public health intelligence, there is also scope for duplication […] This is potentially wasteful, and also risks confusion […] Taking a more systematic approach should also reduce the risk of “partially overlapping” roles leaving significant issues overlooked.\(^{310}\)

181. The DH stated in *Healthy Lives, Healthy People* that, in the transition to PHE, it would be:

drawing together existing public health information and intelligence functions (for example, the Public Health Observatories, cancer registries, and relevant parts of the HPA), working to eliminate gaps and overlaps and to develop the specialist workforce required.\(^{311}\)

The consultation response likewise says that PHE will “bring together in one body the diverse range of public health expertise currently distributed across the health system.”\(^{312}\) At the same time, the Department will set (presumably through PHE) “clear national informatics standards”\(^{313}\) for public health, covering “safety, security, reliability and resilience.”\(^{314}\)

182. To lay the groundwork for the bringing together of the information and intelligence functions that will be subsumed into PHE, the DH has set up a Working Group on Information and Intelligence for Public Health, on which all those functions are represented. The Chair of the Group, Professor John Newton, explained that its remit was to consider:

what should the information and intelligence function of Public Health England do—what should be the products; how we work from what we have now to what we need in the future; and ensuring that essential products are protected in the transition.\(^{315}\)

The Group, which has been meeting fortnightly since February 2011, has a three-phase workplan:

\(^{310}\) Ibid., p 18 (para 29)
\(^{311}\) Department of Health, *Healthy Lives, Healthy People*, November 2010, para 4.86
\(^{312}\) Department of Health, *Healthy Lives, Healthy People: Update and way forward*, July 2010, p 4 (para 4)
\(^{313}\) Department of Health, *An Information Revolution*, October 2010, p 8 (para 9)
\(^{314}\) Ibid., para 2.16
\(^{315}\) Q 350; cf. Q 104
• Phase one (February-May): develop high-level I&I functions for PHE, based on existing activities that will need to continue and new activities required within the new system;

• Phase two (May-September): sense-check high-level functions with stakeholders and start to consider opportunity areas for PHE in relation I&I; and

• Phase three (September-onwards): following presentation to senior colleagues, take forward those projects/elements of opportunity areas that are agreed as part of implementation of Public Health England.316

Professor Newton told us that the Group had produced a draft list of nine “products”, on which it was consulting interested parties, with a view to beginning implementation in September 2011. Healthy Lives, Healthy People: Update and way forward further explains that the projects being undertaken by the Group include:

- focusing on how Public Health England will strengthen surveillance;
- securing active knowledge management through a single and accessible web portal for public health;
- taking a strategic approach to national data requirements for public health; and
- building on relationships with the NHS and local government to ensure Public Health England provides a responsive service in relation to public health information and intelligence.317

**The Health Protection Agency**

183. Around half of the HPA’s staff are based at four major centres, which provide a range of nationally and internationally important public health intelligence functions:

- the Centre for Infections;
- the Centre for Radiation, Chemical and Environmental Hazards;
- the Centre for Emergency Preparedness and Response; and
- the National Institute for Biological Standards and Control.

These Centres will be transferred to PHE when it takes on the functions of the HPA. The Agency told us that PHE would “inherit a proven model of national expert HPA centres working to support local delivery in a seamless, consistent, science-driven and quality-assured system.”318

**The Public Health Observatories**

184. The nine PHOs in England (established to be coterminous with the former Government Office regions) collate and publish public health intelligence at the regional

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316 PH 192
317 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, p 34 (Annex C)
318 Ev 132
level. They are set up on a range of models, often in partnership with academic institutions. They operate a “lead area” model, with individual PHOs developing particular expertise in certain public health topics, such as diabetes, cardiovascular disease, alcohol and sexual health, thereby avoiding unnecessary duplication. The National Transition Director for Public Health Observatories, Professor Brian Ferguson, explained that at the regional level:

Each PHO plays a pivotal role in its own geographical area, acting as: (i) the health intelligence service, (ii) the focus for capacity-building and skills development for health intelligence staff, and (iii) the “bridge” between academic public health and practice. 319

185. The Future Forum recommended that the work of the PHOs “should be reviewed and built on”, to enable the Observatories to provide benchmarking outcomes data for NHS commissioners and clinical networks in future. 320 The Government has made clear that the functions of the PHOs will continue within PHE: the Minister gave us “a political commitment” to the continuing importance of the PHO function, 321 saying this role would actually “be enhanced”. 322 However, we heard there is considerable uncertainty as to how those functions will be discharged in the new system and how the transition to the new system will be accomplished, exacerbated by recent significant cuts in their funding, with talk of the possible “dissolution of the observatories”. 323

186. The Observatories receive from the DH both core funding and money for specific commissioned projects. The PHOs also generate significant sums in revenue themselves (although, we were told, this requires central funding as “seed corn” or “pump priming”). 324 The Department states that the overall budget for public health intelligence (which pays for PHO core funding and some commissioned projects, as well as some non-PHO work) is at the same level in 2011–12 as in 2010–11 (that is £6.5 million). 325 Within this budget, the same potential amount remains available for PHO core funding (that is £5.1 million). However, 23% of this has been withheld (reducing core funding to £3.9 million), potentially to fund “other public health intelligence, including transition costs associated with the move to the new system”. Initially, PHOs’ indicative budgets were reduced by 30% “in accordance with finance protocols”. The DH states that this money was withheld “in order to provide assurance that delivery in the 2011/12 financial year would be achievable in the reduced budget”. 326 At the same time, project funding (only some of which comes from the public health intelligence budget) has also been cut by 23% (from £7.0 million to £5.2 million). Professor Newton told us this was “due to the

319 Ev 118
321 Q 464
322 Q 467
323 Q 398; cf. Q 27
324 Q 31 [Professor Hunter]
325 Ev 169; cf. HC Deb, 17 May 2011, col 320
326 Ev 170
completion of certain time-limited projects and general pressure on central budgets for programmes in support of policy objectives”.327

187. According to Professor Newton and the DH, the full core funding allocation of £5.1 million is still potentially available to PHOs in 2011–12. However, any payment of the withheld 23% of this will only be made if a “style workplan for all PHOs”, commissioned by the Working Group from Professor Ferguson, “sets out critical work that requires additional core funding over and above the £4 million core grant already allocated”.328 In addition, quarterly financial reviews are taking place with each PHO “in order to discuss any emerging pressures”329 and “where necessary additional funding will be agreed”.330 This (being separate from the workplan process) does not, though, appear to involve drawing down any of the withheld element of core funding. In respect of commissioned work, the DH also holds out the prospect that the amount paid for this “may increase during the year”. Despite the theoretical possibility of PHOs receiving more funding in 2011–12, it is noteworthy that Professor Newton’s “best estimate” was that PHOs would receive total funding this year of £9.17 million – that is 23% less than the £12 million they received overall in 2010–11.331

188. The Minister indicated that (the “lead area” model notwithstanding) there was room for efficiencies to be made in PHOs: “Without doubt, there is an overlap, and certainly […] I am slightly appalled at how many people appear to be doing not the same thing but similar and related things and not having a conversation with each other”.332

189. Professor Newton told us that PHOs had been asked “to seek efficiencies by working more closely with each other and with partners such as cancer registries to eliminate duplication of effort and cost”, noting that three PHOs had already merged with their local Cancer Registries to good effect. He also explained that the 23% cut in core funding was “in recognition of the move away from a regional delivery model for public health intelligence to an integrated national model, which should generate efficiencies eg through supporting a single website rather than nine different ones.”333 According to the Department: “So far, we are not aware that the reduction of funding has had any adverse impact on PHO delivery.”334 However, this view was contradicted in other evidence.

190. One consequence of the cuts has been the closure of the Association of Public Health Observatories (APHO) in March 2011, following the withdrawal by the DH of its entire funding (£300,000 over three years).335 According to Professor Newton, a new Interim Operating Group, intended to simplify relations between the PHOs and the DH, “now
carries out the functions that were provided by the Association of PHOs”. However, Professor Ferguson (who was the last Chair of APHO) told us that coordination between the PHOs, managing their relations with other key stakeholders, their marketing profile and communications, which had been “very efficiently undertaken under APHO”, were all now “a lot more difficult”.

191. We also heard that a fifth of PHO capacity had been lost as at 1 May 2011, with around 40% of remaining posts being fixed-term or temporary and unlikely to be renewed. Professor Ferguson told us that, “on the current trajectory”, up to 45% of capacity would be lost by March 2012. Three PHOs (in London, the North East and the North West) have been at “particular risk of closure” since December 2010. We heard that uncertainty about the future was leading staff in the North East PHO with valuable skills to leave and pursue other career options. Professor Ferguson told us that the PHOs appreciated the need to “show efficiencies”, but they were “also acutely aware of the need to retain critical expertise in the public health system through this period of transition”. In order to stabilise themselves, the PHOs needed a “firm commitment” to funding until PHE went live, meaning no more cuts.

192. A particular concern is that the regional aspect of PHOs could be lost. The King’s Fund warned that, while creating a central observatory function in PHE would save money in the short term, it “risks creating a less effective local public health intelligence network and significantly higher overall costs as directors of public health […] each seek to replace the lost capability in their own patches.” The Minister, though, could not guarantee that PHOs would continue as regional bodies, arguing that “in this day and age, where you are physically is not desperately important”.

The National Treatment Agency for Substance Misuse

193. The NTA was set up as a Special Health Authority in 2001 to improve the availability, capacity and effectiveness of treatment in England for the misuse of drugs; it does this chiefly through supporting local commissioners of drug treatment services. We heard from the NTA’s Chair, Baroness Massey, that its role differed somewhat from the other information and intelligence functions that were being subsumed into PHE. The NTA had “a more community-based approach, based on service, public opinion and on stakeholders”, whereas the others did “hard research”.

336 Ev 166
337 Q 99
338 Q 98; Ev 118
339 Q 99
340 Ev 121
341 Q 35 [Professor Hunter]
342 Ev 120; cf. Q 99
343 PH 28
344 Q 469
345 Q 94
194. The NTA does, though, in one respect connect closely with the PHOs, since it hosts and runs, on behalf of the DH, the National Drug Treatment Monitoring System. This is a database, containing detailed information on drug treatment in England, for which data collection and analysis, and intelligence production, are undertaken in six of the nine English PHOs.\textsuperscript{346}

\textit{Cancer intelligence}

195. The Cancer Registries maintain datasets that are intended to capture a complete summary of patient history, diagnosis, treatment and status for every cancer patient. The UK is widely acknowledged as having one of the most comprehensive cancer registration systems in the world, consisting of 11 geographical (regional) Cancer Registries. The Registries and PHOs tend to work closely together, since they have similar (although not identical) functions. The Registries work closely as well with the National Cancer Intelligence Network, a partnership of public and voluntary sector organisations providing analyses to help improve cancer services and outcomes. The Network, which currently sits within the National Cancer Research Institute (another cross-sector partnership), is also to be subsumed into PHE.

