House of Commons
Health Committee

Public Health

Twelfth Report of Session 2010–12

Volume II

Oral and written evidence

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

Ordered by the House of Commons
to be printed 19 October 2011
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.

Membership

Rt Hon Stephen Dorrell MP (Conservative, Charnwood) (Chair)\(^1\)
Rosie Cooper MP (Labour, West Lancashire)
Yvonne Fovargue MP (Labour, Makerfield)
Andrew George MP (Liberal Democrat, St Ives)
Grahame M. Morris MP (Labour, Easington)
Dr Daniel Poulter MP (Conservative, Central Suffolk and North Ipswich)
Mr Virendra Sharma MP (Labour, Ealing Southall)
Chris Skidmore MP (Conservative, Kingswood)
David Tredinnick MP (Conservative, Bosworth)
Valerie Vaz MP (Labour, Walsall South)
Dr Sarah Wollaston MP (Conservative, Totnes)

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.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Sara Howe (Second Clerk), David Turner (Committee Specialist), Steve Clarke (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

Contacts

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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).
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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Oral evidence

Taken before the Health Committee
on Tuesday 17 May 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper  David Tredinnick
Grahame M. Morris  Valerie Vaz
Mr Virendra Sharma  Dr Sarah Wollaston
Chris Skidmore

Examination of Witnesses

Witnesses: 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, gave evidence.

Q1 Chair: Thank you very much for coming along this morning. I would like to open the evidence session by asking you to introduce yourselves very briefly and then tell us something about the organisations you come from and how they fit into the public health world.

Angela Mawle: I am Angela Mawle, Chief Executive of the UK Public Health Association. We are a multidisciplinary group and we represent public health workers across the whole sector: local authorities, NHS, PCTs, community activists and retired people, who pay only £5. They all have a common mission of promoting sustainable development, combating health inequalities and combating anti-health forces, which we say is the tobacco industry and perhaps the food industry—those sorts of things. We are broad based. We don’t have a lot of money and we do what we can with the resources we have, but we are very multidisciplinary.

Professor Davies: I am Lindsey Davies, the President of the UK Faculty of Public Health. We represent specialists in public health. All our members are qualified specialists in public health. We are the body that sets standards for public health practice training in the UK and we also do a lot of public health advocacy work.

Professor Hunter: I am David Hunter, Professor of Health Policy and Management at Durham University. I am the academic here. I head up a little centre called the Centre for Public Policy and Health, which undertakes research on public health, and we have completed two major studies recently, one on partnership working in public health and the other on public health governance in primary care. However, I do get involved in the real world as well. I was a former chair of the UKPHA until a couple of years ago and I am a non-executive director of NICE, with particular responsibility for public health, which is a growing area of its activity.

Dr Sim: I am Fiona Sim, the Vice Chairman of the Royal Society for Public Health. It is a very well-established, centuries-old organisation that has merged over the years from several predecessor organisations. It is a third sector body with a broad membership of people who are interested in public health, from specialists in public health and consultants, people working in local government, in environmental health and nutrition, in leisure services and so on, through to interested individuals and health professionals, including GPs, pharmacists, dentists and so on. It has a number of qualifications, mostly in food hygiene and environmental health, and a strong advocacy role.

Q2 Chair: Thank you very much.

This is the first public evidence session of an inquiry we are doing on the management of public health and the opportunities for public health, which is obviously against the background of the Health and Social Care Bill and the Government’s proposed changes to the way in which health care is managed. The first question is probably best addressed, at least in the first instance, to Professor Hunter. It would be very helpful to us to understand both how public health accountability currently is supposed to work—where the strengths and weaknesses, in your view, of that process are—and then how you think those accountability structures are changed by the Government’s proposals—how you reflect on those. That is quite a wide range of questions, but it would be helpful to get all those issues on the table at the beginning of the discussion rather than them coming up in an unstructured way during the session. Perhaps we can start with Professor Hunter.

Professor Hunter: As you say, it is a tall order, but I will try to be succinct. First of all, debates have raged over what we mean by (a) public health and (b) the public health system. However, I think most people would agree that it is a broad based and complex system. On one level, it affects all that happens in public policy and in the organised efforts of society, as Acheson put it, to improve the public’s health. It therefore embraces what happens in the NHS, in local government, in organisations outside government, including in the private third sectors. Therefore, the boundaries are a problem.

Public health at one level is about everything that affects our lives, and, arguably, that is a strength. Public health challenges, including obesity, alcohol misuse, sexual health, are what might be termed
‘wicked’ problems, that is, they are complex, cut across multiple practitioners and organisations, and defy easy or simple solutions. They do not belong to one sector or agency but require cross-boundary working usually conducted by partnerships of one sort or another. The difficulty, when it comes to accountability and governance, is that the public health function has a very broad, all-encompassing, all-inclusive definition that doesn’t take one very far in terms of effectively holding those parties whose activities impact on the public’s health to account. Generally, there is agreement that the public health community comprises: specialists in public health, who, at the moment, primarily work in the NHS; people working in public health practice, who, again, primarily work in the NHS but also in local government; and then the wider public health—people whose work does touch on public health issues but who would not describe themselves as public health practitioners. At the moment, the public health function is led by the NHS, both locally and nationally. I say “at the moment” because I am not sure what is left of the previous NHS because things are happening to change that now but, in terms of primary care trusts and so on, it does have the principal responsibility for public health. It is also probably useful to say that public health comprises what is generally acknowledged to be three domains: health improvement, health protection and health service development. Whether one agrees that those domains should all come under one specialty or one individual director of public health is arguable, but the public health community generally accepts those three domains as a typology for describing the functions. The controversy—and one of the reasons for the changes being proposed by the government—is that the health improvement part of that agenda has more to do with what happens outside the NHS than inside in terms of improving the public’s health, addressing the social determinants of health and tackling health inequalities. Arguably, that is a non-NHS core function, yet the lead for it has been invested in the NHS since 1974, and that has been a source of tension. It is conceded—and the move towards appointing joint director of public health posts over the last few years is an acknowledgement of this—that local government has to be a central part of that arrangement. Therefore, partnership working is very important and the whole previous structure of local area agreements and local strategic partnerships was an attempt to embrace all that.

Health protection is split between the NHS, local government and nationally, although the NHS has a key though not exclusive role. The wider public health, again, lies outside the NHS for the most part and embraces pretty well everything that local government and other agencies do. Accountability is mixed, in terms of the lead role, at the moment. Prior to joint DsPH posts being introduced a few years ago, it came through the DPH, who was accountable, initially, to the NHS. Now the joint posts held by DsPH are accountable to both local authorities and the NHS. That arrangement has worked variably across the country in terms of the degree of ‘jointness’ and integration. It is, therefore, a bit mixed, messy and uneven across the country.

The Government’s move to make local government the lead agency for public health is a recognition, in some quarters, that public health’s natural home lies in local government. There is a strong view that a mistake was made in 1974 in transferring public health out of local government. The Health Committee report in 2001—10 years ago—which I remember well as I was involved in it, argued at length whether local government should assume the lead role for public health and take public health back from the NHS or whether it made more sense to leave public health where it was and avoid a major organisational upheaval. It was accepted that major structural change should be avoided—why mess around with structures?—and that far more important was the function itself, ensuring the necessary governance structures were in place and holding people to account for what they achieved. Structural re-jigging, the Committee conceded, would be detrimental, unhelpful and a distraction.

This Government have decided to restore the lead role for public health in local government. While the move was initially widely welcomed, in the last few months we have seen some retreat from that position and growing concerns that what might have been seen to be important gains in the NHS for public health might be lost if local government were to take a lead role at a time when local government itself is under severe pressure financially. I could go on.

Q3 Chair: In terms of where accountability rests in the proposed structure, if the Bill goes through in its current form, is it clear in your mind that lead responsibility rests in local government?

Professor Hunter: I think it is confused, to be honest. Part of it—the health improvement component of accountability—lies there and part of it—the health protection component—lies with the new entity within the Department of Health—Public Health England—and the Secretary of State for Health. There is dual accountability. For local government that is a problem, because to have somebody in their chief officer ranks who is simultaneously accountable locally and to a central Department Minister—in this case the Secretary of State for Health—is a problem. Professional accountability to the CMO would be acceptable. The problem would be having a senior local government officer jointly accountable to the Secretary of State for Health at the centre and locally to the chief executive of the local authority. That is a red line that local government would find it difficult to cross. It would set a precedent that local government would find it hard to accept.

Q4 Chair: That remains, in your mind, an unresolved difficulty about the proposals at this moment.

Professor Hunter: Definitely, yes.

Chair: That is helpful.

Q5 Valerie Vaz: Some public health experts have been saying that Public Health England is not the proper way to deal with public health and that there needs to be a population view. What is your view
about some of the proposals that have come through about a special health authority that has only public health.

Professor Hunter: I can see the appeal, but there are drawbacks. In terms of what the Government wanted to achieve, turning the Department of Health into a health department—not an ill-health department, because the NHS would be responsible to the proposed commissioning board which would be hived off. If you take public health out of the Department of Health and put it into a special health authority as some critics of the proposed changes favour, I am not quite sure what is left—you have got virtually nothing except the Minister, or several Ministers, and no function. I am not clear how that would work in practice, plus there is the fact that hived-off agencies do do have problems engaging at the top table and part of the system, however messy and uncomfortable it may be, is preferable to being hived off to a next-steps agency where you may not have that degree of traction on the system.

Q6 Valerie Vaz: The way I understand it is that there would be accountability to the Secretary of State, but they could be left to get on with their work. What do the others think?

Professor Davies: We have a rather different view in terms of Public Health England. We think that it is fundamentally important for public confidence that people who are practising public health are able to speak in a professional way and in a way that the public and professionals can have confidence that they are speaking from their own authoritative judgment on the evidence and drawing on their own experience, as well as that there isn’t any overlay that relates to the organisation that happens to employ them. Obviously, that is a challenge.

As public health people, we are all about wanting to make change, to drive things and to be influential. Sometimes you have to make a choice between being able to influence internally in your organisation and being able to speak freely externally. I made that choice, myself, when I moved from a health authority years ago into the Department of Health as a civil servant. I have been back out and forwards and I have spent a lot of time in both ways of working over the years. I know perfectly well how easy it is—or isn’t—to speak freely as a civil servant on matters of public health. You can say some things but, naturally, you have to be sensitive to where you are coming from. On the other hand, as a director of public health at one remove from the Government, you can and should speak from professional expertise and understanding. If Public Health England is set up as planned at the moment—as one more directorate of the Department of Health—it will lose any opportunity to speak influentially and authoritatively to the public about important health matters. I think that that would be a huge loss. Also, if it is part of the Department of Health, it will not be able to generate the income that, for example, the HPA—the Health Protection Agency—can do from research and other ways that subsidises a lot of its other public health activity.

The model we would see for Public Health England would be that it is set up, ideally, as an NHS body, but, failing that, as an Executive agency of the Department of Health that is able to employ specialists and consultants in public health and to deploy them to work with other organisations—whether local authorities, consortia or whoever—to use specialist skills appropriately and effectively, and able to put surge capacity in place to deal with emergencies and things if it needs to do so. We think that that could work very well.

We acknowledge the issue that of course local authorities will want to feel the people working for them are their people working on their behalf and not on behalf of Government. However, entirely reasonable models already exist. For example, all university academics are employed by universities, but clinical academics, employed by a university, also work in the NHS and there is no doubt that they are working for their trust when they work in the NHS. We see that model as working very well and we are very positive about it. We do not see working as a Directorate of the Department of Health as the right way to go, for the reasons I have explained. I take the point that the Department of Health needs public health expertise. It does, absolutely. There is not nearly enough of that inside the Department of Health at the moment, in our view, but that isn’t the same as the agency that we are talking about.

Finally, on accountabilities, that model, we feel, will work only if the local authority is clearly in charge all the time and not if sometimes it is Public Health England and sometimes it is not. The local authority is in charge, with Public Health England supporting local authorities to discharge their very important responsibilities for health improvement and protection.

Q7 Valerie Vaz: Before I hear the others’ view on that, who, in your models, would have control over the population view if you remove it down to local authorities? They are only interested in their particular area, so who would pull together all that evidence? Who is doing it now and who will do that in the future under both your models?

Professor Hunter: The local authority would be concerned about its population and its community. It would have a population perspective.

Q8 Valerie Vaz: Would the GP have that? Professor Hunter: GPs are variable in whether they see a population as opposed to individual patients. I think it is very much the latter. There are exceptions, but generally there is a problem in general practice and given the reality of mixed boundaries—lack of coterminosity—between GP consortia or whatever takes their place and the local authority, there would be a tension there.
Nationally, at the moment, the top health person is the Chief Medical Officer, and they ostensibly have responsibility for public health in the round in government, not just in the Department of Health. I think we are wrong if we see public health as only being the responsibility of the Department of Health. That has been a weakness in the past. Arguably, in most Governments, Departments of Health aren’t seen to be necessarily the strongest Department. If you think about what happened under the previous Government, it was the Treasury that drove much of the impetus on public health, not the Department of Health. It goes back to Lindsey’s point about the weakness in the public health group, if you like, in terms of the capacity to make public health matter in the Department of Health. 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. It depends on what you are seeking to achieve.

There is a worry with next-step agencies. For example, NICE is a special health authority that has never seen its role as being to antagonise or take on Government as much as it would like to on occasion. Some of its guidance has begun to challenge what the Government is doing, as occurred in its public health guidance that came out last summer in respect of alcohol misuse and cardiovascular disease prevention—the Government resoundingly dismissed it. There were issues there affecting the whole of Government and the Government said, “We’re not interested in all this. Your role is to influence what has happened locally.” NICE withdrew at that point and didn’t confront the Government, so I’m not sure being independent, in reality, makes a great deal of difference.

Q9 Valerie Vaz: I want to come on to NICE, but could I hear from Dr Sim?

Dr Sim: Our view about Public Health England is very much in accord with what you have heard from Professor Davies. I don’t want to take time, but I would simply say that we have very similar views about the need for Public Health England not to be part of the Department of Health—for very similar reasons.

If I may, I will say something more about local accountability because Professor Hunter mentioned dual accountability to the chief executive in local government and to Public Health England. The reality we are picking up from colleagues is that accountability at a local level within local government is not necessarily to the chief executive. If you look back—at what some people are calling “the golden era” and what others are calling “the era well left behind”—the medical officer of health was a very senior officer within local government and had the sort of freedom of speech to which Professor Davies is alluding. If you are a third-tier officer accountable to a director of adult social care, that is somewhat less likely, I feel, and there is significant concern about whether the public health voice would be heard, let alone heeded, in local government if it is that well hidden. That is a real concern among our public health colleagues.

Q10 Chair: Factually, is that where it is now envisaged the local government responsibility will rest as part of adult social care?

Dr Sim: No. Factually, it is an incredibly variable feast, so there are some directors of public health who are negotiating and have already been offered posts that are directly accountable to their chief executive in local government and—

Q11 Chair: But it rather undermines the whole logic of taking public health out of the health service on the grounds that it is a cross-government responsibility. If you take it out of the health service and put it into social services, it’s a step backwards, isn’t it?

Dr Sim: There are certainly examples of that, which is why I am suggesting it is possibly inappropriate. It would be very helpful to protect that role in terms of its breadth within the organisation, which is not the case at the moment.

I was going to respond about general practice very briefly. I work part time as a salaried GP—I should declare an interest, perhaps—as well as being a public health specialist. My GP colleagues, as somebody said, are very variable. It is very common for GPs to recognise and to be aware of the importance of public health. The average GP, or most GPs, are not trained in public health. Their experience, largely, is of delivery and of secondary and tertiary prevention, and they recognise that, particularly with the encouragement of the Quality and Outcomes framework. Those are the main issues around the public health agenda that I think GP colleagues are interested in and have experience of. They recognise that they need public health specialist expertise and—

I do not know if this is an upcoming question or whether I should pick it up now—there is a lot of concern about what that might look like, how they would access it, whether consortia can afford to buy in public health expertise, whether local authority public health departments, if they exist in that form, will be allowed, encouraged or released to provide support to consortia, and whether, as is one of the concerns, there will be an isolated very part-time presence in a consortium that would be its public health presence. In an isolated, very part-time, no team support presence, it is very difficult to be effective.

Many consortia we are welcoming are looking at having a director of public health on the consortium board which, obviously, is very helpful and could well provide a public health conscience for that organisation. However, they will need to call upon the proper resources of public health expertise if they are going to be seriously influential, in the work of the consortium, for the consortium to commission on an evidence base efficiently, effectively and to meet the needs of its population. In our view, they need proper public health expert advice and support to be able to deliver on that agenda.

Angela Mawle: To answer generally, while we were very excited when the public health White Paper came out because it gave a vision, we thought that the cross-departmental Sub-Committee of the Cabinet headed by the Secretary of State gave a too general across-the-board look. We feel in the meantime that, as to the kind of processes—I will not say
factionalisation—there has been a degree of divide and rule that means that people are running for cover and are more worried about posts and positions than about this vision. The actual time taken to achieve this has been far too short and the vision has been lost in the process.

Michael Marmot came out at much the same time and we thought, “Great, the local authorities can take over.” If that was implemented, we would have wonderful public health. Throughout the life of the UKPHA—and I am sure that David will support this—we have been trying to take apart the medical model of public health. Because it is in the NHS, it is very easy to see public health as an NHS function. The public are brought into this, too, so they tend to see health as something provided by doctors, nurses or the clinics—and I am sure the GPs will agree with that—but they don’t see themselves as co-producers. I and the UKPHA see GPs as prime champions in the community alongside the director of public health.

However, the problem arises if there is a cultural difference between the two organisations—local authorities and PCTs. There is a huge cultural difference in the processes, and the kind of member involvement that you get in local authorities you certainly don’t get in PCTs. Therefore, the whole opening up of people to looking at new ways of doing things is very hard for them, particularly when the pace of change is so fast.

When I first came into this post, Wanless was pronouncing the £30 billion saved to the NHS. He said that most people in public health do not have “health” in their title and that public health is everybody’s business. Donald Acheson talked about the organised efforts of society. We don’t want to see lost this opportunity to have champions out there with communities helping people to produce their own health and to understand their role—not to be asked or told how to do it. I am sure that that is not what people want to do, but it is a culture that has built up through the generations and is particularly reinforced by the fact that, since 1974, the public health provision has been in the NHS.

We see accountability as a real issue because, clearly, if the current directors of public health are going to be reporting to social services or somebody similar, that, to them, immediately takes away their credibility, their independent voice, etc. Perhaps if there was a bit more time, but we haven’t got a pause in ours. I know that the local authorities said, “Gosh, no. That’s the PCT. That’s not us,” and he felt that was because they didn’t have the confidence to say that they were health because health is the NHS, not them. That is why I think this is a real opportunity. I am not saying, in the current position, that I could say which would be the best position to be in but, looking to the future, I would definitely see local governance, local collaboration and community involvement and that the person responsible for health

**Q12 Chair:** What is your answer to the question that Professor Hunter raised at the beginning about accountability in the proposed structure of the director of public health? Is it to the local authority or is it to Public Health England—or should it be—and how is that balance struck?

**Angela Mawle:** I have controversial views on this and I haven’t discussed it with people here. My view, and the view of a large number of our members, is that the local authority has always—or should always—had statutory responsibility for health and well-being. That should remain with them. Somebody in the local authority has to be responsible for the health of the population and that should be at the highest level. We argued a long time ago that there should be a cabinet post for public health. We are saying there should be a cabinet post for public health and we want it to be at a very high level—whether it is chief executive or whatever, there should be somebody there—whether you then buy in services from Public Health England for specialisms, or whether you spend time bringing your own work force up to speed so they begin to take the responsibility for health.

Michael Lyons, when he was doing his report on the council tax, was astonished—he reported to one of our seminars, didn’t he, David?—and could not believe that when he talked about public health, that local authorities said, “Gosh, no. That’s the PCT. That’s not us,” and he felt that was because they didn’t have the confidence to say that they were health because health is the NHS, not them. That is why I think this is a real opportunity. I am not saying, in the current position, that I could say which would be the best position to be in but, looking to the future, I would definitely see local governance, local collaboration and community involvement and that the person responsible for health
is at the very senior level of all the collaborations at local authority level which help create a healthy community.

Professor Davies: Can I pick up a number of those points, particularly focusing, first, on the director of public health and their accountabilities? We are saying that the local authority should be clearly accountable for improving and protecting the health of its population. They need somebody who understands how to do that, and who can do the business, put in a position to be able to do that for them and to lead them and enable them to do it. That we see as the director of public health. Of course they have to be senior in the organisation and of course they have to be accountable directly to the chief executive of that organisation and with direct access to councillors. If they do not have that, they will find it enormously difficult to influence across the whole breadth of the local authority and really to realise the potential that that brings with it.

I mentioned that they need to be qualified, but the Bill just says “Appoint an individual”. I have heard it mooted that, in these stringent times, a local authority may decide not to add these to the responsibilities of a director of social services or even the director of education. I would love to think that a director of education was qualified in public health—that would be fantastic and I could see great potential in that—but we really do have to have in the Bill that this person needs to be qualified and we can perhaps touch later on other aspects of regulation.

The directors of public health themselves, I think, need to be able to influence and provide this leadership across all three domains of public health. The health services—making sure you have the right health services when you want them—health protection and protection against harm, and health improvement and healthy lifestyles, if you like, work together. The DPH and their team are the people who can look across all that and advise on balance generally. As individual members of the public, that is what we need.

Professor Hunter: Very quickly, we should not forget that leadership in local authorities comes from elected members, not from officers. Therefore, the role of a DPH moving into local government will be very different from the role they may have enjoyed in the NHS because—and local government will tell you this—using the word “leadership” to describe an officer function is incorrect. It is the officers who support the leadership coming from the elected member. A quite different culture and set of skills are needed for that relationship to work. That might account for some of the protectionism and tribalism we are seeing in relation to fears in some public health quarters about going into local government because—

Local authorities are different. That is the whole point about local government. They will vary in how they want to hold their DPH to account, but that is the price of localism. You are either for it or against it, but if you buy it, you have to buy what goes with it, which is variation and difference.

Q14 David Tredinnick: Listening to you all, it seems there are a couple of big issues here. You suggest first that local government doesn’t have a lot of confidence in becoming responsible for health because it has not done it for so long—since 1974—and, secondly, that if they are to make anything of it, they are going to need expert advice, although I am not sure you see where that is coming from. Is that right?

Professor Hunter: Some local authorities have a very confident view about their role. Birmingham, for example, appointed their own DPH alongside the DPHs from the primary care trusts. There are different models and some local authorities do see their role very much as being about health and well-being. They use the term “well-being” rather than “public health” to describe that, but they would see themselves as being at the forefront of health improvement and of having more employees in public health than the health service, if you take environmental health officers into account, for example.

Q15 David Tredinnick: That is a huge authority you have cited.

Professor Hunter: It is, yes. I am using one extreme.

Q16 David Tredinnick: Is that representative?

Professor Hunter: I don’t think any local authority is terribly representative—that is part of the problem. I don’t think it is fair to say local government—

Angela Mawle: It shows what is possible.

Professor Hunter: It is what is possible but I think local authorities, generally, are up for this. Their worry—the poisoned chalice bit of this—is that they are doing it at a time when they are being massively cut and having to retrench and make savings in all areas that, arguably, contribute to public health. Their worry is that they are taking on this exciting and demanding role at a time when they are being decimated in so many respects.

Q17 Chair: In a nutshell, I don’t think we are hearing from the panel of witnesses a case against a strong local government leadership role of this public health function. It is a question of how that relates to the rest of the system.

Angela Mawle: Absolutely.

Professor Hunter: Yes.

Chair: I think that is a fair summary of the starting point.

Q18 Chris Skidmore: Can I, very quickly, pick up on that? I don’t know if you have read an article that was published in The Lancet back in February: “Public health in England: an option for the way forward?” You all seem to be in broad agreement about local authorities having a greater role and, as far as I am aware, this article mentioned that the big issue with moving public health into local authority
control would be a lack of scrutiny and that “Moving local public health functions outside the NHS risks them being overlooked to a much greater extent than when they were within the NHS, and—crucially—local government is not gaining any of the additional regulatory powers it would need to address the determinants of population health.” Is that a valid risk?

Professor Hunter: I don’t think so. As Angela said, local government has had this power since 2000 for the health and well-being of their communities. We overrate the extent to which public health has been successful within the NHS, to be honest. I’m not sure the evidence base is there to substantiate that. Many of us feel disappointed with public health punching below its weight, in some respects, over the last 30 odd years and the distraction by an NHS agenda has been very powerful. We have seen examples in the past, and the previous Chief Medical Officer, Liam Donaldson, used to complain about public health budgets being raided by primary care trusts to prop up hospital services. There are huge tensions. Going into local government could be a relief and a release from all of that distraction from the core business in public health, which is why I think the three domains are problematic. The third domain, health service development, is not one that should necessarily sit with the DPH moving into local government. You could decouple that function and put it back into the NHS. I accept there’s a public health role in the NHS, but as to whether you need those three domains being overseen by one person is arguable. Apart from being a massive job stretch, it has been a problem in the past.

Q19 Valerie Vaz: When you say “put it back in the NHS,” whereabouts do you mean? Do you mean Public Health England or—

Professor Hunter: It depends on what we end up with, but the commissioning bodies, and/or health and well-being boards, if they continue to exist, and foundation trusts. There are many foundation trusts which are seeing their role in terms of easing demand problematic. The third domain, health service development, is not one that should necessarily sit with the DPH moving into local government. You could decouple that function and put it back into the NHS. I accept there’s a public health role in the NHS, but as to whether you need those three domains being overseen by one person is arguable. Apart from being a massive job stretch, it has been a problem in the past.

Q20 Valerie Vaz: It is quite important, isn’t it, health care public health?

Professor Hunter: Absolutely.

Q21 Valerie Vaz: People seem to be forgetting about that.

Professor Hunter: Because it gets lost in the White Paper. It is not really made enough of.

Q22 Chair: Is it not a core function of commissioning?

Professor Hunter: Yes.

Q23 Chair: I am slightly surprised you put it into a foundation trust. I would have thought health care public health. Professor Hunter: It is both.
implications for health inequalities, if we have an unregistered population that is left out in the cold. But I don’t think that is what we are talking about now.

Q26 Dr Wollaston: It would be interesting to hear your views about cotermoinity and how that could perhaps be changed in the Bill. However, I want to focus on the point about good information for consortia because concerns have been raised about the future of the work of regional public health observatories due to the core cuts of the Department of Health funding. Could you explain the role that they play in the public health system, whether there are grounds to be concerned and what the way forward is?

Dr Sim: Yes. The public health observatories, at the moment, are regionally based and there are 10 in England. They are providers of, to my mind, an extremely robust quantity and quality of information about health and health care, health services and the health status of the population at regional level. For many health topics, the observatories have also provided information and are able to do so at a much more local level. Therefore, yes, they have immense value at a local level. Some of the examples one might take are in terms of their value to primary care commissioning around some long-term conditions where they have done a lot of work, they have a nationally organised association and each of the observatories takes a lead role in certain areas. For instance, around the care of people with diabetes, the observatories have produced information for the whole country at a very local level, which is immensely valuable for commissioning to make needs-based decisions or to allow needs-based decisions to be made about, for instance, the planning of services, planning for primary and secondary prevention and the needs for health care. I am picking up that example as a very common condition with a fair degree of potential for prevention and a lot of potential for high-quality, needs-based commissioning.

What I would say—and my colleagues may not agree—is that I have a very high regard for the information provided by the observatories and I think it is wonderful. But it helps a good deal if, at a local level, you have people who can interpret that information and who know what they can do with it. You still need the local public health expertise—I feel as though I am making a claim for this, as I believe it to be the case—to make really good use of that information, to interpret, analyse and then advise local commissioners, the local authority and local health care trusts, how best to promote the health of the population by using that information. It will be a great loss if they go.

Q27 Dr Wollaston: You feel they do play a valuable role in advising those local public health specialists.

Dr Sim: Very much so.

Professor Hunter: Yes.

Professor Davies: I have a couple of facts. The funding for the Association of Public Health Observatories, which is the co-ordinating function that Fiona was describing, is not there any more, so there is no Association of Public Health Observatories to any good effect at the moment. One of their strengths was that they were well co-ordinated—they had this local ability to influence and give information—and one would take a lead on one thing and another. That is much more difficult now, in their current circumstances, although they are trying their best to do it. They also have a 30% cut in their core funding for 2011–12, which is a cut of £1.5 million in terms of resources going to public health observatories, as I understand it, in this coming year. That, of course, is causing them huge uncertainty. Put that alongside the fact that a couple of them are based in universities, and at one of them in London the staff have already been told that they are at risk of redundancy, if we are not careful, we will end up with a great fragmentation and dissolution of the expertise that is currently really working in a very well-co-ordinated way.

Q28 Dr Wollaston: To clarify, you are saying they have a 30% cut this year and then no funding for subsequent years.

Professor Davies: The Association of Public Health Observatories has lost all its funding. It was funded for £300,000 over three years and that has now ceased. The core funding for the observatories themselves has gone down by 30% for 2011.

Q29 Chair: How are they currently funded? Is it a direct grant from the Department? Does it come out of the university budget?

Professor Davies: Direct.

Professor Hunter: Direct grant from the centre.

Q30 Chair: So it is a direct grant.

Professor Davies: From the Department of Health.

Dr Sim: It is a direct grant but each of the observatories has also been entrepreneurial in terms of its local or region-wide contracts—with both NHS and other bodies.

Professor Hunter: The North East Public Health Observatory, with which I'm most familiar, set up the National Library for Health which is now part of NHS Evidence, which NICE runs, but the contract is with NEPHO—the North East Public Health Observatory. Also, the Learning Disability Observatory is housed there, so NEPHO has been entrepreneurial and there have been all sorts of spin-offs into other areas.

Another thing to mention is that having NEPHO located in an academic setting has been useful because it feeds into training and research in a way that wouldn’t otherwise be the case if you didn’t have that resource or relationship. There are huge databases held by NEPHO that provide a rich resource for students and others to access and use in their teaching and research. It is a valuable spin-off which, again, we lose at our peril, I think.

Q31 Chair: Are there any opportunities for those observatories to generate alternative revenues by using some of those resources you have referred to, either from within the health care system or beyond it?

Professor Hunter: They are looking at that and many of them are exploring the social enterprise option, possibly turning themselves into a different kind of
It didn't go against public opinion—it largely went with the grain of public opinion—and it has worked.

**Professor Hunter:** Public Health and the Department.

**Q35 Grahame M. Morris:** Would you support that view? There not an argument for making a special health authority? Would you support that view? We see Public Health England as a good place for that. I don't see any reason why an organisation that is funded and managed by Public Health England couldn't be nested in a university in much the way they are at the moment. As long as it is a coherent set of functions with good relationships locally, that is how we would see it. We do see Public Health England as having an important co-ordinating role to ensure that that happens.

**Q33 Grahame M. Morris:** In relation to that, the Bill is proposing huge changes to the architecture of the NHS and a new role for the Secretary of State in relation to public health. For me, it is a huge priority. Professor Hunter mentioned the North East Public Health Observatory and the key role it plays in relation to addressing issues associated with barriers to people with mental health accessing health services. That has national significance, hasn't it, even though the work is carried out in the north-east?

**Professor Hunter:** Absolutely.

**Q34 Grahame M. Morris:** I went along to listen to Angela and Professor Sir Michael Marmot last week talking about the impact of cold homes on public health. It was an excellent report with national significance. I wonder where it should sit in order to maximise their potential. These analytical skills are scarce—they are not plentiful—and we do risk losing them. Certainly, with our observatory in the north-east, we have lost staff. Staff sensed uncertainty and disappeared—they have gone. Some went to academic posts and some went outside the university, so we are losing the capacity built up over many years already. It seems to me that we do need to think about the options. A special health authority would be one option, but we should also perhaps be thinking about ways in which we could more creatively make better use of the information and analytical resources we have across NICE, PHOs and elsewhere.

**Professor Davies:** My support for them being part of Public Health England is dependent on Public Health England being constructed as a special health authority or an Executive agency.

**Professor Hunter:** Yes, being an SHA.

**Grahame M. Morris:** Okay, I understand.

**Chair:** We can’t spend all morning on observatories. We will turn to questions about nudge.

**Q36 Dr Wollaston:** Touching on nudge, the Government have effectively said that the Public Health White Paper, ‘Healthy lives, healthy people’ constitutes its response to the review led by Professor Michael Marmot. How adequate a response is that? How adequate a response is that to the Marmot Review?

**Professor Hunter:** Underwhelming, I think. On the first page of the White Paper it talks about this being a response to Marmot, but then the rest of the White Paper is about 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. What evidence there is, which is reasonably positive, says that it will take 10, 20 or 30 years to bring this about, and even then there is no guarantee it will be sustainable. Given that we do not have that amount of time, given the pressures on the NHS budget from lifestyle diseases—obesity, alcohol and so on, which are complex and immense and with which we struggle to cope now—to see this as an issue for individual lifestyle and behaviour change is completely missing the point. Therefore, I am disturbed at the shift from being a nanny to being a nudge. There is a lot to be said for Government showing people occasionally. The public health tobacco ban was a good example of that. It didn’t go against public opinion—it largely went with the grain of public opinion—and it has worked.
There is a role for upstream Government action. To see it all as being about nudge and incentivising individuals is not the right response.

Q37 Dr Wollaston: Evidence for shove but no evidence base for nudge.
Professor Hunter: That would be the conclusion of the Cambridge research unit set up to look at nudge, and the BMJ article earlier this year concluded that, as of now, the evidence base does not exist.

Q38 Chair: There were two elements of your reply. One was that you feel—if I am hearing you correctly—that there is too much emphasis on the local and not enough on the national, while the second is that there is too much emphasis on the nudge and not enough on the shove.
Professor Hunter: Nudge can be at national and local level. It depends what you mean by “nudge”, to be honest. It is a very flaky, slippery term.

Q39 Chair: What do you mean by it?
Professor Hunter: I think what is meant is incentivising people to behave differently by, maybe, bribing them, as they have done in Dundee. They have given teenage pregnant mothers vouchers to shop at M&S if they stop smoking—that kind of thing—which has worked. But there is an ethical argument as to whether you should be bribing people to behave sensibly and how long you keep the bribery going. Presumably, it is for the extent of the pregnancy—whether that then encourages multiple births, I’m not sure. There is an issue about that kind of behavioural response—whether it is both ethically and practically the right solution.