196. David Meechan, of the UK Association of Cancer Registries, told us that, unlike the PHOs, the Registries were not facing real-terms cuts in funding – although they were expected to achieve “more with the same”. However, they were suffering due to uncertainty about their future. Mr Meechan said that, while they had been assured that their function would continue under PHE in some form, “What we don’t know yet is what those structures will be and that uncertainty is leading to the risk of losing skilled staff.”\textsuperscript{347}

\textit{The UK National Screening Committee}

197. The UK National Screening Committee, which was founded in 1996, advises Ministers and the NHS in all four countries of the UK about all aspects of screening, as well as supporting the implementation of screening programmes. It uses research evidence, pilot programmes and economic evaluation to assess the effectiveness and cost effectiveness of screening interventions for a range of conditions.\textsuperscript{348}

\textit{Functions outside Public Health England}

\textit{The National Institute for Health Research}

198. It is intended that the Secretary of State’s statutory responsibility for commissioning public health research will be exercised through the NIHR, a body set up (and partly funded) by the DH which coordinates and funds research for the NHS.\textsuperscript{349} Healthy Lives, Healthy People stated that “Public Health England will work closely with the NIHR in

\textsuperscript{346} Loc. cit. [Professor Ferguson]; Ev 125–6
\textsuperscript{347} Q 133
\textsuperscript{348} www.screening.nhs.uk
\textsuperscript{349} Department of Health, Healthy Lives, Healthy People, November 2010, para 4.56
identifying research priorities.” Also, a School for Public Health Research will be established within NIHR, “conducting high-quality research to increase the evidence base for effective public health practice”.350 The DH will “continue to promote a public health focus within the NIHR and fund, from within the Department’s Policy Research Programme, a new Policy Research Unit on Behaviour and Health”.351 The DH will also “ensure that Public Health England provides the necessary resource to support the cost of public health interventions that are undergoing research outside of the NHS”.352

The National Institute for Health and Care Excellence

199. NICE (originally the National Institute for Clinical Excellence) was established in 1999 as a Special Health Authority, with a remit to evaluate the effectiveness and cost-effectiveness of healthcare interventions. In 2004 NICE was also given a role in evaluating public health interventions; in 2005 it absorbed the functions of the Health Development Agency353 and became the National Institute for Health and Clinical Excellence. It produces Public Health Guidance, which is advisory and not mandatory in status, and has a very small (seven-person) Public health implementation team, working at regional level on implementing this guidance.354

200. Under the Health and Social Care Bill, NICE is to become the National Institute for Health and Care Excellence and will be reconstituted as a non-departmental public body. While its remit will also undergo some change, the Government states that NICE will continue to have a role in respect of public health. *Healthy Lives, Healthy People* stated that PHE would:

> ensure that the National Institute for Health and Clinical Excellence (NICE) adds maximum value by providing authoritative, independent advice on the evidence of effectiveness and cost effectiveness for public health interventions, working to specific commissions from Public Health England; and develop intelligence about the relative cost effectiveness of different interventions to support DsPH in commissioning local services, building on the work already started by NICE.355

We received evidence from NICE itself, making clear that it envisages continuing to play a significant part in evaluating public health interventions. This will include the production of the Quality Standards which will underpin the Public Health Outcomes Framework.356

201. However, we have heard that some disquiet has been caused by the decision, following the publication of *Healthy Lives, Healthy People*, to cancel work by NICE on six public health topics and to suspend its work on a further 13 topics (out of a total of 28 topics). The

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351 *Loc. cit.*
352 *Loc. cit.*
353 The Health Development Agency was a Special Health Authority established in 2000 to develop the evidence base to improve health and reduce health inequalities.
354 Q 35
355 Department of Health, *Healthy Lives, Healthy People*, November 2010, para 4.87
356 PH 139
reasons for this decision, which seems to be at odds with the claims made about NICE’s future public health role, do not appear to be clear.  

202. We also heard in evidence from a member of NICE’s Public Health Interventions Advisory Committee (PHIAC), Professor Steve Morris, that it had not met since December 2010, having previously met every month. The Minister sought to reassure us that:

There is nothing sinister in it not meeting. NICE continues to play a terribly important part […] What we need to make sure we do with NICE is to use it in the most effective way. There would be a danger of scatter-gunning requests to NICE and commissioning work. We need to make sure that Public Health England and NICE are well aligned.

Professor Harper added:

Part of the reason for [PHIAC not meeting] […] is because we have asked NICE […] to reconsider how they play into the new public health arrangements. Ministers have already asked NICE to consider some additional topics. It would be surprising, but not my call, if the Advisory Board did not meet in the relatively near future.

**Conclusions and recommendations**

203. We welcome the Government’s public commitment to evidence and intelligence as fundamental elements of the public health system. The Government’s plans for Public Health England do have the potential to improve the public health information and intelligence function, by integrating and streamlining the work currently done by several bodies. We look forward to the results of the Department’s Working Group on Information and Intelligence for Public Health in this regard.

204. The work of the Public Health Observatories is an extremely valuable part of the public health system. While the Government has promised to continue the work of Observatories, there is a great deal of uncertainty, especially following the substantial cuts to their funding that have been made in the current financial year. We are concerned to hear that three of the Observatories, in London, the North East and the North West, face “particular risk of closure”. We recommend that Ministers clarify their plans for individual Public Health Observatories as a matter of urgency to ensure that this important resource is not lost before Public Health England is established.

205. We welcome the decision to create a new School for Public Health Research (within the National Institute for Health Research) and a Policy Research Unit on Behaviour and Health. We also welcome the Government’s indication that the National Institute for Health and Clinical Excellence will continue to have a function in respect of evaluating the effectiveness and cost effectiveness of public health interventions.

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357 Ev 144; PH 77, PH 79, PH 84  
358 Q 229. As at 27 September 2011, no meetings had been held, or were planned, in 2011 – http://www.nice.org.uk/aboutnice/howwework/developingnicepublichealthguidance/publichealthinterventionsadvisorycommittee/public_health_interventions_advisory_committee.jsp  
359 Q 481  
360 Q 482
206. Against that background the Committee was surprised to learn that the Institute’s Public Health Interventions Advisory Committee has yet to meet this year, having previously met on a monthly basis. The Committee believes that Ministers should make clear as soon as possible exactly what role the Institute will play in future in respect of public health and how that role will be fulfilled.

Public health and NHS commissioning

207. Healthcare public health, as one of the three domains of public health, is a core part of the public health service. Its role, in essence, is to bring public health skills and knowledge to bear on the task of commissioning healthcare services. The Nuffield Trust explained that “The commissioning of health care is complex and requires a high level of technical and managerial skills” and:

Public health expertise is required for many commissioning functions, including: understanding local population needs, strategic service planning, evaluating the evidence for the quality and cost-effectiveness of care, and holding providers to account […]\(^{361}\)

Healthcare public health can also help to realise the potential role of healthcare providers in playing a public health role, delivering a range of interventions, including secondary prevention.

208. Hitherto, the healthcare public health function has resided in PCTs, the local NHS commissioning bodies. In the new NHS “system architecture”, local CCGs will commission most healthcare services, while certain kinds of service will be commissioned by the NHS Commissioning Board (operating nationally and through its sub-national presence). Unlike PCTs, these new commissioning bodies will not be funded to carry out public health functions – yet they will require significant public health input into their commissioning activities. Healthy Lives, Healthy People explained, under the heading “population healthcare”, that it would be a “vital” role of DsPH “to ensure a high-quality public health input into NHS services”. This would partly mean working with GP commissioning consortia on preventive activity, including involvement in “commissioning services for people with established diseases and long-term conditions”.\(^{362}\) It would also involve using “a range of regular informal and formal mechanisms” to engage with local NHS colleagues in:

- advising on commissioning and effective operation of population health services;
- ensuring the provision of services for diverse and potentially excluded groups […];
- advising on how to ensure equal access and equity of outcome across the population; and

\(^{361}\) PH 31; cf. Ev 157–8, PH 13, PH 49, PH 82

\(^{362}\) Department of Health, Healthy Lives, Healthy People, November 2010, Annex A, para 5 (pp 83–4)
• working with and supporting health and social care colleagues to increase opportunities for using contacts with the public and service users to influence behaviours positively and thereby improve health.363

The arrangements described in Healthy Lives, Healthy People would also entail a degree of influence by HWBs on both local NHS commissioning plans and those of the NHS Commissioning Board – of which DsPH would be statutory members.364

209. We heard that in public health circles there had been widespread alarm at what was seen as the failure of Healthy Lives, Healthy People to recognise fully the healthcare public health function and to assign it a proper place in the new system – in contrast to health protection and health improvement. Dr Reid of the BMA said:

Public health has always been about those three aspects. The White Paper reduced it to two aspects and health care public health disappeared. It is because there has not been that appreciation that public health specialists deliver across all three.365

There was scepticism at what we were told was the “naive” belief that DsPH, from within local authorities, would be able to exert any real influence on GP commissioning consortia.366 There was also seen to be “a DH vision that GP consortia will ‘commission’ [public health] input from academic institutions and commercial organisations”. This was predicated on a failure to realise that “The component of Public Health input that makes the difference to commissioning is not the data but the application of the data” by local public health specialists.367

210. The Future Forum recommended, in respect of NHS commissioning, that HWBs should have stronger powers to hold to account local NHS commissioners regarding whether their plans were in line with the JHWS.368 In responding to the Forum, the Government said that HWBs would now have “the right to refer back local commissioning plans that are not in line with the health and wellbeing strategy”369 – “Though they will not have a veto”.370

211. Under the Health and Social Care Bill as it now stands, as well as having a duty to “have regard” to JSNAs and JHWSs, CCGs must, when preparing or revising commissioning plans, involve each relevant HWB and consult it as to whether the commissioning plan “takes proper account” of the relevant JHWS. Where an HWB is so consulted, it must give the CCG its opinion as to whether the plan does take proper account of the JHWS. The HWB may also give the Commissioning Board its opinion on this. The Commissioning Board will assess, in each CCG’s annual assessments, whether it has had regard to the relevant JSNA and JHWS; and it must consult the relevant HWB

363 Ibid., Annex A, para 6 (p 84)
364 Ibid., paras 4.12, 4.13
365 Q 162
366 PH 17
367 PH 13
368 NHS Future Forum, Summary report on proposed changes to the NHS, June 2011, pp 12, 27
369 Department of Health, Government response to the NHS Future Forum report, June 2011, p 4
370 Ibid., para 4.10
about the CCG’s contribution to delivering the JHWS. The Commissioning Board will have the power to intervene in a CCG where it has failed to discharge a function. This power could be exercised in response to something that the relevant HWB has brought to the Board’s attention (although the Board is not obliged to respond in this way to any point raised by an HWB).\textsuperscript{371}

212. In its supplementary memorandum, the DH argues against HWBs having a power of veto over CCGs’ commissioning plans on the grounds that an HWB is “not a forum for one commissioner or elected member to over-rule another commissioner’s decision”. Were they to have such a power, this would undermine CCGs’ autonomy and “give local authorities the ability to block commissioning decisions, without being accountable for the results”.\textsuperscript{372}

213. In its response to the Future Forum, the Government indicates a significant change to its original plan for effective “open enrolment” of patients with GP practices. Now, “a significant majority of the registered patients that a clinical commissioning group is responsible for will have to live within the commissioning group’s boundaries”.\textsuperscript{373} CCGs will, therefore, not now potentially be focused on commissioning for large numbers of registered patients living outside their geographical areas. This, along with the new presumption of geographical coterminosity between consortia and local authorities, should better facilitate HWB input into commissioning by CCGs.