Professor Davies: We were encouraged to see in the public health White Paper the Nuffield interventions ladder, which does acknowledge that there is a whole range of interventions needed. For any public health programme to get population-based change, you need to bring all those things into play. Regulation has a place and so does, from time to time, giving people a bit of help to move in the right direction. To put a huge emphasis on nudging, for which, as we have heard, there isn’t evidence, and to say, “We will do regulation only if nudge doesn’t work,” is not an evidence-based way of going on. There is evidence that regulation, in the right place, when the public are with it, can have an enormous effect and bring about a real step change. We have seen that with seatbelts, drink-driving and tobacco, as we have heard. That would be our position. Everything has a place, but we think you shouldn’t simply wait for the lower levels of the ladder to fall off before you put the top one there.

Angela Mawle: My concern is that it can be manipulative. One of the examples I heard from a learned seminar was when they put a bus stop outside a dementia care home. The reason they put the bus stop there was because people would wander and off and go and find a bus to catch, and they thought that putting the bus stop there would encourage them to wait outside the care home. Ethically, that is very iffy, and if you subscribe to that kind of individual way of going on, as our colleagues have said, you are ignoring the bigger picture. You mentioned—I am sorry, should I call you “honourable gentleman”?
Chair: None of us do.
Grahame M. Morris: That’s the nicest thing anyone has said to me.

Angela Mawle: I am a bit nervous of this setting. You were referring to last week’s launch and that showed that housing costs for the NHS are £2 billion and they are £1.8 billion for the police service—because of dangerous housing and also distracting, delinquent behaviour. Why does the White Paper talk about Marmot and say, “Yes, Marmot is great”—and he was there supporting that argument? The housing costs to health are huge. Of course, it takes me back to my previous statement, about Wanless about prevention—and prevention has always been Cinderella. Public health is prevention and we have never included “public” in public health, as far as I am concerned. We have hardly mentioned at all this morning the people out there who could make it all happen. Nudge is something that you can use—I don’t like the term “armoury”—in a range of ways to help people improve their life, but you have to address the causes of the causes, and you can’t quote Marmot if you are not then prepared to take on the implications of what he says.

Dr Sim: I agree that the evidence for nudge is very limited. What there is suggests that the people who are going to be influenced by nudge are largely those who are already on track for making a behaviour change, rather than those people who are much harder to reach. If it is effective at all, we are talking potentially of widening health inequalities. Certainly we feel—particularly if the public is beginning to realise that certain things are in their interests—that the Government should not shy away from regulation to influence them.

Chair: This huge subject is probably not at the heart of our inquiry, but it is clearly relevant. David, you were going to ask about the role of the Secretary of State.

Q40 David Tredinnick: Yes, indeed.
How would the Secretary of State’s role in respect of public health change under the Government’s proposals? That is my opening question.
Professor Hunter: The honest answer is that I don’t think we know. First of all, it presupposes the Secretary of State will be able to divest himself of the NHS in the manner that is proposed. I am not sure, in reality, that that will prove quite so easy, despite having the Independent Commissioning Board. So I remain to be convinced that a great deal will change in practice. The jury is out on that. In terms of his or her role in respect of the broader health agenda, that is very welcome, potentially. In the past, those of us looking in from the outside have been critical of the Department of Health for not being a health department at all, but rather of being an ill-health or a sickness department and not taking public health seriously. If it changes its philosophy, ethos and culture so that it is more health-focused in the broader sense that we have been talking about, that is to be welcomed, but I am not quite sure what the drivers would be for that. At the moment, you have the
Cabinet Sub-Committee, I think, which the Secretary of State chairs.

Q41 David Tredinnick: Yes, it is the Cabinet Sub-Committee on Public Health. What potential is there for a cross-departmental approach?

Professor Hunter: There is tremendous potential. But we have been here many times before and previous incarnations of these cross-cutting committees don’t seem to have had a great deal of traction or impact. Therefore, one worries that it is simply reinventing the wheel and that the same lethargy or systemic failure will result. Personally, I would be inclined to give that committee chair to someone who is not from the Health Department. If public health is a serious function across Government, it shouldn’t simply be in the silo of the Department of Health or the Secretary of State for Health.

Angela Mawle: I think the Secretary of State should be the champion of public health. I was really impressed by the mental health strategy, about which I spoke to the Secretary of State when it was launched. Clearly, there is an understanding of the breadth of health and well-being, so to have somebody at the head of health who understands that and tries to champion it is really important. As to the actual Sub-Committee, I don’t know whether I would agree with David or not because, unfortunately, people still see, as we have talked about earlier, health as being the NHS domain. We called a long time ago to have somebody who is the head of health chairing that committee and enforcing it. We also called for there to be a chief civil servant and a Minister in each Department responsible for health so that that person then reported to whoever was going to be head of that—in this case it is the Secretary of State—to make things happen. My experience—and all of our experience, I am sure—has been that cross-departmental working is a nightmare because there is no common culture and understanding, and things get reinvented in different Departments. We desperately need to unify and show the public that it is all about being joined up: their transport, their planning, their green space and their housing. Exemplifying that is a brave step to take, and I just hope it happens.

Q42 David Tredinnick: Two different Departments; a department of sickness, too, rather than health.

Angela Mawle: Definitely, beyond a doubt, yes.

Q43 Chair: Can I bring in Professor Davies? I have to say I am a bit of a sceptic about this. It seems to me that what the Secretary of State is envisaged as being in this world is an authoritative voice on some quite sensitive issues of public health. For example, do you think the Secretary of State would have been an effective voice on the MMR vaccine to give people advice about that kind of health prevention, or would it have been better for it to have been from an authoritative voice one step removed from a practising politician?

Angela Mawle: It has to be a relationship. We talked about local authorities and elected members, and the relationship there. There has to be a more mature relationship whereby the political lead is seen as leadership for the whole community and they are informed by expertise. That needs to happen in a partnership—a collaborative approach rather than with these demarcations that occur between civil servants and elected Members. I understand why that happens, but the public don’t trust the system as it currently operates. I see what you are saying—that he or she shouldn’t pontificate on issues about which they are not expert—but if they draw from expertise and then they are shown to have the community and the national population’s interests at heart, I believe it could work.

Professor Davies: I have two points. First, picking that one up, it is fundamentally important that Ministers have confidence in the civil servants working for them and supporting them, and that they do have working for them civil servants who can advise them from a professional understanding on the various other bits of external and independent advice they are getting. They need the Chief Medical Officer, and the Chief Medical Officer needs to be supported by people who know what is what. Ministers need to be confident about that advice. The public need to be confident that there is independent advice that is able to inform them, as I said earlier, from a professional and scientific expert point of view. There are those two different sorts of confidence we need in the system.

My earlier point was going to be about health protection. We have talked an awful lot about lifestyles and a bit about health services. We have not really talked about the emergency response and protecting people. That is where there are some quite important new powers for the Secretary of State in the Bill. For example, he or she will, in an emergency, be able to direct NHS organisations to do things, to stop doing things and to co-operate—to work together. That is going to be terribly important. Unfortunately, what the Bill does not do is say that they can direct providers of NHS services to co-operate. It says he or she can stop and start things, but they don’t have to co-operate. In an emergency situation, given the proposed plans for the NHS and for health generally, where you will potentially have a much more fragmented system than you do at the moment, it is very important that the Secretary of State, or somebody, is able to tell people what to do in terms of health service providers. That is going to be a really important new power; I would almost like to see it extended rather than reduced. On the other hand, if you build other controls into the system so that it is not so fragmented, perhaps those powers are not quite so important.

Q44 Chair: I quoted the example of MMR in order to depersonalise this but to remind you of my own experience—trying to be a public health Minister—in giving people assurance about CJD. The result of that, rightly or wrongly, was that the successor Government concluded that this advice was better given by an independent authority, and I don’t find anybody arguing for going back to the old system on food standards.
**Professor Davies:** I totally and absolutely agree with that. It is that sense of history: the Health Protection Agency was set up for exactly the same purpose. It seems to me that if you do what is proposed at the moment—put the Health Protection Agency, the National Treatment Agency and others into the Department of Health—you will soon find yourself inventing a new organisation to give independent advice, and that doesn’t seem a frightfully sensible way to go forward.

**Q45 Chris Skidmore:** I have a couple of questions around local authorities. They have mainly been answered, but looking at the nuts and bolts of how they work, first, local authorities’ performance has to be judged against a public health outcomes framework, which is in the process of being developed at the moment. What would you hope is put in that framework and how would you see it operating? We have talked about interventions and budgets and all that sort of stuff and whether that is part of it. Would that be acceptable? This framework can be effective only if it has teeth with which to hold local authorities to account. Do you have any experience yourselves or any research that might suggest how this might come about?

**Professor Hunter:** Personally, I think the outcomes framework has to be linked to the quality standards work that NICE has been asked to do for the NHS—150 quality standards over the next five years. It is not clear whether public health is going to be included, but it ought to be. It then ought to underpin the outcomes framework and that ought to be the basis against which local authorities are held to account for delivery. I would like to see the Marmot priorities reflected in those health outcomes. If the Government were serious about responding to Marmot, they would build the six Marmot priorities through the life course into those outcomes from early years interventions right through to old age. To that extent, there are bits there that could come together quite neatly into an outcomes framework, which will cut ice only if it is implemented effectively and people are held to account for delivery. The weakness in the past has been that we have not closed the circle in terms of how people are doing and how they are doing it, as well as what the outcome is. Much as I love outcomes—of course I do—there have to be both.

**Q46 Chris Skidmore:** How would you hold them to account? At the moment we have this health premium idea that local authorities, by reaching their outcome frameworks, might get extra cash at the end of it. For me, that seems to be misjudged in that it should possibly be the other way round. The money should be given to local authorities that are in more desperate need, but surely you should have a system of penalties rather than an incentivisation. If local authorities don’t reach the targets of their outcomes framework, they should be held to account for that. At what level should that be? By the Secretary of State?

**Professor Hunter:** Ultimately. The thing is we have done away with a lot of the instruments and vehicles that were designed to bring that about. The Audit Commission and the comprehensive area assessment initiative it introduced last year have been scrapped, so a lot of the levers for holding a local authority to account are going to have to be reinvented or replaced in some way. At the moment, it is not clear what the space between the local authority and the centre is going to be in that regard. Obviously, there is a local accountability dimension to this as well, but clearly there is a lot of uncertainty about the national level at the moment.

**Professor Davies:** Absolutely. If you look at experience in the NHS, why is it that there hasn’t even as much emphasis on public health in the NHS as we would like to see? Frankly, until you make improving health as important to a chief executive as balancing their books, you are not going to get the kind of change that you want to see in health. We have to find some levers that will enable that to happen, and that is what we are grasping for at the moment. There needs to be a really robust set of outcomes in the framework over the whole lifestyle, but we have to be realistic about that. A lot of public health outcomes—changes in health—take years to implement and need sustained action. Somehow the system has to reward sustained action over years, but encourage people in the short term. The idea that local authorities will have to report against the indicators in that as well so that we can see what people are doing and how they are doing it, as well as what the outcome is. Much as I love outcomes—of course I do—there have to be both.

**Q47 Chris Skidmore:** The other nuts-and-bolts issue I wanted to address was funding. Obviously, the White Paper talks about the £4 billion towards public health. There are two issues. First, I wanted to ask you if you think that is enough. By my calculations, if you are doing a whole-area calculation with 60 million people, that is roughly £67 per person per year. Is that going to be effective to deliver public health interventions that will work? Secondly, there is the issue of that funding being ring-fenced. Professor Davies, I saw in your White Paper response that the risk in a ring-fenced budget for public health will obviously be that that would be expected to cover all public health interventions. That mirrors what the local government group has said in its paper. It is worried that ring-fencing will mean that councils will tend to view the ring-fenced sums as the total resource available for public health. The two questions I wanted to ask were, first, whether you think that is enough money at £4 billion. We have a situation, with Wanless, where the local demographic need will always increase over the next 30 years. Where can you see that sum rising to? Secondly, is ring-fencing a good idea—yes or no?

**Professor Davies:** Is £4 billion enough? I have no idea. It all depends what you want that £4 billion to do and, at the moment, we have no idea what the boundaries of the budget are going to be. The Faculty of Public Health did a survey a little while ago asking people what they thought was spent on prevention, and—a significant number—thought that at the moment we spend about 25% of the budget on public health. That is interesting; I wish we did. Until we know what the boundaries of that budget are, I do not know if it is enough or not. I am 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. The value of ring-fencing, on the other hand, will be that if its boundaries and uses are defined and clear, there will hopefully be a bit of protection for public health when things get tough and a lot of other priorities come in. It is a way of maintaining focus on public health but, equally, we have to make sure that it is marketed in the right way and that everybody understands that they still have to do their bit.

**Professor Hunter:** I agree with that, but I take a slightly different stance on the last issue about ring-fencing. It is problematic in local government to give a particular function a ring-fenced budget when that is not the norm in local government. When you are bringing public health into local government, it is precisely the wrong time, perhaps, to give it special treatment and special favours in respect of a ring-fenced budget. I would prefer it if local government welcomed public health with its budget—akin, perhaps, to bringing your own bottle to the party, where you put it into the general collection—“Here’s my budget. I’m going to put it alongside yours.”

Under the previous Government, we had the Total Place initiative, which was about pooling resources across all the agencies in a local area—Michael Bichard of the Institute for Government and others were the architects of that initiative—and the pilots were quite encouraging. I don’t think the experiment ran long enough to demonstrate great successes, but in terms of process factors and people beginning to break down silos and to think about a place-based approach to improving health, having those integrated budgets was quite important. The present Government have held on to that through the notion of community-based budgets or place-based budgets, so it is not dead, but it seems to me that the ring-fencing notion flies in the face of that other driver to integrate budgets and not see them as little silos kept separate and protected.

**Angela Mawle:** I endorse what David said, and what Lindsey said to some extent. How can you have the public health responsibility across the whole authority and £4 billion across the land? It is a nonsense. If you look at the outcomes framework and all the things like social capacity, cycling and housing—and fuel poverty is in there—how on earth can you deliver on the public health framework with £4 billion? It is a contradiction, because if you are genuinely saying that the local authority is responsible for health right across, all the budgets should be used. Are you saying, therefore, that £4 billion across the country is only going to be for health programmes such as obesity and all the usual stuff such as smoking etc.—and I am not denigrating the usual stuff by any means? If it is only going to get funnelled down those particular programmes, that is a real lost opportunity, unless it is seed corn ing other activities and the DPH, or whoever, goes and says, “Here is what we want to do together. We can feed this much into it. What are you going to do?” and looks at those outcome indicators in a way which means you can deliver them. What is the point of having them if you are not going to deliver on them in a few years’ time?

Going back to your first question about the indicators, process is really important in terms of an indicator because you need to involve communities in this. Over time, it has been shown how much you can achieve by involving communities in their own areas, in asset mapping rather than needs assessment, and you can get a co-production of health out there with communities if you look at that new way of doing things. Traditionally—and I have worked in both PCTs and local authorities—I am afraid you do things the way they have always been done, and if you don’t, you basically get knocked on the head. In some authorities it is okay, but if you are working with communities in your own different ways, you have to be given the responsibility and confidence that you can do that, and work with GPs—everybody in that community. The process indicators, I think, are really important. The outcomes framework and the indicator that is being developed shows that £4 billion is almost a distraction.

**Dr Sim:** I was going to add that I have no idea if the amount is adequate or not, but our view is that, ring-fenced or not, it is really important that local authorities take responsibility across the board—across all directorates. One of the important concerns to us is that it gives a message that it is only local authority responsibility if the ring-fenced public health budget goes into local government. That, immediately, is quite easy to interpret as “Nobody else has responsibility for public health, so the NHS is off the hook” and so are other sectors, potentially. That would be really unfortunate. Whether the amount going into local government is adequate or not, I have no idea, but the message that says the amount for public health is only going into local government is unfortunate.

To pick up on outcomes, obviously the amount does depend a little on what we are trying to achieve by way of outcomes. Our view is that—and I think it has already been mentioned—they have to be evidence based. A lot of the outcomes suggested in the consultation document were beautiful, aspirational things, but with no evidence base to them. The other thing that would have ownership of outcomes is to have some sort of local discretion. Some health outcomes are going to be much more relevant to certain communities. If you get local ownership with inter-agency contribution to achieving them, they are much more likely to be achieved. There is something about not just having a blanket approach with the “targetitis” that we have seen historically but having outcomes that are meaningful to populations.

**Q48 Grahame M. Morris:** I have a supplementary question because that is leading nicely to the point I wanted to raise about the risk of fragmentation in relation to the new commissioning arrangements with GPs, especially where there is no coterminosity with the local authority boundary. If public health is the preserve of local government, will GPs commissioning services simply think, “That is not really our concern any longer”? What are your views on that?
Dr Sim: That is a major concern, certainly. I was saying earlier that most GPs view public health as being very important. Increasingly, they are viewing it as something that is relevant to consortia. Precisely what that means is still being bottomed out. I am aware, for example, that the Royal College of GPs is holding seminars around the country to introduce the role of consortia, including their public health role, which is extremely helpful. But we have a long way to go and, unless there is resource to support those aspirations, that is going to be a real problem.

Q49 Grahame M. Morris: I have some real concerns about that. I don’t know if you remember the “Miserable Measures” report that you did for the local authorities with PCT funding. I wonder whether the GPs would recognise the value of such a report. I am sorry, it is just a comment.

Professor Davies: I absolutely agree with all of that and totally share your concern. One way that you could begin to mitigate that risk is if the health and well-being boards, which are proposed as being the places where all the concerns come together, have real teeth and are able to sign off the commissioning plans. If the health and well-being boards make sure that those plans are aligned with the joint strategy and the joint strategic needs assessment, you can then see that you have some way of bringing coherence to the system. However, if the health and well-being boards are simply fairly benevolent talking shops, where are you going to go, really? There is nothing there to encourage and inspire anybody.

Q50 David Tredinnick: What impact will the abolition of the boundaries have on the collection of information and statistics that are relevant to public health?

Professor Davies: It will make it hugely more complex. The best we can hope for is that the abolition of boundaries means that GPs do not have their patients in particularly widespread areas. But there is the potential, particularly with commuting and so on, for them to have patients spread over a huge number of local authorities. That will make things much more complicated, although not impossible, because it means that the analysis and the collection of data will take longer and will need to be much more carefully thought through in terms of the way it is brought together.

Q51 Chair: Nobody has commented specifically on Chris’s question about health premiums and the extent to which incentivising authorities to do things is a sensible approach.

Professor Hunter: I agree with your scepticism. I don’t think they are a good idea. I think they will prove unworkable, particularly for the local authorities that, for whatever reason, do not meet the criteria for the premium through no fault of their own—through circumstances beyond their control. Battering people over the head if they don’t perform, even though their ability to perform is limited by what they are able to do directly, is a rather curious way of trying to incentivise behaviour. I am not sure it is a mechanism that is going to survive, to be honest, or have real impact.

Professor Davies: I cannot see how you could make it work. All I can see is that it will exacerbate health inequalities rather than tend to reduce them.

Professor Hunter: Yes. It will do the opposite.

Professor Davies: It is a totally perverse incentive.

Q52 Valerie Vaz: Kensington and Chelsea would get the most money.

Professor Davies: Yes. That is especially the case in local authorities where you have a lot of what they call churn—as soon as the population starts to be doing better and gets a bit healthier, they move on. How do you measure whether that local authority is really doing good stuff or not? If it does not seem to be making a difference, you will not be giving it extra money—that is not fair.

Q53 Dr Wollaston: Can I go back to an issue that was touched on briefly before: whether GPs tend to focus on the patients who are in front of them in the consulting room rather than the population as a whole, and whether they are even less concerned with those who aren’t registered with them as their GP? Several members of the panel have expressed concerns about the abolition of practice boundaries, particularly with the new funding formula coming in. How fair is it to doubt that GPs will take a public health view when acting as commissioners?

Professor Hunter: How fair?

Q54 Dr Wollaston: Yes. Do you think people are right to be concerned?

Professor Hunter: It is fair to be sceptical. As I said earlier, I am sure there are exceptions. The GP par excellence in this area was probably Dr David Colin-Thomé who, before coming into the Department of Health to head up primary care, ran a very successful health centre in Runcorn in Cheshire—Castlefields—that put public health at the centre of its activities. It was, in many ways, a mini version of Kaiser Permanente in the United States, in terms of encouraging people to stay well. It is not undo-able here, but it is not part of the general ethos and culture of general practice to behave or operate in those ways. There is either a huge training issue here—a huge development issue—as we have to accept that some GPs will do it and others will need a lot more help and support. I. It is high risk.

Q55 Chair: If primary care is to fulfil its part in the re-fashioning of health care, you cannot accept that they will not do it, can you?

Professor Hunter: No, because primary care is not general practice. We often confuse the two, but if you go back to WHO and Alma-Ata in the 1970s, it is not about general practice. Primary care is much broader.

Angela Mawle: There are some hugely brilliant GPs around. There are the ones we work with up in the north-west and in Bromley-by-Bow. Bromley-by-Bow is unbelievably good. It is a total public health experience, or health and well-being improvement experience, if you go there as a patient, I am sure. Obviously I am not a patient there, but it just shows.
If it becomes the ethic or the way we go forward and society points in that direction, more and more GPs will want to join that. Before now, it has all been siloed—very professionally demarcated out—as to who does what and where. Patients see it like that too, so you don’t get this freeing up of the energy we spoke about earlier, about how you can engage in new and different ways of working. I believe that GPs are very capable of it and, because they have always been traditionally small businesses as well as altruistic doctors, they have been able to forge their own way, take chances and move on. I think that is what they need to do, and I am sure they will. They should do it and have to do it.

Q56 Dr Wollaston: Do you think there is a risk, though, that where it is happening well already, it will continue to work well, but in the parts of the country where general primary care is, if you like, failing, we will see that inequality widen?

Professor Davies: That is a huge risk. Fiona will know more of the detail. I would say there is middle ground, though. There is a young GP principal known to me up in the north-west who has become really inspired and energised by this and can see all sorts of exciting things to do. She has been in general practice a while and, yes, it is great seeing the patients and everything, but this has given her a new lease of life to get on and do different things and see what they can do together. It has generated a lot of enthusiasm and I am sure that will be great for their patients—and they are going out and getting the advice to do it and I am sure that will be great for their patients—can do together. It has generated a lot of enthusiasm to get on and do different things and see what they can do together. It has generated a lot of enthusiasm and I am sure that will be great for their patients—and they are going out and getting the advice to do it right. At the other end of the spectrum, Fiona, you might come in here.

Q57 Chair: Before you come in, can I take the discussion a stage further? We can all acknowledge that there is wide variation of experience of general practice and the full scope of primary care. From a policy point of view, how should we go about trying to address those variations of experience? What is the right way of addressing that, rather than simply tolerating the variances you describe?

Angela Mawle: Personally, if we are talking about a new era, with the health and well-being boards, there has been a move up in the north-west who has become really inspired and energised by this and can see all sorts of exciting things to do. She has been in general practice a while and, yes, it is great seeing the patients and everything, but this has given her a new lease of life to get on and do different things and see what they can do together. It has generated a lot of enthusiasm and I am sure that will be great for their patients—and they are going out and getting the advice to do it right. At the other end of the spectrum, Fiona, you might come in here.

Q58 Chair: I was asking the question in the way that I did so as not to lead the witnesses. It seems to me that one of the big questions now is: can we see health and well-being boards being a repetition of what we had in the past, where they are glorified talking shops where people have no power to do anything, and then go back to their host organisations and life goes on unchanged. It is another layer in the system creating significant transaction costs. There are huge risks around health and well-being boards as presently conceived.

Angela Mawle: As presently constituted.

Dr Sim: There is a big difference between what GPs do, what they might do, and what the responsibilities of the consortium are going to be, and I think we are possibly conflating those things. The enthusiastic GPs—the people who are providing wonderful services—are usually providing wonderful clinical services as well as being public-health orientated. Good general practice, very often, is holistic general practice with a public health—
Q59 Chair: That is a big subject. Perhaps we will not go too far down there. Did you want to comment? Professor Davies: Very briefly, I agree that we do need to look at the contract. There is potential there within the contract, but even if that is done, there is still going to be the need for robust, believable, timely information at a practice level because being able to see where your practice compares with others and other people being able to take that oversight is a very powerful lever for change. We have demonstrated, over time, that if we do not have the good information, we are not going to be able to begin to do that.

Chair: It is also one of the things we covered in our second report on commissioning: is it wise to have the commissioning process for primary care separate from the commissioning process for secondary care? We made our view clear.

Q60 Rosie Cooper: I was really taken by what Angela said because in our last report we said that health and well-being boards should disappear—frankly, I am 300% behind that—as they are so constructed. This last weekend I talked to a councillor who is a retired pharmacist, and he was enthused beyond words. He wanted to get on a health and well-being board and change everything, so he was asking me what powers it would have. In my usual style, I said, “A power to spout. You can talk and talk and talk and no one will listen.” There is a huge danger here if people start to see the health and well-being boards as something that will draw together—which they can—all that expertise. But if they cannot and do not have the power to do anything to join up those things, they are the lever that will destroy all this.

Angela Mawle: I agree with you, but if we are looking at a new era, which is how I always try to look at it, it is an opportunity to join people up with a common purpose and with powers to go with it. You talk about commissioning. Commissioning has not been done that brilliantly in the past. It is a foreign subject to most people, even in the health service. If you talk to the public about commissioning, they don’t know about it and just turn off. What I am trying to say to you is that if we can re-fashion the structures that are there now to make them more usable for the public, and to feed in the information and then give it the power, we could make it work. I quite agree with you that it could be seen as a talking shop, but the concept is great. The partnership working, the collaboration and people being able to do this is very risky because they are not generally very good at it and, as David said, they just become talking shop after talking shop. If you could genuinely create now, in this new generation of practitioners and community, something that is fit for purpose out of the mixture of what you have suggested, with a local commissioning board, and make that somehow answerable or interrelated to the health and well-being board, that would be so effective. It would bring people in to understand the process.

Talking about local data, we heard about the PHOs and how important local data is, but the public do not ever access that. I sometimes had trouble accessing it as a health worker foraging through the system. What the good public health person or GP in their community would be doing is to say, “Here is the information, here is the board, here is the public. What are we going to do about our community?” To create that commonality and joint sense of purpose, you have to give them the opportunity to be not just a talking shop. That is what I am saying.

Q61 Rosie Cooper: It is just very dangerous as it is currently because it will destabilise everything if it remains and does nothing.

Angela Mawle: I agree.

Professor Hunter: I absolutely agree.

Q62 David Tredinnick: I would like to ask a few questions about emergencies. The Government’s plans include significant provisions for major disease outbreaks. I would like to ask Professor Davies about what the Faculty of Public Health has said. It is argued that Public Health England must be a category 1 responder under the Civil Contingencies Act 2004 as the Health Protection Agency currently is. Can you explain this thinking, please?

Professor Davies: Yes. Category 1 responders are those who are at the front line of the response when disaster strikes. There are all sorts of duties for them, but one of them is that they need to co-operate and work with other category 1 responders. That makes a very powerful response. We think that if Public Health England is going to be the organisation that has within it all the public health expertise, or a lot of it, and it is charged with the duty of supporting local authorities to discharge their health protection responsibilities, Public Health England really does need to be designated as a category 1 responder—somebody acknowledged as having responsibilities to respond and to co-operate with others when disaster strikes.

Q63 David Tredinnick: The Faculty of Public Health says that there is lack of clarity on the accountability of Public Health England and local authorities and that this “puts the health of the public at serious risk, particularly in emergency or epidemic situations.” Can you explain why that is, please?

Professor Davies: One of the fundamental principles of effective emergency planning and response is that people have to know what they are expected to do and they have to know who is in charge. All parties need to work co-operatively and they need to accept the direction and leadership of the person or the organisation that is in charge. That needs to be something, ideally, that reflects the way in which things work on a day-to-day basis, because another principle of emergency planning is that you don’t suddenly do something totally different in an emergency. It is much better to base your emergency response on things that you are used to, working with people whom you are used to, with plans that, between you, you have developed over time. As the current proposals are cast and the responsibilities are described, it is very difficult to see who, in any one situation, would be in charge because local authorities are described as being responsible for the health protection of their population and so is Public Health England, in some circumstances.
There will, of course, be times of national or very significant local disaster or emergency when it is important that the Secretary of State is able to say, “Okay, I am going to take charge. This is so important that I have to be able to see top to bottom in the system and I will direct Public Health England to direct the local authority,” or whatever. That is entirely reasonable. But, for the general run of things, it needs to be understood that the local authority is in charge and Public Health England will support it—whether there is an outbreak, an epidemic, a flood or whatever it is locally—so that it can then take a lead in the planning and preparation and so that, when the emergency arrives, everybody knows who is doing what.

Q64 David Tredinnick: The Secretary of State is proposing that he has extensive powers under the Bill to direct emergencies if necessary. Do you think that is a good thing?

Professor Davies: It is important that somebody does, given that the system is going to be very fragmented. There is a risk that unless there are those powers vested somehow, we will end up with a lot of time and resource wasted by not being able, for example, to persuade providers of care that they should let some of their staff come and work with other providers to fill gaps or whatever. It is important that someone is able to do it if you have a system where there are all sorts of different providers—

Q65 David Tredinnick: There will be civil contingency exercises and surely, soon after the new arrangements are brought into place, you will see where the problems are. Is it really going to be that difficult? Under a new system, won’t it naturally shake down?

Professor Davies: I would love to believe that that is how it would happen. I hope very much that that it is how it would happen and that everybody would act in the best interests of the communities in the situation, but there might be times when priorities are really very different for different organisations in different situations. At that sort of time, it is important that somebody external is able to say, “This has to happen. Now everybody get together and do it.” My experience most recently was as director of pandemic influenza in the Department of Health. We had many exercises for that across the country and there was lots of learning, both in the exercises and when we had the pandemic—fortunately, not a severe one. It was very clear that when thinking through initially how NHS hospitals and private sector hospitals would work together in an emergency, for example, some private sector organisations were really keen to offer their staff and their resources to support the NHS and others were absolutely not inclined to do so.

Q66 David Tredinnick: On that specific point, do you think you ordered too much flu vaccine?

Professor Davies: I couldn’t possibly comment.

Q67 Graeme M. Morris: Before we move on, I have a really quick question because you raised exactly the point I was interested in. I am thinking about the practicalities of how it worked in our region in the north-east and the role that the SHA—the strategic health authority—played when there was some doubt about where the distribution centres would be. What are the implications now that the SHAs are going, in terms of saying, “No, there will be a distribution centre in Tyneside, Wearside, Teesside, Weardale”? Who is going to take charge of that? It needs an organisation or an individual if it is a national outbreak like a flu pandemic.

Professor Davies: I am very worried about that. I know that, sitting as I did and colleagues did at the Department of Health, both during the preparation and the response, how the people working in the strategic health authorities and in the local resilience forums took this forward and really made things happen locally. They have the relationships, they can make things work and they know where their things should be. Similarly, the Health Protection Agency’s local units and their regional directors did a fantastic job in setting up the initial response centres. Whatever system we put in place, we have to make sure that there is the ability not just to have the right line of sight and the relationships and trust locally, but also, somewhere in the system, a focus that is not too distant.

Chair: Thank you for that. We have a concluding set of questions on professional regulation.

Q68 Valerie Vaz: I am sorry that we are making you work very hard. I will be breaking all the rules on questions by asking a three-headed one, but it might help in terms of your answer. First, what is happening with the public health work force at the moment? What is morale like? Secondly, how do you see their role in future under the new system? Thirdly, could you comment on Dr Scally’s review on training? Everybody else can comment afterwards if they want to.

Professor Davies: I have quick answers on both and I can expand them if you like. In terms of morale at the moment, it is very low indeed. People are exhausted. A year ago they were really enthusiastic, encouraged by the fact they were told Christmas was coming early for public health. This new emphasis by the Government that public health is really where it was. There is no doubt about that and it is very, very good, encouraging and heartening for everybody in the work force to see that. However, when you have such a major change in every system going on at the same time and you have the cuts that need to be made in terms of funding, directors of public health, consultants and specialists are telling me that they are hardly able to spend time on the day job of improving the health of the population at the moment. They are spending all their time on HR, on thinking where they are going to go and on managing staff in very difficult circumstances. We know that the cuts are having an impact. For example, they have lost a lot of the support that they were getting from the regional teams, which have gone, and the national support teams 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. I have enormous respect for
how they are carrying on—just keeping their heads up and doing their best—but I really feel for them and I hear from them every day.

The worry at the moment, though, is that that is beginning to turn into not just frustration and exhaustion, but anger at the continuing uncertainty. Although the pause in some ways is good for people to reflect—again, they are encouraged that considered thought is being given to what is being done—for them it is putting further delay and uncertainty into what they are going to do.

Trainees in public health are in a particularly difficult situation at the moment. There are those who will come to the end of their training because they have time-limited training posts, and they can see the abyss of unemployment, frankly. We have invested huge amounts of money and effort into getting the brightest and best to come and go for it in public health, but of course jobs are not being advertised at the moment.

The faculty has to approve all the job descriptions to make sure that things like the right standards are being required, but we are seeing hardly any. Who would recruit at the moment? There is nowhere for the trainees to go into. We are trying to get some help for them. It would be good if there could be funding supplied to extend their training for that little bit longer and to give them the confidence to stay on, but we haven’t been able to negotiate that yet. It remains a real problem. Yes, there are real worries and a fragility in terms of what we will have to support—what comes next—in this exciting new world that we are trying to put in place.

Of course, the people working in health care public health are particularly anxious about where they might be and how they are going to have a future because they don’t see themselves acknowledged in any of the reports or the Bill. But, we are hoping. As you say, we have models and we can see a way forward on that. Morale, however, is not great.

On the role of the workforce going forward, we have spoken about that a little already, and I can elaborate on particular issues if you like. We are particularly concerned that, going forward, there will still be in this country, as there is at the moment, an internationally recognised specialist and practitioner workforce in public health. We are really well respected for having that, and others can talk about it. Focusing on the specialist workforce, we need to understand that many specialists in public health work in all three domains at the moment. It is quite unusual for somebody to do only the health improvement bit or only the health service bit, and that is where a lot of the strength comes because you understand all of it. Assuming that you can artificially divide people and put them in different places will mean that you end up with a number of the links being very wobbly, at least in the short term. That said, once things are settled down and there is a vision that people can all work around, they will be up for making that happen and putting their backs into it to support this new drive to improve the public’s health.

Who forms part of the specialist workforce and how can the public be confident in the advice that they are getting and the advice that local authorities, Ministers and others are getting? We think that it is very important, as Gabriel Scally recommends, that there is statutory regulation for all specialists in public health. You shouldn’t be able to be a specialist in public health unless you are on a statutory register, and that should be legal. At the moment, if you are a doctor and you want to work in public health, you have to do your medical training, get on to the medical register, do post-graduate training and then be put on the specialist register for the GMC, or as a dentist for the GDC. That is the law. It is statute. If you are not a doctor, you can do exactly the same training—Fiona is the expert on this—and there are a number of other routes by which you can get on to a voluntary register.