214. Another recommendation of the Future Forum was that there should be local multi-specialty “clinical senates”, to advise local commissioning consortia, HWBs and the Commissioning Board and to act as a forum for collaboration, advice and innovation across specialties.\textsuperscript{374} The Government accepted this too, promising that the senates would be hosted by the Commissioning Board. \textit{Healthy Lives, Healthy People: Update and way forward} makes explicit that senates will include public health specialists.\textsuperscript{375}

215. The response summarises the future healthcare public health role of DsPH as follows:

Directors of Public Health and their teams will provide public health expertise, advice and analysis to clinical commissioning groups and health and wellbeing boards and (for primary care and other directly commissioned services) to the NHS Commissioning Board.\textsuperscript{376}

It makes clear that provision of such support will be one of the six mandated services that local authorities must commission or provide. The response further explains that precise details of this, and other mandated services, will only come once the DH has worked with stakeholders “To ensure that we get the detail of the policy right”.\textsuperscript{377}

\textsuperscript{371} Health and Social Care Bill, cl. 23; Ev 169

\textsuperscript{372} Loc. cit.

\textsuperscript{373} Department of Health, \textit{Government response to the NHS Future Forum report}, June 2011, para 3.45

\textsuperscript{374} NHS Future Forum, \textit{Summary report on proposed changes to the NHS}, June 2011, pp 11, 28

\textsuperscript{375} Department of Health, \textit{Healthy Lives, Healthy People: Update and way forward}, July 2011, para 2.26

\textsuperscript{376} Loc. cit.

\textsuperscript{377} Ibid., para 2.21
216. The Government’s changes to the Health and Social Care Bill leave much to the discretion of CCGs and local authorities. Key stakeholders and commentators have advocated substantially different arrangements. The ADPH told us:

GP consortia should be required to work through and with DsPH to ensure consortia decision-making is underpinned by expert, professional public health advice. DsPH should have a formal relationship with GP consortia, and local commissioning plans should be signed-off by the Health and Well-being Board.\(^{378}\)

Some supported the idea of there being a specific obligation on local commissioners to show that commissioning decisions are based on appropriate public health advice.\(^{379}\) Professor Alan Maryon-Davis thought that the Government had “missed a trick” in not including a public health expert on the list of mandatory CCG board members which it had agreed following the Future Forum report: “That was a great mistake, and I think work will have to be done to make sure that that input gets in there.”\(^{380}\) Some thought that such a position should be mandated for the local DPH, or a nominee of the DPH\(^{381}\) (in line with a recommendation in the Committee’s second report on NHS commissioning).\(^{382}\)

**Conclusions and recommendations**

217. Public health expertise is an indispensable part of commissioning NHS services. With the NHS facing major financial challenges, these functions are more important than ever. Yet *Healthy Lives, Healthy People* was widely seen as downgrading the role of public health in the commissioning of healthcare services. In its response to the Future Forum and in the consultation response the Government outlines changes to its plans intended to provide reassurance on this count, but we do not believe these are enough.

218. In its earlier report on commissioning the Committee recommended that the local Director of Public Health should be a member of the Board of each local commissioning body (now Clinical Commissioning Group). This remains our view.

219. The Committee also believes there should be a qualified public health professional on the NHS National Commissioning Board, and that the Commissioning Board should routinely take advice from qualified public health professionals when commissioning decisions are being taken.

**Commissioning public health services**

220. In *Healthy Lives, Healthy People*, the DH explained that PHE “will have three principal routes for commissioning public health services”:

- determining the public health ring-fenced budget which is passed to local government;

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378 Ev 115
379 PH 31, PH 158
380 Q 402
381 PH 158
• working with the NHS Commissioning Board in commissioning services, such as screening services, and the relevant elements of the GP contract; and

• commissioning or providing services directly.383

221. At the same time, other commissioning routes would also be possible, “for example, if appropriate, there may be an option for GP consortia to commission on behalf of Public Health England”.384 Proposals regarding how specific public health services would be commissioned were set out by the DH in its consultation document about commissioning routes under the new system. The DH gave its response to the subsequent consultation in the consultation response. The consultation document on commissioning routes accepts that “For some services, commissioning may be best carried out at a sub-national or supra-local level”. This would apply to specialised services requiring specialist expertise and facilities. However, there would be “no formal structural provision for sub-national commissioning.”

222. We heard there were doubts and concerns about whether all local authorities would be competent in commissioning particular types of service and the consequent risk of inconsistency in services between areas.385 Some identified to us the need for PHE to lay down national frameworks for services.386 The Chartered Institute of Public Finance and Accountancy made the point that local authorities could differ markedly in their preferences regarding which services they choose to commission and how those services are provided. It suggested there was a need to lay down principles for a “consistent core offer” in public health across the country.387 The Government has responded to these concerns by making clear that local authorities will be under a statutory mandate to commission certain services, to which we turn next.

**Mandated commissioning by local authorities**

223. The consultation response lists the following mandated services or steps, which local authorities must commission or provide:

• 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;

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383 Department of Health, *Healthy Lives, Healthy People*, November 2010, para 4.41
384 Ibid., para 4.42
385 PH 120
386 PH 126
387 PH 24
• elements of the Healthy Child Programme.\textsuperscript{388}

The planned mandated responsibility of local authorities for commissioning “comprehensive open-access sexual health services”\textsuperscript{389} will include:

• testing and treatment for STIs, including partner notification activity, opportunistic Chlamydia testing, and opportunistic testing and treatment in primary care;

• contraception outside of the GP contract, for instance through community pharmacies, for patients who do not wish to discuss contraception with their GP or whose needs are complex;

• fully integrated termination of pregnancy services, including contraception, and STI testing and treatment; and

• sexual health promotion and prevention.\textsuperscript{390}

The Government says that services are being mandated where:

• services need to be provided in a universal fashion if they are to be provided at all […];

• the Secretary of State is already under a legal duty to provide a certain service, but in practice intends to delegate this function to local authorities. Mandation will ensure that these obligations are met;

• certain steps [are needed] that are critical to the effective running of the new public health system.\textsuperscript{391}

224. The DH’s supplementary memorandum emphasises that mandation “will not define what is ‘important’” in local authorities’ public health functions. It also indicates that keeping the extent of mandation to a minimum will be in keeping with the Secretary of State’s statutory “duty as to promoting autonomy” in respect of health services (under the Health and Social Care Bill).\textsuperscript{392}

225. When we asked Professor Harper, of the DH, to explain the choice of mandated services, he told us that they “are services that are considered to be special, for whatever reason”.\textsuperscript{393} In one case, he was able to explain that it was a matter of ensuring the collection of a comprehensive national dataset: “if you take the national child measurement programme […], it would not be very helpful if a number of local authorities opted out of

\textsuperscript{388} Department of Health, \textit{Healthy Lives, Healthy People}, November 2010, para 2.20. Regulations to this effect will be made under the Health and Social Care Bill, cl. 15.

\textsuperscript{389} Department of Health, \textit{Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health}, December 2010, para 3.16

\textsuperscript{390} Loc. cit.; Department of Health, \textit{Healthy Lives, Healthy People: Update and way forward}, July 2011, p 27 n 8

\textsuperscript{391} Ibid., para 2.19; cf. Ev 168

\textsuperscript{392} Loc. cit.; Health and Social Care Bill, cl. 4

\textsuperscript{393} Q 503
that [...]” However, he seemed hard put to explain why sexual health services were included on the list but smoking cessation services were not:

There are a number of special features about sexual health services—how they are delivered and what is required of local authorities as part of the overarching system. Without going into too much of the detail, if you took something like smoking cessation services, it would seem entirely appropriate for local authorities to decide, having the outcomes set, if that is one of the outcomes [...] and to do whatever they considered necessary to deliver those outcomes. With sexual health services, there are some very specific characteristics. It is hard to pick them at the moment, but if you take chlamydia screening or STI treatment—if you take the services that, at the moment, we consider are appropriate for local authorities but not, for example, HIV treatment, there are some very particular elements which, together, have led to this relatively short list.395

226. In its supplementary memorandum, the DH made clear that the provision of “open-access contraception services” is to be mandated because this is a statutory obligation on the Secretary of State396 which is to be delegated to local authorities. The mandating of “open access, confidential STI testing and treatment services” was justified because this “is a health protection function”.397 We heard from the National AIDS Trust why this must be mandated: “inconsistency is unacceptable when dealing with services which are meeting acute ill-health, such as STI infection, or are addressing the spread of infectious disease in a population.”398 However, the Department leaves unexplained why termination of pregnancy services and sexual health promotion services are also to be mandated. It is likely that this is considered necessary because, as we heard from the Family Planning Association:

there is a risk that certain elements of sexual health service delivery could become politicised given the involvement of locally elected representatives […] although it is clear that delivery of sexual health services must include abortion, some people seeking elected office may wish to make it a political issue.399

The Terrence Higgins Trust made the same point about services such as “HIV prevention outreach in public sex environments”.400

**Fragmented commissioning**

227. We heard about significant concerns regarding the danger of some services becoming fragmented, due to the involvement of multiple commissioners at the same time. In the
consultation response, the DH responds as follows to the raising of such issues in its consultation:

We have amended our criteria for deciding commissioning routes for public health to take account of concerns raised around fragmentation. In reviewing our proposals, we followed four fundamental principles:

- Effectiveness – getting the biggest positive impact on health;
- Localism – empowering local communities;
- Efficiency – getting the best value for money; and
- Equity and comprehensiveness – reducing health inequalities and increasing fairness in the provision of services.\(^1\)

On this basis, details were given of several changes to planned commissioning arrangements. However, several areas seem to remain contentious, as we next discuss.

**Sexual health**

228. As well as the mandated sexual health services listed above, it was also initially proposed that counselling and support services for victims of sexual violence would be commissioned by local authorities.\(^2\)

229. The NHS Commissioning Board will commission HIV treatment services, as part of its responsibility for commissioning treatment of infectious diseases (partly because “efficiencies can be made from procuring drugs and services at scale”)\(^3\) The Board will also commission those contraceptive services provided as part of the GP contract.\(^4\) In addition, genitourinary medicine will apparently be commissioned by CCGs.\(^5\) There could also be the potential for national prevention initiatives in sexual health to be commissioned or provided by PHE, as part of its national health improvement role.\(^6\)

230. We heard concerns had been expressed that the proposed arrangements “will undermine attempts to provide an integrated sexual health service”.\(^7\) The NHS Confederation told us it could potentially result in “services that do not meet people’s needs as they fall through the gaps between the different commissioners”. It recommended such services be “jointly commissioned as a package between commissioning consortia and public health departments within local authorities”.\(^8\) We heard in one submission that fragmented commissioning of sexual health services was “not efficient and could result in

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\(^1\) Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, Annex A, para A.3 (p 26)

\(^2\) Department of Health, Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, December 2010, para 2.13, p 19 (Table A)

\(^3\) Ibid., para 3.16

\(^4\) Loc. cit.

\(^5\) Q 164

\(^6\) PH 111, PH 122

\(^7\) PH 70; cf. PH 103, PH 120, PH 122, PH 182

\(^8\) Ev 129
either duplication or gaps in service for vulnerable people. These are highly specialised clinical services which local authorities do not have experience of commissioning.” It was suggested that: “If Public Health England were given responsibility for sexual health and delegated this locally to an appropriate commissioner, meeting specified quality standards, then this could get around concerns that some local authorities may not do the job well.” It has also been argued that Sexual Assault Referral Centres should be commissioned nationally, as specialist services.

231. the DH has defended the proposed split in the commissioning of sexual health services, whilst saying that it will “examine ways to ensure that prevention work does not become isolated from treatment services.” It also states that it will “consider further” arrangements for commissioning Sexual Assault Referral Centres.

232. The Minister, in defending the proposed commissioning arrangement for HIV services told us that it was “not exclusively a sexually-transmitted disease”, although she admitted it was overwhelmingly sexually transmitted in this country. Professor Harper then told us that the epidemiology of HIV was not the basis on which the commissioning route for HIV services had been chosen. Rather, it was “the type of treatment [and] the duration of treatment”, which clearly differed from those of other STIs, that had determined how the service was to be commissioned.

Children’s public health services

233. The Government plans that public health services for children under the age of five (including health visiting and the Family Nurse Partnership) will initially be commissioned by the NHS Commissioning Board. This is in order to facilitate its plans to increase the health visiting workforce by 4,200 over a period of four years from 2011. The intention is that eventually (from 2015) this responsibility will pass to local authorities – which will from the outset commission services for children aged between five and 19 (including Healthy Child Programme for school-age children). Maternity care, meanwhile, will now be undertaken by CCGs, although it was originally intended that this would be undertaken by the NHS Commissioning Board; the Board will, though, still be responsible for specialist neonatal services.

234. Councillor Rogers of the LGG told us that the initial split in commissioning children’s public health services:

409 PH 120 [Dr Andrew Clark and Dr Cathy Read]
410 PH 92
412 Ibid., Annex A, para A.7 (p 27)
413 Q 511
414 Q 512
415 Q 513
416 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.43; Department of Health, Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health, December 2010, paras 3.27–8, p 18 (Table A); Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, Annex A, para A.6 (pp 26–7)
417 Department of Health, Liberating the NHS: Legislative framework and next steps, December 2010, paras 4.97–9
doesn’t make sense. There is obviously a serious risk of a gap developing around the age of five, and it doesn’t make sense for school nursing to be in one place and health visiting to be in another. We would argue [...] that much of this can be done at local level. There might be need for some coordination arrangements at something above that, but sub-national, and we certainly wouldn’t want to see the artificial creation of any gaps.418

We also heard from DsPH in the South West region that the plans risked “incoherent services” and left it unclear how safeguarding would be commissioned.419

235. In the consultation response, the Government says it will “reflect specifically on the detail of how our proposals should be implemented”, but made clear they would not be changed as such, since:

we believe that the commitment to raise numbers of health visitors by 2015 is best achieved through NHS commissioning and thus will retain our existing proposal that the NHS Commissioning Board should lead commissioning in this area in the short-term.420

Conclusions and recommendations

236. There is a danger that the involvement of local authorities, Public Health England and the NHS Commissioning Board in various facets of public health commissioning will produce a lack of coordination and cohesion in public health services. This danger is compounded by the definition of the mandated services which will be the responsibility of local government which, for example in sexual health services and child health services, creates a dysfunctional division between services which need to be coordinated. The Committee recommends that these distinctions be reviewed.

Emergency preparedness, response and resilience

237. The Government’s plans will make significant changes to arrangements for dealing with public health emergencies, such as major disease outbreaks, at local, regional and national levels.

The current system

238. Currently, at the national level, the HPA, which combines public health and scientific knowledge and research with emergency planning in a single organisation, has a lead role in preparing for new and emerging health threats. The Centre for Emergency Preparedness and Response, one of its four specialist centres, operates on a national basis.

239. The Secretary of State currently has the power to give directions to any body or person exercising functions under, or by virtue of, the existing core NHS legislation (excluding...

418 Q 165
419 PH 158
NHS Foundation Trusts), where he considers it “necessary” to do so by reason of an emergency in order to ensure that a service is provided.\textsuperscript{421}

240. The HPA also runs a Laboratory Network, incorporating laboratories around England which provide a wide range of clinical and public health microbiology tests for clients including the NHS and local authorities. Each English region has a designated lead clinical and public health laboratory, which acts as a regional hub.

241. At the local level, the HPA’s 26 HPUs (each of which covers several PCT and local authority areas) provide health protection expertise and advice to the NHS and others, including in emergency situations. Within the NHS, PCTs have a significant health protection role. The HPA and all NHS bodies are designated as Category 1 Responders under the Civil Contingencies Act 2004. This places a statutory duty on all such organisations to assess risks, plan, inform each other and the public, and cooperate with each other.\textsuperscript{422} The HPA, NHS bodies and other Category 1 Responders, such as blue-light emergency services, local authorities and the Environment Agency, are brought together in multi-agency partnerships called Local Resilience Fora.\textsuperscript{423}

\textbf{The case for change}

242. The creation of PHE is partly seen by the Government as a means of addressing problems which Healthy Lives, Healthy People described as follows:

> The current system for health protection is fragmented. The UK has responded excellently to public health incidents and emergencies in recent years, but the system lacks integration and is over-reliant on goodwill to make it work. A stronger, more integrated system is needed, which is equipped to meet future threats and has a clear line of sight from the top of government to the frontline.\textsuperscript{424}

The Impact Assessments for Healthy Lives, Healthy People, while also noting HPA successes, elaborated as follows:

> HPA staff are not directly accountable to DH: they have their own management chain, and business priorities do not necessarily match the Department’s – for example as to the relative importance of surveillance as compared to other tasks. Potentially, this risks delay in identifying public health problems […]\textsuperscript{425}

243. Professor Harper similarly told us:

> The system has been tried and tested and has been shown to work extremely effectively in an emergency […] What has happened to date has been effective. What will happen in the future, I think, will be even more effective and the risk will be reduced. This is about having the right powers and links between the different

\textsuperscript{421} NHS Act 2006, section 253
\textsuperscript{422} Q 80; Ev 134
\textsuperscript{423} Ev 107
\textsuperscript{424} Department of Health, Healthy Lives, Healthy People, November 2010, para 2.17
\textsuperscript{425} Department of Health, Healthy Lives, Healthy People: Impact Assessments, November 2010, p 17 (para 28)
organisations and very clear concepts of operations—very clearly knowing what the relationships are at all levels between the different parts of the system—right through to that critical front-line piece, which is [...] the alignment not just at the sub-national level but at the very local level for emergency preparedness.  

**The new system**

244. In the consultation on *Healthy Lives, Healthy People*, and in evidence to us, concern was expressed about lack of clarity regarding lines of responsibility and accountability. There was also concern at the risks associated with transition to the new system. the HPA warned that the combination of the NHS and public health reforms “could create considerable risks to the national capability to launch multi-agency responses to incidents and emergencies”. These risks would need to be managed “up to and beyond the Olympic Games in 2012”.  

In the consultation response, and in evidence to us, the Government has sought to assuage such concerns and lay out more details of its plans. The particular issue regarding the potential impact on preparations for the Olympics of PHE taking over from the HPA in April 2012 has now been addressed by the decision to move the transition date back by a year to April 2013.  

As well as giving more time for the transition, this also aligns the assumption by PHE of its full responsibilities with the date when local authorities will take on their new public health role, removing a potentially complicating factor.

245. Concerns were also expressed about how the different elements of the new system would fit together. We heard from a number of quarters that the Government needs to make clear which organisations will be designated as Category 1 Responders under the Civil Contingencies Act 2004. The HPA, which is currently so designated, told us that this must also apply to PHE and we heard the same from several other sources. The ADPH argued that GP commissioning consortia (now Clinical Commissioning Groups) must also be Category 1 responders, just as PCTs currently are. (Given that CCGs will be NHS bodies, it does appear to follow automatically that they will also be Category 1 responders.) Professor Harper explained to us that:

The bodies that are currently designated as Category 1 responders, such as the Health Protection Agency, would suggest very strongly, and we work on that basis, therefore, that Public Health England will be a Category 1 responder. The blue-light services, local authorities in their own right, are Category 1 responders in some instances [...] The constituent parts will not change. Ambulance services will be Category 1 responders in the new system in just the way that they are currently.

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426  Q 354  
428  Department of Health, *Healthy Lives, Healthy People*, November 2010, para 3.8  
429  Q 80  
430  Ev 115  
431  Q 355
The DH states that functions of the NHS Commissioning Board will include “oversee[ing] planning for emergency resilience and lead[ing] the NHS operational response to significant emergencies.”

246. The LGG found Healthy Lives, Healthy People contradictory in saying it was intended to “devolve public health leadership” (which the LGG assumed included preparing for emergencies) yet also referring to emergency preparedness as “a core role that national government should perform”.

247. There was concern as to whether the primary leadership role would sit as unequivocally with the DsPH as it does under present arrangements, along with the related question of the future relationship between the DsPH and HPUs.

248. The BMA pointed out to us that it is the staff within the local authorities under the DsPH who will actually carry out the frontline health protection role (inherited from PCTs), not the PHE staff in the HPUs. The BMA pointed out that, in the current system, “The HPA has principally an advisory and surveillance role, whilst front-line health protection is delivered primarily by PCT and local authority staff.” The BMA further pointed out to us that, consequently, there will not be a “clear line of sight” from the Secretary of State to the front line in health protection.

Conclusions and recommendations

249. We welcome the updated and enhanced powers that the Bill gives to the Secretary of State in the event of an emergency. We also welcome the Government’s decision to delay the implementation of its new arrangements for health protection until April 2013, lessening the potentially disruptive impact on preparations surrounding the 2012 Olympics and allowing further transition time.