That is fantastic. It is there and putting that voluntary register in place over the last few years has been a huge achievement, but it does not have the ring of statute around it. It is possible at the moment, as I mentioned earlier, in the Bill, for example, for a director of public health to be appointed who was not on a statutory medical or dental register and not on the voluntary register—not on any register. Given that, to all intents and purposes, although they may come from a range of professional backgrounds, they are essentially the physician to the population who is taking decisions and giving advice that can impact hundreds of thousands of people, it seems to us to be a dangerous thing to say that they do not need to be qualified to do the job. It is a matter of public protection in just the same way as you would not want your heart surgery done by somebody who was not on the statutory register. We do think there needs to be a statutory requirement for registration for public health specialists.

Q69 Chair: Would anyone else like to comment on those issues?

Professor Hunter: There has been some concern that the Scally report has upset the wider public health workforce—those specialists and practitioners who come from a multidisciplinary background and who have been keen to promote that. The report has been perceived as destabilising and undermining what the voluntary register has achieved. As Lindsey said, it has been a great success in many ways. People are unclear why the Scally report came out in favour of a statutory model based on the Health Professions Council, which has no history of doing public health regulation. The fear is it would adopt a narrow medical one-size-fits-all model that would not reflect the wider interests in public health. Far from going forward, we are in danger of going back in terms of public health being seen to be a predominantly medically qualified clinical specialty. So there is fear about that. Rightly or wrongly, that is the concern out in the field and this uncertainty, at the moment, is again a further factor making for destabilisation and low morale among those in training or in the profession. So it is a concern, I think.

Dr Sim: As far as the workforce are concerned, the changes—the reforms—are already happening so part of the low morale is the reality that budgets are being cut. Where clusters of PCTs are forming, it is not uncommon—certainly in London it has already
happened—that the number of directors of public health has been reduced to reflect the clusters rather than the PCTs, so people’s jobs are already threatened and that is not helping morale, clearly. At the moment, they have been slotted in as consultants, but obviously the future is very vague.

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 the population because those interventions are no longer being delivered by those people who have been doing so. Therefore, there are real issues about ongoing reforms that have little to do with what we are talking about in terms of the future. They have already cut quite deep in many places, and that is in addition to the future uncertainty.

As far as regulation is concerned, when I was at the Department of Health, I was responsible for establishing the voluntary register for public health specialists. It was set up with a view to becoming statutory in due course, so, at a personal level, I do have an understanding that there should be—as there always was—a view that all public health specialists doing equivalent jobs to people on the medical specialist register should be registered in a way that is entirely equivalent. The voluntary register has made great strides in going in that direction. It is effective as a voluntary register and could continue to perform that function for years to come. It does need the support, however, of employers being required to appoint people who are on the register, which is the case. There has been guidance to the NHS for many years—and I cannot remember the year that the letter came out, but I think it was about 2005 or maybe 2004—that requires NHS employers to appoint people to consultant posts or director of public health posts who are on the GMC, the GDC or voluntary registers at specialist level.

Thus, moving to local government, even without changing the regulatory framework, there is great uncertainty as to what would be permitted by way of appointments. The Royal Society for Public Health has, in its response to the White Paper, put in a proposal to create a charter status to strengthen voluntary regulation as a possible middle way rather than going all the way to setting up either a new statutory register or coming under the wing, as I think David has mentioned, of the HPC or another existing register that may or may not be fit for purpose.

Angela Mawle: Very briefly, we totally support a multidisciplinary approach. We tend to feel that we are tinkering with 20th century structures that are not fit for purpose for the 21st century. We produced a report on health visiting. Health visitors are broad public health practitioners, to some extent, although they are currently employed in the NHS. It looked at widening the entry gates and at a new professional entry and professional development for that work force. It led us to think that the same could be done for all people entering public health and that now is the time, if we are going to look at these systems. Clearly what works now is good and efficient, and the voluntary register is doing a very good job, but it still seems to me that you are creating another sanctum within a sanctum, or an external sanctum, of a largely medical model because it is very specialised—even the voluntary register. That is not to say that you need that particular specialism in the tool box, but in terms of Marmot’s report and the coming difficulties of this century, we are struggling with looking at it in the mechanistic way and seeing that there should be a root-and-branch review of what the public health work force should look like in 10 to 15 years’ time and what it will have to deal with and, therefore, how we create career structures for bright young things now to come forward and pick up on these huge challenges.

Professor Davies: I have one very quick point, if I may. On the general view of the work force in public health on statutory regulation, we are a multidisciplinary specialty and we surveyed our members earlier in the year on what they thought about that. The overwhelming response was that they wanted statutory regulation; they all want to be the same. One can understand that, and the risk is almost like saying that as doctors are registered already, they want to be sure that local authorities or whoever don’t say, “I will have the doctor because I know what that is.” We need to be sure there is a clear ring of confidence around the specialist work force in total.

As to the advisory appointments committee, as Fiona has said, that really is an important point: in the NHS you can be appointed only to a consultant specialist, DPH post through a statutory committee set up in the right way with the right content and with advisers and so on around it to ensure that standards are there. The statutory instrument does not apply anywhere other than in the NHS. It does not apply in the civil service and it does not apply in local authorities, and we would like to see that extended to make sure that standards are maintained and the public can be confident.

Chair: On that note, thank you very much. We have covered a huge amount of ground this morning at a fairly brisk pace, but it has been a very useful session. Thank you very much for coming.
Tuesday 7 June 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Yvonne Fovargue
Grahame M. Morris
Chris Skidmore
David Tredinnick
Valerie Vaz

Examination of Witnesses

Witnesses: 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, gave evidence.

Q70 Chair: Ladies and gentlemen, thank you very much for coming. Could I ask you briefly, please, to introduce yourselves and the organisations that you come in from in order that we can get that into the record? Professor Heymann, perhaps you could start.

Professor Heymann: David Heymann, Chairman of the Health Protection Agency.

Baroness Massey: Doreen Massey, Chair of the National Treatment Agency for Substance Misuse.

Professor Ferguson: Brian Ferguson. I am here as the elected Chair of the Association of PHOs between 2006 and 2011 and National Transition Director for PHOs from April this year.

David Meechan: I am David Meechan, representing the UK Association of Cancer Registries.

Q71 Chair: Thank you. The place we would like to start, if we may, is this. The Government has proposed that the Health Protection Agency is abolished and goes into the Department, presumably as the core of Public Health England, and that each of your organisations becomes part of that newly-established section of the Department. To begin with, we would like to hear from each of you how your organisations react to the bare bones of that proposal and what you think are the key issues we ought to be looking at as a Committee in considering the impact of that proposal. Perhaps we can start with Professor Heymann.

Professor Heymann: Thank you very much for giving me the opportunity to speak with the Committee. The Health Protection Agency board supports the commitment to public health, improving public health and reducing inequalities. It also supports the principles of the public health strategy and the move to Public Health England. We do this, however, understanding there are certain risks and that those risks involve independence of information, to maintain independence of the evidence necessary to form policies, and maintaining the specialist expertise within the Health Protection Agency at present.

Baroness Massey: We also, obviously, support public health. Drugs is not just about health issues. It is about a whole range of issues, impinging on crime, communities, families, employment, housing and so on. The reason that we are so supportive of Public Health England is because we have built up, over the years, some really good models of public health in that we have worked across Government Departments and, at local level, our regional managers have worked across a whole range of stakeholders, from housing, education, health, families and so on. Public health has always done this and been keen to promote positive community and individual health.

We have also focused on user involvement, equalities, family and community wellbeing and communications to support the importance of public health as well as the robust collection of data to support and back up the outcomes that we have desired. We have evaluated models of care, done public opinion polls, stakeholder polls on substance misuse and appraised value for money on substance misuse. All of those are issues which one should be looking at in relation to a broader spectrum of public health. The one thing I regret about public health—you have said in your introduction that it is neglected, and I agree—is that in this country we don’t do, in my view, enough research into public health issues. We do lots of superb medical research but we rely on the States and other countries for our health issues. We do not anticipate GP consortia containing people from local communities. We would expect those arrangements to be carried on within any new arrangements. We do not anticipate GP consortia necessarily playing a direct role in commissioning for drug and alcohol services, but, of course, they will have an indirect role through their general care.

Q72 Chair: Are you clear how the work of the National Treatment Agency will be carried on in the context of Public Health England? Will there be changes in the way you relate to commissioners who are responsible for commissioning the service that is delivered?

Baroness Massey: If you look at the Drugs Strategy in the public health White Paper, we see that most drugs and alcohol services are commissioned by local authorities through directors of public health, as you know, supported by Health and Well-being Boards—or will be. What we are looking to is a continuity of good commissioning. There is good commissioning about and local authorities will inherit the commissioning responsibilities of drug and alcohol partnerships, which, as you also will know as MPs, contain people from local communities. We would expect those arrangements to be carried on within any new arrangements. We do not anticipate GP consortia necessarily playing a direct role in commissioning for drug and alcohol services, but, of course, they will have an indirect role through their general care.

Q73 Chair: My question was more precisely related to the work of the NTA as it is currently carried on. Do you envisage that work being carried on, in effect, unchanged in Public Health England or do you think...
Public Health England will change the way that role is delivered?

Baroness Massey: It could do, depending on issues of, for example, the funding of local authorities and how that will impinge on the NTA’s work: who will pay for what? The same applies to the prison services: who will pay for what? It will be important to examine the funding streams and see how they are working out. In general, I hope the principles of what we are now doing would carry on.

One of our worries is that if local authorities have total responsibility for drug treatment budgets, then they may get somewhat neglected. Drug users are sometimes seen as miscreants and not worthy of spending money on. That has been defended, of course, by the pharmaceutical companies, who have said that they are not at fault for the drug problem. We have to see that and, indeed, I would hope, the NHS Commissioning Board as well. In the new system we have to make sure that scarce health intelligence skills—and those that alcohol and drugs would be given some priority at a local level by local authorities and that the money would not go from drugs and alcohol to serve other very well-deserving things like schools, hospitals and so on. But I think there is a danger in the funding issue which we are aware of and very concerned about.

Q74 Chair: Has there been any proposal to change those pooled budget arrangements at a local level?

Baroness Massey: We understand that the Department will be funding the local authorities but I note that, at the moment, they don’t fund alcohol. I would hope that alcohol and drugs would be given some priority at a local level by local authorities and that the money would not go from drugs and alcohol to serve other very well-deserving things like schools, hospitals and so on. But I think there is a danger in the funding issue which we are aware of and very concerned about.

Q75 Chair: I don’t want to monopolise it so could we move to Professor Ferguson?

Professor Ferguson: Good morning and thank you for the opportunity to be here. The nine observatories in England produce a range of health intelligence tools for local organisations as well as outputs in support of national public health priority areas. It is important to say we also support NHS commissioning with a range of health intelligence tools.

All the observatory directors would very much welcome the opportunity for PHO functions to be seen as central to the work of Public Health England. I would particularly welcome the opportunity that brings to have greater integration of health intelligence, both across health intelligence organisations, such as the PHOs and the registries, but also integration between NHS commissioning intelligence and public health.

I would like to highlight a couple of risks as well as those opportunities. The PHO outputs and advice over the last 11 years or so are widely viewed as credible, authoritative and independent and we feel that consideration will have to be given to how that independence will be assured in the new health intelligence system within Public Health England. Finally, it is worth reinforcing the point about the work that we do supporting a range of local commissioners—not just Public Health England—and, indeed, I would hope, the NHS Commissioning Board as well. In the new system we have to make sure that scarce health intelligence skills—and those skills and expertise are scarce—have to be organised in an efficient way that integrates intelligence across commissioning and public health.

David Meechan: The Cancer Registries have two main functions. The first is to collect and collate information about every patient diagnosed with cancer and to submit that information to the Office for National Statistics for the publication of statistics on cancer incidence and survival. The second function is to analyse and interpret cancer data to support both the public health functions—such as surveillance and health needs assessment—and the planning and monitoring of cancer services, both at local and national level.

Some of the key issues within Public Health England are how Cancer Registries will relate to the NHS as well as to the public health community, whether that is within Public Health England or local directors of public health and Health and Well-being Boards. Then there is the need to maintain the links both with provider hospitals for the receipt of data about patients with cancer and also in terms of supporting local stakeholders, if you like, whether that is local clinicians through supporting clinical audit or the planning, commissioning and monitoring of cancer services, both locally and nationally. We work quite closely with the National Cancer Intelligence Network and I know that the National Clinical Director for Cancer, Professor Sir Mike Richards, is very keen that the valuable data generated from Cancer Registries is able to continue to be provided. Clearly, there are opportunities within Public Health England, as Brian said, to continue to work closely with Public Health Observatories, as we already do, and also to continue to work with the cancer screening and quality assurance centres.

As to the other threat, I would echo what Brian said about the risk of losing scarce skills, particularly during the transition period while there is uncertainty about the future structures of Public Health England and the processes for moving from where we are now into that new structure.

Chair: It is the new structure that Mr Tredinnick would like to ask you some questions about.

Q76 David Tredinnick: Can you explain why the Health Protection Agency would prefer Public Health England to be an executive agency rather than part of the Department, please?

Professor Heymann: The Health Protection Agency, at present, deals with various issues, including infectious diseases, environmental hazards and the safety and efficacy of biological medicines. These are important for the public health of the country. What is also important is that the evidence which comes from what the Health Protection Agency does is the best possible evidence with the best possible science behind it—science that can then be used to develop policies within the Department of Health. We feel that, as an executive agency, the Health Protection Agency and the other public health functions of England could be protected from any type of non-independence of its evidence.
At the same time, the Health Protection Agency conducts research that is at the cutting edge of public health. This research is funded by various bodies such as the MRC and the Wellcome Trust—funding that comes into the Health Protection Agency to do this research—which might not be accommodated within the Department of Health. If that should be the case, and this research were stopped, the excellence that is within Public Health England would possibly gradually disappear into university and academic environments and the Government would lose some of its best scientists.

Q77 David Tredinnick: Thank you. Health Protection Units are a key part of the Health Protection Agency. Can you explain what they do and how satisfactory you think they are, please?

Professor Heymann: The Health Protection Units are the transcription of what is decided at the central level into action at the peripheral level by serving as guidance to the public health activities at the local level. Whatever is designated a national policy can be implemented through the HPUs which provide advice to the public health activities at the local level.

Q78 David Tredinnick: You are happy, therefore, that this will all sit comfortably under the new proposals.

Professor Heymann: Yes. As long as the risks that we have identified as a board are addressed, Public Health England seems to be the solution because it will bring together the epidemiology and technical skills of the Health Protection Agency, which would be moved there, with other activities within the Department of Health at present. This would make a more complete response to issues such as sexually-transmitted diseases or others.

Q79 David Tredinnick: Do you not think there might be a need for local health protection committees? The Health Protection Agency and the Association of Directors of Public Health have both proposed that there might be a need for that. Do you think that—

Professor Heymann: I am sorry, would you repeat that?

David Tredinnick: Do you think there might be a need for local health protection committees? This is something that the Health Protection Agency and the Association of Directors of Public Health have both proposed. That is my last question.

Professor Heymann: A mechanism that effectively links PHE to local communities and supports local community engagement is clearly essential. Local health protection committees could be one of those mechanisms bringing together directors of public health and local PHE units and ensuring that working relationships are clear—provided that agreements to priorities and to share important information have been established. It is important to remember that committees can’t manage emergencies and incidents but that the responsibility must sit with the local PHE director.

Q80 Grahame M. Morris: There are a number of questions I would like to pose to Professor Ferguson, but while we are dealing with the evidence on the Health Protection Agency, I will follow that line of questioning to Professor Heymann. I note, from your opening statement, the importance you place on maintaining the independence of the Health Protection Agency but could you elaborate a little on your response to the consultation and the written evidence that you have given us here? You said that the planned changes “could create considerable risks to the national capability to launch multi-agency responses to incidents and emergencies.” I am thinking of things like a flu pandemic or, most recently, the E.coli outbreak we have seen in Germany. Could you give us your thoughts on what those risks are?

Professor Heymann: The Health Protection Agency has been designated as a category 1 responder under the Civil Contingencies Act. Its duties are to plan and prepare for risks, share information and to warn and inform the public about the risks. The Act also gives a duty to others to co-operate with the Health Protection Agency. Public Health England, we feel, needs to be designated as a category 1 responder as these mutual duties are an important part of ensuring the wider system is well prepared to respond to any incident.

Q81 Grahame M. Morris: Can I follow up on that? In those circumstances, who would take the lead both at the local and at the national level under the new arrangements?

Professor Heymann: Those are the arrangements which are being worked out at present. Our concern is that there be a coherent response from the central level all the way out to the peripheral level. I, myself, come from an agency in the US, which is a federal agency, which does not have authority over how states respond. It provides guidance and support. It is a very difficult issue, sometimes, to have states respond in the way that the federal government feels they should respond. The HPA has solved those issues and we hope that PHE will continue to solve those issues to make sure that there is a seamless response which follows national policies and national guidance.

Q82 Grahame M. Morris: At a local level, will a particular individual be identified as the lead in relation to a major incident or a health protection issue?

Professor Heymann: I believe those mechanisms are still being worked out. We are working with the Association of Directors of Public Health to make sure that the thinking is in line with what the Association is thinking as well.

Q83 Chair: Could we pursue this subject of the independent structure? Each of you has expressed concerns about the implications of this function being part of the Department rather than statutorily independent. I would like to hear views about that, in particular how such an agency, if it was established, would relate to the delivery of service at a local level of the kind Professor Heymann was touching on.
Professor Heymann: Would you repeat the first part of your question again?

Chair: Independence: should it be an agency or should it be part of the Department, basically?

Professor Heymann: If Public Health England is part of the Department of Health, and the Department of Health is making the policies for public health, the evidence will not be as clearly perceived and trusted as if it were coming from an agency which was not working within the Department of Health but working as an executive agency. It is very important that trust be maintained in scientific evidence and that that scientific evidence be obtained in the best way possible so there is no interference in providing that evidence to the policymakers.

Q84 Chair: What about in terms of the relationship with emergency service and delivery locally?

Professor Heymann: Our concern is that those be seamless from the centre through the commissioning and into the public health activities at the local level.

Q85 Chair: Does that not become more difficult if, at national level, it is independent in order to be an independent information-gatherer?

Professor Heymann: An executive agency would still be within the Government and this agency would respond in the way that the Secretary of State would request.

Q86 Valerie Vaz: Who do you relate to at the local level? Would it be the commissioners or your own outposts? How does that information filter down and back up again?

Professor Heymann: These are issues which are still being developed at present. We are hoping it can be developed in such a way that the Public Health Units will provide the guidance necessary for a seamless and responsive filtering.

Q87 Chair: Could we hear other witnesses on this point of the proposed structure?

Baroness Massey: This is a very interesting issue. I have worked for an arm’s length body, as they were called—the Health Education Authority—many years ago. There are tensions when you have an agency which is reporting to Government but is independent, in a sense. It often depends on very clear communication between the two to make sure that toes are not stepped on and things are consistently performed. In this case, as I understand it, Public Health England would be the agency, with all of the people that you have mentioned earlier in it, like the Health Protection Agency, ourselves and so on. That would require a good deal of working out. I don’t see why it shouldn’t work, provided that one did pay attention to the knock-on effects at a local level—because there will be knock-on effects. We know working locally is very important and that we need agencies which are not only at a national level. We would have to work out exactly how those local agencies operated and we would have to work out the commissioning and budgetary issues, but I don’t see that there would necessarily be any difficulty about that.

Professor Ferguson: I would very much echo the comments that Professor Heymann made about scientific credibility and how authoritative the PHO outputs and advice are seen to be. In the new system, that can be protected but it is a risk. Suddenly, outputs that may not fit with Government policy—for example, that give unpalatable messages about wider determinants of health—may not be seen as useful as perhaps they have been to date. The Observatories have had very much a quality assurance role around health intelligence as well and, with the right safeguards, that can continue into the new system. In terms of local organisations, they look very much to the Observatories to help with comparative data—how their own organisations sit with others regionally or with clusters of their own organisations nationally. In my own PHO in Yorkshire and Humber, we are SHA—strategic health authority—employees, but it is fair to say that the SHA looks to us as very much an independent and credible source of advice on a whole range of health intelligence issues. At the moment, that feels possible within the current system. We need to make sure that that is safeguarded in the new system.

David Meechan: I would agree with that in terms of safeguarding the independence of the work and the output. The key thing for Cancer Registries would be the need to ensure that the relationship with NHS bodies, both locally and nationally, is able to continue—the mechanisms for enabling that to happen. Specifically, with cancer, we would need to ensure the continuation of the current NHS Act provision under which Cancer Registries are able to hold and process patient-identifiable data. That is potentially easier within the NHS, but I suppose there would be other ways around that. The final point relates to the ability to generate income from other sources as well. The Cancer Registries, to a certain extent—not a great extent—do commissioned work on behalf of local cancer networks or research bodies. I am also the director of a Public Health Observatory and I know that Public Health Observatories have been successful in generating income from a range of sources. Again, potentially, that could still be done from within the Department of Health but I suppose it would be easier as an executive agency or special health authority.

Q88 Valerie Vaz: Could you describe that process, the income generation?

David Meechan: Both the Cancer Registries and the Public Health Observatories do work for a range of different customers, if you like. On the cancer side, we do small-level commissioned work on behalf of cancer networks, for example, and we do work with local academics on research projects. The Public Health Observatories have also been commissioned. I am director of the East Midlands Public Health Observatory and we take the lead on renal health. We have been commissioned by NHS Kidney Care to do some work. It is that ability to add to the core funding which enables us to broaden our expertise.
Q90 Yvonne Fovargue: I would like to focus on the drug and alcohol services, if I may. What roles do you see the directors of Public Health, Health and Well-being Boards and the GP consortia playing in commissioning the local drug and alcohol services?

Baroness Massey: Our understanding is that Public Health England itself will not commission services but will have an important role in giving specialist advice to local authorities about planning drug and alcohol services, benchmarking performance of systems and disseminating best practice. I mentioned the national role earlier on and it is obviously important to achieve the Government’s ambition of transforming communities into drug-free places. I touched on the issue of budgets earlier and the tensions that there might be there. I also touched on the issue of there needing to be some sort of sub-national level to handle issues of commissioning and also to engage staff and communities in change. Public health is about the health of communities and you have to involve them in that. In the interests of efficiency, we would want new structures—new arrangements—to map on to emerging structures, for example, the NHS Commissioning Board and the work of the Health Protection Units.

Q91 Yvonne Fovargue: How local a presence do you think Public Health England would need to have to fulfil the role effectively?

Baroness Massey: Very local. There is a lot to be said for collaboration between local authorities, particularly where the borders coincide. Drug users migrate from one place to another and the knock-on effects on health in one area coming from drug problems can translate itself into another area very easily and quickly. Thus, I think this should be as local as is humanly possible.

We have a structure, currently, of regional managers who do work with drug and alcohol action teams at a very local level in communities. The drug and alcohol action teams have generally worked—where they have worked—very well indeed in that they have representatives from all the current and important agencies such as health, education and so on, at a very local level—local authority level. It needs to be as tight as that.

Q92 Yvonne Fovargue: Thank you. The National Treatment Agency has said that: “For the first time, funding streams for drug and alcohol treatment will be aligned in both community and criminal justice settings.” How do you think this will work? What do you think will be the benefits and what do you see as being any issues for this?

Baroness Massey: First of all, as you know, prisons are incredibly complex and difficult places, especially in relation to mental health and drug and alcohol misuse. For prisoners we need to have, as people in the community do, a care pathway and a key worker. The Ministry of Justice Green Paper and Drugs Strategy have confirmed that prison-based treatment will be funded entirely by the Department of Health and made available to local partnerships as part of the “One pot, one purpose” ethos. This means that local partnerships and, in due course, local authorities will be able to commission evidence-based treatment services that meet the assessed needs of prisoners in their particular areas.

The benefit of this will be a renewed emphasis on prisoners recovering from dependency and also stronger links with community services to ensure that dependent clients receive treatment and recovery when they leave custody. When someone leaves custody is a crucial time. They can easily fall back into substance misuse habits and they need to be grabbed then. I think that is the answer to that one. Is that all right?

Yvonne Fovargue: Yes. Thank you very much.

Q93 Chair: Am I missing something? It seems to me that the National Treatment Agency is an agency that is primarily responsible for supporting commissioners’ system delivery—care and support delivery—whereas the other three agencies we have on the panel this morning are more concerned with the dispassionate collection of scientific evidence. I don’t really understand why the NTA is lumped together with the other three witnesses we have this morning. It seems to me that you are doing something completely different.

Baroness Massey: You are absolutely right. We are very different. We deal with delivery of services to communities via a regional mapping. We have done—I wouldn’t call it research—surveys, but we are principally, as I said earlier, working with a range of organisations at national and local level to deliver good drug services, to encourage people to emerge—

Q94 Chair: In the discussion we were having about the independence of Public Health England, the case that Professor Heymann was making was that this is evidence collection that should be independent because it is factual and science based. Of course, your services are factual and science based as well, but it is a different concept, isn’t it?

Baroness Massey: Yes. This is a more clinical approach, whereas we are, if I could use the expression, a more community-based approach, based on service, public opinion and on stakeholders. This is not hard research such as David is talking about.

Professor Ferguson: There is one area where there is a much closer connect between the NTA and the rest of the agencies, and that is in the National Drug Treatment Monitoring System.

Baroness Massey: Yes.

Professor Ferguson: The data is collected, analysed and intelligence produced, in many cases by the Observatories. The NDTMS function is provided in six of the nine Observatories around the country.

Q95 Chair: But that is an Observatory function rather than a service design function.
Professor Ferguson: It is. That is correct. The money comes to the NTA and then the service is essentially commissioned from the Observatories.

Baroness Massey: We can follow trends in this way and every local authority has a trend.

Q96 Chair: Both are necessary. Don’t misunderstand me. It just seems to me they are different in nature. Baroness Massey: They are different.

Q97 Grahame M. Morris: Chairman, if I may move on to some issues around the Public Health Observatories, I would like to ask Professor Ferguson for his view on the Minister’s response to an adjournment debate that was held on 17 May, initiated by myself. The Public Health Minister, the Member for Guildford, told the House that “the core public health information and intelligence budget remains similar to previous years” and, with additional grants, “overall funding will be about the same.” How accurate is that statement, in your view? I am sure the Minister would not deliberately mislead the House.

Professor Ferguson: I would make four points, factually, about the figures. The first is that PHOs were told, in a letter on 18 February from the Deputy Chief Medical Officer, of a 30% budget cut to funding levels in 2011–12. The precise wording of that letter was that financial plans of the Observatories should be based on an allocation of 70% of 2010–11 funding levels. That is consistent with what the Minister said in the House about a cut to the core functions of Observatories.

The second point is that in 2011–12 the PHOs’ core budgets were reduced from £5.1 million to £3.9 million. The total figure that we think has been allocated to the Public Health Observatories from the Department of Health in 2011–12 is just over £8 million. The £12 million figure that was quoted in the House is not a figure I recognise but, then again, it didn’t relate to any particular time period. Indeed, it didn’t say what it did and didn’t cover. Therefore, I can’t reconcile to the £12 million but that may be because I don’t know what is in the £12 million.

Q98 Grahame M. Morris: In terms of that £12 million, when your colleague mentioned being involved with a particular Observatory that was doing some work commissioned through the renal service, is that that kind of direct grant?

Professor Ferguson: Yes. What is in the £8 million is the core allocation to PHOs, which, as I say, is about £3.9 million. There are then allocations to some of the specialist Observatories, and that is in areas such as child health and obesity. Then there are some specific projects, such as health profiles. There are small sums of money in there. In the case of David’s Observatory for renal there is about £25,000 in those figures. All of those add up to about £3 million. If you add in the National Drug Treatment Monitoring System figures, then you get to just under £10 million, but, as I say, that is funding through another source. I would make one final point about the funding. The really important issue for this Committee about the funding is not that there has been a cut in funding—everyone else in the NHS and elsewhere is taking funding cuts—but the significant loss of capacity that has already occurred across the PHO network, which is roughly 20% in the last 12 months. Those are hard figures. On the current trajectory, that will worsen during this financial year if action isn’t taken to stabilise the Observatories.

Q99 Grahame M. Morris: Can I follow up on that? I am grateful for that response. It is very illuminating. I note, Professor Ferguson—and you have already stated, for the record, that you were previously Chair of the Association of Public Health Observatories which had all of its funding withdrawn by the Government last year, so I understand, and no longer exists—that, as part of the drive to efficiency, you acknowledge in your written evidence that Public Health Observatories need “to show efficiencies”. However, you are “acutely aware of the need to retain critical expertise,” which you have just mentioned, during this transition period. You specifically ask for a “firm commitment to funding until Public Health England goes live”—so there is no hiatus—“with no further cuts during” the current financial year. Can you, for the record, and for the information of the Committee, give some indication of what this “firm commitment” to funding would enable the Observatories to do?

Professor Ferguson: The firm commitment to funding, at least until Public Health England goes live, would allow us to stabilise the capacity loss that we have seen in the last year. If we continued in our current situation, about 40% of the remaining posts within Observatories are on fixed-term or temporary contracts and about 80% of these actually finish this year. What we have been told to date by the Department is that we cannot renew those contracts, and indeed those staff who have already left we cannot replace. My estimate, which I think is a conservative estimate, would be that we would lose between 40% and 45% of capacity by March 2012 on the current trajectory. That, in an area where health intelligence skills are very scarce, as we have already said, is a real risk to the establishment of a solid public health intelligence function within PHE.

On the APHO issue, we have accepted in the Observatories that APHO has gone. The key issue for us is whether the new mechanism, whatever it is, is an efficient way of organising business across the nine Observatories in England. I would have to say, at the moment, that the co-ordination of those activities and indeed the managing of our relationships with other key stakeholders, such as NICE and the Information Centre—our marketing profile, our communications—is a lot more difficult than it was a few months ago. Co-ordination of those activities, as you might expect me to argue, was very efficiently undertaken under APHO.

Q100 Grahame M. Morris: Very briefly, to follow on from that point—and indeed, Baroness Massey raised in her opening remarks about not having enough public health intelligence and relying upon academic studies that are carried out in the States, in
particular—we are losing 20% capacity this year. But if we lost 40% to 45% capacity, given some of the big stories that are in the news at the moment about the re-emergence of TB in inner city areas, issues around MRSA-resistant strains that are in cattle and the risks to public health through transmission into milk, and obviously E.coli, and with the Olympics coming up and hundreds of thousands of people coming here in July next year, do you think this is a substantial risk that we should identify clearly to the public and to the Department?

Professor Ferguson: I personally do. One area I haven’t touched on is the one that you have mentioned, which is the links to the academic sector. I would say—

Q101 Grahame M. Morris: And the opportunity cost if we have to buy in that expertise which already exists and is very cost effective.

Professor Ferguson: Indeed. In areas like child and maternal health, obesity and elsewhere, we have very well-established links with academics. As I said in the written evidence, we have been part of the Department of Health-funded Public Health Research Consortium across the Observatories since it started in 2004, I think it was. Those links are very much valued by the academic community.

Q102 Valerie Vaz: As a follow-up to that, where is that expertise going?

Professor Ferguson: From the Observatories?

Valerie Vaz: Yes.

Professor Ferguson: We did an analysis of that in January or February when we had lost about 10%. Some of it has been lost to the system completely and, as always happens in transitions, some people take the opportunity to go. Some have gone to the commercial sector. One or two people have gone back into training, and sometimes public health training, which is good, in the sense that it is not lost to the system completely. That was the analysis we did then. We would like to do an analysis of more up-to-date figures because what we calculated in terms of that 20% figure was that 75% was made up of public health consultants or specialists and information analysts. That, for me, is a real worry because it is the bedrock of what Observatories do, and we are losing people like that now.

Q103 Valerie Vaz: You have the grand title of National Transition Director. Could you explain what the role is?

Professor Ferguson: I have a couple of things to say. I was asked to take on that role from April by the Deputy CMO and by the transition managing director for Public Health England. The essence of the role is twofold. One is to help define the future state of the intelligence function within Public Health England; it is there to oversee existing intelligence functions and, where appropriate, to make sure that the workforce associated with those functions goes into Public Health England; and the third and final role of the group is to ensure that essential functions are protected during 2011–12 as we go through transition.

Q104 Valerie Vaz: Finally, what is happening to the group that is chaired by Professor John Newton, the Information and Intelligence Group? What is happening to that?

Professor Ferguson: That group is meeting as we speak. In fact, it meets tomorrow. The role of the working group is threefold. It very much mirrors the role I described for myself in relation to the Observatories. It is there to design the future state of the intelligence function within Public Health England; it is there to oversee existing intelligence functions and, where appropriate, to make sure that the workforce associated with those functions goes into Public Health England; and the third and final role of the group is to ensure that essential functions are protected during 2011–12 as we go through transition.

Q105 David Tredinnick: We heard evidence previously about Public Health Observatories. I got the impression that it was a first-class organisation with PHOs in different regions taking national responsibility for particular aspects of health or particular disease areas and that it all worked extremely well. My colleagues have asked you lots of questions about the transition, but are you confident that, when we have gone through the transition and there have been these funding changes and you have had these losses of employees—some going into training and some retiring—that you are going to have a system that is at least as good as the one that went before it, please?

Professor Ferguson: In response to the first observation you made, I would argue, as you said, that we had a very efficient network in terms of taking lead-area expertise. Indeed, as I am sure David would recognise, the Cancer Registries and others have very much followed that model in terms of how UKACR operates. The lead-area model has been very successful.

In terms of my confidence about where we are going, the honest answer is I am not sure because we have, currently, a loss of capacity along the lines I have described, with the trajectory for us to lose more people. As we speak, the University of Durham is meeting with the North-East Public Health Observatory director. That meeting is with the executive committee of the university to decide whether to make the staff of the North-East PHO redundant—at least the university-employed staff. Who knows what the outcome of that will be? There is not a lot of optimism out there among the PHO directors that we will be able to stabilise capacity at
the moment. That situation can be rescued very, very quickly.

Coming back to the question that was asked earlier about the commitment in the House to the level of funding being at roughly the same level as before, it would be very interesting for us to know how we access that additional funding, which I think was described as coming through Department of Health additional grants and so on. If in fact what has been planned is an additional sum of money that would allow us to not have a 30% cut in 2011–12, then clearly we would be interested in knowing how to access that.

David Meechan: If I can follow up on that comment, both on behalf of the Cancer Registries as well as in terms of my role with a Public Health Observatory, there are two issues as well as the funding issue. One is the general uncertainty of the staff within the organisations, not knowing (a) whether they have a job, (b) where that job might be and, (c), who their employer will be. The sooner that uncertainty is resolved, it will remove a significant risk. That obviously depends on getting clarity as soon as possible on the future functions and structure of Public Health England.

Q106 David Tredinnick: There is a degree of fog out there at the moment: uncertainty, people are leaving the organisation and, as we have already heard in previous evidence sessions, there is not enough data about health issues in the country on which to make objective decisions. Professor Ferguson, you have said that you are not quite sure how it is going to work out—and you are in charge of transition. Going back to my original question: do you think we can have a system that is as good as the old mechanism, confidence that, at the end of this road, we are going to my original question: do you think we can have a system that is as good as the old mechanism, confidence that, at the end of this road, we are going out—and you are in charge of transition. Going back to my original question: do you think we can have the better results. Is that right?

Professor Ferguson: For me, it is early days for the I&I working group that the question was asked about earlier. A lot of good work has brought together the different agencies involved, but I think everybody in the group would probably say it is early days. The real test will be in a few months’ time when we really are looking at the design stage of the new system. There have to be very demonstrable efficiencies as we organise health intelligence better across the agencies—the Registries, Observatories and so on. Once that is done, we have to be in a position where the intelligence that is provided is done using economies of scale at sub-national level, at national level and so on. We are simply not there yet, but that is the design work that has to take place in that group. It feels like early days.

Q107 David Tredinnick: You need to design a better framework to get the better results. Is that right?

Professor Ferguson: Yes.

Q108 Chair: It would be a correct inference, wouldn’t it, from the title that you hold—National Transition Director for Public Health Observatories— that the Government wishes to maintain a national system of Public Health Observatories?

Professor Ferguson: Indeed.

Q109 Chair: Is that a correct inference?

Professor Ferguson: I think it is, yes.

Q110 Chair: You think it is.

Professor Ferguson: It is.

Rosie Cooper: You hope.

Professor Ferguson: I hope, yes.

Q111 Rosie Cooper: Will you have the resources to be able to function?

Professor Ferguson: There are not the resources to enable us to co-ordinate the activities of the Observatories in the way that we did before because of the issues raised around APHO. Colleagues who sit in the Observatories will be aware that only in the last few weeks were we told there will probably be no co-ordination function across the Observatories from August or September time either because of the loss of APHO or within the Department. That is something we need to follow up with Department colleagues very urgently because I am concerned that if we don’t have the co-ordination function across the Observatories then we will continue to see a loss of capacity.

Q112 Grahame M. Morris: Can I come back on that, please? It is a really interesting point. Certainly, coming from the north east, I am very concerned about what is happening with our Public Health Observatory. It has done some excellent work in relation to direct commissions from the Department, dealing with health inequalities for people with learning disabilities as well as some excellent health inequality stuff—“Miserable Measures” and other reports it has been involved in producing. But I still can’t understand in my own mind why the PHOs are being treated differently to the cancer networks. In view of what is happening with threats to existing Observatories and loss of key staff, how can you be sure that, under the new arrangements, you won’t either be abolished or merged into something else?

Professor Ferguson: The honest and short answer is we can’t be assured of that. I perhaps should have said at the start that I am a co-director of a Cancer Registry in Northern and Yorkshire, as well as being director of Yorkshire and Humber PHO. It does, exactly as you say, feel very different. I sit in executive meetings at our Cancer Registry and we have taken a less than 1% hit on funding in 2011–12. We are carrying on largely “business as usual,” although David, I am sure, would be the first to say there is a lot of national work to centralise and be more efficient in the registration function in the Registries, but it feels very much “business as usual”. We talk about when we are interviewing, when we are recruiting to vacant posts, and it feels like a completely different world in the Observatories. I am sure all my colleagues in the Observatories around the country would echo that.
Q113 Rosie Cooper: It is a bit like currently knowing you have a PCT till 2013. It is like the Mary Celeste. You might call it that, but it doesn’t necessarily deliver anything like it did before. Therefore, I don’t take a great deal of comfort from the fact that you are still there with a lot less staff, possibly a lot less direction and you are not co-ordinating. Are we going to have a load of little silos with a few little people but it looks good? Professor Ferguson: It is my job to make sure, working with other organisations on the I&I group, that we do as much as we can to mitigate against that eventuality. If the question is, “Am I confident that we will get there?”, then, as I have already said, I hope that we will get there. The reality is that, on the current direction of travel, we will continue to lose people in this financial year.

Q114 David Tredinnick: Going back to co-operation and co-ordination, again when we had evidence before, one of the strongest aspects of the Observatories was that everybody knew what everybody else was doing. We had these specialist organisations and there was a feeling of confidence about them. There was almost a collegiate style of co-operation and management. Now you have told us that the co-operation and co-ordination aspect is one of the most serious issues, haven’t you, in the future? Professor Ferguson: What I am saying is that, with the loss of the central funding we had before, the co-ordination function is much harder to perform. I can give you a couple of practical examples that might help. We have had very good relationships with a number of partner organisations, such as NICE and the Information Centre. I used to have top team meetings between APHO and the Information Centre, but those have gone because it is not my remit to do that anymore. We used to have a very strong conference presence at places like the NICE conference and the NHS Confederation. All of that has stopped. That means it is very difficult to disseminate the outputs that we previously had. We previously co-ordinated the production of a range of technical briefing and other reports across APHO. Those have stopped. The website is no longer actively managed. It is maintained but it is no longer developed. There is no proactive development work of the APHO website. All these things may change. Certainly these are things that have been flagged within the I&I group and people recognise they need to be dealt with but, as of now, these are the sorts of examples of the co-ordination that has stopped.

Q115 Chair: I am sorry to be personal, but you are the National Transition Director. Are you not telling us something that should be done and does the buck not stop with you? Professor Ferguson: The work that we are doing within the I&I group is exactly the work I am describing. Here we are in June. APHO stopped in March, which is why I said it is early days on the I&I group. The work that needs to be done to prepare the Observatories for the new system is exactly the work of the I&I group. I need to play a part in that and I am playing a part in that alongside colleagues from the other agencies. The problem is that the other agencies on that group are not facing the same scale of budget cut as the Observatories have faced and it feels a very different place in the Observatories.

Q116 Grahame M. Morris: If the DH were commissioning a study in order to compile an evidence base on a particular issue, what would the difference in cost be? Do you have any figures about the cost of using the in-house service with the analytical expertise that the PHOs have compared to, say, KPMG or some international private health care consultancy? Professor Ferguson: Our core funding is, as I said earlier, around £3.9 million—

Q117 Grahame M. Morris: It is small beer in the context of £103 billion, isn’t it? Professor Ferguson: It is a small amount of money and we have generated, in response to the point David made earlier, in the order of another £11 million in 2010–11 on top of our core funding. I think we have demonstrated that we have been hugely successful across the Observatories in operating in a health intelligence market, which is what we have done in the last five years or so.

Q118 Rosie Cooper: I have some questions to address to Mr Meechan about the Cancer Registries in the future, but, before I do, I have a personal question that I have been thinking about. You hold 8.5 million cancer registry records linked to 34 million hospital records. Yet, last year, when I met cancer charities they all complained that you don’t collect information about staging. Is that (a) accurate; (b) where we are; (c) how did you get there and (d) isn’t that stupid? David Meechan: Where shall I start? It is partly correct. The Registries do collect some information on the stage of disease—that is, how advanced a patient’s cancer is at the time of diagnosis. One of the key things that was picked up in the recent National Audit Office report and Public Accounts Committee and, indeed, is a key part of the cancer outcomes strategy, is the challenge for all Cancer Registries to get to the level of the best Cancer Registry in terms of having at least 70% of cases with stage recorded.

Q119 Rosie Cooper: Why would you not record them all? It is the very thing that defines treatment. The whole thing is just nonsense. David Meechan: There are reasons, which I haven’t got time to go into now, as to why 100% isn’t an appropriate target. The reasons it has not happened so far are several, but one key one is that the Registries are reliant on receiving that appropriate information from provider hospitals and that information hasn’t been flowing as well as it should have done.

Q120 Rosie Cooper: What could you have done to make it flow? To me, this is the core of where the
whole treatment thing starts. It bewildered me then and it baffles me even more now.

**David Meechan:** You are correct that it is a key component of the data that we should be collecting. What is happening now is, first of all, the NHS framework requires hospitals to provide that information to Cancer Registries. It is also part of the standard contract between PCTs and hospitals that they should provide that information to Cancer Registries. What we are also doing within the Registries is adopting a common national system. In effect, we are developing a single national cancer registration system using a common computer system, common approaches, if you like—common processes—and the target is that all Registries will be at that 70% level by the end of 2012.

**Q121 Chair:** I am still struggling with this idea that there are 30% of people who have had a diagnosed case of cancer where we don’t need to know what stage the disease has got to.

**David Meechan:** There are certain cancers for which it is not really appropriate. The best Registries at the moment achieve that 70% and, building on that expertise, the aim is to get them all to that level of 70%. If I give you another example, that might help. There is a small of number of cases for which the only thing we know about the patient is that this patient has had mention of cancer on their death certificate. That patient was never diagnosed in a hospital as such, so it is not appropriate for it to be staged in that instance. There are several—

**Q122 Chair:** Our prime focus should be living patients, shouldn’t it?

**David Meechan:** Yes.

**Q123 Rosie Cooper:** Perhaps you could let the Committee have some information on it.

**David Meechan:** We will do.

**Q124 Rosie Cooper:** Frankly, you have existed for this long and not got this absolutely crucial piece of information. “Bewildered” is a polite way of putting it. I understood that name, everyone has been doing. The doctor needs to know that information to treat. That will tell us whether cancer has been diagnosed late and that plays into all the decisions that follow thereafter. How anyone could say, “I’ve been involved in a registry and we haven’t actually got that information,” I don’t know. Hospitals may not have given you that information, but you haven’t dealt with it via the Department of Health, or whatever, to ensure that you get it and are now just saying, “We’ll have 70% of it by 2012.” I question what the heck is going on.

**David Meechan:** I agree entirely in terms of the need for it. Part of the issue is, as you quite rightly say, that the stage of cancer should be recorded at the multi-disciplinary team meeting where the patient’s treatment is discussed. That happens most of the time. What doesn’t always happen, though, is that stage is recorded in an appropriate computer system or whatever.

**Rosie Cooper:** Perhaps you need Professor Heymann to give you a hand.

**David Meechan:** That is the first issue. The second issue—as well as it not necessarily being recorded within the hospital notes—is that that is not then routinely transmitted to Cancer Registries. That is what is being addressed at the moment.

**Rosie Cooper:** So that’s okay then.

**Q125 David Tredinnick:** Following on from Rosie, I find it very hard to take on board, with primary care trusts in position for so long, that we are now being told they are not providing the information that you require to make assessments. I understood that it was roughly three months a stage in cancer, as a rule of thumb. If you are not having information of anybody in stage 1 cancer, there must be some failure to provide treatment for those who develop cancer at a later stage.

**David Meechan:** There are two issues there. The first is, as I said earlier, that a stage is, by and large, discussed clinically in terms of informing the treatment of the patient. I would reassure you that that is the case. Then the issue is over the recording of that stage, whether it is put in the hospital systems, and then the transmission of that stage to the Cancer Registries. That is where the emphasis is, currently, to improve that flow of data. That is why, as I say, within the NHS operating framework this year it has been explicitly stated that NHS trusts are expected to provide that information to Cancer Registries. Secondly, it is why it is in the standard contract between PCTs and the trusts in terms of information flows.

**Q126 Chair:** I think we have covered that. What the Committee would like is a note as to this 30%: why is 70% acceptable? It sounds an extraordinarily low number to me. On a slightly different point, the Cancer Registries carry out the same function for cancer patients as Public Health Observatories do for patients in generality. It is striking that both Professor Ferguson and Mr Meechan are, reciprocally, members of the other team at a local level. Do we need two separate processes here—two separate cultures, as Professor Ferguson was describing it?

**David Meechan:** You are absolutely correct that there are very close similarities and there is a lot of current joint working. There are joint directors, such as Professor Ferguson and myself, and there is close liaison between many Registries and Public Health Observatories. The one key difference between the two, as I think I said earlier on, is that Cancer Registries have two functions. One is the analysis, interpretation and intelligence function, if you like, which is the prime function of the Public Health Observatory as well. The other function that Cancer Registries have is the collation of data and the building up of a dataset about everybody who is diagnosed with cancer. That is the collation, the building and managing of a dataset which the Public Health Observatories do not have—a prime data collection or collation.
Q127 Chair: Is this individual patient notes, effectively?
David Meechan: Yes, it is generated from individual patient notes. I would agree entirely with the point that Brian made earlier, that we need to maintain and develop the closer integration of public health intelligence functions between Public Health Observatories and Cancer Registries, but also with other intelligence functions between the HPA and the NTA.

The other thing for Cancer Registries is the need to look both ways: to similar public health intelligence functions but also to the cancer community, if you like, and the need for the specialist functions of the registration, the data collection, the coding side of things, and also in terms of specific analyses, like cancer survival analysis, and to relate to things like the National Cancer Intelligence Network, which is a partnership of public and private bodies, including the major cancer charities. Again, as I said earlier, Professor Sir Mike Richards, the National Clinical Director for Cancer, is very reliant on the National Cancer Intelligence Network, of which Cancer Registries are partners, in terms of providing useful information to monitor the progress of the national cancer outcomes strategy, including the aim of saving 5,000 lives a year. That also requires the need for improved data on how early patients are being diagnosed. That is a critical factor.

Q128 Chair: Is there a reason why there is a Cancer Registry and not, for example, a diabetes registry or a heart disease registry?
David Meechan: That is a good question. You would have to go back in time to understand the origins. I suppose it is because cancer is a major killer. There are over a quarter of a million new cases of cancer diagnosed each year. It is a major disease in which there is a lot of interest.

Q129 Chair: The parallel with coronary heart disease would be pretty precise in that respect. Therefore, the answer to my question, “Is there a good reason?” is, “If there is, it is history.”
David Meechan: Yes, probably. There is clearly the need for an equivalent intelligence around heart disease, but it is structured differently.

Q130 Rosie Cooper: May I continue where we were before. In essence, you have described difficulty in getting data to the level you want, but now there is an element of compulsion. How confident are you that Public Health England will be able to have systems in place to get that comprehensive, accurate and timely information which you require, especially if the NHS becomes fragmented—more diverse—with other providers coming in? You can’t do it with a tame bunch. How are you going to do it when we are out there with everybody having a go?
David Meechan: That is also a good question. In terms of the current situation, if I can reassure you again, the Cancer Registry is working with the National Cancer Intelligence Network and they are putting a lot of effort into providing more timely and complete data, including stage. With current systems, that is what we are doing and the aim is to achieve that target by the end of 2012.

The point you made was if there is more plurality of NHS providers, then that will make the system more complicated and we would have to make sure that there were appropriate mechanisms in place to ensure that that data flows. Therefore, we would need to make sure that the kinds of things which are currently in the NHS operating framework are built into the new system. Building it in through commissioning consortia—in their arrangements with provider trusts, there might be some contractual agreement that they would provide the necessary information to the Registry—is one way of doing it. At the moment we have the issue that, if a patient is solely treated in the private sector, we don’t necessarily know about that patient’s cancer. We do in some cases, but it is on a goodwill basis. There is no contractual—

Q131 Rosie Cooper: That is minimal, isn’t it? In the numbers, that would elicit concern.
David Meechan: It is relatively small, but there is an increasing amount of private sector treatment. It will depend on whether a patient is diagnosed in the NHS sector, in which case we should know about them. You are correct that if there is more diversification of providers, we would need to make sure that, in the new system, those safeguards are built in.

Q132 Rosie Cooper: You couldn’t get all NHS providers to give it you and they are contracted to you. How confident are you that you can get on top of this and actually deliver?
David Meechan: I’m pretty confident that we will. As I say, we are moving towards a single system. We have appointed a single lead for cancer registration modernisation within England. We are being very closely monitored by the Department of Health and people like Professor Sir Mike Richards.

Q133 Rosie Cooper: How will it fit within Public Health England? That is what I am really saying. Are you sure they will have the resources and that this will all fit in as you have described?
David Meechan: Going back to an earlier point, although our financial allocation for this year has not yet been formally confirmed, our understanding is that the funding for 2011–12 for Cancer Registries will be similar to last year. The efficiencies will be through achieving more with the same rather than taking the kind of cuts that the Public Health Observatories have. The biggest risk, again, as I said earlier, is in the uncertainty. All we have been told so far is that the cancer registration functions—and indeed the same applies to Public Health Observatories—will be within Public Health England. What we don’t know yet is what those structures will be and that uncertainty is leading to the risk of losing skilled staff. That is the biggest single risk in terms of the resilience, if you like, of this moving forward into public health.
Rosie Cooper: In my world, a one-year assurance is not very much assurance at all.
Q134 Chair: This session has come to a close, unless there is anyone on the witness panel who would like to make any closing comment or any observation that has been buzzing around.

Baroness Massey: Could I make one closing comment about monitoring? This has been a fascinating discussion that we have been having here. Could I send you some information about how the drug treatment monitoring system works because it did have a rocky start? Difficulties had to be overcome but were overcome. It was a rather complex process and I can send you details of that if you would be interested.

Chair: It would be useful. Thank you very much.

Professor Heymann: I would like to bring up two issues that were raised, again to underline the importance. One is the need for a seamless response—levers to pull when there is a pandemic and the assurance that what needs to be done will be done at the very local level. That includes the type of partnership that exists today between the directors of the Health Protection Units and the local authority directors of public health. They need to remain keen partners in this.

The second is to come back to the issue of expertise. HPA is also losing expertise. It is losing expertise because of the uncertainty in what will occur in the future. Some of the best people—two of the best people, in fact—have already left and gone to a university environment. It is very important that we ensure that decisions are made rapidly and that staff are reassured of what will be coming in the future.

Professor Ferguson: I have one word, the integration word, which I know I have used a few times. There is a role that I have to play and all the other agencies have to play in the designing of Public Health England, which is about making sure that what we end up with is a better integrated system of intelligence than the system we have now. Personally, I am absolutely committed to that, but, as everybody here today has said, we have to make sure that, as we move from where we are now to where we need to be, we protect the scarce skills and expertise that we have in the system.

Chair: Thank you very much. Thank you for your thought-provoking evidence.

Examination of Witnesses

Witnesses: 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, gave evidence.

Q135 Chair: Good morning. Thank you for joining us. Could I ask you, briefly, to open the session by introducing yourselves and telling us where you come from?

Councillor Rogers: I am Councillor David Rogers. I chair the Community Wellbeing Programme Board of the Local Government Group. I am a county councillor in East Sussex.

Jo Webber: My name is Jo Webber. I am Deputy Policy Director at the NHS Confederation.

Dr Atherton: Good morning. I am Frank Atherton. I am a Director of Public Health up in Lancashire but I am also the President of the Association of Directors of Public Health.

Dr Reid: Good morning. My name is Keith Reid. I am a consultant in public health in Bristol and I am the Co-Chairman of the BMA Public Health Medicine Committee.

Q136 Chair: Thank you. I think you all heard the previous evidence session, or some of it. One of the issues that came up there was a discussion about whether Public Health England should be seen as part of the Department of Health or whether it should have a more independent status in order to provide it with a degree of separation between Public Health England and a Whitehall Department. Could we open the session by asking what position each of your bodies takes on that question?

Councillor Rogers: Thank you. We would certainly support it being an arm’s length body. That would allow for there to be more clearly-defined relationships between Public Health England and the public health responsibilities of local government. To that end, we supported an amendment—when the Commons was last discussing the Bill—to that effect, which, as you will know, was not successful. That position has been one that we have supported for quite a while.

Jo Webber: We would think that an arm’s length body may be one way of doing this. The most important thing is to ensure that there is an independent voice there, that the advice given by Public Health England can be independent and that it can be a strong voice for health protection and health improvement advice.

Dr Atherton: We support everything that Professor Heymann mentioned for pretty much the same reasons. It is important that Public Health England is not just independent in terms of its advice and its information but that it is perceived by the public to be independent. We believe that the risk of the loss of funding streams is a significant issue. We also see the construct of Public Health England, either as an NHS special health authority or an executive agency, as being a solution to some of the problems of loss of capacity that was coming to be apparent at the end of the last session because it could then be a host for public health staff across the board. We are very
supportive of it not being part of the Department of Health.

**Dr Reid:** To continue the theme, we would be very strongly supportive of Public Health England being an NHS special health authority, a key reason being to establish the independence of the advice which emanates from Public Health England. A further reason would be to ensure that it can accommodate specialists across all three domains of public health practice. At present, it is focused largely on health protection and health intelligence issues and not seeking to embrace those in health care public health. We feel that they have a place in a public health service. The third reason is largely to ensure that there is a better interface between Public Health England and the local delivery of health services and public health services. We feel that would be better accommodated by Public Health England being an NHS body.

**Q137 Chair:** Can I ask each of you again, perhaps in reverse order because it might be more interesting, what would that look like if it were separated in some way from the Department? Would it employ the public health workforce and second them to local authorities? How deep into the system would this organisation go?

**Dr Reid:** Our key concern is that it should act as a welcoming home for the public health specialist workforce, so it should employ them. Since the bulk of the specialist workforce is employed within the National Health Service at the moment, we would see creating a body, probably within the NHS, as being a very easy way of making the transition. It simply involves gathering up the public health specialist workforce into a body which is part of the organisation which already employs them rather than creating special arrangements.

**Q138 Chair:** Is there not a danger, just to challenge that, that if you do that you lose one of the bits of value added intended in the proposals, which is to engage the public health professionals more actively in local authority decision making?

**Dr Reid:** I absolutely accept that that is a danger. My counter to that would be where we see the engagement with local authorities working well at the moment. It is working well with the public health specialist workforce coming from an NHS base. It is working well because the public health workforce in the NHS is acting right at the interface between local authorities and external bodies, so it is causing local authorities to face outwards in addressing public health determinants. Obviously, those are affected by housing, planning, the environmental situation locally and all those sorts of issues. It doesn't make sense for

We have seen evidence from the current joint working arrangements that that can be accommodated within a model which employs the director of public health in the NHS.

**Dr Atherton:** I have a similar view in that the bigger risk in the system, as currently proposed, is the fragmentation of public health. Keith has talked about the three domains of public health and there is a real worry in the public health community that health improvement staff are going to move to the local authority, health protection staff may move to Public Health England and nobody quite knows where the staff who will support GP commissioning—the health care public health people—will sit in this new system. We regard that as a bigger risk than the risk of loss of ownership by the local authority.

Ownership is really important. I think all our organisations have welcomed a greater focus within local authority on public health and greater leadership of the public health agenda. Thus, ownership of the staff is really important but that can be achieved just as well through secondments and arrangements, which currently exist in various forms, as they could by direct employment. At a stroke, it would solve a lot of very difficult and deep HR and transitional issues.

**Jo Webber:** We would probably be supportive. The main thing is to get the system working well locally. It may be down for local agreement as to where the public health specialist sits for pay and rations. The most important thing is to ensure that we don’t lose all the bits that have been talked about before, making sure that the evidence base used in commissioning health interventions is still there locally and available, but also making sure that the links are stronger between the GP commissioners and the local authority commissioning package, whether that be straight public health or other things like housing support services, leisure and those sorts of services as well. I don’t think we would say necessarily that people need to be employed within the NHS or within the local authority. It needs to work for local systems and there needs to be some recognition that, locally, this needs to be very clear about how all the domains of public health are delivered.

**Councillor Rogers:** From a local government perspective, we recognise the concerns that Dr Reid and Dr Atherton, in particular, have mentioned about where the expertise should sit and how that should then be deployed. For us, the most important point is the intended integration of public health within local government. If that is the underlying principle, then it doesn’t seem logical that the employment issues should lie elsewhere.

Of course, there is almost inevitably a transitional process and it might make sense for the employment, during a transitional process, in order to make sure that that expertise and competence and all the rest of it is not lost, to lie elsewhere. But, in the long term, for the very reasons that, as I understand it, these changes are being proposed, it is all about the integration of the public health function and the wider health determinants. Obviously, those are affected by housing, planning, the environmental situation locally and all those sorts of issues. It doesn’t make sense for
the employment in the medium to long term not to be with local government as well.

**Q139 Chair:** On that model, what then would be the model of the independent agency? What would Public Health England look like on your model?

**Councillor Rogers:** The independence of the public health professional I don’t really see as an issue that is significantly different from the vast range of other independent advice that is offered to members of local authorities before they make sometimes very difficult decisions about how resources are allocated locally. There are something like 480 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, as I said, to those. The maximum benefits would be derived from a full integration of the public health workforce within that system.

**Q140 Valerie Vaz:** What about the budget? Are you in favour of ring-fencing the budget or not?

**Councillor Rogers:** “What about the budget?” That is an excellent question. There are at least two issues there. The first of them is that although some work is underway, as I understand it, to identify what the baseline is, we don’t yet know the outcome of that and, therefore, we don’t know. A figure of £4 billion has been speculated upon. The BMA, when we met public health representatives at a round-table last week, were talking of £5 billion as being the current situation. The real issue is that we don’t know what the totality is. The question, beyond that, is: how much of that would be transferred to local authorities in order to have this responsibility and how much would be retained by Public Health England—whatever format it might have—in order to undertake the national responsibilities? The first question is to identify the total sum and then to ensure that the necessary resources are allocated to deal with the functions, however they are decided upon.

**Q141 Chair:** Almost by definition, it implies that we are talking about an inadequately defined range of functions if we don’t know how much we are currently spending on them, doesn’t it?

**Councillor Rogers:** Yes.

**Dr Atherton:** On the budget, I agree that £4 billion is a somewhat artificial construct, but there is work going on by the Department of Health—and it has been trialled in the north west—to look at what is being spent on public health. There is clearly more work that needs to be done on that. Your question was about the ring-fencing, I think. The ring-fencing from the directors of public health point of view is useful, probably in the short term. It is useful at the moment, particularly to protect resources of view is useful, probably in the short term. It is useful for the wider budget in a different way to develop better public health interventions?” But you may well need the ring fence in the short term, and only in the short term, to give people the space to develop new ways of working in their new partnerships and the new health and wellbeing plan based on a strategic needs assessment.

**Q144 Chair:** Others want to chip in, but can I ask you to bear in mind that a ring fence was once described as a fence made of rings. I wonder whether it creates a false sense of security and that you need to be able to make those arguments in reality from day 1.

**Dr Reid:** The point is well made that there are two elements to this. There is one to ensure that those services currently delivered elsewhere—which are badged “public health”—for which responsibility transfers to the local authority, the funding for them is clearly identified. Those services are protected. There is a longer term issue around bending the culture and the way of working in local authorities so that our consideration, every time a pound comes up for spending is, “What is the public health gain or benefit from spending this pound?” The two things go hand in hand, one on a longer timescale and the other one is about protecting vital and important public
health services during the transition. That is what we mean when we talk about protection of public health budgets, whether that is transitional or whether we see that as being a longer-term solution.

Councillor Rogers: We have all used the word "transitional" and I understand it in that context because I understood Dr Atherton to say that one of the issues was protecting the baseline before any transfer. That may well be an issue but, in the longer term and in principle, we don’t believe that the money should be ring-fenced because if the objective is integration—as I was explaining a few minutes ago—it makes sense for the budget to be seen in that way as well. Also, that ties in with 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.

Chair: We never thought you might make that point.

Q145 Rosie Cooper: I have real worries—and I accept the argument in theory—about the practice. As a member of a health authority, we had a big meeting with councillors, the community and every strand of person with an opinion represented however that was constructed. With an economically-reducing pot, we looked at how we would deal with the health pressures across a health economy. At the end of it, no matter who you were or what you did, cardiovascular disease was at the top and sexual health or dentistry was at the bottom. We all looked at each other and said, “This is not the model we want to describe or want to have, but, with financial pressures, that is where we are.” You are going to move into a situation where finance is really tight. I know we can all work smarter—we’ve learnt all that rubbish—but, at the end of the day, councillors will be forced to choose between X and Y. You are not, surely, going to say that you are sure things like sexual health will not end up where mental health is in the Health Service currently—the Cinderella service on the edge because you can’t see it and it’s not in your face every day. It will fall off the end and money will be used for other resources which local taxpayers want. The Council Tax payers will want their roads fixed and will want X, Y and Z done. One person at director level is not going to be able to deliver down to that degree under that kind of pressure. Or is that what you are telling me?

Chair: That one is probably directed at Councillor Rogers.

Councillor Rogers: I am happy to start. There are two things I would like to say there. First, we have not yet talked about Health and Well-being Boards, the joint strategic needs assessment and the strategy that would then derive from that.

Chair: I have to say that we don’t plan on spending very long on those this morning.

Q146 Rosie Cooper: No, but the Health and Well-being Board has no power whatsoever. It only has power to talk.

Councillor Rogers: We don’t know that yet.

Rosie Cooper: It is a powerless talking shop.

Councillor Rogers: We don’t know what the shape of the Bill might be in due course. The point there is that—

Q147 Rosie Cooper: Hopefully it will disappear.

Councillor Rogers: If the joint strategic needs assessment identifies sexual health or any of the other Cinderella services as being a priority for that area—and they might well do in a particular area—that would inform the commissioning processes, both for the intended GP commissioners and for the services that local authorities commission. That is, if you like, the principle. Of course, I accept your point that we are in a time of unprecedented strain on public finances and that there could well be some casualties. But we can’t sit here and say what that would be. That would be a matter for local determination through the structures that are intended and judged against other priorities. That has always been the case in relation to public spending whoever is making those decisions.

Q148 Rosie Cooper: We need to go to bed praying not to be suffering from anything that is not a priority then.

Dr Atherton: Can I perhaps give a little comfort? One thing to say is that the public health budget has never been terribly safe in the NHS. It has been a low priority. We know that. You will remember back to Sir Liam Donaldson’s report, which talked about the raiding of public health budgets when times got financially tough, round about 2005–6. We remember all that. It has not fared very well historically, even though we intuitively know that better spend on prevention will lead to better health outcomes and will reduce the need for high-cost tertiary care. We never quite get there in the NHS.

There are examples in local authorities, even in tough times. Very recently—one very specific example—Lancashire County Council decided to make all roads in residential areas near schools and other residential areas 20 miles per hour zones because they were convinced by the evidence that it would reduce road traffic accidents and, particularly, that it would reduce road deaths for children in more deprived areas. So there are examples where you can use evidence to bend the mainstream, and that would cost several million pounds, in a time of hardship.

Rosie Cooper:: Absolutely. As a Member of Parliament who, unfortunately, has to deal with Lancashire County Council, that might be a really great decision but it will take eons to deliver.

Q149 Chris Skidmore: That raises the question of the definition of public health. Many people would say that the public health budget should not fund road reduction schemes—that it is not necessarily a public health issue—and would question that. It does come down, also, to the Government’s new outcomes framework which will help to decide its public health remit. In particular, Councillor Rogers, I was interested in the Local Government Group’s idea of a single outcomes framework, having the NHS, social care and public health. I know you have talked about integration, but I was wondering if you could give a bit more explanation of your reasons.
Councillor Rogers: You have hinted at the answer yourself already in that if the principle underlying all of this is integration of a pathway for a patient, a client, a service user—whatever term we choose—and we see it from that person’s point of view, what they want is something that addresses all of their needs, whether those have traditionally lain with the NHS, with social care or with public health. I really think that we ought to be looking at it from that end of the telescope, if you like. That is why we have argued for a single outcomes framework. Of course, there is a degree of evidence that there are similarities between the three that are currently proposed, and it is good that there are overlaps, but, in our view, having a single one would not only make the case for integration stronger but would also ensure that the commissioning decisions—as I said, whether those came from GP consortia or from local authorities, or indeed from anywhere else—would be addressing the real needs of that particular community.

Q150 Chris Skidmore: There is also an issue of the measurements that occur in the outcomes framework. In the evidence from the NHS Confederation, Ms Webber, you mention the issue of the time lag between implementation of policy and achieving those improvements.

Jo Webber: Absolutely. There are some proxies that you could use for the short term—and by “short term” I am meaning one, two or three years—but, with some public health interventions, it is going to take you 10 or 20 years before you see what that outcome might be, by which time you are going to have had probably two or three changes of idea about which way this is all going. Therefore, there is an issue about getting the right proxies in place as well in the short term and then allowing the evidence base to be built. Over the long term, you can change and refine the outcome so that you get something which really does give you a feeling for whether you are meeting the needs of local people. It is a very different timescale from, say, the NHS outcomes framework, where a lot of this is about how much you meet within a set period or over the course of a year. With public health it is a completely different timescale. It is a completely different partnership that you need to have working together to deliver any one of those outcomes.

Q151 Chris Skidmore: Could I quickly then roll on to the next question which is on the specific issue of taking a set period of time? We have the issue of the health premium. One thing I have noticed in the evidence put before the Committee here is that all of you use the words “unintended consequence” in your evidence. I was wondering if you might be able to give a better explanation about the concerns you have with the health premium. We have our own concerns, but it would be interesting to hear what your views are on this.

Dr Reid: As to the health premium in concept—the idea that it should be a reward element for improving local health, reducing health inequalities—the wording used in the consultation document was it would be devised by a simple formula. My problem is that I can’t see how a simple formula can lead to such an important element being devised. I am concerned about how we measure change. How will we establish where we are and where we have got to over the fixed time period for which the health premium will be given? I have concerns about measuring reliably over historical periods. I am concerned that it will be given retrospectively, so you will get a reward for something which has happened previously. It is not linked to current practice or devised in such a way as to incentivise innovation and bold attempts at addressing inequalities. I am concerned that, as expressed, there is not a link to the size of the problem. We know that health inequalities exist everywhere, even locally in Westminster, but the number of people affected by health inequalities is the number of people in poor health, and to be in poor health is different in different places, despite the existence of health inequalities. Therefore, I am concerned it needs to be linked to the number of people whose health status has been improved as a result of specific actions rather than just reducing a gap.

Dr Atherton: I have similar points. The ADPH point of view has been very clear. We should be looking to target extra funding towards need rather than to reward good health status. If we are going to use it as a performance reward, then it should be based on relative improvement rather than just absolute health outcomes, for the very reasons Keith said. It is easier to improve and have a good health outcome in leafy Fylde in Lancashire than it is in parts of east Lancashire.

Jo Webber: We don’t disagree.

Q152 Chair: We probably don’t need to hear the same point repeated. Is there a different point? Do you agree with it?