250. We further welcome the clarification given in Healthy Lives, Healthy People: Update and way forward about the role that Directors of Public Health will play in emergency preparedness, response and resilience. The Government must specify which bodies will be designated as Category 1 responders under the Civil Contingencies Act 2004.

251. Public Health England will need a clear leadership and coordination role when public health emergencies cross local boundaries – which they will often do.

252. There is an important need for “surge capacity” at the supra-local level in the event of an emergency; the Committee recommends that PHE take responsibility for ensuring that this capacity exists through coordination of local authority structures.

432 Department of Health, Developing the NHS Commissioning Board, July 2011, p 11; cf. ibid., pp 7, 12, 22
433 Ev 139; Department of Health, Healthy Lives, Healthy People, November 2010, para 4.68; cf. Ev 168
434 Ev 160–1; cf. PH 44
3 The public health workforce

Regulation of public health professionals

253. Both the General Medical Council and the General Dental Council record public health as a specialism on their respective registers, meaning that consultants in public health with medical or dental qualifications are effectively subject to statutory regulation. This applies to “about 75% or 80% of current senior public health professionals”.\(^{435}\) However, public health specialists without such qualifications, who hold posts including those of consultant and DPH, are not subject to statutory regulation. In order to allow non-medically / non-dentally qualified public health specialists to demonstrate appropriately high standards of practice, a voluntary UK Public Health Register (UKPHR) was established in 2003. The voluntary register is recognised under the current NHS rule requiring DsPH and public health consultants to be appropriately registered.\(^{436}\)

254. In the light of concerns about the effectiveness of the current arrangements for professional regulation, a review of those arrangements by Dr Gabriel Scally was commissioned in early 2010 by the then CMO. In his report, published in November 2010, Dr Scally stressed that the purpose of professional regulation is the avoidance of “morbidity or mortality resulting from poor professional practice”.\(^{437}\) His overall conclusion was that:

> The current pattern of regulation, a mixture of statutory and voluntary, and the growing number of routes to specialty registration are unsatisfactory. The time is right to bring quality and clarity to the approach to specialist regulation.

Having considered the options for change, he found that:

> There was strong support for a system of statutory regulation and a desire to avoid the requirement for multiple registration with different regulators. Contributors stated a strong desire for a system that was both equitable and as simple as possible.\(^{438}\)

Accordingly, Dr Scally recommended:

> that the Health Professions Council [HPC] should regulate public health specialists as an additional profession, and that there is no substantial change in the roles of the General Medical Council [GMC], the General Dental Council and the Nursing and Midwifery Council in respect of public health.\(^{439}\)

Dr Scally told us that his preferred solution had been for the GMC to take on the registration of all public health specialists. However, this was not feasible, given the major issues with which the GMC was currently grappling.\(^{440}\) The arrangement he had

\(^{435}\) Q 378 [Dr Scally]
\(^{436}\) Q 69 [Dr Fiona Sim]
\(^{437}\) Department of Health, *Review of the Regulation of Public Health Professionals*, November 2010, p 4
\(^{438}\) Ibid., p 1
\(^{439}\) Ibid., pp 40–1
\(^{440}\) Q 381; cf. Department of Health, *Review of the Regulation of Public Health Professionals*, November 2010, p 33
recommended was analogous to that adopted in respect of the pathology profession, whose medical members registered with the GMC and non-medical members with the HPC.441

255. While the conclusions of the Scally Review were widely welcomed, the Government was sceptical. In Healthy Lives, Healthy People it called for views on the report, but made clear that: “As the Government believes that statutory regulation should be a last resort, its preferred approach is to ensure effective and independently-assured voluntary regulation for any unregulated public health specialists.”442

256. Professor Alan Maryon-Davis referred in evidence to the role of public health specialists in dealing with outbreaks of deadly diseases, such as E. coli or pandemic flu as well as other emergency responses. In such cases, poor practice could “have a direct effect on the health, life and limb of the general public”.443 He argued that the changing balance of the profession (with a preponderance of non-medics coming into the specialty) reinforced the case for compulsory registration. The NHS Future Forum also recommended “that registration by an appropriate national body should be compulsory for non-medically qualified public health staff.”444

257. In Healthy Lives, Healthy People: Update and way forward, the Government recognises “the strong support in the public health profession for a compulsory statutory regulation system for all public health consultants.” It does not, though, concede the case for such regulation, but rather says it:

 would welcome further evidence from the profession on significant risks to the public which would necessitate a statutory regime and which cannot be addressed through other means. This evidence will be considered carefully over the summer with the profession, employers and other interested parties and final proposals will be put forward in the in the autumn.445

In evidence to us, the DH indicated that it might consider the option of “chartered” status for non-medical public health professionals,446 an option which the RSPH has put forward as a “middle way” between statutory and voluntary regulation.447

**Conclusion and recommendation**

258. There is widespread support for the recommendation in Dr Gabriel Scally’s report that non-medically qualified public health specialists should be subject to statutory regulation. In view of the rising proportion of public health specialists that do not have a medical or dental background, the Committee recommends that the Government review its opposition to this proposal.

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441 Qq 362, 381  
442 Department of Health, Healthy Lives, Healthy People, November 2010, para 4.96  
443 Qq 367–8  
444 NHS Future Forum, Clinical advice and leadership, June 2011, para 3.20  
445 Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, para 2.59  
446 Q 515  
447 Q 69 [Dr Sim]; cf. Ev 146
The future of the public health workforce

259. In *Healthy Lives, Healthy People* the Government set out its “vision for the public health workforce”:

We envisage that the public health workforce will be known for its:

- **expertise** – public health staff, whatever their discipline and wherever they work, will be well-trained and expert in their field, committed to developing and maintaining that expertise and using an evidence-based approach to practice;

- **professionalism** – they will demonstrate the highest standards of professional conduct in their work;

- **commitment to the population’s health and wellbeing** – in everything they do, they will focus on improving and protecting the health and wellbeing of their populations, taking account of equality and rights, whether it be a DPH in a local authority, an infection control nurse in an acute trust or a microbiologist within Public Health England; and

- **flexibility** – they will work effectively and in partnership across organisational boundaries.\(^448\)

It was also promised that a detailed Public Health Workforce Strategy would be developed “by autumn 2011, working with representative organisations.” This would “support a smooth and effective transition, informed by the views of people on the frontline of public health delivery.”\(^449\)

260. Uncertainty has however inevitably been created by the transition to new structures. Professor Lindsey Davies, President of the FPH, told us that “In terms of morale at the moment, it is very low indeed. People are exhausted […] Morale […] is not great.”\(^450\) We heard from one DPH of “an uncertain and demoralised workforce” that was “being asked to take on an ever more complex and demanding task of change management that could be a major distraction” from its actual job.\(^451\) Professor Newton was somewhat less gloomy, telling us that “We are seeing a mixed picture in terms of morale.”\(^452\) Ms Marsland, of the DH, admitted that “It has been a difficult period for colleagues”, but also told us “I think morale is improving.”\(^453\) The CMO was more upbeat, telling us that, when she attended the recent FPH conference: “I expected low morale. Actually, people were really up for it”,\(^454\) a view that somewhat contradicts that of the Faculty’s President.

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\(^{448}\) Department of Health, *Healthy Lives, Healthy People*, November 2010, para 4.89
\(^{449}\) *Ibid.*, para 4.90
\(^{450}\) Q 68
\(^{451}\) PH 12 [Dr Bruce Laurence]
\(^{452}\) Q 308
\(^{453}\) Loc. cit.
\(^{454}\) Q 318
261. The process of transfer of functions to new bodies inevitably creates uncertainty. The Department says in *Healthy Lives, Healthy People: Update and way forward* that:

Work will continue over the summer 2011 on the development of the Public Health England “People Transition Policy” that will set out the principles applying to the HR and employment processes supporting the transfer of staff into Public Health England.455

In addition, the DH is:

responding to the concerns raised by developing a high level HR “concordat” in partnership with the NHS and Local Government Employers on the effective transition of public health staff between the NHS and local authorities.456

The DH has stated that these will be covered in the System Reform Update on workforce issues, which will “address concerns relating to terms and conditions”.457 Where current postholders are transferred to a new employer TUPE rules will apply.458 There are, though, no such obligations where roles or posts are transferred but actual postholders are not. *Healthy Lives, Healthy People: Update and way forward* makes clear that the forthcoming Workforce Strategy “will not make specific proposals for the terms and conditions of service of constituent workforces, which are matters for individual employers and employer groups”.459

The DH told us its approach to developing the Workforce Strategy was:

consultative, through a workforce strategy group chaired by a Regional Director of Public Health [Yvonne Doyle, the DPH in the DH South East Region]. The group, whose membership is flexible, will engage more widely with others as its work proceeds. The strategy will be published for wider formal consultation later in [2011] […]460

According to *Healthy Lives, Healthy People: Update and way forward*, the Strategy (focused on the specialist workforce, but also “inclusive”) will:

- scope the current situation of public health workforces;
- consider the role and purpose of the public health workforce in the context of the White Paper […]

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455 Department of Health, *Healthy Lives, Healthy People: Update and way forward*, July 2011, para 2.58
456 Ibid., para 2.57
457 Department of Health, *Healthy Lives, Healthy People: Update and way forward*, July 2011, p 6 (para 7)
458 For transfers of employment outside the public sector, the relevant provisions are under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006 / 246); for transfers within the public sector, the Cabinet Office Statement of Practice on “Staff Transfers in the Public Sector” (2000) applies.
459 Department of Health, *Healthy Lives, Healthy People: Update and way forward*, July 2011, para 2.57
• examine how best to transform the workforce to meet the challenges and opportunities of the future, but also offer career pathways to those with different entry points;

• set out how to deliver a high quality, sustainable, specialist workforce with the flexibility to move across employment sectors;

• look at the training and education opportunities to support wider public health workforces (such as health visitors, school nurses, many allied health professionals and others) and the relationship between Public Health England and Health Education England;

• consider how best to build on and use workforce data effectively, not least for planning the future.461

262. Some witnesses expressed the fear that the public health workforce could become fragmented in the new system, and that this may undermine the cohesion of the profession and disrupt established pathways for education and training.

263. We heard that the move of public health away from the NHS could make it a less attractive career choice for clinicians.462 We heard this “may well be an important factor that particularly influences career choices among recently qualified doctors, the vast majority of whom are employed in the NHS”.463 Some see a risk that Specialty Registrars in public health might no longer have adequate access to the full breadth of experience and settings needed to fully develop their specialist public health competencies.464

264. There are particular concerns that local authorities will not have sufficient appreciation of the qualifications and experience required by the public health workforce. It is feared that councils have too little understanding of how medical and public health training works (particularly the role of the postgraduate deaneries).