Councillor Rogers: I do agree with the need to differentiate between good and bad areas, but the other issue is whether it would be based on local outcomes or national outcomes. Obviously, I would argue the localist case—you wouldn’t expect me to do otherwise on that—and also to ensure there was some way of reflecting the diversity of communities. Often health inequalities occur in very specific pockets within a wider local authority area. That is an important point to bear in mind too.

Jo Webber: There is also an issue around some inner city areas where the churn of turnover of population is such that you can never improve because, as people improve, they leave and more people and more deprived groups come in. You never get an improved outcome, even though you are doing well in terms of your health improvement activity.

Dr Atherton: People are not ring-fenced.

Chair: They go through the rings.

Q153 Grahame M. Morris: Councillor Rogers and Jo have covered the issues there. The Committee went to Hackney and Shoreditch and that was the point I wanted to make. My area is fairly stable and does not have the turnover—although we have had huge problems with health inequalities often associated with heavy industry and so on—but where there is a huge transient population, it does not make any
difference how good or targeted the health interventions are. As you say, populations aren’t ring-fenced. We appreciate that.

Q154 Chair: Can I come back to one of the structural questions and the impact on a specialist workforce? Is it the LGA’s view that local authorities should be free to appoint people that satisfy their tests to this public health function, or do you think that appointments to the public health function should be required to be from certain specialisms defined elsewhere? Secondly—a different but related point—if a director of public health in particular falls foul of his local authority, do you think there should be some safeguard to his position from some external body?

Councillor Rogers: I will deal with the first part of that first. As I understand it, the faculty currently accredits people both from a medical background and from other backgrounds. Provided that were to continue to be the case, we would have no difficulty with such a process. If a director of public health had been thus accredited. Nevertheless, we think it should be a local authority appointment. I come back to the point that if the responsibility and the accountability is to be there, which is where I believe it should be, then it doesn’t make sense for there to be in the long-term—and again we might need transitional arrangements—anything other than the appointment and, in extremis, dismissal processes that apply elsewhere. Of course, the latter is not something to be entered into lightly or without the proper engagement of partners. Who those partners might be is one of the uncertainties that we all know surround much of this.

Q155 Chair: You don’t really support any kind of dual accountability to local authority and Public Health England?

Councillor Rogers: There is a difference between line management accountability and professional responsibilities. Again, I would make the comparison with a whole range of other professions where the people concerned would be in very close contact with their professional associations.

Q156 Chair: That is a different point, though, isn’t it, the professional association and the accountability to Public Health England as an executive agency?

Councillor Rogers: Indeed. In that case, I am clearly arguing that the responsibility should be local. Dr Atherton: I will deal with a couple of your points. One is about the requirement that certain standards are met for a director of public health. Councillor Rogers is absolutely right. The current position is that the faculty approves that. We are truly multi-disciplinary—we have medical and non-medical directors of public health—and that has brought a great strength to the profession. But, as directors of public health, we make decisions which impact on the health of our populations. We provide advice which needs to be quality assured. We are strongly of the view that the current system for regulation is really important and that that remains in place, that directors of public health are properly trained, accredited and appointed to—

Q157 Rosie Cooper: Should there be a statutory register?

Dr Atherton: We believe that, for all directors of public health, it should be on a statutory basis. They should have statutory registration. In fact, we go beyond that and apply that same principle to the public health specialist workforce. At the moment, medically qualified directors of public health and consultants are statutorily regulated. Non-medical equivalents are not. I think there should be the same playing ground for everybody.

Your point about the dual accountability, though, is somewhat problematic because we don’t really understand where the director of public health role in respect of health protection would be in the future. If the director of public health is going to have a significant role in health protection, as we believe they should because we certainly do at present, then they need to be officers of Public Health England as well as an officer of the local authority. We believe that dual accountability is quite important to discharge those functions. However, it is not entirely clear, as I sit here, what the future arrangements are for health protection and what the future intended role of the director of public health is around health protection.

That is a major issue and concern which we need to address as soon as possible.

Q158 Grahame M. Morris: Can I seek some clarification as to your views in relation to emergency preparedness? You were in for the earlier session and I think it was Professor Heymann who said—and he was sitting where Councillor Rogers is sitting now—when we asked about the category 1 responders, that it was kind of a work in progress. He said Public Health England should be a category 1 responder, that there should be a coherent response at local level and that it was still being worked on by the Government. I am sorry to go on about E.coli—I am becoming obsessed by it—but where there is a significant disease outbreak or there is a public health emergency, how would this emergency preparedness be tackled at a local level under these new arrangements? Should it be a local lead or a Department of Health, Public Health England lead?

Councillor Rogers: Of course, if we are looking at examples elsewhere, such as in Germany, the clarity is not there, is it? I am not entirely convinced that there is the clarity under the existing arrangements that there should be. To my mind, this is another example of where greater clarity in the detail of the proposals is needed, and we have touched on that in relation to a whole range of other issues already.

Q159 Grahame M. Morris: What is your preference? Should it be at a local or a national level?

Councillor Rogers: I think the two go hand in hand because, even if you have a degree of national responsibility for such incidents, you can’t deliver that without the engagement of the local authority and other partners at local level. It needs to have everyone...
involved in a partnership arrangement, but that does need to be defined very clearly, to answer your fundamental point.

**Dr Reid:** It is quite clear who is responsible at the moment. It is the director of public health who is legally responsible for mounting the response. Under the proposals, that should continue. On the face of the Bill as it currently stands, there is a proposal to put responsibility for health protection of the local population on to the local authority. The responsibility will then have to be exercised through a local officer. The key person to do that is the director of public health, who will have the skills, the training and expertise to do that.

The key words which David Heymann mentioned earlier were the duty to plan and prepare, which arises from the Civil Contingencies Act. It is about making sure that responsibilities are explicit, that each person knows the role they are expected to play and that they prepare to play those roles. Therefore, when an incident does arise, it is a well-oiled machine which springs into action and we are not sitting around thinking, "It would be good if we had a plan. Let's come up with one later." My concern is that, as currently proposed, Public Health England will stop at the level of the Health Protection Unit, which will not be at a local authority level but will be sitting above a number of local authorities. There is a potential difficulty at the interface between Public Health England and the local authority under the current model and the idea is that that should be bridged through the person of the office of the director of public health. How can that person do that effectively unless they have a good relationship with Public Health England? One way of establishing that good relationship is through accountability. An even better way would be by seconding them out to local authorities. There is a potential difficulty at the moment, we make things happen to respond to incidents largely through goodwill, our relationships and our contacts, but primary care trusts, of course, are category 1 responders. In the new system, we would suggest that all NHS bodies, both commissioning and NHS-funded providers, need to have the same duties to respond to public health emergencies that currently sit with primary care trusts, otherwise the leaders become weaker and it gets harder to get things done when you need to.

**Q160 Rosie Cooper:** I have a practical question. When you have difficulties with winter pressures and hospitals getting clogged up, do you see that working in this new world? Let’s say there is an outbreak of something—I do not know what—hospitals are getting clogged up and you need to get people moving. How are you going to deal with that?

**Dr Atherton:** I will kick off. Again, this is one of the key scenarios. I think Professor Heymann talked about some joint work which the Association of Directors of Public Health and the HPA have been doing, and that is one of the scenarios we have been looking at. In the current circumstance, we have an SHA which would co-ordinate that, hold to account the acute trusts and co-ordinate the efforts of community providers—of everybody. There is a potential weakness in the system because we don’t know who will hold that role in the future. Will it be the National Commissioning Board? Will it be Public Health England? As part of that transitional risk, and until we know quite how Public Health England is going to be constructed and what the responsibilities of the local authorities are, I don’t think anybody could tell you how that will be managed.

**Rosie Cooper:** Absolutely, and obviously that is the point I was making. There is a huge risk here because you are going to have a lot of people running round with nobody, in this interim period, having the power to make it happen.

**Q161 Valerie Vaz:** Can I move the debate on slightly? Both Dr Reid and Dr Atherton mentioned, in their opening remarks, that no one seems to be talking about health care public health. Could you explain why it is so important, how the system runs now and how you see it under the new NHS commissioning role?

**Dr Atherton:** Currently what happens is that, within public health teams, there are consultants in public health who specialise in things like needs assessment work, prioritisation, bringing an ethical dimension to commissioning and helping to support prioritisation of investments and disinvestments. These are really important things, especially in a challenged financial environment. If we are going to meet the £20 billion so-called Nicholson challenge those kinds of skills are going to be really important to GP commissioners in the future.

At the moment, they are provided as “free goods”, really, through PCTs. It is variable. Some places are very well resourced in that regard and some places very poorly resourced, so there is some variation. But there are a number of models starting to emerge which might be possible. One is that if those public health staff people move into the local authority, they could...
be provided back to the GP commissioners to support their work. There are places where GP commissioners are looking to directly employ public health consultants, but that raises the spectre of a lone employee. There is a possibility that they could look to the private sector—these are people who have very specialised skills who could find a home for themselves, should it be needed, in the private sector—and the point that was made earlier about buying back resource more expensively from the private sector could well happen. Our preferred option would be to keep that resource as part of the public health workforce: to keep an integrated workforce and have it available to provide back to the GP commissioners to support their work.

Dr Reid: Can I follow that up? I suppose I should declare an interest because I do work full time in health care public health at the moment supporting the South West Specialised Commissioning Group. The key thing for this group is that it is a small number of individuals who do this full time. There is a larger number of individuals who will do this as part of their role and may take the lead in one aspect of health care. There is a point about capacity—and be involved in commissioning services through that. There are smaller groups of individuals, like myself, who do it as a full-time specialism. The key is to make sure that we don’t lose this resource. The other key is to make sure it is organised in such a way that there is a critical mass and we don’t have the situation which we have had in the past where we have had individuals become isolated and become ineffective as a consequence. The way to do that is to look to create a single home for the specialty health care public health, or perhaps two homes. One would be in the National Commissioning Board, where a health care public health function would sit quite happily along with the other clinical advisory roles which are going to be provided to that Commissioning Board. You could see that as being a smaller cohort of specialists, perhaps including those who currently provide specialist Health Service advice like myself, numbering about 15 to 20 across the country. The other home would be a larger number of about 180 who could form a central resource available to health care commissioners. Against this, a model of having an independent employer of the specialist public health workforce has advantages because it would allow those individuals to be employed as a single central resource and seconded out on a contractual basis to others to provide health care advice to them. It would enable them to maintain their professional skills and expertise; it would enable the critical mass to be maintained; and it would identify them as being independent of other interests so that their advice could be seen to be impartial and independent. Those are the preferred models. There are other models which Frank has alluded to but these would come further down our list of preferred models.

Dr Reid: I think it is because there is a lack of understanding of the scope of public health. It is wider than simply encouraging communities and individuals to live fulfilled and healthy lives and protecting them from infectious and environmental hazards. It is also critically, about ensuring they have access to appropriate, affordable and quality health care at a local level. 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.

Q163 Valerie Vaz: What representations have been made to the Secretary of State about that?

Dr Atherton: We have made very clear representations to senior civil servants and to the Secretary of State himself. He understands our concerns, I believe, on that. He understands that we are arguing for an integrated system rather than a fragmented system. What we have not seen yet is a response to the consultation on the White Paper because that has not yet been delivered.

Dr Reid: To my mind, that is the key when we talk about the public health service. The public health service needs to have its function within the NHS and they need to have access to a single central resource and seconded out on a contractual basis to others to provide health care advice to them. It would enable them to maintain their professional skills and expertise; it would enable the critical mass to be maintained; and it would identify them as being independent of other interests so that their advice could be seen to be impartial and independent. Those are the preferred models. There are other models which Frank has alluded to but these would come further down our list of preferred models.

Jo Webber: There are some services, at the moment commissioned together, that are going to be commissioned in three different places within the new system. If you look at sexual health, HIV and AIDS services, they are going to be commissioned through the National Commissioning Board. Genitourinary medicine services are going to be commissioned through the consortia. Teenage pregnancy and other services probably are going to be commissioned through local authorities. There is something about bringing those bundles of public health services around a particular specialism together in one place. If you are not commissioning them in one place, you have to bring them together somewhere, which brings us back to, “Is there a role for the Health and Well-being Board? Is there a role for the director of public health working with Public Health England to make sure that this is all linked together?” This is particularly for sexual health and dental services as well, which is in the same situation. General dental practitioners commission nationally and community dental services, like school dental services, are commissioned by the consortia, dental public health being commissioned through the local authority. It makes no sense when you are looking at it from the patient’s point of view, or the individual’s...
point of view, that you could well find yourself without a service because everybody thought somebody else was doing that particular bit of it. You need to be able to bring these together in coherent bundles.

**Q165 Yvonne Fovargue:** What would be your preferred solution to that?

**Jo Webber:** There is quite a lot of this that could be done at local level—I don’t think everything has to be done through the National Commissioning Board—or at least at a regional level with an input that brings it all together. Maybe that is one of the roles of the director of public health when we are talking about the health care elements of public health as well, to ensure that the commissioning of this is brought together locally and understandable to GP commissioners and local authority commissioners so that we don’t get services with holes in them.

**Councillor Rogers:** I agree with what Jo Webber has just said. I would like to present another example to you, and that is the whole issue of children’s health. As currently proposed, services for under-fives would be commissioned by the National Commissioning Board and for five to 18-year-olds would be commissioned locally. To us, that 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, as Jo was saying just now, that much of this can be done at local level. There might be need for some co-ordination arrangements at something above that, but sub-national, and we certainly wouldn’t want to see the artificial creation of any gaps.

**Q166 Yvonne Fovargue:** The Local Government Group has said that too much has been commissioned nationally and not enough locally. How would you draw the lines and how would you allow for local variation but also have a strategy that would cover various areas as well?

**Councillor Rogers:** This is about subsidiarity, isn’t it? Everything that can readily be commissioned and provided locally should be. Where there are strong arguments, as there are for some acute services, for arrangements that are at a level beyond that, then that would be the responsibility of the professionals to ensure that was put in place. But we would start from the point of view of maximum locally and devolution upwards, if I can put it that way.

**Q167 Rosie Cooper:** If I might go back to the question Chris asked about a single outcomes framework and some comments made by Dr Atherton before, just trying to bring it all together—and I am being devil’s advocate—how would you manage the situation? How would you differentiate between what some people would call a real health outcome and some might call prevention? Using the example that Dr Atherton gave before of the 20 mile-per-hour zones that Lancashire County Council say will save the lives of children round schools, that very same council is also decimating Dial a Ride, for example, which leaves elderly people in a rural area like mine with very little help. It will probably cost £5 for a trip to get to their doctor or to get to hospitals, and there’s the social isolation. There are real health outcomes which happen today as a result of that decision, not a prevention agenda. How do you make those decisions and defend them to the people who are paying that Council Tax who are desperately worried?

**Dr Atherton:** My answer has to be in general terms. The architecture that is proposed in the local authority seems sensible. I hear your scepticism about Health and Well-being Boards. I have been involved in Health and Well-being Boards for a number of years and many of them have been talking shops, I absolutely agree. But there is a chance now to do something different. That is why we have been arguing—I think probably most of the organisations represented here, if not all of them—that local authorities and Health and Well-being Boards should have some form of sign-off of what GP commissioners are about. That is one point. The other point is that the health and wellbeing strategy should bring those priorities into stark relief and should be a way of trying to make those relative choices. I suppose councillors have been making difficult choices for years, but we need to make it more explicitly and more based on evidence.

**Q168 Rosie Cooper:** If you have sign-off on what we would like to call NHS commissioning authorities, should they have some sign-off on local authority decisions, such as what I would consider is a desperately bad decision to deprive old people of their ability to get about?

**Dr Atherton:** It is a good question and David, I think, has the answer to that.

**Councillor Rogers:** You wouldn’t expect me to comment specifically on the budget decisions of a member authority of the Local Government Association. However, in principle, there are tough decisions that need to be made, especially in the current Spending Review period. I am sure all of you will be aware of the 25% or 28% reduction in funding for local government, and these tough decisions need to be made.

**Q169 Rosie Cooper:** I get all that. We have all heard those tapes. The problem we have right now—the question I am asking—is the difference between you making a decision, which is possibly about prevention, and you making a decision which will have a real health outcome today.

**Councillor Rogers:** Yes. I agree there with what Dr Atherton said, that the Health and Well-being Board should have sign-off on local commissioning for GP consortia, clinical consortia—whatever they might be in the future—but also on the commissioning intentions of the local authority in relation to these matters.

**Dr Reid:** There is another point here which is about accountability and responsibility to the population. If it is the local council and local councillors who are making that decision, that needs to be explicit and then the way for accountability to be exercised is through the ballot box. But that raises the question of what advice councillors base their decision on. They
may have chosen to ignore very well-founded advice or they may have chosen to take into account advice of the consequences and press ahead regardless. There is a role here for the director of public health being able to be independent, albeit slightly distant, from the local councillors and being able to make clear the advice that was given to councillors in arriving at a decision. That will help in clarifying processes that lead to contentious decisions and in being clear where responsibility for those decisions lies.

Chair: We are now into the management of commissioning processes. We have probably spent enough time, as a Committee, on that for the moment. Are there any other questions?

Q170 David Tredinnick: I have one other question on a separate but related subject to do with the Scally report, the “Review of the Regulation of Public Health Professionals”. Scally recommended statutory regulation of public health specialists but the Government favours voluntary registration. What positions do your organisations take on this issue, please?

Dr Reid: We favour statutory regulation of all public health specialists and, additionally, we would like to see the Scally recommendation for protection of the title of director of public health.
Jo Webber: The same here.
Councillor Rogers: Yes.

Q171 David Tredinnick: Can you expand a little on why is it so important?
Dr Atherton: It is the point I was making earlier. It is a public safety issue. If you were going to see an orthopaedic surgeon or you were being cared for by a nurse, you have an expectation that those people will be trained or accredited to certain professional standards and that they will be in a properly-regulated profession. It is the same with public health for the reason that I mentioned earlier. We are providing specialist advice on which decisions are made and if the wrong decisions are made that adversely affects people’s lives and health.

Q172 David Tredinnick: Do you think there is a case for allowing health professionals who are registered with a non-statutory body but a body that is recognised by the Government as an authoritative body?

Dr Atherton: Are you talking about outside of public health now? We are making this argument for public health specialists, but for public health practitioners the general view that I have seen is—and it is certainly the view of the ADPH—that voluntary regulation, voluntary registers, etcetera, are appropriate.

Q173 Chair: How far down below the level of the director of public health would the requirement for a—

Dr Reid: Directors of public health and consultants in public health or public health medicine.

Q174 Chair: Yes. The director of public health might not be a doctor but a consultant in public health medicine would be a doctor.

Dr Reid: The director of public health should be trained to the status of consultant in public health/public health medicine. The distinction is whether they are a doctor or not. Not being a doctor is no bar to being a director of public health and being a doctor is no guarantee of being an excellent director of public health, I add quickly being married to a non-medical consultant in public health. Below that is the level of consultant in public health with the rider of “medicine” if you are a doctor. Some choose to use it and some choose not to. That is the specialist workforce.
Jo Webber: Bearing in mind that people like health visitors are obviously already registered as part of the NMC.

Q175 Chair: Do we have any other concluding questions or comments?

Councillor Rogers: Could I make one comment? The Association of Directors of Children’s Services and ADASS—for adult services—are, I think, not represented here this morning but are saying very similar things to what you have heard from us this morning.

Chair: Thank you.
Rosie Cooper: They might have possibly got more of a roasting.
Chair: Thank you very much.
Tuesday 21 June 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Yvonne Fovargue
Grahame M. Morris
Mr Virendra Sharma

Chris Skidmore
David Tredinnick
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: 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, gave evidence.

Q176 Chair: Good morning. Thank you for joining us this morning. Could I ask you to begin this session by briefly introducing yourselves?

Dr Allen: I am Dr Jessica Allen. I was the Project Director for the Marmot Review.

Professor Goldblatt: I am Peter Goldblatt. I am a member of the Marmot Review Team.

Professor Morris: Hello. My name is Steve Morris. I am a health economist and I am interested in resource allocation in health care.

Q177 Chair: Thank you. We would like to begin by focusing the questions, if we may, on the Marmot Review and its implications for policy. Perhaps I can begin by saying that, for the members of the Committee, broadly speaking, it is common ground that there are close linkages between social background and health outcome. That aspect of the Marmot Review findings we can, therefore, probably take as read.

What we are interested in is the conclusions that that leads to in terms of policy and the way the Government has reacted to the Marmot Review findings and recommendations from a policy point of view. Could I begin by asking Professor Goldblatt to open the proceedings by summarising where you feel the Marmot Review led us in terms of key policy recommendations and how you react to the Government’s response to the Marmot Review so far?

Professor Goldblatt: I will begin and share the response with my colleague. Broadly, we came up with six recommendations around the life course. The first of them was on early-years development and the importance of that. The second was on education and training in life, to give people control over their lives. The third was on work, the workplace and employment. We then had recommendations on the environment in which people live and ill-health prevention and, finally, a recommendation on a minimum income for healthy living.

So we had six broad areas of recommendation. There is more detail to each of those. The broad intention is to give people and communities in which they live control over their lives, this being central to good health and good well-being, recognising that many of these, as you said, are all related to the social determinants of health—to the circumstances in which people are born, live and work.

What we concluded in general terms is that to address the six areas, you need a whole-of-Government approach. The NHS is important, but it cannot deliver these on its own. The Government has to work across all parts of Government and a lot of these have to be delivered at local level. It is not purely about central Government policy, though that, of course, is key; it is also about how local agencies work together in partnership to deliver these objectives.

Q178 Chair: There is probably nothing you have said, I do not think, that any member of the Committee would disagree with, although it is not my job to speak for them. I guess the added value I am looking for, certainly, in the health policy arena is something that takes the argument beyond a proposition that stands on its own, independent of its linkage to health. For example, improving life chances and control over one’s own life is something that, it seems to me, is a social policy objective you can justify in its own terms quite independently of the effect on health. The question is: what, additionally, the public health argument adds to a proposition which is a free-standing proposition that most of us would sign up to, independent of the effect on health?

Dr Allen: Where policies are aligned in their objectives—the example that you gave is a good one—and if you add in the importance to health of that particular policy objective, I think it should be given additional priority as a result of that. As a free-standing policy objective it is a very good one and one you would all, maybe, sign up to, but, when you add in the importance to those policies to health, which is not necessarily recognised in the design and implementation of policy, it changes the shape of the policy a bit. We argue that it should mean that those policies have greater priority and, therefore, resources and effort, going towards achieving them.

Professor Goldblatt: What I would add to that is around the evidence base. The link between those policies and health—in what particular ways do you need to deliver those policies I outlined in order to achieve the maximum health benefit. That is through the life course, identifying the ways in which early child development affects health. What matters in terms of an under-five, what matters in the womb, what matters to an infant as to how they will develop and then have a healthy life, as a consequence. All this is within the evidence base and requires particular
actions which, as you say, turn out to be very similar to what you would say is needed to ensure that we had a vibrant economy and that we reduced crime in the community, etcetera. They are fairly similar, but there are specifics which lead to greater health benefits.

**Q179 Chair:** I understand the principle. Could you give the Committee a couple of examples of specifics where the health argument adds value to those general propositions?

**Dr Allen:** In the report we looked particularly at climate change mitigation efforts because it seemed that there were some very clear similarities in actions taken to reduce the impact of climate change and things which, say, encourage active travel, better quality of green spaces and so on. That was one area we prioritised. Earlier, as I think Peter said, there is some very clear evidence on the linkages and benefits of those policies being aligned. That is another area where we would like to see this very explicitly.

Can I make one additional point about the gradient, which does have implications for policy design? The links between social and economic status and health are on a very clear gradient; we are not just dealing with the gap between the top and bottom, which I think a lot of policy has been designed around previously. We argued that, as a result of all the evidence which points to this social class gradient in health, policy should be designed in a way which is both universal, to tackle and lift the gradient, and also proportionate to the depth of the problem, so we see more action towards the bottom end of the social class gradient than towards the top, but necessarily universal as well.

**Q180 Chair:** Proportionate universalism is a new concept for which we are indebted to Sir Michael and his team.

**Dr Allen:** Not the best term, but yes.

**Q181 Chair:** The second part of my question was about the Government’s response. What are the headlines of your reaction to the Government’s response?

**Professor Goldblatt:** We welcomed the emphasis—in the White Paper—on our recommendations, on taking a life course approach and on accepting the principle of proportionate universalism. However, we would have preferred that they accepted all six of our recommendations and we do see a minimum income for healthy living as being an important recommendation. The early years recommendation was the most important but we do also see it as important that people have sufficient income—including benefits (i.e. net income after benefits and taxation)—to participate in society and to be able to buy the necessities to have a healthy life for themselves and their children.

When we compare the poverty levels overall to the amount that particular groups in society have in the way of income—the evidence which we presented in the report showed, for example, that lone parent families were particularly badly off in terms of a minimum income for healthy living. Other groups were less badly off compared to the poverty level. The minimum income is a shift in policy. It is focusing on particular circumstances of individuals, and participation in society is key to having control over your life. That is what we see as missing in the current structure of policy. That is a very specific area where we would have liked to see more done.

The other area where we would have liked to see more emphasis is on local delivery, on partnership working locally, on accepting and putting forward proposals on how to promote a whole-of-Government approach. That is, as I said, at local level as much as at central level. It is not simply about Government Departments being joined up; it is about ensuring that local partnerships are more vibrant than they are at the moment. Again, moving public health into local government is, in principle, welcomed. Of course, the devil is in the detail as to how that is implemented.

**Chair:** Shall we be coming on to that.

**Dr Allen:** I have a couple of points. As Peter mentioned earlier, we need to look at all policy areas across Government to really understand health inequalities. We do have concerns that some of the wider Government policies and the financial situation generally will impact on health inequalities down the line. We have some worries about the cuts, particularly to local government budgets and how that will impact on the services which are being delivered on the people who are most vulnerable and increasing numbers of people who are being made vulnerable as a result of some of the financial situations. Of course, this is not unique to England; it is happening across Europe, and Governments across Europe are struggling with a similar problem.

There is one additional point. We have seen a very good response locally. The national Government response we have talked about but, locally, the response to the Marmot Review has been very encouraging. A large number of local authorities, PCTs and, increasingly, GP consortia, are taking on the agenda and developing their own plans and strategies, which is absolutely central to what we said in the Review and, I think, central to a lot of the Government’s agenda as well. That is an encouraging sign which we are very pleased about and we are working with some of those local authorities to embed some of the high-level recommendations which we made in this to get them implemented locally. That has been a very encouraging development.

**Q182 Dr Wollaston:** Can I follow on from that and ask you for some specific examples of where you think that has been particularly successful?

**Dr Allen:** Yes. We have been working quite closely, in London, both with the Mayor’s Office—they have a very strong health inequalities strategy, which we are helping embed within all the local authorities in London—and we have also been working with Ealing local authority and their new Health and Well-being Board, to try and get a good agenda for them to kick off with, as they begin to develop their plans. We have been looking at parenting and early-years strategy with them and they will take that to the wider local authorities there.
The north-west of England has done some excellent work, as a region, in trying to embed our recommendations and there are examples, across the country, of local authorities and PCTs who have their health inequalities and public health strategies based on the six recommendations we came up with. There is a different take on them all across England but, basically, there is a general acceptance in many areas that this is the way to tackle health inequalities.

Q183 Dr Wollaston: They are using your report as a framework.

Dr Allen: Yes.

Dr Wollaston: Thank you.

Q184 Chris Skidmore: Can I come in on that point of the general acceptance? It does seem, on this principle of proportionate universalism, that it has been universally accepted. I wondered if there was any criticism of that principle within the health community or within the health academics. From my own point of view, looking at the nature of intervention, and, obviously, different communities will respond differently to interventions—I know, Professor Goldblatt, you mentioned about giving communities control over their own lives. I may be wrong, but is there not the risk that one community will take greater control over its own life—possibly an affluent community—whereas a more disadvantaged community will not? The more affluent local area may respond better to intervention than a more deprived community and, therefore, you might see a widening gap taking place. Has there been any criticism of this idea of proportionate universalism? Elsewhere, internationally—say in the States, for instance—what you see with ideas with ObamaCare and, say, Jeff Brenner of the Camden Coalition, is a completely different idea of outreach interventionism, where you are focusing on the bottom 1% and going in really hard to tackle those communities. I just wondered, by having a universal approach, is there not a risk that we create this widening gap?

Professor Goldblatt: Yes, there is a criticism based on the traditional way of addressing inequalities which has been to target the most disadvantaged communities and see an inequality strategy as separate from the bulk of NHS universal care. What we are looking to do is to blend those two so that the effort and resource that goes into is proportionate to need. I think you are quite right that it is far easier to achieve health gain in the most affluent areas. That is where the concept of proportionate universalism applies across local areas as well as within local areas. Earlier this year, with the London Health Observatory, we published indicators, both between and within area, related to our preferred target indicators to show those areas which had an overall high level of ill-health and deprivation and those areas, which are not the same, which have a large gradient within the area. Some of the most affluent areas in the country, like Westminster, have a large gradient.

Q185 Chris Skidmore: With a gradient—obviously, with any gradient—you have to have the Y axis and the X axis. What is the information you place on those two axes? One of the problems I find is we do not have the patient information, sometimes, to be able to locate where the areas of need are. Would you be able to go into some of the data and outcomes?

Professor Goldblatt: Yes. Broadly, until we do have that information at individual level, we have largely used—and we used in Fig. 1 of our report—proxy information on the level of income deprivation of neighbourhoods. That is what we have largely used as the basis for assessing the gradient within an area. But when you look, say, at Westminster, it is fairly self-evident that different parts of the borough have very different levels of affluence.

Q186 Chris Skidmore: Is it a lower super output area type of material?

Professor Goldblatt: Yes. Some of them are based on lower super output areas and some on middle level output areas, depending on the availability of the information.

Q187 David Tredinnick: Westminster is the absolutely extreme case. I would suggest to you, where, north of the railway line, you have north Paddington—

Professor Goldblatt: Exactly.

David Tredinnick: —which is deck access housing with all kinds of social issues. You have a whole plethora of issues to deal with up there and, at this end, you have the highest longevity in the country. Professor Goldblatt: Absolutely. That is why I was using it to illustrate—close to home, if you like—that you can use proxy information provided the information is at a low enough geographic level. If you purely use the information for Westminster as a whole, you lose that texture. If you have neighbourhood information, then it is very clear that neighbourhoods vary considerably.

Q188 Chair: It is quite an interesting philosophical issue, isn’t it? You have said, very directly, that interventions are more effective in affluent areas than less affluent areas. That leads to the conclusion that you want proportionate universalism, which I understand, but, in terms of an intervention that generates a good for a citizen, then the intervention is likely to be more effective if the citizen is affluent.

Professor Goldblatt: Absolutely, which is why we have focused on the life course in saying that you need to get to that point where, if you are talking about adults, every individual has a greater life chance to be able to take advantage of those interventions and why we say that interventions need to begin in the early years. It is only by doing that that, in future years, interventions will become easier in the poorer areas. It is exactly that point.

Q189 Chris Skidmore: Coming back to the life course—you touched on it as well—the NHS cannot do everything. It is quite clear, just looking at the stages you have set out, we have the issue of childhood and early intervention and then, obviously, with social care, there is the issue with the NHS taking over those people who, clearly, in the last stages of
their life often have multiple illnesses and chronic conditions. Take, for instance, the one issue, the case where the NHS often doesn’t see people for a long time, is in the work and family building stage, age 19 to 64, that is obviously where we have a problem because the lack of diagnostic testing means that people only turn up at A&E hospitals once everything has gone catastrophically wrong. What type of interventions can you realistically make without the NHS in that period that is often a dark age period for the NHS?

Dr Allen: One of the clearest evidence bases is the relationship between employment and health: first of all, that employment is good for health and long-term unemployment is very bad for health. Across all the social classes you see a drop. Even for the wealthiest, most qualified people you see a drop in their health as a result of unemployment. That is the first point that is very well known.

The second point is that it is not just any work which is good for health. It is good quality work. There are certain types of work where the control and reward balance and the effort and reward balance is the equal and has good impacts on physical and mental health—and mental health is very important in that. You see the gradient, in terms of quality of work, by social class as well. There are very easy and effective things which can be done to improve quality of work which have a big impact on quality of life and on physical and mental health. We made quite a lot of recommendations in the report about improving the quality of work which is really for the private sector, for large employers, for the NHS to implement. I think you would see some big improvements across the social gradient if some of those efforts to improve the quality of work were implemented.

Q190 David Tredinnick: This is a question for Dr Allen and Professor Goldblatt. The Government has emphasised the need to build individuals’ confidence and self-esteem as a central part of getting them to choose healthy lifestyles. How credible do you think that approach is? Is it sufficient to tackle health inequalities generally?

Professor Goldblatt: It is necessary, but not sufficient.

The important thing is that if you are dealing with a number of adults of working age and they have lost out in childhood and they have lost out in education, they will not have that ability to control their lives which is necessary to take advantage of lifestyle and behaviour initiatives. That is why I said it is much more difficult to achieve improvements from that starting point. Taking the long view, I reiterate that you need to start with early years, with education, and education around the whole of the social and emotional life of the child. It is about whole-school initiatives. You need to be taking initiatives right across the life course to get to that point. That is not to say, of course, that you cannot take initiatives to build up esteem among adults, but it is going to be more expensive, in essence, to do that.

Q191 David Tredinnick: What about the ladder of interventions that is mentioned in the White Paper? How do you feel about that? How adequate is nudging, generally, as a way of addressing health inequalities?

Dr Allen: It is very clear that the most successful interventions which have had the greatest impact have come through quite strong regulation—the bans on smoking in public places, wearing seat belts and so on. Those quite strongly regulated public health interventions have been the most impactful. As Peter just set out, building individual confidence through nudging or through various other means through education is absolutely essential to improving health, but it is not sufficient. You need a whole range of interventions including, we argue, fairly strong regulation, for example, of the food and drinks industry which is something we have argued for in order to have sufficient control over your life, as we have said before, to make those healthy decisions.

Q192 David Tredinnick: Just on that point, and looking at the drinks industry generally, to take the case of obesity, which is part of a strategy, there is a lot of emphasis now on diet drinks, diet colas. I listened to a professor in the other House—not in the Chamber, obviously, but in a Committee room—who was suggesting that, whereas with diet colas, for example, the calorie intake is suppressed because sugar is taken out, the sugar substitutes actually stimulate appetite. Although you drink a less fattening cola and you get all the points, an hour later you are ravenously hungry. Would you like to comment on that?

Dr Allen: I am not aware of that evidence. Are you?

Professor Goldblatt: No, but I think, in terms of the more general issue about obesity, it is not simply about making choices over a single drink. It is about the balance of healthy food that you eat and your ability to have sufficient control over your life, as we have said before, to make those healthy decisions.

Q193 David Tredinnick: On that specific point, with television advertising—social marketing—there is a massive emphasis on advertising food to children now. The food industry actually makes money by getting people to eat more food. There is a lot of subliminal advertising, a lot of fast frames coming up. Do you think we should be regulating that? How important is that, in your view, please?

Dr Allen: I think it is important but regulation should go further than just the messages which are put out. Those are very important, but there are plenty of other things. For example, there is what is called an obesogenic environment, which is about the amount of activity people can do playing outside. Much wider issues are to do with the importance of early years, good nutrition, proper parenting and so on. It is a very wide social programme which is needed to tackle obesity.

There is far more that the food and drinks industry can do—food labelling would be one example, promoting healthy foods, reducing portion size and so on—but they are almost at the end of a spectrum of interventions. They are perhaps the most obvious but they come at the end of a long chain of interventions which start with the wider social environment and...
with education in the early years. Our focus has been much more on the upstream interventions than on the downstream interventions, which are important, and we would like to see more regulation and so on within the food and drinks industry and the supermarkets having a different approach to some of these issues, perhaps, but, also, we would like to see far more upstream.

Q194 David Tredinnick: Can you take the jargon out? “Upstream” and “downstream”? I used to row a bit, but I don’t recognise those in the health context. What do you mean by that?
Dr Allen: The downstream interventions—sorry about the jargon—are interventions which relate directly to individuals and are about changing behaviour at the point of purchase. Upstream interventions are much more about the wider social context. They are the big social policy movements or changes—for example, in education in early years—but you are further away from an individual perspective.

Q195 Chair: Individual regulation has a role to play but it is not, by itself, enough. Certainly, you minimise the effectiveness of it if you do not set a more receptive social and individual context. I understand that. That is a fair way of putting it.
Dr Allen: Yes.

Q196 Dr Wollaston: Presumably, you can reduce the obesogenic environment by not having things like crisps and sweets right next to a point-of-sale.
Dr Allen: Yes.

Q197 Dr Sarah Wollaston: Presumably, that will be more effective than just educating people that they should not eat them, or do you think they are both equally effective?
Dr Allen: Yes. Two points, though. That would be effective, in a small way, but people would still buy crisps and sweets. We know that, but, yes, having them inaccessible there would be a useful thing to do. The point about education is that it is not just educating people to eat healthier; it is about having a better education system. These are big social things which would have an impact on health, and there is plenty of evidence to show that. We know that people with higher qualifications have better health, live longer and have less illnesses, partly because they have more control over their own lives, because they have aspirations to be healthy and so on. You are really talking about interventions which do not seem to have anything to do with where the crisps are located in the shop, but do.

Q198 Chair: They might not be in the sweet shop in the first place.
Dr Allen: Yes, quite possibly.

Q199 Mr Sharma: You suggested that when the people miss out in their childhood, in their education, it is also very important that their adult health will be looked after. You said that this can be handled, but it will be very expensive.
Professor Goldblatt: Yes.

Q200 Mr Sharma: But we cannot ignore it?
Professor Goldblatt: No.

Q201 Mr Sharma: Can you make some recommendations on that or have you done so?
Professor Goldblatt: Yes, we have made recommendations on that. As you say, the main recommendation, in essence, is about adopting a proportionate universalist approach because you recognise, if you are going to change the health and lifestyles and behaviour of the most disadvantaged people, that that requires proportionately more effort to get the same improvements—and those are specifically around ill-health prevention activities and improving the workplace.

As Jessica said, in terms of the workplace it is about the kinds of recommendations that Dame Carol Black recommended in her report; about an improved occupational health service and about getting people into good quality work. It is about, as we have just been discussing, reducing the obesogenic environment, which is both about food regulation and the availability of fast food outlets as well as green spaces in which people can exercise more—again, an observation that, in poorer areas, there are less safe, accessible green spaces than in the leafy suburbs. It is also about improving active travel—again, the more affluent are adopting healthier ways of travelling because of all the advantages they have, whereas the most disadvantaged are still not getting the amount of exercise they need. It is both exercise and food that are key to reducing the obesogenic environment.

There are also recommendations we made about the availability of alcohol which, as we have seen in other countries in Europe, has become a predominant factor in early mortality. It is becoming more and more important in this country. There has been a steady rise in early-onset cirrhosis as an indicator, but excess alcohol use has a range of other health-threatening conditions. Again, there are a variety of things you can do—just going back to the point—persuading someone who has a life which they are less able to control in terms of their daily life who is then less able to adopt all of these healthy behaviours.

Mr Sharma: Thank you.
Chair: Professor Morris has sat extremely patiently. Chris will be going on to your specific line of questioning.

Q202 Chris Skidmore: We are getting on to the line of questions on which I am sure your expertise will be valued, and that is the budget for public health. Additionally, the Government have come out in their White Paper to say that the estimated budget is going to be something just over £4 billion which seems to chime nicely with the table in the Marmot Review for the ill-health prevention expenditure—that correlates in with that.
But I have seen, from your written evidence, that you both suggest that is not enough and that you would ideally like to see 7% of the NHS budget spent on public health. I was wondering if you could give a justification of why that should be the case—how you came to that rough percentage figure and how you see the public health budget expanding in the future. One
of the issues with public health is that there are so many things you can claim is a public health responsibility. We will come on to that in a later question on ring fencing. Why do you think we should probably need to double the public health budget by 2015?

**Professor Goldblatt:** We came at it from three different angles. The first was, simply, when you look at that breakdown in our report, which came from a Health England report and from the OECD split on how you define public health expenditure, you see that much of public health expenditure is on vaccination and immunisation and on the Health Protection Agency, which, of course, are important things—they need to take place, it is important to overall health—but it is about prevention. It is not about earlier interventions in public health to improve the overall health of individuals. It is to stop particular diseases and problems. The first element was that you need a certain amount for that kind of intervention we have been talking about. At the moment, very little of the public health budget is spent on that. Some people have estimated it is something like 0.5% being spent on that element. Our first take on that was you need at least an equal amount, and that is why we suggested a doubling.

The second take was looking in the Health England report which showed that we spend about one third as much, in terms of the proportion of health expenditure, on public health as they do, say, in Canada, and less than the OECD average. Therefore, doubling seemed a modest increase.

The third element was around the specifics of what that budget should be spent on, which is, I think, what you were talking about. The first is on overall health improvement—the universal part of it—which we were discussing earlier. The second is about enabling public health to come to the table in discussions with local authorities and other sectors with some budget of their own to address partnership working. If you go into a partnership and you have no money to offer, then you are in a very weak position. That money is for seed money to encourage initiatives which, as we discussed earlier, have a more general benefit but a particular public health focus. It is encouraging others to come along with that. Again, in terms of Health and Well-being Boards, it is looking at what resources they can bring to the table to start bending mainstream spending. You will only really achieve the big gains when you address the mainstream budgets for education and housing and so on, but you need to have some money to start initiatives in those areas.

**Professor Morris:** If I may, it is quite easy to say that the proposed £4 billion is not enough. That is a fairly knee-jerk reaction. Actually, it is easy to build a fairly convincing case that it is not because of the way in which the figure was assembled. You have seen the tables, but, essentially, it is based on a report—this one—which is basically an estimate of prevention expenditure in England in 2006–2007, defined according to some very specific rules as to what ought to count as prevention according to OECD guidelines in there when they produced the health accounts. With that in mind, it is easy to say why, given what, in the public health White Paper, this budget is supposed to be spent on, it is probably not enough. Very briefly, I can think of three reasons. One is based on what Professor Goldblatt has just said. 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. That is not covered there—essentially because it was not asked for in this information. That kind of activity would not be covered by the £4 billion or—I am sorry—what the £4 billion would cover is only an estimate of the current cost of prevention activities, not the cost of that promotion. The second issue is that, even if you buy into this £4 billion for prevention activities, that is an estimate of current spending—and, of course, that assumes that the current spending on prevention is appropriate. To give you one example, the prevention expenditure figures here include things like the national Bowel Cancer Screening Programme. At UCL we have done a lot of work on the uptake of that and, currently, 54% to 55% of people eligible for screening actually do it.

If you look at the split, in the richest areas it is about 60% and in the poorest areas it is about 45%. There is a lot of variation. You could argue that the current level of spending is inappropriate.

The third reason is a slightly picky kind of thing that an economist would say, and I apologise for that. The £3.7 billion figure is for 2006–2007. Obviously, there is not a lot of difference between then and now, except also in this report they present time series data. What they show is that between 2000 and 2006–2007 the figure on prevention at least doubled. That what would say is, if you are drawing the line, you would end up with a lot more than £4 billion. One of the things I wanted to suggest was, if people are considering going in to bat with that figure, it seems to me that analysis ought to be updated to try and get a more accurate figure on the current level of prevention activities.

**Q203 Chris Skidmore:** When the table that has been finally provided with the total prevention of public health services gets to the £3.7 billion figure by removing the £1.4 billion spent on medication, what would be the rationale to remove the medication element of the public health services?

**Professor Morris:** It is because it is captured by another bit of the resource allocation. There is a particular prescribing budget. The difficulty would be working out how to split that. I think that is why it has been taken out. That is mainly, often, going to be the spending on statins and cholesterol-lowering drugs, but that is covered elsewhere.

**Q204 Chris Skidmore:** As to this £4 billion budget, obviously, in terms of the budgetary restraints over this CSR period, we have a flat £4 billion even if it is, in real terms, an increase of 0.4%. Whether it is ring fenced—I guess they will also have that small real-terms increase—but what you are saying, for instance, is that, as a result, if you have the success of proportionate universalism taking place of bowel cancer screening, even if it goes through that 32% or whatever up to the 54%, you get a levelling out. By necessity, the public health budget almost needs to be ring fenced in a way that it will increase on that sort
of gradient because it is only going to be a victim of its own success.

Professor Morris: Yes, that is right. More importantly, this is prevention and it does not include the cost of all the health promotion activities, which might be partnerships for, say, building more playgrounds, fire and rescue services providing home safety checks and that kind of thing. That kind of activity is not included in these figures. My reading of the White Paper is that this health premium is the sort of thing which is supposed to be funded by that and that is supposed to be coming out of the £4 billion but was not actually in the figures we used to calculate it. Does that make sense?

Q205 Chris Skidmore: Yes. In terms of breaking down the budget and how resources might be allocated to more deprived areas, obviously PCTs had a weighted capitation formula that focused, almost singly, on helping deprived communities. I believe, Professor Morris, you have done some work on that. Professor Morris: Yes.

Q206 Chris Skidmore: Now we have had this reorganisation and we are going to see, obviously, PCTs eventually disappearing by 2013, what work do you know is going on to look at replacing the weighted capitation formula and how it will be implemented? How can we ensure that the budget is in place by 2013 that will provide this gradient approach, so that not only will we have the gradient in terms of intervention but we will have a gradient in terms of the finances?

Professor Morris: Do you mean with respect to the public health moneys or more generally?

Q207 Chris Skidmore: More generally, in terms of focusing on health outcomes for those deprived, ensuring that the money which is in place, certainly for primary care, ends up being directed to those most in need. Professor Morris: Okay. I will try and give as brief an answer as possible, although it is hard to be too brief. One specific element of the weighted capitation formula which is designed specifically for that is the health inequalities adjustment. More generally, the aims of the formula are equal opportunity of access in reducing and avoiding inequalities. Arguably, all of it is designed in some way for focusing on the more deprived populations. Whether it has achieved that is a matter of some debate but, arguably, that is the aim of all of it. However, the bit that seems particularly relevant in the context of public health is the health inequalities adjustment.

Q208 Chris Skidmore: That will be taken into account for the local public health budget, you believe.

Professor Morris: The health inequalities adjustment is currently applied to 10% of allocations; it used to be 15%. Essentially, it is based on the level of health in an area. We did a small project for the Department of Health recently, looking more closely at it. It seems that the aim of this particular adjustment has three things it is supposed to be trying to achieve. One is this prevention activity, the second is the health promotion activities, which we have just talked about, and then there is this third element to do with unmet need with regard to treatment. While there is an amount of budget allocated according to it. How it should be broken on those three things is not very clear. My understanding is that, with the public health budget, that might take away those first two bits but the third one would still remain within the remit of the rest of the weighted capitation formula. One of the issues about that particular adjustment is that it is not ring fenced. Therefore, it could all be spent on treatment, for instance, to quote an extreme case.

Q209 Chair: Do you understand how this formula is supposed to work, bearing in mind that the largest single item of this £3.7 billion is payments to general dental practitioners and payments under the QOF system that are all national contracts? It is not clear to me how the systems are supposed to interface with each other.

Professor Morris: We are in the dark as to how the £4 billion, or however much it is, is supposed to be allocated. I can only presume it might be according to the current method used in the health inequalities adjustment, but that is speculation on my part.

Q210 Chair: Presumably the budget holder in local government will be bound by the contract with the general dental practitioner and with the general medical practitioner under QOF.

Professor Morris: Yes.

Professor Goldblatt: I think the £4 billion is a post hoc calculation of how much was spent. The allocation of money goes down different routes. Money goes to acute care spending and also goes to GP practices. At the moment, the proposals are that more of that money will be diverted through GP practices. In fact, as Professor Morris said, there is no way in the current formula of ring fencing that. Once money is given, as in the past, to PCTs or GP practices, it was down to their discretion how they spent it within the targets that were set for them. A lot of the money that went to GP practices was to meet their vaccination and immunisation targets. That is, as you said, is one of the biggest components. Although that is not ring fenced, it is constrained by the way in which the target system worked for GPs.

Professor Morris: Yes. Presumably all the health promotion activity to the extent that there are for vaccination and immunisation.

Q211 Chair: I want to bring Grahame in, but I don’t understand what levers the local authority has to pull, in particular if we are going back to a national contract for GPs. We already have, as I understand it—but I am open to correction—a national contract for dentists. Professor Morris: I agree with that and it comes back to what I saying before about the idea that this £4 billion is essentially based on that specific set of themes. There might be things over and above that—the health promotion angle—that the local authorities
Q212 Grahame M. Morris: I would like to ask some questions about the health outcomes framework but, before we move off that issue about the ring fencing, I wonder if I might ask this of Professor Morris. His colleagues may wish to comment as well. It seemed to me positively a good thing when it was announced there would be a ring fence for the public health moneys. However, having looked at it in a little more detail, and given that half of it goes to the GPs for the prevention of non-communicable diseases, which is also a good thing, what is the downside to ring fencing the public health budget—just for the record?

Professor Morris: I would say the potential downside is that one needs to be very clear as to what is included in that—I am not sure whether it is the “ring” or the “fence”—to make sure you do not try and pile in all and sundry. As you said, some of the money might already be accounted for and you need to make sure there is enough left for all these other activities. That is the issue.

Q213 Grahame M. Morris: I wonder if I might move on to the Government’s public health Outcomes Framework. This is going to be the yardstick by which improvements in public health are to be judged. We heard, earlier on, from Professor Goldblatt and Dr Allen about the six key recommendations of the Marmot Report. Do you think they should be the cornerstone of the public health outcomes framework? I would also like to know how we will measure these outcomes of performance.

Professor Goldblatt: Yes. We would say, wouldn’t we, that we thought our recommendations and the framework we developed for outcomes should be the cornerstone? It has turned out that they play a part in that, but not as large a part as we would have liked. In particular, if you look at all the outcome indicators, there is a matrix that shows which of them are available or not on the basis of inequality. 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 done.

In our report, we identified a small number of key indicators which we thought were crucial. I think, from what we said earlier, it does not take much to guess what those were. The first one we identified was both life expectancy and healthy life expectancy and their social distributions—their distributions across neighbourhoods. Those are reflected there but in order to monitor measurement of them on a regular basis more work needs to be done.

Secondly, we identified, as an outcome of early years, readiness for school as an indicator and, again, the social distribution of that. As I said, we commissioned the London Health Observatory, early in the year, to start the ball rolling on monitoring that—indeed, independently of the outcome framework, but it should be in there. When we produced our report, we said that there should also be, aspirationally, a measure of well-being, and that would need to be developed. We were overtaken by the Government coming in afterwards and the Prime Minister saying there should be an indicator of well-being. A lot more development work needs to be done to define how well-being relates to health.

We also identified, as an important indicator, the number of people not in education, employment and training, which is linked both to successful schooling, in that they are able to take up employment or education, and also to the employment environment. Those were the ones we highlighted as being key indicators. As I say, we produced our own framework, which we think is necessary to look at some of the processes in moving towards better health, in order to monitor progress across the life course.

Q214 Grahame M. Morris: Following on from that—you have come on to the point that I wanted to raise as a supplementary—in your written evidence to the Committee on how we would monitor progress in tackling public health, you have mentioned some of those indicators about life expectancy and readiness for school, variations across neighbourhoods and so on. I wanted to ask, because it is a bit of a horse of mine, about the future role of the Public Health Observatories. Would you say that they were key in assessing how well we are doing in tackling health inequalities, looking at the evidence and doing the benchmarking and yardsticks between areas and so on?

Professor Goldblatt: Absolutely. They have a key role to play. It needs to focus on the wider determinants of health and they need to move towards that, as many of them are. The important issue is that we have to look at the changes going on in the NHS and public health as a whole and say, “Is the information expertise in the NHS in the right places?” We said in our submission that, as we move to GP commissioning, it is not a traditional part of GP work to do population-based needs assessment. That has been sitting, in the past, within PCTs and supported by the Health Observatories. We are now seeing several of the Health Observatories, under threat, losing key expertise and the expertise that remains is with people, generally, on short-term contracts. As we mentioned earlier, there is a twoday gap between where we are now and where the reforms will be in 2013. In two years, a lot of expertise can be lost.

Q215 Grahame M. Morris: Is it fair to say, Professor Goldblatt—and I don’t want to put words in your mouth, but it is important for the record—if we are going to effectively measure public health outcomes then we need an effective public health observatory system to do that?

Professor Goldblatt: I would say that we need an effective system for monitoring public health, and for two reasons: one, to ensure needs assessments are done in order to implement proportionate universalism. You cannot do that without a needs assessment. The Joint Strategic Needs Assessment in place at the moment provides that starting point—QOF provides that starting point—and more work needs to be done on those.

You need organisations that have the information and intelligence expertise to provide that to the GP
commissioners. Secondly, as you rightly say and as we emphasise in our report, you need a monitoring framework to see how we are progressing, not just on the end outcomes, like life expectancy, but along the process that is necessary to move to that. At the moment, the Public Health Observatories are providing a large part of that. Some of it was provided within PCTs. The PCT element is disappearing quite rapidly, so what you are left with are the Observatories. There is a need to fulfil the role that Observatories are playing.

Q216 Chris Skidmore: Regardless of that, Professor, am I right in saying you would probably agree that, generally, the information we have on patient care records and the availability of that to be analysed is woefully inadequate compared to other countries? If you look at Denmark, for instance, a much smaller country, they have a system where they can analyse public health data because the data exists. You mentioned about NEETS and things like that but all that data is open to easy manipulation.

I can remember looking at the staffing, say, for NEETS—the 16 to 18-year-olds. It has risen rapidly but that does not take into account the number of kids going off on a gap year, for instance. There are lots of ways in which the data can be used, but until we have a system that will bore down to individual level your job is going to be a lot harder. Equally, a lot of the outcomes—life expectancy—you can’t really measure in one year. You have to measure at least five years, if not 10 years. The benefits of the recommendations in your report will not necessarily be apparent until several years down the line. Would you agree?

Professor Goldblatt: Yes.

Q217 Chris Skidmore: At what point would you say an intervention becomes apparent and the evidence is there?

Professor Goldblatt: There are several points I need to answer from that question. The first, which relates to my previous point, is that what we did in terms of our own framework of indicators was to define processes and outcome indicators so that on terms of the life course approach, you can see you are on track to be delivering those ultimate health outcomes like life expectancy. By going through those processes which generate ill-health, along with the social and health processes, enables you to check that you are making progress in the early stages of the development of social disadvantage and of health disadvantage. We spelt out the details of how you would do that.

You are quite right that the information systems we have in this country, while better than those of many countries, are not as good as Scandinavia’s. They are not as good as Scotland’s; we do not have to go as far as Denmark. Scotland has very good link data, dating back to decisions in the 1980s to have a health identifier which links to other systems. We do not. However, a lot of work has been done and I do not think we are making best use of the systems we have. For example, the NHS Information Centre has mortality records by GP practice which could be made more use of in terms of linking them to other types of record.

Q218 Chair: They could be made available to the patients.

Professor Goldblatt: Yes.

Q219 Mr Sharma: How important is coterminosity between the various players in the NHS and public health systems in addressing health inequalities and measuring outcomes?

Professor Goldblatt: Coterminosity has always been important in delivering partnership working. There have only been two or three years, in its history, where the NHS and local authorities have been coterminous, that has created huge difficulties in creating partnership working when it is not clear, for some of your population, whether you should be partnering with your major local authority partner. As to needs assessment, it is essential that you can jointly do a needs assessment for health which links to needs assessments in terms of housing and education.

In those technical terms, coterminosity is important but when we go on to monitoring, again, it is challenging if you don’t have coterminosity but on the ground if you are a GP commissioner and you are not coterminous with the local authorities who can deliver improvements in housing, in health, etcetera, it means you are having to deal with several local authorities covering your patients. That does not facilitate partnership working.

Dr Allen: Also, in relation to accountability for public health, there needs to be some element, both in terms of the discussion about monitoring and in terms of the coterminosity, for the public to know who is accountable locally for public health. That would be amplified if there was coterminosity.

Q220 Mr Sharma: The Government proposes that the health premium will be paid to those local authorities that show the greatest improvement in public health. How effective could this be, particularly in respect of tackling health inequalities?

Professor Goldblatt: What we have said earlier is that, for the most affluent areas, achieving health gain is, in relative terms, the easiest. It will be easier for the local authorities that have the most affluent populations to achieve the targets needed to get the health premium. Conversely, areas of great disadvantage could put a lot of effort in but, in terms of the achievement, will achieve a lot less and will, therefore, get a lot less money from the health premium. 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.

Q221 Chair: Professor Morris, have you looked at the health premium and how that would work in terms of resource allocation and the effect of the application of the principle?

Professor Morris: No. I am not aware of research that has gone on at all to identify the size of the premium. I agree with the comment just made by Professor Goldblatt. However, going back to what I said before,
a very positive aspect of this, which we ought not to lose sight of, is that this seems to be all about health promotion. This is not the prevention bit. This is the bit of the budget that is to do with promotion and working together across communities over and above the prevention activities. In that sense only, I think the health premium is good but, as we heard, the devil is in the detail as to how to make the allocations.

Q222 Chris Skidmore: What economic research has gone on, independently of your own research, into health premiums and their effects? There must be some research somewhere. They would not just introduce a premium blindly without having any—

Chair: Discuss.

Professor Morris: There has been some work, and we quoted this as well—this was something I omitted to mention to your question before—looking at the relationship between funding and health outcomes: how, if you give more money to an area, its health goes up or down. I don’t want to bore you with the details, but it is quite complicated because you give more money to areas that are less healthy where you would expect the health to be worse. There are various hits of work, and an increasing body of work, being undertaken at the moment to say that if you give more money to areas the average level of health in that population goes up.

We did some work, when we did a small project for the Department of Health looking at the health inequalities adjustment, looking at the relationship at all course funding on disability through life expectancy. As an example—and the results were quite tentative—we found that if you spend an extra £100 per person in an area, the disability-free life expectancy goes up by about 0.8 of a year. That was a positive effect. One of the things I was going to suggest, and it is something I forgot to mention before, is that, in terms of the funding, that is another approach that ought to be used, which embeds quite nicely with the health premium. However, it is not fit for purpose at the moment. My understanding is that there is not an algorithm that can be used to “push the button and go”. There is more research that needs to be done to investigate it.

Q223 Chris Skidmore: I guess another approach is that if you sort out problems like middle class drinking, for instance, that leaves a greater resource available in the longer term for the budget to be spent on more deprived areas which have, maybe, more chronic conditions.

Professor Morris: Yes.

Q224 Dr Wollaston: Is another case for proportionate universalism saying that, with the health premium, you make the premium greater for disadvantaged areas and less or would you have another thought about how you would recommend the Government adapts this? Would you say scrap it altogether and use something else? What would be your recommendation?

Professor Goldblatt: As you say, it needs to be focused on more disadvantaged areas. Following your logic, it is the most advantaged areas that have the greatest number of middle class people whose health problems you can sort out more easily, so it is the most advantaged areas that would gain most from a formula which was not proportionate. It needs to be focused either on the socioeconomic characteristics of the area or on providing an incentive for the areas that have furthest to go in terms of achieving health gain. I am not prescribing a particular way of doing it; I am simply saying the end result needs to be progressive rather than regressive across areas.

We mentioned, earlier, the fact that, as with the existing resource allocation, you give the money to a commissioning area. You do not then, on the whole, have a say about how it is spent within the area. Again, this comes back to the point about monitoring. You then need to be monitoring the outcomes in those areas and across people or across neighbourhoods in an area to see how, locally, the money had been spent and whether it was reducing inequalities within the area.

The history of health in this country is that we have seen progressive improvements in the health of all members of the population for quite a considerable time. However, what we have seen is parallel increases that maintain the inequalities between groups within areas. Everyone’s health, for some 20 or 30 years, has been increasing. The trick, as far as we are concerned, is to achieve greater improvements in health among the least advantaged areas and among the least advantaged individuals.

Q225 Yvonne Fovargue: How satisfied are you that there will be an adequate public health input into NHS commissioning to ensure that the inequalities in service provision and access are identified? You have raised concerns about Health and Well-being Boards. Do you feel that ours are now strong enough?

Professor Goldblatt: There is not enough evidence, yet, on how our Health and Well-being Boards will operate. There are certain indicators which suggest, as we indicated in our written response, that the public health input needs to be strengthened. The role of the director of public health on the Health and Well-being Board needs to be stronger and the advice available to commissioners and to Health and Well-being Boards needs to be strengthened. We were talking about the role that Public Health Observatories might play. Again, you also need people in the local area who can provide that public health expertise.

At the moment, with this two-year interregnum, we are seeing a loss of public health expertise at local level. It is not, like any profession, something you can re-gain once you have lost that expertise. We have seen that in some of the other NHS reorganisations in the past. It took some time to re-gain that kind of expertise. There was a long period when there was a huge shortage of directors of public health. We now need to be moving forward in terms of a greater diversity of expertise among directors of public health. There has been some movement in that direction over the last few years, but we need further movement in that direction and, at the moment, while we go through this interregnum, we seem to be moving in the other direction.
Q226 Yvonne Fovargue: Can I quickly raise the issue of fragmented commissioning of the public health? Concerns have been raised before, and particularly about children’s services. What implications does this fragmentation have for health inequalities?

Professor Goldblatt: As I said earlier, we are very concerned to see partnership working and what we called a whole-of-Government approach. At a local level, that is typified by whole-school initiatives where social services and health and education are all working together with the children right across the social spectrum. It is not solely about the most disadvantaged or the most at-risk children; it is about providing proportionate services, again using Sure Start centres to provide proportionate interventions.

That needs to be joined up. There needs to be partnership working. If mainstream budgets are not tied to these sorts of objectives and are held on to within silos, it will be much more difficult to implement the sorts of initiatives of policy change at local level that we were recommending.

Q227 Chair: On that note, we need to move on. Can I ask the witnesses whether there is something you have been burning to say that we have not asked you?

Dr Allen: There is one point we made in the report that puts some of the discussions we were having about costs and so on in context. We had a team of economists which estimated the costs to the economy of health inequalities. They said that, as a result of health inequalities, you see productivity losses of £31 billion to £33 billion—this is every year; lost taxes and higher welfare payments in the range of £20 billion to £32 billion; and additional health care costs—and I think this is a very conservative estimate—to the NHS as a result of health inequalities of £5.5 billion. That is a huge financial cost, let alone the cost to individuals in terms of illness and early death. The costs to the economy are very significant. It puts the discussion we were having about the size of the public health budget in some sort of context.

Q228 Chair: These are estimates referred to in the Marmot Review, are they?

Professor Goldblatt: Yes.

Professor Morris: I did calculate that figure. That is in a Department of Health report.

Chair: Thank you.

Q229 Grahame M. Morris: Could you send us a note about that? It would be helpful if you could, unless it is already in the evidence and I have missed it.

Professor Morris: Yes.

Grahame M. Morris: Thank you.

Professor Morris: Very quickly, it is important to think of the funding at three levels. The first level is what the size of the national budget ought to be, and I hope I have given fairly compelling evidence that I do not think £4 billion is enough.

The second level is how to allocate that money to areas, and I suggested that there are two broad approaches to do this: distribution of ill-health like the health inequalities adjustment or according to the relation between funding and health outcomes.

There is then the third question, which we have not really touched on: what should the areas do with the money once they have it? I guess that is left for local decision and that is partly what is in the White Paper. However, one small point is that one of the things I do is sit on the Public Health Interventions Advisory Committee at NICE, and we make recommendations about how funds ought to be spent locally to improve public health. For some reason, the workload of PHIAC has reduced dramatically. Since December last year, we have not met and, usually, we meet monthly. Everyone is a bit mystified. It seems to me, at a time when one wants to be providing more guidance to local areas about how they ought to spend public health money rather than less, those kinds of activities ought to be beefed up rather than reduced. Thank you.

Chair: Thank you very much.

Examination of Witnesses

Witnesses: 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, gave evidence.

Q230 Chair: Thank you very much for coming and thank you for sitting through most of the previous session as well. Could I ask you, briefly, to introduce yourselves and tell us where you are coming from?

Professor Gilmore: Thank you. My name is Ian Gilmore. I am a physician in Liverpool and a professor of medicine at Liverpool University. My specialty is liver disease, which is why I developed an interest in alcohol, which is responsible for about 80% of liver deaths. While I was President of the Royal College of Physicians, I set up the UK Alcohol Health Alliance, which now comprises 32 health organisations who are concerned about the impact of alcohol on health.

Dr Halpern: I am David Halpern from the Cabinet Office Behavioural Insight Team, which I head. Essentially, our work is to look at other ways in which you can affect behaviour across a range of policy areas. We have looked at health as well as a number of other areas too.

Chris Arnold: My name is Chris Arnold. I am a marketing and advertising expert. I run an advertising agency. I used to be at Saatchi & Saatchi. I also wrote the book Ethical Marketing and the New Consumer. I have sat on the UK’s largest trade body for marketing. I have also chaired the Agencies Council for ad agencies and the Creative Council.
Mark Baird: Good morning. My name is Mark Baird. I am Head of Corporate Social Responsibility for Diageo Great Britain. Over the last couple of years I was seconded into the Scottish Government Alcohol Policy Department, working on the Scottish Government alcohol industry partnership. I have extensive experience of working with and within Government in improving public health and areas of tackling alcohol misuse and I have been involved in drafting Diagio’s responsibility deal pledges.

Q231 Chair: Thank you very much. We would like to start, if we may, by addressing some questions to Dr Halpern specifically, because one of the concepts at the heart of the Government’s approach to public health is what is referred to as “nudge”, which I guess is a popularisation of the result of a Behavioural Insight Team. We would be interested to hear you explain to us how your department works, what we should understand by the concept of nudge and how you work with the Department of Health to develop that as a public health tool.

Dr Halpern: I am certainly very happy to do that. As to nudge, interestingly, the original title for that book with Richard Thaler and Cass Sunstein was “Libertarian Paternalism”. His publisher advised him that this would be a better term, and indeed it was, as I think we can all agree.

The essence of the idea is quite a simple one. All kinds of complex factors affect our behaviour and you can work with them, ideally leaving as much agency as possible with the individual but none the less having a big impact. As you may or may not know, I did a previous stint in Government—I have, otherwise, often been in academia—and while at the Institute for Government one of the reports we did was something called MINDSPACE, which was essentially trying to boil down some very large literature indeed now about various kinds of behavioural effects. Every time you go into a laboratory it feels like a new effect or result is found. Partly, the challenge is to work out which ones are robust and might work in the field versus which ones just melt like the dew in the morning sun. We put together—we commissioned by the previous Administration, at the tail end—a report called MINDSPACE which is, essentially, a way of summarising the main kinds of effects: messenger effects, incentives, norms, defaults, etcetera. Maybe we will talk about some of those as we go along.

They can be used in lots of areas. You asked specifically about our work with the Department of Health. If you had a look across many policy areas, health is one which is surely going to spring to mind. We know, from lots of data, that more than half of all years of healthy life lost are to known behavioural factors—smoking, drinking, diet and so on. Yet, only a small fraction of our effort has been focused on behavioural factors. A remarkable figure actually came up through the Darzi Review that, just to take the research issue alone, less than 0.5% of health research, which is very substantial, is on behavioural factors. Of that, most is medical compliance—when people take their pills. It is a striking juxtaposition between the sheer scale of the behavioural effects as opposed to the effort we spend focused on behavioural factors work with the Department of Health. We cannot claim to be health experts, particularly, but “Let’s see: how can you use these kinds of approaches?” Alongside the White Paper on public health, which makes a lot of reference to the use of these approaches, a document came out, around the new year, giving some examples of those sorts of approaches. I will give you a nice recent experiment on social norms. Social norms are a powerful effect. We don’t do things because they are the right thing to do; we do them because that is what everybody else is doing. Right? When you come into the building, as to whether you use the doors or the bit that turns in the middle or the lift depends a lot on what other people are doing.

To illustrate that—a little health example in a recent study—someone tried putting up a sign where the lift is and the stairs. They try a health sign saying, “It’s much healthier to take the stairs; why don’t you do it?” It has absolutely no effect whatsoever, as is often true for many informational campaigns. On the other hand, they then use a sign which says, “90% of people take the stairs.” It wasn’t necessarily true, but they put the sign up. What happens is there is nearly a 50% increase in the number of people who take the stairs. Not only that but, when you take the sign down, it carries on. It is an effect which is persistent. There is a simple, everyday example of using a kind of nudge—in this case, giving people information about what other people do. It can be very powerful. It is sometimes called channel effects. What look like irrelevant details of policy design or what goes on can often be very big. That is basically what we were doing in health, as we do in other areas.

Q232 Dr Wollaston: I was wondering what the evidence base is for nudging. Could you elaborate a bit more? You have given the example about the stairs but in other areas of life—for example, in the Government’s police on alcohol—how strong is the evidence base for what they are doing?

Dr Halpern: There are two kinds of evidence, of course. There is a very big body of evidence from other areas. Indeed, 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. Obviously, one of the conversations today is going to be about alcohol but, to take a social norm example to follow that through, there has been a lot of work about whether people mis-estimate, make errors about—

Dr Wollaston: “Misunderestimate”? That is a coin of choice.