265. Unite the Union told us of concerns that local authorities could disperse public health staff across their organisation, potentially leaving those staff without sufficient professional support, coaching, management and mentoring. It has also been argued that local authorities will be unable properly to support staff in achieving revalidation and undertaking Continuing Professional Development.465 Councillor Rogers of the LGG, though, rejected this:

There are something like 480 [types of] professionals that currently work in local government. They are all valued and they are all subject to professional competencies, training, ongoing professional development and all that sort of thing. I don’t see it as any different in the longer term […] to those.466

461 Ibid., para 2.56
462 PH 27, PH 58, PH 131, PH 180, PH 190, PH 191
463 PH 87A [UK Public Health Register]
464 PH 129, PH 180
465 PH 100
466 Q 139
266. Little thought appears to have been given to the future of the academic public health workforce, which plays an important role, particularly in the PHOs, where public health research and practice come together. The BMA told us: “We are particularly concerned about the place of academics in public health under the new arrangements.” The latest report by the Medical Schools Council on Medical Clinical Academic Staffing Levels in Medical Schools had reported a steady decline in staffing levels in public health, amounting to a 21.7% drop since 2000, including “a massive 76.9% drop in lecturers since 2000 from 57 to just 13 in 2010”.

Conclusions and recommendations

267. The uncertainty caused by the transition to the new public health system is inevitably having an unsettling effect on the workforce, which is undermining morale and causing people with valuable skills to leave the profession. The structures will rely for their effectiveness on the availability of motivated and committed professional staff; it is therefore important that uncertainties around staffing issues are resolved as quickly as possible.

268. It is also important that the public health specialty is fully integrated into its forthcoming proposals for healthcare workforce planning, education and training.

269. Finally, we attach importance to the future role in the workforce of public health academics, particularly in their role in the Public Health Observatories. The importance of academia as a career option within public health should not be ignored.
4 The national policy dimension

270. The Government sees local initiatives and devolved budgets as the key to improving the health of the population, rather than “Whitehall diktat”, and its “broad intention” is “for health improvement to be devolved to a local level”. However, it does acknowledge that there is an important national policy dimension to health improvement. This, however, will not focus on “nannying about the way people should live”. Rather, it will be based on:

- strengthening self-esteem, confidence and personal responsibility;
- positively promoting ‘healthier’ behaviours and lifestyles; and
- adapting the environment to make healthy choices easier.

271. A crucial objective of health improvement policy is to reduce the longstanding and stark health inequalities in England. A major review of the most effective evidence-based strategies for doing so was conducted by a team under the leadership of Professor Sir Michael Marmot. In its report, published in February 2010, the Marmot Review Team confirmed the extent of health inequalities and found a “social gradient” in health (meaning that “the lower a person’s social position, the worse his or her health”). It recommended action to reduce the gradient by seeking to improve health throughout society “but with a scale and intensity that is proportionate to the level of disadvantage” (an approach it called “proportionate universalism”). Since health inequalities resulted from social inequalities, action was needed “across all the social determinants of health”. The review also recommended the adoption of the “life course approach” to improving public health.

272. Six specific policy objectives were recommended:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities

469 Department of Health, Healthy Lives, Healthy People, November 2010, p 2
470 Ev 168
471 Department of Health, Healthy Lives, Healthy People, November 2010, p 2
472 Ibid., para 2.31
• Strengthen the role and impact of ill health prevention

273. The Government stated that *Healthy Lives, Healthy People* was its response to the Marmot Review. It pledged in that White Paper to apply proportionate universalism, by improving the health of all whilst “improving the health of the poorest, fastest”; and to take the life course approach, addressing “the wider factors that affect people at different stages and key transition points in their lives”.

274. While these commitments have been strongly welcomed, there is still some scepticism as to whether *Healthy Lives, Healthy People* constitutes an adequate response to the Marmot Review. Members of the Review Team told us they were particularly concerned that *Healthy Lives, Healthy People* only picked up five of the six domains of recommendations from the Marmot Review – being silent on the need to “Ensure a healthy standard of living for all”, which:

- involves establishing a Minimum Income for Healthy Living, and proposes an overhaul of the tax and benefit system, to ensure that the system as a whole is progressive and avoids financial “cliff-edges” between employment and unemployment wherever possible.

Professor Hunter told us that he found *Healthy Lives, Healthy People* “Underwhelming” as a response to Marmot, since the Government’s policy was essentially focused on:

- individual lifestyle behaviour change and that is not really what Marmot was saying in his six areas of policy priorities, all of which seem to be about tackling the upstream social determinants of health. There is a role for lifestyle and behaviour change in the mix, but to see that as a centrepiece of changing people’s lifestyles flies in the face of the evidence. The evidence doesn’t exist to back that up.

275. In its approach to health improvement, the Government makes much of the idea (developed by the Nuffield Council on Bioethics) of a “ladder of intervention”. This is based on the recognition that, in dealing with particular lifestyle-related public health issues, a range of policy options, on an escalating scale of intrusiveness, is available. *Healthy Lives, Healthy People* states that:

- Where the case for central action is justified, the Government will aim to use the least intrusive approach necessary to achieve the desired effect. We will in particular seek to use approaches that focus on enabling and guiding people’s choices wherever possible.

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474 *Loc. cit.*
475 Department of Health, *Healthy Lives, Healthy People*, November 2010, para 3.1
476 *Ibid.*, para 4.1
477 *Ibid.*, para 3.1
478 Ev 154
479 Q 36
480 [www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_122249](http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_122249)
481 Department of Health, *Healthy Lives, Healthy People*, November 2010, para 2.33
This favoured approach it refers to as “nudging people in the right direction rather than banning or significantly restricting their choices”, using “the latest techniques of behavioural science”.482

276. The Government is pursuing this approach in tackling a range of social issues (including ones relating to public health). A Behavioural Insights Team has been set up in the Cabinet Office to develop policy in this regard, using the “MINDSPACE” framework developed by the Institute for Government.483 Dr David Halpern, Head of the Team, indicated that there was an evidence base for nudging, but it was generic, with little relating specifically to health:

There are two kinds of evidence […] There is a very wide evidence base from many areas […] partly, our role is to look at what works in another area and say, “Would it work in health?” If you move to health, more specifically, then you get to a smaller field of evidence […] [T]here is a fair amount of evidence. It is particularly strong when you look in other areas. When you apply it specifically to health, or any given issue, of course the field becomes smaller.

Consequently, work in this field was “very empirical”, involving “trials” to “find out whether or not it works in the field”.484

277. From other sources, we heard forthright scepticism about nudging as a public health intervention. Professor Hunter was “disturbed at the shift [by the Government] from being a nanny to being a nudge”. While interventions that involved the Government “shoving people” (such as the ban on smoking in enclosed public places) were demonstrably effective, nudging, which was ill-defined (“a very flaky, slippery term”), was little supported by evidence. He referred to us the conclusions along these lines drawn by the Behaviour and Health Research Unit at Cambridge University, as recently reported in the British Medical Journal.485 The recent report from the House of Lords Science and Technology Committee has since confirmed how thin the evidence base for nudging is, as well as the unevenness of evidence between different fields of behaviour change.486

278. We also heard that “the evidence base supports measures which stop or re-engineer potentially harmful modern marketing nudges”, rather than trying to nudge in the opposite direction.487 We were further told that “Upstream whole system measures”, such as the smoking ban, could address factors that made “positive health behaviours and healthy choices more difficult” for many people, as well as protecting vulnerable groups whose choices are limited, such as children. Such measures had proven both effective and cost effective; and they had been shown to address health inequalities.488 A drawback of

482 Ibid., para 2.34
483 “MINDSPACE” is a mnemonic which summarises nine behaviour change techniques: Messenger, Incentives, Norms, Defaults, Salience, Priming, Affect, Commitment and Ego.
484 Q 232
487 PH 84 [National Heart Forum]
488 PH 78 [British Heart Foundation]; cf. Q 191
nudging as an approach, on the other hand, was that it actually risked widening health inequalities, being most likely to influence those who already had the best health and least likely to influence those with the poorest health.489

279. Complementing the Government’s adoption of the ladder of intervention and its preference for nudging is its intention that it “will aim to make voluntary approaches work before resorting to regulation”.490 Thus the intention is to ascend the rungs of the ladder step by step, advancing towards a more interventionist approach to each public health issue only when a less interventionist approach has been tried and has not succeeded. This is, of course, not simply an issue of public health policy. In a free society the burden of proof should always remain firmly on any advocate of regulation to show that restraint of freedom is necessary to secure a desirable social gain and that the restraint is in proportion to the gain.

280. A key vehicle for the Government’s escalator approach is the Public Health Responsibility Deal, whereby:

the Government will aim to base these approaches on voluntary agreements with business and other partners, rather than resorting to regulation or top-down lectures […] if these partnership approaches fail to work, the Government will consider the case for ‘moving up’ the intervention ladder where necessary.591

The Deal, which was launched in March 2011, has core commitments and specific pledges (which include deadlines for implementation) covering: Alcohol; Food; Health at work; and Physical activity. (The tobacco industry was specifically excluded from the Deal, on the grounds that there is no safe level of consumption of tobacco – in contrast to the products of the food and alcohol industries.) All the pledges are underpinned by the threat of mandatory regulation by the Government if they are not abided by. They have been developed by five networks (made up of partners from industry, the voluntary sector and the public health field), with one each corresponding to the four commitments and groups of pledges, and a fifth relating specifically to Behaviour Change.

281. We heard that, just prior to the launch of the Deal, six leading health organisations (including the Royal College of Physicians) had refused to sign up to it. They had done so because of serious reservations about the proposed alcohol commitment (“We will foster a culture of responsible drinking, which will help people to drink within guidelines”) and associated pledges. They were specifically concerned that:

- there was inadequate recognition of the need to reduce alcohol-related harm;
- the pledges were “not specific or measurable and do not state what would be evidence of success”;
- the pledges were those favoured by the alcohol industry, rather than health bodies;

489 Q 39; PH 151 [Allied Health Professions Federation]
490 Department of Health, Healthy Lives, Healthy People, November 2010, para 2.19
491 Ibid., para 2.35
• the focus was on unevidenced interventions, while ignoring issues such as “availability or promotion of alcohol”;
• there was a lack of an evidence based “cross-departmental strategy” on alcohol; and
• there was no indication of alternative actions if the pledges did not reduce alcohol-related harm.492

282. Professor Sir Ian Gilmore, Chair of the Alcohol Health Alliance (one of the bodies that refused to sign up to the Deal), explained that the alcohol industry’s “paradigm” was that “alcohol is a normal product, but a few people misuse it. Therefore, we should target that small number of people and let everyone else get on with life and take personal responsibility”. By contrast, the public health “paradigm” was that alcohol was no “ordinary commodity” but “a drug of dependence” that, while it should remain legal, needed to be controlled. Professor Gilmore argued that measures were needed to counter “the 24 hour, 7–7 exposure to alcohol marketing, alcohol sales and the cheap prices” which constituted an “alcogenic” environment, leading to widespread misuse of alcohol which caused significant harm to health within the population. The necessary measures included both a nudging approach and, at the same time, “firmer measures”.493 A key such measure was a statutory minimum price per unit for alcohol, which was supported by a sound evidence base.494 Professor Gilmore stressed that he did not reject the idea of the Deal, nor was he suggesting that the specific issue of pricing could have been addressed through the Public Health Responsibility Deal.495 The problem with the Deal was that it reflected the industry’s approach and did not take account of that advocated by the public health representatives.