Dr Halpern:—how much you think other people drink. You can see why it will happen. If you are a student on a campus, you don’t hear the students who are busy studying in their rooms, but you do hear the ones who are drunk and stumbling through the campus at 1 o’clock in the morning. We know that there is a systematic overestimate by people about how much they drink, or indeed by students about how much other students are having, and lots of other things too. There are a number of trials being done in
the US, and a particularly famous one in Montana, using this example—

**Dr Wollaston:** Yes. I have seen that.

**Dr Halpern:**—where, if you give people more information about the social norm, that itself affects behaviour. That doesn’t mean to say there aren’t lots of other things that affect behaviour like price—to anticipate some other line of questioning. We know price is important to lots of things, particularly where there is an alternative product which is available.

Therefore, there 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. That is one of the reasons why this work has to be very empirical. It is influenced by the fact that you have to do trials and find out whether or not it works in the field? Of course, that is what happens in marketing. It is just that Government doesn’t do much.

**Q233 Dr Wollaston:** I meant specifically for the Public Health Responsibility Deal. What kind of evidence base is there that that is going to work?

**Dr Halpern:** It is early days, of course. You would have, for the most part, to look at where it stems from. A nice example, and a particularly good example on health responsibility, is salt. There is good evidence that, if we reduce salt, lots of downstream consequences follow as well. There are some precursors of it. Some EU work suggests that you can get manufacturers to adjust their salt levels, and we know that people cannot tell absolute levels of salt. It will all amount to a strong package that suggests, assuming it sticks—I do not know if that is in your question—and assuming there is a follow-through and it is implemented, yes, if you reduce salt levels, people won’t notice the salt level and there will be far fewer strokes and all the rest of it. One has to take it issue by issue.

**Q234 Chris Skidmore:** On the responsibility of salt specifically, to take that issue, the research showed it reduced salt intake by 0.9 grams but if you look at Japan and Finland, which, obviously, took a legislative approach, they reduced salt intake by 5 grams. At what point do you think a nudge becomes ineffective and you need to go further? Salt is a very good example of where you are able to go a lot further by taking extra action beyond the nudging process.

**Dr Halpern:** You can go further. Of course, you can regulate. That is partly about what you want to do in any given issue. Health is also interesting because it has such a range of behaviours that we are talking about. In some cases it is obvious we are talking about regulation and, in relation to smoking, we have been for a long time. In others, there is much more hesitancy to do so.

One of the advantages of some non-regulatory and voluntary agreements is that you can implement them quite rapidly. Of course, well constructed regulation is a subject where we have many examples of well-intentioned regulation which leads to various kinds of perverse effects. If you can get a genuine hearts-and-minds engagement and solve some of the collective action problems around some issues, then you can achieve very substantial change using non-regulatory tools.

**Q235 Chair:** Would it be fair to characterise your position that there is the opportunity to change behaviour through nudge and through promotion and we need to test how far we can change behaviour and whether that is enough in a given set to deal with a particular issue?

**Dr Halpern:** Yes. Indeed, in terms of responsibility, “Let’s roll up our sleeves and work with the major players who affect our behaviour in an everyday sense and let’s use all the tricks that are available to us”, frankly.

**Q236 Chair:** Mr Arnold, you introduced yourself as a professional marketing guy. How realistic is this?

**Chris Arnold:** Behavioural economics and things like social norms is something in our business we understand quite a lot, actually. It is interesting that, usually, the message you get through the media and the Government is that everybody is getting drunk, everybody is having sex and everybody’s smoking. That is the worst thing you can be saying because you are telling people that is the social norm; what you need to be doing is the other way round. When we did the One Too Many campaign, a Drinkaware campaign run in all the colleges over about 10 universities, we found out that, when we did the surveys afterwards, a lot of students went out drinking because they thought that was the social norm. You actually found, in some of the groups, that a lot of them did not want to get drunk. They just thought that is what you are meant to be doing. If they had all been very open with each other, they would have said, “Actually, only about one of us wants to get drunk. Maybe we shouldn’t.”

There is an enormous amount to be done in educating people. As David said, if you tell them the truth, that most people aren’t getting drunk—most people aren’t getting trashed and they don’t all want to get bladdered—a lot more people behave more responsibly. I think that applies in sexual health and other areas. I used to work for Family Planning as well and I used to be chairman of Family Planning. We had very similar issues with that. If you ask people, everyone thinks they are having sex. The reality is that most of us don’t have sex till we are 19. The perception is that we should be and we are.

**Q237 Grahame M. Morris:** Can I ask a conflict of interest question, Chairman? Clearly the industry and the representatives who are giving evidence in this session are opposed to the idea of regulation and legislation and would rather have voluntary agreements. You support the nudge philosophy. Is there a conflict of interest here between your commercial interests and the impact you have had in terms of policy formulation?

I have been looking through the Register of Members’ Interests and I note that Ian Wright from Diageo made donations to Nick Clegg’s office and that Andrew Lansley was a paid director of Profero and his clients were listed as Pepsi, Mars, Diageo’s Guinness and Pizza Hut. Of course, Mr Lansley’s wife runs a
consultancy called Low Associates, and Kraft is among the clients listed there. Is there a reasonable issue of conflict of interest? How can we legitimately take your point of view when you have a clear commercial interest in not regulating?  

**Chris Arnold:** Personally, I can answer that. I used to sit on the board of the DMA, which is Europe’s largest trade body. As I said earlier, I used to chair the Agencies Council. There is not, actually, an aversion to a certain amount of legislation anyway. In some cases, I think some of us genuinely believe that in certain areas it is not such a bad thing. There is a lot of legislation in the drug industry, for example.

Picking up on a point that you mentioned earlier about subliminal advertising, we are not allowed to do subliminal advertising. It is illegal. There is a lot of regulation already. Sometimes it is not a bad thing to bring it in. Other times it is good to have the industry enforced. We have very strong self-enforcement laws, the ASA, CAP and the DMA. We have very strong laws within the industry that we have to obey. You can’t stop those who work outside the industry from abusing it, but these are not the people we are talking about today.

**Q238 Grahame M. Morris:** In terms of influencing opinion and putting moneys into health promotion campaigns, say, for example, for Diageo—is it one of your clients?

**Chris Arnold:** Yes, I work with Diageo but only on the One Too Many campaign which is by Drinkaware.

**Q239 Grahame M. Morris:** Do you have any knowledge, in general, what proportion of Diageo’s profits would go into such health promotion campaigns?

**Chris Arnold:** Absolutely none, I am afraid. I do not have that information.

**Q240 Chair:** Does Mark Baird know?

**Mark Baird:** We put 1% of our pre-tax profit globally each year into CSR.

**Q241 Grahame M. Morris:** How does that compare with the profitability of the brand and of the company?

**Mark Baird:** We don’t report those financial figures at a GB level. Those are at a global level where we make £2.24 billion but we do put 1% of pre-tax profit into CSR. In the UK, that amounts to a seven figure sum. For example, in the UK alone we put over £1 million into Drinkaware and that is between subscriptions to Drinkaware themselves but, also, into activating the “Why let good times go bad?” Drinkaware campaign. In GB, just on responsible drinking, it is a seven figure sum and at least £1 million of that goes into Drinkaware as well as all the other campaigns that we put into up and down the country.

**Q242 Chair:** Can I bring in Professor Gilmore?

**Professor Gilmore:** Yes. I don’t think I have any conflict of interest other than the influence by the young people I see dying in the wards most weeks. It is a difficult issue. I was involved with setting up the Drinkaware Trust, which is a charity and is funded purely by industry. It took three months of very hard work and knocking heads together to get even 50% of non-industry people on the board of that, and it is very difficult still. I think the health community is not yet persuaded of the independence of Drinkaware and we are watching that with great interest.

Industry, clearly, has to be a partner or a player here when you are discussing the implications of public health policy and how that will affect the industry and jobs. However, I do have a problem when industry is in, at the start, developing public health policy. I think that is where there is a potential for conflict.

**Q243 Chair:** Could you elaborate on that? Is this in defining the targets that we are trying to meet?

**Professor Gilmore:** Yes; even the very approach to take. To parody this, most people would agree that the industry paradigm is 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. Whereas the public health paradigm, which is very much adopted by the Department of Health in Scotland, is that alcohol is not an ordinary commodity. It is a drug. It is a drug of dependence and it is a psychoactive drug but it is legal. We are not trying to make it illegal. The problem is with the product. We have to try to make the environment less “alcogenic”, if I could borrow the obesogenic term, and try to get away from the 24 hour, 7-7 exposure to alcohol marketing, alcohol sales and the cheap prices and use ways, both to nudge but to use firmer measures when nudging is not sufficient, to move people away from misusing that product.

**Q244 Chair:** Would you care to characterise your approach as looking for proportionate universalism in your message on alcohol?

**Professor Gilmore:** Yes. If it is a conflict of interest, I was a commissioner on the Marmot Review and learnt a lot about early-life experience that has, hitherto, been a closed book to me.

**Mark Baird:** If I can contextualise the responsibility deal for a moment by quoting from the World Health Organisation and their global strategy to reduce harmful use of alcohol, from last year: “The Secretariat would provide support to Member States by continuing a dialogue with the private sector on how they can contribute to the reduction of alcohol-related harm.” Also: “The Secretariat encourages Member States to encourage active and appropriate engagement of the private sector and industry associations.” The World Health Organisation actually encourages Member States to involve the private sector in tackling alcohol harm, not making policy. The two are very different.

**Q245 Dr Wollaston:** Can I also take you up on something else the WHO said—that because of the disproportion between spending on CSR and spending on marketing, the actual spend becomes meaningless? wasn’t that their exact words? Can I ask you perhaps, further? You have mentioned that Diageo spend 1% of their pre-tax profits on CSR. How much of their pre-tax profit do they spend on marketing?
Mark Baird: We spend £1.4 billion on marketing.

Q246 Dr Wollaston: What percentage is that of your pre-tax profit, so that we can compare it with the percentage you said?

Mark Baird: It was £1.4 billion against £2.24 billion.

Dr Wollaston: I am sorry—

Mark Baird: £1.4 billion on marketing—

Dr Wollaston: You have spent £1.4—

Mark Baird:—billion on marketing globally, and there is £2.24 billion profit.

Q247 Dr Wollaston: So we can make the figures comparable, you said you spend 1% of your pre-tax profit on CSR—

Mark Baird: Globally. That is £224 million.

Q248 Dr Wollaston: Could you put them both into percentages for me? Do you know what the percentage is?

Mark Baird: I don’t have a calculator; I am sorry. Could I come back to your point on marketing versus CSR spend? I think it is an invalid comparison. You are making the assumption that our spend on marketing is promoting irresponsible drinking. You are almost making a comparison that our marketing of our brands is fighting against our responsible drinking campaigns, when that is not the case. Our brand marketing activity is not promoting irresponsible drinking. Therefore, I would suggest it is an invalid comparison to match that against the activities we do which promote responsible drinking. I would also say that the brand marketing campaigns we have all carry the Drinkaware.co.uk brand name and website address. Therefore, all of our brand marketing is, actually, promoting responsible drinking.

Q249 Dr Wollaston: To pull you up on the proportionality, I was looking at the back page of a well-known Sunday paper, which of course is going to be very clearly visible to children. If you look at the size of the promotion and then at the size of the Drinkaware logo, you would need to have very good eyesight to see it. I think, again, there is an issue about how prominently that is placed. Also, can I ask you to go further on the amount you spend on marketing? Would that include sponsorship in that figure?

Mark Baird: Yes, it does.

Q250 Dr Wollaston: For example—going back, perhaps, to subliminal marketing—it is a great concern to many people that the FA Cup is now going to be sponsored by a drinks brand. Would you say that is a form of subliminal marketing, the link between sporting success and alcohol? We know, obviously, under the Portman rules, you wouldn’t be able to imply that alcohol led to sporting success, but do you think there is an issue there about subliminal placement?

Mark Baird: You are absolutely right. The Portman Group Code doesn’t allow us to associate alcohol brand with sporting success. I think you are making a great leap to say that the sponsorship of a tournament is implying success.

Q251 Dr Wollaston: You don’t think a link would be made in some people’s minds in having a very heavily marketed brand directly against a major sporting event seen by children worldwide.

Mark Baird: We are very clear that we are not allowed to link sporting success with alcohol, so we don’t.

Q252 Dr Wollaston: Why do you sponsor?

Mark Baird: The rules, as you well know, for alcohol marketing is 75% of the audience and above would need to be over 18, which they would be.

Q253 Dr Wollaston: Many people would say that should be a 10% cut-off rather than a 75% cut-off.

Mark Baird: I am aware of that.

Q254 Dr Wollaston: If you think of just the proportion of the general population, what proportion of the general population are under 18?

Mark Baird: I don’t know those figures.

Q255 Dr Wollaston: In other words, it doesn’t really cut it off, does it?

Mark Baird: The 75% rule has been in place for some time. It seems to work. Our marketing regulation or our codes in the UK are often put forward as best practice worldwide. The Portman Group Code has been recommended by the Better Regulation department as a good example, and the International Harm Reduction Association, for being among the top 50 best practices. We have very, very tight regulation in the UK and, by all accounts, it seems to work.

Chris Arnold: Could I add, first, that the subliminal advertising thing is a bit of a myth. It is hard enough selling stuff in your face without trying to be subliminal about it. There is this idea that subliminal works, but it doesn’t. The average consumer is getting 5,000 to 15,000 messages a day being pumped into them from every channel in every way. It is hard to be that less than 5% that cuts through and less than 0.5% that tends to get any kind of results. Subliminalism is much more of a myth. It has always been around in the ad industry and even when they did tests back in the late 1950s, which is what started exploding the myth, it proved to be pretty ineffective. The idea of just having a magazine lying on a floor and thinking that the kid is going to see it and be influenced into buying something has no evidence to prove it either.

Advertising is a lot more effective in switching brands than it is in changing behaviours. Trust me on that because, even when I worked on a lot of campaigns on sexual health and other areas, it is really difficult to change behaviour. It works much more from the bottom up when you want to change behaviour. However, what does improve behaviour more so than advertising is the media. You only have to show Beckham doing something and, I tell you, all the kids and all the adults will follow. You do it on an advert—

Q256 Dr Wollaston: If Beckham had, for example, an alcohol brand on his shirt, would that not have influence, in your view?
**Chris Arnold:** No, because that is sponsorship. There is a big difference to how the consumer sees being paid for and doing things naturally. If they are seen to, we know that consumers respond, but not if they think that the stars are being paid to do things. Mumsnet have just done a survey for us looking into this. One of the things that came back is about when consumers see that somebody is being “forced” to do something. If I am going to be paid to promote Coconut Water, they won’t believe it. If I naturally drink Coconut Water, which is a big trend at the moment, then people will follow suit. That is an interesting one because a lot of people are getting into this and there is no marketing for it at all. It worked from the bottom up.

**Dr Wollaston:** Except you have done some wonderful product placement here today.

**Chair:** Indeed. You will be pleased to hear we are on radio, not on television.

**Professor Gilmore:** I have a couple of comments about marketing and hearing that it doesn’t work. Some £800 million is spent on it by the drinks industry in the UK. There has been two recent reports, one from the European Commission and one within the UK, looking at the impact on young people. Both have come to the conclusion—proper scientific reviews—that marketing influences the age at which children take up drinking and how much they drink when they take it up.

There is a fascinating study from Stirling, from Gerard MacKintosh and Crawford Moodie, “The Impact of Alcohol Advertising and Marketing at Age 13 and Initiation of Drinking,” that clearly demonstrates an association between response to alcohol advertising and marketing at age 13 and initiation of drinking. The researcher has to take a series of measures of drinking or how much the youngsters drank between ages of 13 and 15. The study was designed to prove that alcohol marketing increases or has an effect on youngsters drinking; in fact, it proved the opposite.

**Q257 Dr Wollaston:** I think you will find that Professor Hastings strongly disputes that.

**Mark Baird:** Those are Professor Hastings’s words.1 Professor Gilmore: It is not what I heard from him, but I don’t know.

**Q258 Chair:** Since he has been quoted, it would be helpful if you could produce a report that demonstrates what Professor Hastings has said and we might inquire from him what he thinks.2

**Mark Baird:** Certainly.

**Q259 Rosie Cooper:** I was going to ask why you spend a penny on marketing if the returns are so poor, but Professor Gilmore amply answered the questions I had. I cannot understand, Chris and Mark: if your view is such that it is not unduly affecting those youngsters under 18 and/or not encouraging people to drink, why are you doing it?

**Mark Baird:** If I could speak for us, we market our brands for three principal reasons. One is it maintains the integrity, credibility and image of the brand. Two, it maintains the loyalty of customers who already drink our brands. The third reason is to try and get people to switch from another brand to one of ours. For instance, our marketing on Bell’s Scotch Whisky is to try to encourage people who drink Grouse or some other brand to switch to Bell’s. We can see, by the way the alcohol market has gone over the last few years, that the market is not growing. The purpose of our brand marketing is to get people to switch from another brand to our brand.

**Q260 Rosie Cooper:** Can you do the link for me, then? Why would you advertise your brand on a football shirt or a rugby shirt or whatever? How does that really help you? What qualities there say, “Drink my alcohol,” that is not, “Be successful. Be a winner.” Is there anything there say, “Drink my alcohol,” that does not say to people, “Drink Guinness” but it associates the 1 Note by witness: More accurate would be to say that “these are the words from The Hastings Report.”

2 Professor Hastings subsequently sent the Committee this note: The study at issue here is Ross Gordon, Anne Marie MacKintosh and Crawford Moodie, “The Impact of Alcohol Marketing on Youth Drinking Behaviour: A Two-stage Cohort Study,” Alcohol and alcoholism, vol 45 (2010), pp 470–480. I was responsible for helping with the design and development of the research for this study. The peer-reviewed journal article published by my research team clearly demonstrates an association between response to alcohol advertising and marketing at age 13 and initiation of drinking and increased frequency of drinking by age 15. The interpretation given by Mr Baird appears to rest on a misunderstanding of the research methodology. In looking for evidence of a relationship between advertising and drinking, the researcher has to take a series of measures of both phenomena. Analyses are then conducted to look for relationships between each of the advertising variables and each of the marketing variables, whilst allowing for potentially confounding factors. To this is added the dimension of time. If an advertising variable can be shown to pre-date and predict a drinking variable, this is deemed to be a good indicator of causation. The fact (to which Mr Baird was apparently alluding) that some of the advertising variables did not predict drinking variables does nothing to undermine the indication of causality that was found.
brand with some of the core consumers we would expect from Guinness, which might be over-18-year-old rugby fans.

Q261 Chair: Professor Gilmore, you drew a distinction between the execution of policy and the determination of the objectives of policy. What do you think should be the objectives of public health policy concerning alcohol?

Professor Gilmore: I think the final objective is to reduce the burden of health harm and improve health and well-being. We know that that is best achieved through a population approach. Rather like talking about Sir Michael Marmot’s gradient, if you just tackle one end you make much less impact than if you tackle it at a population level and you shift the whole consumption curve down. The tool with which one can best reduce health harm is by taking a population approach to alcohol consumption, per capita consumption.

Q262 Chair: Your objective would be to reduce alcohol consumption across the population.

Professor Gilmore: Yes.

Q263 Chair: Is there a level of alcohol consumption that is—and I need to use this word carefully—in the normal meaning of the word, “safe”?

Professor Gilmore: This is one of the reasons why there has been so much controversy over safe drinking limits. The Royal Colleges produced guidance, 20 years ago, on up to 21 units a week for men and 14 units a week for women. The Government, in the mid 1990s, changed that to up to 4 units a day for men and up to 3 units a day for women. Everyone rubbed their hands and said, “Gosh, that sounds like an increase to 28 and 21.” They then said, “Perhaps you should have two alcohol-free days a week.”

The problem is that the risks of drinking vary by the condition. For example, the risks for getting cirrhosis are probably quite different from those for getting breast cancer. Drinking one or two drinks a week increases a woman’s chance of getting breast cancer for women? I wondered if there was a distinction between the execution of policy and the determination of the objectives of policy.

Q264 Chair: The reason why I asked the questions in the order that I did is that, if you want to reduce alcohol consumption across the population, the question is whether it is an objective of policy to reduce alcohol consumption in those sections of the community that are already within safe drinking guidelines.

Professor Gilmore: It is not the primary aim. What I said is that the primary aim is to reduce health harm, and we know that is most effectively done by shifting the curve down. While the primary aim is not to reduce the moderate drinker to even more moderate consumption, we know, in a public health sense, that will reduce the health burden.

Mark Baird: To touch on Professor Gilmore’s point—Chair: I was going to bring in the other side of this argument and then come to you.

Mark Baird:—that the easiest way to reduce health harm is to reduce consumption at a population level, I should say that since 2004 consumption of alcohol in the UK has been coming down steadily. This year, for instance—the figures have just come out in May—not only is consumption down but binge drinking is down, under-age drinking is down, harmful drinking is down and hazardous drinking is down. The unfortunate thing is that we have seen that, over that period, as consumption has come down hospital admissions have gone up. That is one of the indicators we use for health harms. What we have seen over the piece is that we have reduced the population consumption at a population level, but harms have gone up. There seems to be an inverse correlation between health harms and consumption at a population level.

Professor Gilmore: To say that there is an inverse relationship is perverse in the extreme when we have seen harm and consumption rise, pari passu, for the last 50 years. There has been a small fall-off in the last few years. It is very small compared to the huge increase there has been, and there are various factors. There probably isn’t time to go into them, but we do know that the number of people who don’t drink at all, possibly for ethnic reasons, is increasing and there may be fewer people drinking more for the rest. There do seem to be more people drinking in a harmful pattern. Clearly, the population approach versus the individual approach is not a black and white approach, but I think you will find any serious public health specialist will tell you that the population approach will give you greater benefit.

Q265 David Tredinnick: On Professor Sir Ian Gilmore’s points, do you think there is a case for making people more aware that drinking within safe limits does bring or can bring on problems such as breast cancer for women? I wondered if there was a very obvious example of a problem for men drinking within safe limits.

Professor Gilmore: I think it is a very difficult one. They have looked at this in Australia. They looked at what level of drinking would only increase your risk of dying of an alcohol-related cause by 1%. They came up with such a tiny consumption that it was laughed out of court by the general public. We are living in the real world. We know that if a woman drinks about half a bottle of wine a week she will increase her risk of breast cancer by 10% but increases it from 10% lifetime risk to 11%. Many women might take the view that, while that is a significant increase and it has been shown on a population basis, many other things in life—not least 3

Witness correction: In my evidence I suggested that women drinking half a bottle of wine a week increased their risk of breast cancer by about 10%. I would like to make clear that in fact in women drinking one bottle of wine per week (9 to 10 units) the risk of breast cancer is increased by around 10%.
getting up in the morning—carries risks. It is a very difficult concept to get across and I, personally, have not pursued targeting people who are drinking moderately to drink less. But, as a by-product of a population approach, if you get moderate drinkers consuming a little less there will be health gains.

**Mark Baird:** I would like to agree with Professor Gilmore on the importance of making people aware of unit information and the weekly guidelines and bring this back to the Public Health Responsibility Deal. There are a number of things in there that will help us inform the population, such as some of the improvements we will see on alcohol labelling. There are also pledges on putting as much information as possible into on-licensed premises and off-licensed premises. The trade will make that happen. If we also look at Drinkaware, they have done what I suggest is a terrific job over the last five years, perhaps, in making people aware of drinking limits to the point where 90% of the population are now aware that alcohol is measured in units and 75% are aware roughly of what the daily guidelines are. Those have increased significantly over the past four or five years.

I think both Government and industry and Drinkaware have done an increasingly credible job of making the public aware of not only the daily drinking guidelines but also the risks associated with over-drinking.

**Q265 Yvonne Fovargue:** Have you talked about the Public Health Responsibility Deal. How would you respond to the argument that, by signing up to that deal, you are attempting to avoid the introduction of a regulation that would damage your commercial interests—for example, a statutory minimum price per unit?

**Mark Baird:** It was said earlier that the industry is against regulation. We are not against regulation. Regulation has its place in areas such as drink-driving, blood alcohol limit, sales to under-18s, buying for under-18s, under-18s buying alcohol, and selling alcohol to drunks. We are not against regulation. We are against regulation that seems to be unfair, ineffective or inappropriate or, more specifically, not evidence-based.

**Q266 Yvonne Fovargue:** What evidence have you got that it is ineffective?

**Mark Baird:** That what is ineffective?

**Yvonne Fovargue:** That statutory minimum pricing would be ineffective.

**Mark Baird:** There is no evidence anywhere in the world to show that minimum pricing, as proposed in the UK, would work. It has not been tried anywhere. The evidence, as it is—

**Q268 Chair:** Those two propositions don’t help us much, do they? If it has not been tried anywhere, there will not be any evidence.

**Mark Baird:** Yes, but the point I am trying to make is that the Sheffield report, which is the model used most often to defend minimum pricing, is but that—it is a model with many, many flaws. It takes no account of income so it suggests that, if a minimum price is put in, a millionaire or somebody on income support will act in exactly the same way. There is no account taken of income at all. If you look at the Sheffield report, the prediction of a minimum price of 50 pence is that an 18 to 24-year-old binge drinker will reduce their drinking by, roughly, half a pint of beer a week. I do not think anybody would agree that that is going to make much of a difference in tackling alcohol misuse. Therefore, the evidence base does not seem to be there for pricing.

**Q269 Yvonne Fovargue:** What commercial interests, if any, do you feel you are sacrificing in support of public health?

**Mark Baird:** We do not believe there is a conflict of interest between our duty to our shareholders and promoting responsibility. We want consumers to enjoy our brands, which they cannot do if they drink to excess. Our brands and our reputation are harmed if our products are misused. Our corporate reputation and our brand reputation is important to us and we realise that our commercial success and our reputational success can only be achieved in the future if we rigorously pursue a responsible drinking agenda.

**Q270 Chair:** Can I ask Dr Halpern if he is enjoying being in the snake-pit?

**Dr Halpern:** Let us be clear about a few things. The overwhelming evidence is that price affects behaviour here. It affects it generally at population level and so on. We know that from many products and we have information to suggest it would work also for alcohol.

**Q271 Chair:** It is hard to draw up an economic model based on the proposition that price has no effect.

**Dr Halpern:** Indeed. In fact, one of the things which caused some tension—remember that responsibility is an ongoing process—among some partners is that in the budget there are price changes. They are coming, in October, on super strength and also, interestingly, of course, at the lower end. Having the ruling on not selling below cost effect creates a de facto minimum price, which you can then adjust and revisit. You have to work fairly hard to not think that price is relevant. Of course, advertising, it is true, is primarily aimed at brands.

One of the things we would, additionally, say is that there are quite a few other things you can do and other kinds of tools that can be used, not least because of the health harms. You will remember that the harms from alcohol that follow from violence and so on—

which mean you end up in A&E or whatever—are at least fourfold greater. The examples are that portion sizes are incredibly important in relation to lots of areas—so where you have a smaller glass. The interesting question there is whether, sometimes, we introduce regulations which stop us being able to have smaller portions, like the schooner arguments being in play, or whether our guidance is in the right place on the promotion of low alcohol products.

There is a lot of stuff about not just advertising in general but what, exactly, you advertise. Advertising really cut-price alcohol in relation to the retailers would be an example, and to get them to move away from cut-price promotion would be an important thing to do, although you have to work out the implication
of competition law and so on. Social norms and the way in which we drink is, clearly, a big part of the story. The fact that people come together is very interesting because of the health effects of having social networks. Coming together and seeing friends and so on, as far as alcohol is part of that culture, that has positive effects. The way in which we drink and how we are consuming it via the off-trade versus the on-trade lifestyle are really important parts of the story. There are lots of other things in play, too, but of course price and advertising are part of the story.

Professor Gilmore: If I might make a comment about the Responsibility Deal and the health community, we did go along with it because, although we think information and education are not the whole answer, we felt we should give it a try. It was a new Government’s initiative. There were those around, like me, with a memory for how long there have been voluntary partnerships in the drinks industry. It was the cornerstone of the 2004 Tony Blair harm reduction strategy. There was a report by KPMG, commissioned in 2008 by the Home Office, which showed that the 10 years trying to get unit labelling by voluntary agreement had been a failure.

We understandably had some reservations about further voluntary partnerships and, when we turned up, it was clear that we were largely spectators at the party, and it seemed to be the main party in town. We felt uncomfortable with that as the evidence base was pretty slim, the pledges were already written and very difficult to change, it was co-chaired by Government and industry and it was only with a lot of effort that we managed to achieve a third co-chair from the health group.

The evidence base around the pledges was weak. It wasn’t clear at all at what point it would be said they would not be working and, if they weren’t working, whether Government would then move up the ladder of interventions. We felt, in the end, that we were in danger of being used as a figleaf of respectability to the process, so we withdrew and did not sign up to the final deal. However, we did offer, quite clearly, to stay engaged and help, behind the scenes, to set the monitoring and the independence of evaluation, which we felt would be a much more appropriate use of health professionals. That offer has not, as yet, been taken up.

Q272 Chair: You have not reacted warmly to the limited proposals that the Government have tabled for minimum pricing—not to sell at less than duty plus VAT. Why do you not regard that as at least a modest step in the right direction?

Professor Gilmore: I did say, publicly, that it was a modest step in the right direction—

Chair: I stand corrected.

Professor Gilmore:—but I said it was very modest indeed. On the positive side, it is an acknowledgement by Government that price is important, and we have heard it is acknowledged by Governments, whereas it was not some years ago. There have been significant tax increases, although we do not think tax is a very attractive way of getting a significant rise that would make a difference to the public health. The problem is, as you know and was widely quoted by The Guardian, that if you put a floor as low as duty plus VAT, you will hit one in 4,000 alcoholic beverages sold. It will not affect three litres of 7.5% white cider for £2.99 where you can get your weekly recommended limits in one bottle. That would not be hit by that floor. In principle, yes; in practice, no.

Q273 Dr Wollaston: The point is often made by Government that if we had a minimum price of 50 pence a unit it would disproportionately affect those groups on low income. Could you clarify for the Committee which groups in society are most adversely affected by the effects of alcohol?

Professor Gilmore: Notwithstanding the criticism of modelling—that modelling as done by Sheffield and there has been a Sheffield 2 since that I think is even better—it does take the evidence and make the best use of the evidence available without any axe to grind and no conflict of interest. It does show that a minimum unit price affects the heavy drinker much more than the light drinker and that heavy drinkers, whatever their income, gravitate to cheaper brands of alcohol and are more hard hit by a minimum unit price. One of the strengths of a minimum unit price is that it doesn’t affect the price of a pint of beer in a pub or a glass of wine in a restaurant at a time when pubs are closing. It is, in effect, a targeted tool.

It is said, “What about the poor moderate drinker?” We will probably be hearing, shortly, someone speaking up on behalf of the poor in this regard. The modelling suggests that the impact on the poor moderate drinker is very small indeed—pence a week. Indeed, if you look at all the advertisements for supermarkets, particularly coming up to Christmas, they are for alcohol. Alcohol is used as the hook to get people into the stores. How are they doing that? By discounting.

We published a very interesting paper in the RCP Journal, about a year ago, showing that the moderate drinker is probably paying more for their weekly grocery basket now because they are subsidising the heavy drinker. It is the heavy drinker who is coming in and buying the cheap drink and if those subsidies weren’t going on drink they might be going on fruit and vegetables—hopefully, not on any obesogenic products—on a healthy diet.

Chair: It might be going on McDonald’s.

Professor Gilmore: The argument that this would hit the poor moderate drinker really does not stack up.

Q274 Chris Skidmore: Where does the standard of proportionate universalism come into all this? I am intrigued. I am wondering if there are arguments to be made following along the lines of the Marmot inquiry. I have reservations about proportionate universalism, that we should be focusing on making the poor drink less than the rich.

Professor Gilmore: We are not focusing. We are saying it would impact on heavy drinkers across the social scale. It is not targeted at the poorest people. The impact on the less well off would be very small indeed. I know this was and is a great concern to Governments. Governments, quite rightly, have concerns about who is going to vote for them in the next election. I had vigorous debates with Alan
Johnson over this, but I think he has changed his views since leaving office as to the value of a minimum unit price.

**Mark Baird:** I gave evidence at a House of Lords inquiry a few months back on behaviour change. Sitting alongside me was Debbie Bannigan, who is the CEO of Swanswell Addiction Centre. Her view was, for people with serious alcohol problems, price is not the pertinent issue. She said that for people who suffer most from alcohol, price is not an issue. They will avoid spending it on other things and they will turn to many different ways to get money for alcohol. I would like to go back to what Professor Gilmore said about labelling. I have to agree that the purely voluntary arrangement on labelling was not successful, which is why we believe the Responsibility Deal offers us an opportunity to make things much better. If you look at the agreement we have now on labelling, it is a distinct commitment, it will be measured by an independent source, more than 80% of products will have that and organisations such as ours have said it will be more than 90%. What the Responsibility Deal does is not an alternative to regulation and it is not voluntary. It brings in some rigour to commitments that involve the alcohol industry, along with NGOs and others, in delivering public health outcomes and it provides a vehicle to do that in a way which can be more effective, quicker and certainly cheaper than regulation could.

**Q275 Rosie Cooper:** I would like to ask this of Professor Gilmore. We have heard the national regulation argument. The Government is giving a lot more power to local authorities on the public health agenda. Do you believe that they should have power to set local targets—for example, local pricing of alcohol? Do you think that would help in any way?

**Professor Gilmore:** Clearly, there are strong arguments for allowing local communities to have more control over their own environment and they know what their particular problems are. However, there are many examples of really good initiatives locally tackling alcohol problems, particularly in Australia with problems in some indigenous populations. The great difficulty is sustainability. It keeps going while there are some enthusiasts locally in council, or whatever, driving it through, but it is very difficult to sustain it without a national framework and without national leadership. Yes, more responsibility and more opportunity to do good things locally but, if left to local initiatives, it does not work. I am delighted that in the councils around Greater Manchester they are talking about whether they could bring in a minimum unit price. There is a commitment and they see the health benefits. Whether that would be achievable with people driving across to the next village to buy their alcohol, I don’t know. I would support local empowerment, but it has to be seen in the context of being supported by strong national frameworks. That would include, in my view, tougher regulation about price around marketing and availability.

**Q276 Chair:** Would you answer, Professor Gilmore, Mark Baird’s point that, to the really hardcore alcohol user, price is not a significant issue?