283. Mark Baird, for the alcohol company Diageo, replied that the Deal was about more than just nudging, citing as an example his company’s pledge to fund the training of 10,000 midwives to enable them to pass on information about the dangers of drinking in pregnancy. He stressed that the Government had done something to tackle the issue of pricing, without going as far as introducing a minimum price per unit (the evidence base for the effectiveness of which he disputed); and that a cross-Government alcohol strategy was due later in the year.496

284. An important issue regarding the Deal is that of the actual mechanisms for determining that an approach has failed and it is time to move up a rung to a more interventionist one. The Minister told us:

If you look at what is going on in the Responsibility Deal, we are looking at how we monitor and evaluate and the timescale on that. I think we have to have yearly ones, although we would be looking at possibly interim ones as well in some areas. We have to see an impact quite soon, and I think all those involved—and it goes much

492 www.rcplondon.ac.uk/press-releases/key-health-organisations-do-not-sign-responsibility-deal
493 Q 243
494 Q 273
495 Q 276
496 Q 282; cf. Department of Health, Healthy Lives, Healthy People: Update and way forward, July 2011, p 28 n 9
wider than industry—are very aware of that. In a way, the regulatory route is a sword of Damocles.497

Conclusions and recommendations

285. We welcome the Government’s acceptance of the Marmot Review principles of “proportionate universalism” and the “life course approach”. However, we are unclear why the Government only endorsed five of the six policy objectives outlined by Marmot. Ministers have recognized the importance of the social determinants of health, and committed themselves to address health inequalities, so it is not obvious why Healthy Lives, Healthy People did not explicitly endorse the importance to public health of securing a healthy standard of living for all.

286. We regard the idea of the “ladder of intervention” as no more than a restatement of a principle that is fundamental to a free society.

287. Against this background we do not oppose the exploration of innovative techniques such as “nudging”, where it can be shown, following proper evaluation, to be an effective way of delivering policy objectives. The Committee were, however, unconvinced that the new Responsibility Deal will be effective in resolving issues such as obesity and alcohol abuse and expect the Department of Health to set out clearly how progress will be monitored and tougher regulation applied if necessary. Partnership with commercial organisations has a place in health improvement. However, those with a financial interest must not be allowed to set the agenda for health improvement. The Government cannot avoid its responsibility for constantly reassessing the effectiveness of its policy in delivering its public health objectives.
Conclusions and recommendations

The Secretary of State for Health

1. We welcome the Government’s intention to give greater prominence and priority to public health policy, whilst also emphasizing that “public health is everybody’s business”. We also welcome the new emphasis on the public health role of the Secretary of State for Health and the embodiment of this in new statutory duties in relation to health protection and statutory powers in relation to health improvement. (Paragraph 28)

2. We do not understand why the Secretary of State’s new statutory duty to reduce health inequalities under the Bill appears to apply only to the exercise of his functions in relation to the health service. We recommend that the Bill be amended to make it clear that the Secretary of State’s duty to reduce health inequalities applies in the exercise of all his functions, including those applying to public health. (Paragraph 29)

3. The creation of the Cabinet Sub-Committee on Public Health, chaired by the Secretary of State for Health, is a significant step forward in developing a much-needed cross-departmental approach to public health. We recommend that its remit should be defined to include consideration and publication of evidence-based health impact assessments prepared by each department of state on policies within its sphere of responsibility. (Paragraph 30)

The Chief Medical Officer

4. We welcome the continuing role of the Chief Medical Officer (as the Government’s principal medical advisor) in respect of public health, particularly the production of an independent annual report on the nation’s health. However, we have concerns about the devolution of the Chief Medical Officer’s broader duties relating to healthcare to the NHS Medical Director. The NHS Medical Director is a management role within the NHS; the role of the Chief Medical Officer has traditionally been to provide a professional voice on healthcare issues which is independent of NHS management; the Committee regards this as important function which is not recognized in the new arrangements. (Paragraph 34)

Public Health England

5. The Government’s case for combining within Public Health England a range of public health functions currently carried out by several organisations appears to rest on the perceived need to streamline a system that is currently fragmented. While acknowledging “considerable strengths” in the current system, the Government argues that it can still be made to work better. The Committee does not disagree with this view but sees the main case for change in the need for an independent voice for public health at the heart of government. (Paragraph 60)
6. Public Health England must be – and, just as importantly, must be perceived as being – independent of the Government. Only in this way will it maintain the reputation for independence and evidence-based expertise, as well as the important trading activities, of the Health Protection Agency and some of the other bodies which Public Health England will succeed. We, therefore, welcome the Government’s decision that Public Health England will not, as originally planned, be constituted as an integral part of the Department of Health. (Paragraph 61)

7. It is important that the Government ensures that the arrangements for the new body provide it with sufficient guarantee of its independence. The Committee believes that the principle that Public Health England must be visibly and operationally independent of Ministers is more important than the precise bureaucratic formulation. (Paragraph 62)

8. We are concerned at the lack of clear plans for Public Health England to be established at the regional level. The idea of “sub-national hubs”, in some – as yet undefined – alignment with the sub-national structures of the NHS Commissioning Board and the Department for Communities and Local Government does not seem to us adequate. The Committee believes, in particular in view of the sensitivity of its health protection responsibilities, Public Health England needs a clear structure of regional accountability, along the lines currently provided by the regional structure of the Health Protection Agency. (Paragraph 63)

Local government and Directors of Public Health

9. We welcome the new public health role planned for local authorities, leading in health improvement, and the emphasis that this places on tackling the wider determinants of health. We also welcome the new role envisaged for Directors of Public Health, as public health leaders in local communities, located within local authorities. However, several concerns have been raised with us about the details of implementation. (Paragraph 92)

10. The lack of a statutory duty on local authorities to address health inequalities in discharging their public health functions is a serious omission in the Government’s plans. We recommend that the Health and Social Care Bill be amended to rectify this. (Paragraph 93)

11. Some witnesses have argued that local authorities need additional regulatory powers to allow them to achieve public health improvements in their area, including, for example the ability to extend the scope of the ban on smoking in enclosed public places or set a minimum price per unit for alcohol. The Committee recommends that these proposals be the subject of further public consultation. (Paragraph 94)

12. We endorse the joint appointment of Directors of Public Health by local authorities and the Secretary of State (through Public Health England). We recommend that, in addition, these appointments should be subject to a statutory appointments process, involving an Advisory Appointments Committee, and accredited by the Faculty of Public Health, as is currently the case in respect of Directors of Public Health within the NHS. (Paragraph 95)
13. The Government argues that the involvement of Public Health England in the appointment of Directors of Public Health will be sufficient to ensure that those appointed are appropriately qualified and trained. The Committee does not agree; it believes that there should be a statutory requirement for Directors of Public Health to be a member of an appropriate professional register. (Paragraph 96)

14. The Committee believes that Directors of Public Health should be appointed at chief officer level, reporting directly to the council Chief Executive. The Government says that it “expects” Directors of Public Health will be appointed at this level, but there will be no sanctions that can be applied if they are not. We recommend that this be laid down as a statutory requirement in the Health and Social Care Bill. (Paragraph 97)

15. We endorse the plan for Directors of Public Health to be, under statute, mandatory members of their local Health and Wellbeing Boards. We also welcome the proposed statutory obligation on Directors of Public Health to prepare an annual report, which the local authority must publish. (Paragraph 98)

16. We are concerned that, in fulfilling their role, Directors of Public Health should be free to speak out, if necessary to criticize their local authority, without inhibition or restriction. We, therefore, recommend that any local authority wishing to terminate the appointment of its Director of Public Health must be required by statute to have the Secretary of State’s approval. (Paragraph 99)

17. We are concerned that too little attention is paid in the Government’s plans to the role of lower-tier authorities. Given their areas of responsibility, in particular in the commissioning and provision of social housing, there should be a statutory requirement for upper-tier authorities to involve them in the work of the Health and Wellbeing Boards. (Paragraph 100)

The Public Health Outcomes Framework

18. We welcome the Government’s intention to measure progress in improving the health of the population by reference to outcomes rather than process targets; and we endorse the overall Outcomes Framework that has been outlined for public health. (Paragraph 123)

19. There is a good case for having a single, integrated Outcomes Framework for public health, the NHS and adult social care. It is disappointing in this regard that the first NHS and Social Care Outcomes Frameworks have been finalised before the Public Health Outcomes Framework. (Paragraph 124)

20. We recognise the need to minimise data collecting burdens. However, outcomes data must be sufficiently localised and detailed to reflect accurately trends and patterns in the health of the public. Datasets must be of an adequate size to be able reliably to detect relevant characteristics of populations at the appropriate level. This must include levels below those of local authorities, so that inequalities within authorities’ areas are detected. Data should also, as far as possible, be capable of disaggregation regarding the full range of protected characteristics under the Equality Act 2010. (Paragraph 125)
The overall public health budget

21. Healthy Lives, Healthy People stated that early estimates suggested that the current spend on services for which Public Health England will be responsible could be over £4 billion. More than 12 months later the Government has been unable to provide any detailed explanation as to how this figure was arrived at, or – more fundamentally – which services will in future be the responsibility of Public Health England. The Committee believes that this policy confusion is undermining confidence in the Government’s public health strategy and making service planning impossible. (Paragraph 138)

22. The Department of Health is currently compiling its definitive baseline public health expenditure, with the intention of publishing it later this year. When it does so, it must show in detail exactly how this figure has been arrived at. The Department must clarify whether it intends to make any adjustments to the baseline, relating to factors such as localised underspending and the impact of the reduction in management and administration costs occurring since the baseline year. (Paragraph 139)

23. The Department of Health must also make clear how the actual level of funding for public health will relate to the historic baseline. We seek reassurance from the Department that, in setting the public health budget, it will take account of objective measures of need. This must apply in respect of both the national budget and allocations to local authorities. (Paragraph 140)

24. Although the Department of Health states that, in the current reduction of NHS management and administration costs, frontline public health services are being protected, we have heard evidence to the contrary. Furthermore, the Department has failed to give a convincing account of its distinction between frontline and non-frontline spending in public health services. Unless it can do so, the suspicion will remain that it is an arbitrary distinction and that public health services are suffering, and will suffer, in consequence of the cuts that are being made. (Paragraph 141)

Local public health budgets

25. We are concerned by the government’s decision to reduce the weighting for health inequalities in Primary Care Trust allocations for 2011–12 from 15% to 10%. (Paragraph 173)

26. We are concerned about the proposed introduction of the Health Premium. We believe there is a significant risk that, by targeting resources away from the areas with the most significant continuing problems, it will undermine their ability to intervene effectively and thereby further widen health inequalities. (Paragraph 174)

27. Although many witnesses welcomed the proposed ring-fencing of public health budgets transferred to local authorities, and the Committee understands the short-term attractions of this approach, it does not believe it represents a desirable long term development. Ring-fencing risks encouraging local authorities to see only spending from the ring-fenced budget as relevant to public health and runs counter to a “place-based” approach, which would allow the wider determinants of health to
be more effectively addressed. Furthermore, even with ring-fencing, there is a risk of local authorities “gaming” the system and effectively raiding their public health allocations by “redesignating” as public health spending services that they are already providing from other budgets. (Paragraph 175)

28. The Committee therefore proposes that the ring-fenced public health budget should operate for no more than three years. During that period it should be a statutory duty of Directors of Public Health to certify that the ring-fenced budget is used appropriately for public health purposes. (Paragraph 176)

Public health evidence and intelligence

29. We welcome the Government’s public commitment to evidence and intelligence as fundamental elements of the public health system. The Government’s plans for Public Health England do have the potential to improve the public health information and intelligence function, by integrating and streamlining the work currently done by several bodies. We look forward to the results of the Department’s Working Group on Information and Intelligence for Public Health in this regard. (Paragraph 203)

30. The work of the Public Health Observatories is an extremely valuable part of the public health system. While the Government has promised to continue the work of Observatories, there is a great deal of uncertainty, especially following the substantial cuts to their funding that have been made in the current financial year. We are concerned to hear that three of the Observatories, in London, the North East and the North West, face “particular risk of closure”. We recommend that Ministers clarify their plans for individual Public Health Observatories as a matter of urgency to ensure that this important resource is not lost before Public Health England is established. (Paragraph 204)

31. We welcome the decision to create a new School for Public Health Research (within the National Institute for Health Research) and a Policy Research Unit on Behaviour and Health. We also welcome the Government’s indication that the National Institute for Health and Clinical Excellence will continue to have a function in respect of evaluating the effectiveness and cost effectiveness of public health interventions. (Paragraph 205)

32. Against that background the Committee was surprised to learn that the Institute’s Public Health Interventions Advisory Committee has yet to meet this year, having previously met on a monthly basis. The Committee believes that Ministers should make clear as soon as possible exactly what role the Institute will play in future in respect of public health and how that role will be fulfilled. (Paragraph 206)

Public health and NHS commissioning

33. Public health expertise is an indispensable part of commissioning NHS services. With the NHS facing major financial challenges, these functions are more important than ever. Yet Healthy Lives, Healthy People was widely seen as downgrading the role of public health in the commissioning of healthcare services. In its response to
the Future Forum and in the consultation response the Government outlines changes to its plans intended to provide reassurance on this count, but we do not believe these are enough. (Paragraph 217)

34. In its earlier report on commissioning the Committee recommended that the local Director of Public Health should be a member of the Board of each local commissioning body (now Clinical Commissioning Group). This remains our view. (Paragraph 218)

35. The Committee also believes there should be a qualified public health professional on the NHS National Commissioning Board, and that the Commissioning Board should routinely take advice from qualified public health professionals when commissioning decisions are being taken. (Paragraph 219)

Commissioning public health services

36. There is a danger that the involvement of local authorities, Public Health England and the NHS Commissioning Board in various facets of public health commissioning will produce a lack of coordination and cohesion in public health services. This danger is compounded by the definition of the mandated services which will be the responsibility of local government which, for example in sexual health services and child health services, creates a dysfunctional division between services which need to be coordinated. The Committee recommends that these distinctions be reviewed. (Paragraph 236)

Emergency preparedness, response and resilience

37. We welcome the updated and enhanced powers that the Bill gives to the Secretary of State in the event of an emergency. We also welcome the Government’s decision to delay the implementation of its new arrangements for health protection until April 2013, lessening the potentially disruptive impact on preparations surrounding the 2012 Olympics and allowing further transition time. (Paragraph 249)

38. We further welcome the clarification given in Healthy Lives, Healthy People: Update and way forward about the role that Directors of Public Health will play in emergency preparedness, response and resilience. The Government must specify which bodies will be designated as Category 1 responders under the Civil Contingencies Act 2004. (Paragraph 250)

39. Public Health England will need a clear leadership and coordination role when public health emergencies cross local boundaries – which they will often do. (Paragraph 251)

40. There is an important need for “surge capacity” at the supra-local level in the event of an emergency; the Committee recommends that PHE take responsibility for ensuring that this capacity exists through coordination of local authority structures. (Paragraph 252)
Regulation of public health professionals

41. There is widespread support for the recommendation in Dr Gabriel Scally’s report that non-medically qualified public health specialists should be subject to statutory regulation. In view of the rising proportion of public health specialists that do not have a medical or dental background, the Committee recommends that the Government review its opposition to this proposal. (Paragraph 258)

The future of the public health workforce

42. The uncertainty caused by the transition to the new public health system is inevitably having an unsettling effect on the workforce, which is undermining morale and causing people with valuable skills to leave the profession. The structures will rely for their effectiveness on the availability of motivated and committed professional staff; it is therefore important that uncertainties around staffing issues are resolved as quickly as possible. (Paragraph 267)

43. It is also important that the public health specialty is fully integrated into its forthcoming proposals for healthcare workforce planning, education and training. (Paragraph 268)

44. Finally, we attach importance to the future role in the workforce of public health academics, particularly in their role in the Public Health Observatories. The importance of academia as a career option within public health should not be ignored. (Paragraph 269)

The national policy dimension

45. We welcome the Government’s acceptance of the Marmot Review principles of “proportionate universalism” and the “life course approach”. However, we are unclear why the Government only endorsed five of the six policy objectives outlined by Marmot. Ministers have recognized the importance of the social determinants of health, and committed themselves to address health inequalities, so it is not obvious why Healthy Lives, Healthy People did not explicitly endorse the importance to public health of securing a healthy standard of living for all. (Paragraph 285)

46. We regard the idea of the “ladder of intervention” as no more than a restatement of a principle that is fundamental to a free society. (Paragraph 286)

47. Against this background we do not oppose the exploration of innovative techniques such as “nudging”, where it can be shown, following proper evaluation, to be an effective way of delivering policy objectives. The Committee were, however, unconvinced that the new Responsibility Deal will be effective in resolving issues such as obesity and alcohol abuse and expect the Department of Health to set out clearly how progress will be monitored and tougher regulation applied if necessary. Partnership with commercial organisations has a place in health improvement. However, those with a financial interest must not be allowed to set the agenda for health improvement. The Government cannot avoid its responsibility for constantly reassessing the effectiveness of its policy in delivering its public health objectives. (Paragraph 287)
Formal Minutes

Wednesday 19 October 2011

Mr Stephen Dorrell, in the Chair

Rosie Cooper
Grahame M Morris
Dr Daniel Poulter

Mr Virendra Sharma
Chris Skidmore
Valerie Vaz

Draft Report (Public Health), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 287 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Twelfth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Tuesday 25 October at 10.00 am]
Witnesses

**Tuesday 17 May 2011**

Professor David Hunter, Director, Centre for Public Policy and Health, Durham University, Professor Lindsey Davies, President, Faculty of Public Health, Angela Mawle, Chief Executive, UK Public Health Association, and Dr Fiona Sim, Vice Chair, Royal Society for Public Health.

**Tuesday 7 June 2011**

Professor David Heymann CBE, Chair of the Board, Health Protection Agency, Baroness Doreen Massey, Chair of the Board, National Treatment Agency for Substance Misuse, Professor Brian Ferguson, National Transition Director for Public Health Observatories, and David Meechan, Executive Committee member, UK Association of Cancer Registries.

Councillor David Rogers OBE, Chair of the Community Wellbeing Programme Board, Local Government Group, Jo Webber, Deputy Policy Director, NHS Confederation, Dr Frank Atherton, President, Association of Directors of Public Health, and Dr Keith Reid, Co-Chair, Public Health Medicine Committee, British Medical Association.

**Tuesday 21 June 2011**

Professor Peter Goldblatt, Senior Research Fellow, Marmot Review Team, Dr Jessica Allen, Project Director, Marmot Review Team, and Professor Stephen Morris, Professor of Health Economics, University College London.

Dr David Halpern, Head, Behavioural Insights Team, Cabinet Office, Professor Sir Ian Gilmore, Chair, Alcohol Health Alliance, Mark Baird, Head of Corporate Social Responsibility, Diageo Great Britain Limited, and Chris Arnold, Creative Partner, Creative Orchestra.

**Tuesday 12 July 2011**

Professor Dame Sally C Davies DBE, Chief Medical Officer, Anita Marsland MBE, Transition Managing Director, Public Health England, Professor David R Harper CBE, Director General, Health Improvement and Protection, Department of Health, and Professor John Newton, Chair, Department of Health Working Group on Information and Intelligence for Public Health, South Central Strategic Health Authority.

Professor Alan Maryon-Davis, Honorary Professor of Public Health, King’s College London, and Dr Gabriel Scally, South West Regional Director, Public Health, South West Strategic Health Authority.

**Tuesday 19 July 2011**

Anne Milton MP, Parliamentary Under-Secretary of State for Public Health, and Professor David R Harper CBE, Director General, Health Improvement and Protection, Department of Health.
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Coalition of biomedical research stakeholder organisations and research funders

Directors of Public Health from the South West of England

Dr Ingrid Wolfe, Dr Hilary Cass and Professor Sir Alan Craft

Northern Housing Consortium Limited

The Hepatitis C Trust

NHS Bristol’s Public Health Directorate

I CAN and The Communication Trust

National Pure Water Association Ltd

Greater Merseyside Directors of Public Health

Department of Public Health, Liverpool Primary Care Trust

County Councils Network

The Cheshire and Merseyside Directors of Public Health

Youth Justice Board for England and Wales

Department of Health Equality, NHS Nottingham City

Asmat Nisa

Transport and Health Study Group

The Queen’s Nursing Institute

British Association for Sexual Health and HIV

Roche Products Ltd

Jean Gross

Royal College of Speech and Language Therapists

Sanofi Pasteur MSD

Royal College of Physicians

The Faculty of Sexual and Reproductive Healthcare

Northgate Public Services

Royal College of General Practitioners

John Kapp

Unilever UK and Ireland

Institute of Public Health

Stephen Peckham

Spearheads

Shamsher Diu

Training Programme Directors of the Faculty of Public Health

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