**Professor Gilmore:** Clearly, if someone is physically addicted then they are much more difficult to deal with. That is why nothing is in isolation and there are the three priorities that the Alcohol Health Alliance espouses, one being around price, one being around marketing and the number one priority is around treatment services. As I may have mentioned earlier, within less than a decade, the number of addicted people has gone up from 1 million to 1.6 million in this country. For them, the issues are much more difficult, I cannot say that we know, with certainty, that their drinking habits would be influenced.

What we do know is that treatment services are very effective and cost effective. This came out very clearly from the NICE studies that were published earlier this year. Right across the spectrum, from those who are just beginning to drink a bit above recommended limits having brief interventions to the hardcore—if I could put it that way—that are often, even by health professionals, almost given up as revolving door patients. They don’t see them again. We only remember the ones that come back, but treatment services, which are incredibly patchy in this country, are very effective and cost effective where they work well. I cannot say that a minimum unit price would halve or third consumption among alcohol-dependent people but, by God, it might well stop a few hundred thousand more from drifting into that stage of alcohol dependence.

**Mark Baird:** It is fair to say that price is not in the Responsibility Deal because alcohol companies are not allowed to sit together and discuss price. The Secretary of State made that very clear at the start of the process. It is not fair to say, however, that availability and advertising and marketing are not in there. If you look at one of the individual pledges which ASDA put forward, it was that they would stop putting alcohol in the foyer of the stores, which is all about availability. They have done that and delivered on that already.

There is a pledge, looking at advertising and marketing—further action—and that is specifically around introducing a sponsorship code, touched on earlier, which has been trialled, scored and seen to be successful. We would hope, in the future, that we will see a sponsorship code which will put certain things forward that industry must do if they are involved in sponsorships. On advertising, marketing and availability, there are pledges in there, within the Responsibility Deal, but it is fair to say there is nothing in there on price.

**Professor Gilmore:** It is also fair to say that none of the pledges in those areas brought forward by the health community were accepted. We do not accept that the ones which are in there are evidence-based and likely to have an effect and have hard outcomes that can be tested.

**Dr Halpern:** There was a key point about the price issue. It was kept out, as Mark said. It is genuinely a tricky issue about how to lay the negotiation without getting into trouble with the OFT. Certainly for some players, and noticeably the retailers, given how they
got burnt on milk—for quite a lot—they are genuinely worried about it. Interestingly, OFT have no problem about variations in using licences at local level—going to your question—and that is a genuinely interesting area. The canny use of licensing in order to squeeze out VAT and affect the way in which people drink is interesting.

I want to challenge him a tiny bit, although I think we are 99% close. I think there are some areas which still interesting within that envelope of the Responsibility Deal going forward. The availability thing is really interesting. It was ASDA, of course, who made that pledge, and an interesting thing to watch carefully is what is the other supermarkets are doing. If a net result of this is that ASDA find they are removing the more visible products and no one else follows or takes advantage, that is a problem. It is important we celebrate what ASDA has been doing and put pressure on other players to do something similar, otherwise that does go to the core question of the flexibility of the Responsibility Deal.

Another one is the levels of alcohol within certain brand products. At least one major brand has reduced the levels within one of its minor brands and some other players have been interested in it around defaults for house wines and so on. You can get a lot of alcohol out in a system where you look across the whole in that way. Again, the trickiness of doing this is sensitivity about, "Do you want to shout about the brand you have actually reduced the alcohol level in?" It is going to be really important we celebrate what ASDA has been doing and put pressure on other players to do something similar, otherwise that does go to the core question of the flexibility of the Responsibility Deal.

Professor Gilmore: Absolutely. Can I just come back on that and say that I am not saying the Responsibility Deal should be abandoned? What we did say was we thought we were in danger of giving it a respectability without having the input into changing it. We were better on the outside than the inside, but that does not mean that it should be given up.

There are things in there that it will be interesting to watch and see whether industry is nudged in the right direction. I must say that the history of these things doesn’t fill me with great optimism. The important thinking from our point of view is that it doesn’t allow the eye to be taken off other policies outwith the RD. I absolutely agree with you that I have never said price should be in there. It cannot be in there. But price has to be in there somewhere in the overall strategy. We must not be diverted from those by the Responsibility Deal.

Q277 Chris Skidmore: I have a point on process to address to David. Obviously, there is the Behavioural Insights Team, set up at the Cabinet Office. At the same time, you have the Department of Health focusing on social marketing. To what extent can you apply it as a Venn diagram? Do you see social marketing as being identical with whatever is being done in terms of behavioural insight or is there a danger of either duplication or in the way two departments are not working together? I noticed, in the April document that was published on Changing Behaviour, Improving Outcomes, the Department of Health is working with the Cabinet Office on piloting a payment-by-results approach in appropriate areas. I was wondering if you might be able to discuss the work that has been going on between the two Departments, conversations that have been had or whether the Cabinet Office is working entirely separately, and see where we are going with this over the next six months to a year.

Dr Halpern: Yes, of course. The Cabinet Office team is very small. It is eight, including me, and we cover lots of areas. We cannot do everything every time. We would like to. Health is interesting because of its potential to do a paradigm change. We talk frequently to the Department and always agree about everything they are doing. We certainly do not see our approach as reducible only to social marketing, to be clear about this. It is part of a tool but there are lots of other things you can do.

Q278 Chris Skidmore: Sean Worthe went into the Department of Health recently, didn’t he?

Dr Halpern: Yes, that is right.

Q279 Chris Skidmore: He has come from the Prime Minister’s unit.

Dr Halpern: He has, yes. That is right.

Q280 Chris Skidmore: Is Sean one of your linking contacts?

Dr Halpern: I do know Sean. We have overlapped for a long time at No. 10, although Sean is a political appointment and ours is not. Yes, Sean is, absolutely. At No. 10, in general, people are very keen. There are some very big wins. I know we are focusing on alcohol today, but, for example, around nicotine replacement there are incredibly interesting areas, which are not about social marketing but how we approach that whole area. You have absolutely enormous potential. You turn the numbers and do things around that you can do more than much of the NHS.

Q281 Chris Skidmore: Particularly on that—I know and understand you have limited resources if there is only a team of eight of you, and you have to pick and choose who you work with. In terms of the smoking cessation, you decided to work with Boots, I believe, in the paper published in December.

Dr Halpern: Yes.

Q282 Chris Skidmore: I guess that also reflects the social marketing strategy which mentions that, taking a life course through, it showed a trusted brand will deliver support on all topics that are relevant to the person at that stage. I am assuming that trusted brand might also probably be Boots as well. Generally, with things like diet and weight, you will be establishing a partnership with Lazy Town, the TV programme, which will encourage healthy behaviour in children. I know that as a result of Opposition work with the producers on the Lazy Town book. It is quite specific choosing one particular programme or one particular company in order to deliver your results. Would you hope to try and expand this? It is a slight conflict, isn’t it? You have behavioural change using specific agencies to achieve this, yet the public health agenda,
from what we have heard before, in the earlier session, is obviously trying to achieve a far wider “catchment area”.

**Dr Halpern:** One of the things we are trying to do, if you remember, is identify exemplars. You need to be able to put it into concrete to see how it works and if it will work. A good example—that comes into play in July, I think I am right in saying—is that the default will change at the DVLA on organ donation. That is a very particular example, but we think it will lead to a change from roughly 30% moving on to the register to about 70%, just using the so-called prompted choice, which is not presumed choice. That is a specific example. It does not change the entire world, but it is quite consequential and shows you the efficacy of the approach.

Boots is an example. We don’t all agree on everything; in our reading of the wider literature we were a bit more upbeat that there were ways of getting some smoking cessation which had not been fully explored, not least by getting people to commit out of their own resource, in some way, to a pot and if they manage to succeed in staying off smoking they get that back. We could argue for ages, but Boots are a very substantial company and they have quite a large reach. The alignment of their interests is more straightforward in relation to smoking than it might be for some other company so if they want to try it, absolutely. Let us work with it and make sure it is rigorously evaluated. As I said, we are quite open-minded, in some ways, about how we make this stuff work and, generally, the No.10 view is that it is an overtly pro-business Administration in lots of ways, but that does not mean that business does not have responsibilities.

**Mark Baird:** The phrase was used earlier that the Responsibility Deal is the only game in town. I think that is unfair.

**Professor Gilmore:** I didn’t say that. I said it appeared at that time there were no plans for an alcohol strategy from Government.

**Mark Baird:** That is the important point. We have already seen a review of taxation and pricing and we will see an alcohol strategy later on this year. The Government is doing more than just the Responsibility Deal. It is also fair to say that the Responsibility Deal is more than just nudge. Some of the pledges in there—for instance, Diageo’s pledge to fund the training of 10,000 midwives, which, unfortunately, received some unfair criticism last week—are much further than nudge. That is making a real different to the future of many unborn children in the UK. There are many more things within the Responsibility Deal. Let us remember that it is only six months old and, in fact, it has only been announced two months ago. There is a lot more to come. Whereas nudge is behind the theory of the Responsibility Deal, there will be many things in there which will make a discernible difference to alcohol misuse.

Q283 Dr Wollaston: It is an interesting discussion to be had there as to whether Diageo, which I think includes vodka in its range, having a brand which has been widely taken up by young women, now—having spent some time marketing these brands to young women—is in a position where you are part-funding midwives to tell them not to drink it when they are pregnant. You could say you would be better not to market to young women in the first place, wouldn’t you?

**Mark Baird:** The difference you are making is that we are not marketing to pregnant young women. What we are doing is funding a programme to allow midwives to get the messages across to pregnant women that drinking is not a sensible thing to do while pregnant. Trying to link that to the marketing of vodka, I don’t think, is fair. I don’t think the two come together.

Q284 Dr Wollaston: You don’t think there has been an increase in the levels of vodka consumption by young women over the last decade?

**Mark Baird:** Yes, there has been.

Q285 Dr Sarah Wollaston: There has been. That is partly as a result of marketing, presumably.

**Mark Baird:** Partly, yes. I still don’t see the link to warning pregnant women about the dangers of alcohol misuse and why it is wrong for an alcohol company to fund that when the alcohol company has not been involved in the development, design or delivery of that programme. What we are doing is funding a programme which probably would not—in fact, almost certainly would not—have been funded. That funding would not have been there. As part of the Responsibility Deal, it has forced us to go further. We have taken up a successful pilot that trained 500 midwives over the past two years and 94% of those 500 midwives have said that they believe this particular training should be given as part of midwives’ general training.

Q286 Dr Wollaston: I get all that. If you were really looking at social responsibility, wouldn’t it be better not to be heavily marketing vodka to young women in the first place? To give you an example, I was sent an e-mail this week from somebody who went to see a 12-certificate film, and there were no fewer than four very heavy and very effective alcohol marketing advertisements. That was before a 12-certificate film. Is that responsible?

**Mark Baird:** Cinema advertising, like all advertising, has to conform to the CAP Code such that 75% of the audience who will see that film are generally over the age of 18.

Q287 Dr Wollaston: A 12-certificate film?

**Mark Baird:** The regulations which apply also apply to the cinema. The regulations are there and they are there for a reason. It is controlled by the Cinema Advertising Association and it is done in conjunction with a panel. They look at films and decide which films it is appropriate to advertise alcohol within. Again, it is tightly regulated, as it is on TV and as it is on all forms of advertising within the UK.

**Chris Arnold:** I am surprised to hear that. I think that isn’t an issue about advertising. That is an issue to do with why those were running during those shows. That may have been a miscalculation. Generally, you would not get that running. The regulations we have
to abide by are so strict within our industry. We are not allowed to do certain things and we are not allowed to say certain things. That is why most brands spend the time trying to move from one brand to another rather than trying to increase the market. It is too expensive to do that.

Q288 Dr Wollaston: Would it not be more effective just to advertise in cinemas at over-18 certificate films rather than 12-certificate films?

Chris Arnold: The way the cinemas put the ads up is that they were only running that and I am a bit surprised when you tell me there is a 12-certificate film running lots of booze ads because—

Dr Wollaston: There were four.

Chris Arnold: That is not actually an issue for the industry. That is an issue as to why they were running those and whether somebody had made a miscalculation or not. I don’t think that is something you would find happening regularly. I have certainly never seen it before, taking my kids to the cinema.

Professor Gilmore: I have had examples sent to me of 12-certificate films clearly aimed at young people. The Dark Knight was one of them where there were several alcohol adverts before the film was shown.

Dr Wollaston: Thank you.

Chair: At that point, we are beyond our witching hour. Thank you very much for coming and thank you for a spirited debate. We shall reflect and try to draw some conclusions.
Ev 64  Health Committee: Evidence

Tuesday 12 July 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Dr Daniel Poulter
Mr Virendra Sharma
David Tredinnick
Valerie Vaz

Examination of Witnesses

Witnesses: Professor Dame Sally C Davies DBE, Chief Medical Officer, Department of Health, Anita Marsland MBE, Transition Managing Director, Public Health England, Department of Health, 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, gave evidence.

Q289 Chair: Good morning. Thank you very much for coming along this morning. Welcome in particular to Dame Sally Davies, the new CMO, on your first appearance before the Committee in your new role. I apologise for keeping you waiting. We have a bit of a backlog of reports building up that we are trying to get out and we have been discussing those as well as preparing ourselves for this session. Could I begin by asking you to introduce yourselves and the particular areas of departmental responsibility that you come from?

Professor Davies: As you know, I am Sally Davies, the new Chief Medical Officer. I am also the Chief Scientific Adviser to the Department and I hold the R&D portfolio, which I had previously managed as Director General. As Chief Medical Officer—I have actually brought the job description in case you wanted to get right into the details—I am the principal medical adviser to the Government to advise on health and the population’s health. I am both independent as well as part of the Government. In that role I attend the Cabinet Sub-Committee on Public Health—the only official who does—and I am clearly the advocate for the public’s health cross-Government and generally. In the job description I have been given a new role, as professional head of the public health profession, and as we develop our plans, I have to make sure they are all right. 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. I will be writing an annual report, which is independent, and continuing in that way. I will stop at that point and pass over to Professor John Newton.

Professor Newton: Good morning. My name is John Newton. I am the Regional Director of Public Health for South Central and I chair the Working Group on Information and Intelligence, which I believe is of interest to the Committee. Thank you.


Professor Harper: I am David Harper. I am the Director General for Health Improvement and Protection within the Department of Health. I am also the Department’s Chief Scientist and Head of Profession for scientists.

Q290 Chair: Thank you very much. Could I begin by asking Dame Sally a question about the role of the CMO as a result of the changes the Government proposes in the structure of public health in England. How do you see the role of the CMO changing in the context of the proposals as they have developed over the last twelve months compared with the historic role of the CMO in public health issues?

Professor Davies: 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. That plays out in a number of ways. I am going to set up—I have not yet because it is unclear to me the best way to do it—a public health advisory committee that will advise me, and through me, Ministers. It will have the function, relating to Public Health England, of keeping an eye on it, challenging it and doing deep dives, if necessary. Therefore, it will be looking at public health and advising. As Public Health England will not have a non-executive board, this CMO advisory committee becomes particularly important in its challenge and monitoring functions.

As to the important role of the annual report, I see it as being in two parts: one, a quite old-fashioned one about the state of the public’s health and the data that need to be out there for transparency and for everyone to use, and another doing an in-depth review of an area that matters. I am considering doing infection as the first and getting experts to contribute to that in a way that antique CMOs did—but not the last one. I think they would be antique now anyway, if they are still alive.

Then there is the role of leadership: externally showing that this matters to me, to the Government, to everyone and trying to make the linkages; and inside the Department and Government advising, chivvying and pulling—doing what we all do.

Q291 Chair: In your introduction you drew out the fact that you were the head of the public health profession rather than the medical profession more generally. Do you, therefore, see the role of the CMO now as almost a director of Public Health England?

Professor Davies: No. It is not an executive role. There will be a chief executive reporting to the Permanent Secretary. It is a serious advisory and
Q292 Chair: The classic three domains of public health include health care public health and the question is how far you interpret the role of the CMO, as you have defined it, allowing you to get into health care questions as opposed to prevention and health protection?

Professor Davies: Being me, I am reserving my right to range widely, but there is a limit to what one person can do. My role is to make sure the public health profession play that out. In the Government’s response to the Future Forum they accepted that the public health third pillar would be delivered by Public Health England and out of local authorities, and we are working on how to do that. If there were concerns that came to my attention, or to your attention and you remitted them to me, clearly I would pick them up. Infection is an example. We have infection in the NHS, we have infection broadly in the community and we have infectious threats. That is why I thought I would try using infection as the first expert report to show that I am going to reach into every area on certain issues if I need to.

Q293 Chair: Infection is a classic health domain—prevention—arguably. Suppose, for example, there were concerns about—an issue very rarely out of the headlines—cancer outcomes and the delivery of cancer outcomes in different parts of the health care delivery system. Would that be something, as CMO, you would follow up as part of health care public health, or would you say that is now defined elsewhere in the system?

Professor Davies: The executive role would sit with the National Commissioning Board and the medical director there. Clearly, if I was concerned, I would be asking questions, throwing a light on it and advising about the science and what might be considered, but the executive role is in the Commissioning Board.

Q294 Chair: Thank you. Can I move the spotlight to Anita Marsland to understand what is proposed now in terms of the structures for Public Health England? We have moved from it being a core function of the Department to it being an Executive agency. The question in many people’s minds is what that means in practice. What is the degree of independence implied by an Executive agency? Some people have said that it ought to be a special health authority. It becomes a bit of an anorak issue, if you are not careful, about “Why an Executive agency rather than a special health authority?” and “What are the implications of the choice?”

Anita Marsland: I will take the Committee through the development of thinking on this. Ministers have been very clear about the importance of a clear line of sight between them and the front line when it comes to health protection issues. This is akin to the defence of the realm. We look to central Government to defend us against threats which we, as individuals or communities, are not well placed to tackle. That is why Ministers have taken the view that a non-departmental public body like the HPA, however responsive—we would agree with the proposition that the Health Protection Agency is very responsive—is less fit for purpose than an organisation that is part of the Department.

However, we have heard a consistent message and concern that that was going too far. We believe that locating Public Health England completely within the Department would risk compromising the attributes of scientific excellence and independence that we depend upon. Executive agency, therefore, in the Ministers’ view, is a sensible compromise. Executive agencies are part of the home Department but have an operational distinctiveness. Such status would allow Public Health England to build and maintain a distinctive identity but within the Department. Also, it will support the ability of scientists in Public Health England to give expert independent scientific advice and make it easier for PHE to continue earning significant sums from external sources, as the HPA does at present, as I am sure the Committee is aware. Shall I go on to “Why not a special health authority?”

Chair: Go on, yes.

Anita Marsland: I would refer you to my previous answer in part, that Ministers have of course been very clear about the importance of the clear line of sight. It is also important to recognise, though, 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.

Q295 Chair: I am less interested, personally, in the precise structure than I am in the principle that Public Health England is seen to be, and wins public confidence as, an independent voice that speaks truth unto power.

Professor Davies: That is terribly important, and is why I am happy we are going to have an agency rather than incorporate it into the Department. If you think about the MHRA, it is seen internationally as a model and functioning independently. Most people do not even know that it is an Executive agency. We will have to work hard with the scientists, but as Chief Scientific Adviser, it is one of my roles to guarantee the independence and to get them talking about what they are doing to power and to mediate where necessary.

Q296 Chair: Not necessarily speaking truth in private.

Professor Davies: I hope they will speak truth in private.

Chair: That is not what I meant.

Professor Davies: That is important. When it is needed, we will have to speak truth publicly if it is not heard, yes. I would prefer to have the uncomfortable stuff discussed.

Q297 Valerie Vaz: Do you see Public Health England, in this new structure, as part of the NHS? For instance, will there be joint appointments or will it be jointly appointed?
**Professor Davies:** It is going to be separate from the NHS but will work very closely with the NHS.

**Q298 Valerie Vaz:** Is it still part of the NHS?

**Professor Davies:** It is funded by the same vote that funds the NHS, so it is part of the health bit, but what we are trying to do is give a much bigger emphasis to public health and prevention than we have ever given it before.

Do you want to pick up on the links across?

**Anita Marsland:** You have said what I would have said, Sally. I think that is clear.

**Q299 Valerie Vaz:** Is it joint appointments or jointly appointed?

**Anita Marsland:** Do you mean of the director of public health?

**Valerie Vaz:** Yes.

**Anita Marsland:** It is jointly appointed.

**Professor Davies:** That is between Public Health England and the local authorities.

**Q300 Valerie Vaz:** That is not what the Secretary of State said last week.

**Professor Davies:** Directors of public health in local authorities will be jointly appointed between Public Health England and local authorities so the NHS will work through the local Health and Wellbeing Boards at the local level. At the national level there will be working between PHE and the National Commissioning Board and we are looking at our sub-national hubs to try to make sure they not only match with the DCLG 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 cannot let the NHS walk away from public health. They are a key part of it.

**Q301 Chair:** When you say “co-located with the Commissioning Board,” that raises another question in our minds about the nature of the structure that Public Health England intends to have below the national level. The Commissioning Board is itself developing its ideas about offices outside Richmond House. Is that a conversation that is going on in parallel with PHE and the National Commissioning Board and we are looking at our sub-national hubs to try to make sure they not only match with the DCLG 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. They are a key part of it.

**Professor Davies:** I will let Anita give you the detail, but yes, of course it is a conversation we are having together. 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.

**Anita Marsland:** Thank you. We are not proposing a regional structure but we will align the hubs that we create for Public Health England with the DCLG resilience hubs and with the NHS Commissioning Board. 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. We are not able to say anything definitively today about that as we are still working on it, but we feel very strongly that alignment is important.

**Professor Newton:** As an existing regional director of public health, of course I have a view on this. The important thing is that Public Health England can interact with a variety of bodies. No single arrangement is likely to dovetail perfectly with all of them, so we need flexible national coverage that allows us to work effectively with all the other organisations we need to work with.

**Q302 Rosie Cooper:** Can I jump in and ask a question? All these reorganisations are supposed to make life easier. Is this better or worse than where you have been? Is this simpler or more complex than where you have been? What are the real upfront advantages of yet another mess?

**Professor Davies:** I believe, for public health, that when we get to the end of this it will be better.

**Q303 Rosie Cooper:** When will we get to the end of it?

**Professor Davies:** We expect to have Public Health England up and running from 2013. We are looking to appoint a chief executive for it this autumn.1 They will be able to do shadow running so it should start at a run. At the moment there are lots of very good bits, but they are rather separate. By creating Public Health England in the way we envisage, we are bringing it together. We will get efficiency savings, which we need, and we should get a much better information, intelligence and surveillance system. John is leading on that and can talk to you about it. I do believe it will be better.

**Q304 Rosie Cooper:** You are involved in it. You are all professing independence and yet you are all part of it. I hear you, but I do not know whether the public out there will actually buy this “I am part of the health department, but I am independent” line that everyone keeps saying.

**Professor Davies:** I think I am the only person who sits here with an independent role, as it happens. My colleagues are civil servants. If I thought it was wrong, I would say so. I think we will end up with a better system. I believe that or I would not be doing this.

**Q305 Chair:** Could you elaborate for the Committee what you think are the three or four key improvements that come from this process?

**Professor Davies:** The efficiencies in the delivery of services by bringing them together, the increased focus on health improvement and behaviour by bringing it together, the wins from putting local public health into local authorities, back where it came from, and—

**Q306 Rosie Cooper:** With no money.

**Chair:** We will come to that, Rosie. Let us do it one by one.

1 Witness correction: The appointments process for a Chief Executive starts this autumn, and a Chief Executive will be appointed by early 2012.
Professor Davies: They are going to have a budget. Oh, dear, you kind of interrupted me.

Rosie Cooper: I am sorry.

Chair: Savings, integration, local government.

Professor Davies: Yes. As I had a heavy winter with flu, I also saw how having the disparate bits made for complications and slowness. It worked fine, but if we get a really nasty E.coli or something, I would like it to work better. I believe—I am trying to make sure—we are designing a system that will work better.

Q307 Valerie Vaz: This is an opportunity to talk about what is happening now. You are talking about your hopes for the future and where it is going to go. We are all quite confused because we don’t know either, even though we have had various people in front of us. Could you elaborate on or give us a snapshot of what is happening on the ground now? Where do you see the transition? How is it going to get to this wonderful new structure that you are hoping will work terribly well?

Professor Davies: I am determined it will work well. I will start with Anita and then hand over to John.

Anita Marsland: Obviously we are working on all the dimensions of this reform, which is complex. Starting with the local system, the regional directors of public health have the lead for putting together transition plans in their areas, working with directors of public health and the wider public health community and local government to ensure that there is a smooth transition into local government. Progress is variable thus far around the country, but what we are seeing is a real appetite for that transition. That is working well.

The other aspect, of course, is establishing the new national organisation with its hub structure. We are working with key stakeholders to design that organisation. There is lots of activity at the moment. It is really important that we involve people who are part of the system in designing it, but also the public, and we are engaging with as many people from as far and wide as possible in that discussion. I am going around the country with some of my colleagues talking to as many local authorities as possible because it is equally important to them what Public Health England is like for the local system because they are so interrelated. There is a lot happening. There is a lot of discussion and debate and a lot of energy and enthusiasm. I believe we have the right people involved in those discussions.

Professor Davies: Can you talk about the pathfinders?

Q308 Valerie Vaz: I am still not clear what the transition is and what is happening. You are talking to lots of people, but where is it? It has only recently been announced that we are going to have Public Health England so the structure can’t be clear in your minds. What is the morale like out there? Do we have a workforce? What is happening to all the data in terms of health inequalities? What is happening to all of that? Are they doing no work or are they just talking?

Anita Marsland: I will invite John to comment. It is variable, as I have said, but I think morale is improving. It has been a difficult period for colleagues.

Professor Newton: If I could answer one of your earlier questions, there is a huge potential benefit in having a national integrated public health service. There is no doubt about that. There is huge benefit in the transfer of health leadership to local authorities, but like any change, there is good and bad. Some people are seeing more of the good and some people are seeing less of the good. We are seeing a mixed picture in terms of morale.

What are we doing? There are two jobs. Whether you are talking about Public Health England or the local system, there is a continuity job to be done. We are trying to find out exactly what we are doing at the moment. It is not easy working out what everyone is doing in the primary care trusts and in other areas. So there is a continuity job. What are we doing? How do we make sure that the good things carry on? That is the point you made about the inequalities data and so on.

Then there is the opportunity job. We are doing all this for a purpose. We must make sure we realise the opportunity in having local councillors involved in health strategy and so on and, at national level, realise the opportunity in bringing together disparate organisations whose mission is determined by which ICD chapter they are responsible for. I am talking about the classification of diseases. You have the Health Protection Agency doing infections, Cancer Registries doing cancers and Public Health Observatories doing some of the other things. In some areas, like childhood accidents, we have very little activity. Here is the opportunity to bring that together and take a rational view of what the public health priorities are for the population, how we use our resources most effectively to address those and then follow that through in a properly founded structure. That is my quick summary of the task. If you wanted to know more about any of those elements, I am sure we could elaborate.

Chair: Mr Tredinnick wants to follow up on some of the local stuff.

Q309 David Tredinnick: We may well be getting into some of these points, Chair, through you, later on. I am sure you will have a chance to elaborate. I want to focus on local government and the directors of public health—the new arrangements—because, of course, up until 1974, as we are all aware, public health was the responsibility of local government. Now the proposals are for Public Health England to share that with the higher echelons of local government, including unitary authorities.

I would like to ask, first, a question about the Department’s memorandum which says that Directors of Public Health “will be qualified in the specialty of public health which includes those from both medical and non-medical backgrounds.” Does this mean that there will now be a statutory requirement for them to be appropriately qualified?

Professor Davies: I had better answer that. The Government has not yet decided. It is still under debate. The profession feel very strongly that there
should be statutory regulation. The debate centres on the cost-effectiveness of that, and I know you are addressing it in your next session.

What we are clear about is that the director of public health in local authorities will be appointed jointly by the local authority and Public Health England and will, therefore, be an appropriately qualified and certified person—a professional.

Q310 David Tredinnick: What if there is a disagreement between the local authority and Public Health England about the appointment? How will that be dealt with?
Professor Davies: Do you mean at the appointments committee?

Q311 David Tredinnick: Yes. Are you going to have guidelines for that?
Professor Davies: I have seen many appointments committees where there have been disagreements and we have always resolved them.

Q312 David Tredinnick: Fine. Fair enough.
Professor Davies: Often the third party walks through the middle.
David Tredinnick: Thank you.
Professor Davies: But it will be an appropriately qualified person.

Q313 Chair: It is a dual key.
Professor Davies: Yes.

Q314 David Tredinnick: The memorandum says that the Government is “working with local government to ensure that there is maximum flexibility” to ensure directors of public health continue to be independent advocates for population health. What form exactly will that flexibility take and will councils be free to decide how flexible they are?

Anita Marsland: The democratic accountability of local authorities is a strength of the new system, not a weakness. We would expect directors of public health to be senior officers and to have the same corporate responsibilities as any other senior officer. The Bill gives them clear duties that they would be expected to undertake in a professional, impartial and objective way. The Bill also gives the director of public health a duty to produce an annual report on the health of the local population and, importantly, the local authority to publish that report. Finally, before dismissing a director of public health, local authorities would have to consult the Secretary of State. All together, that gives quite a bit of independence in terms of their voice.

Q315 David Tredinnick: I put it to you that the key issue is the seniority of the public health officer and whether they report directly to the chief executive or whether they are going to be an underling somewhere, buried in the infrastructure. Can you explain to us how directors of public health are accountable to you as the Chief Medical Officer? How will that fit in with their accountability to local authorities and to Public Health England in the new system?

Professor Davies: People are formally accountable to their employers. DPHs will be accountable in the local authority to the chief executive. We expect them to have chief officer status with a direct line of accountability to the chief executive. Thus, their accountability to me is a professional accountability that will be exercised through Public Health England in general, but, clearly, if there are issues, I may have to step in.

Q316 David Tredinnick: We have a dual reporting system here, reporting to you and reporting to the council.
Professor Davies: It is not unusual in health that doctors are part of a formal structure for accountability, and so we should be, but also have professional responsible lines.

Q317 David Tredinnick: Thank you. I have one other question. What work is the Department undertaking to ensure continuity of the public health work force in the transition to local government’s new public health role, please?

Anita Marsland: As David Nicholson made clear in his most recent letters to NHS colleagues, there is a clear expectation that sufficient resources are retained within the system to enable critical public health functions to be delivered. The NHS is itself in the process of completing a people and function migration map to make local decisions about the nature and shape of their work force. The regional directors of public health, as I mentioned earlier, are actively supporting those local transition plans and charged with managing the transition process locally.

Q318 David Tredinnick: You have been looking at these, obviously, with great care. Is there anything that particularly worries you in your portfolio at the moment?
Anita Marsland: It is complex, and we certainly have to be careful that our colleagues in public health continue to feel valued and are supported through the process. It is our responsibility to ensure that clear processes are put in place so that they can continue with their roles, their professional development and their ambition, for the very reasons that brought them into the jobs that they do. To that end, we are in the process of producing a concordat with local government to guide some of that transition so that they feel more secure in their profession and roles going into the future. We are producing an HR transition framework as well to further support the whole of the public health system. While those things are clearly very high on my agenda, we have processes in place to manage them and I am confident that we can. I am sure we will be successful.

Professor Davies: Perhaps it would be helpful to tell you that I addressed the Faculty of Public Health last week—500 public health practitioners—and I expected low morale. Actually, people were really up for it, but the concern they had—it was a general concern and they made me well aware of it—was whether there would be jobs for the public health specialists that we are training at the moment. I was
not aware that there was this concern and I went back
to the Department about it. There is quite a bit of work
going on about that and I believe that by the end of
the week I will have a report on how we are going to
handle it. Clearly we cannot be training doctors or
other public health professionals and not finding jobs
for them. We need them. The fact I did not know does
not mean the team did not know and work had not
been ongoing, but that was the biggest concern the
profession gave me in Birmingham at the Faculty.

Q319 Valerie Vaz: Will there be jobs for them?
Professor Davies: I am assured that we should have
jobs for them. David Nicholson, in one of his letters,
has specifically alluded to this—trainees should have
jobs. I am waiting for the report. Having been
apprised of the issue, I am now looking into it.

Q320 Rosie Cooper: Can I pursue that a little more?
The whole health service is in a complete state of flux
or disarray. As to PCTs, doctors and nurses, nobody
knows if they have a job. But you are able to say here
today that if you are a public health professional
doctor David Nicholson is going to guarantee your
job. Is that what you are saying?
Professor Davies: No, I did not say that. I was talking
about the trainees who are coming through.
Rosie Cooper: I can be a trainee doctor or nurse and
not be sure I am getting a job, but if I am a trainee
public health doctor, I am going to get a job.
Professor Davies: I would see what you have said as
an exaggeration, speaking as a medical practitioner. I
come from the hospital sector, which is not changing
its structures significantly. We are training doctors and
nurses and we have jobs for the vast majority of them,
if not all of them. I can only talk to you about public
health—

Q321 Rosie Cooper: Can I tell you that there are
loads of people out there listening to you—in your
independent status—telling us that as far as you are
concerned, we do not have a problem; that people are
not going to be losing their jobs all over the place and
that you do not know there are nurses and doctors out
there who are going to lose their jobs? As the leading
medical doctor, are you really saying that to me?
Professor Davies: You are over-interpreting what I am
saying. We are in a time of austerity; there is a
reduction of 30% on management costs and that will
mean losses of jobs, and as we change the structures
of care across the whole of the NHS to more
integrated pathways and things, people’s jobs and
opportunities will change. I do not think that the NHS
has bottomed out what that means for all the staff. I
definitely do not know what it means for all the staff.

Q322 Rosie Cooper: But you do know what it means
for public health doctors.
Professor Davies: I am responsible for public health.

Q323 Rosie Cooper: They are assured of jobs.
Professor Davies: I am apprised of a concern that we
have a number of trainees coming through who think
there may not be jobs. I am told that we should be
able to look after this. I have not promised it yet. We
are looking into it and I hope it will be all right. If we
train any professional for public health or health they
are a precious resource for this country.

Q324 Chair: Before we leave it, I would like to come
back to one of the answers Anita Marsland gave
David Tredinnick, which I think was that it was the
Government’s policy that every director of public
health should be a chief officer of the local authority,
should be accountable to the chief executive and
should not be accountable to any other senior officer
of a local authority. Given the concerns that have been
expressed about this among public health professionals,
if that is what you said, it is a very important announcement. Have I heard you correctly
or am I over-interpreting? I am not seeking to do so.
Anita Marsland: Maybe a slight—
Professor Davies: I think you are over-interpreting.
We expect this, but we cannot mandate it, as I
understand it, into local authorities. By being strong
about the expectation, we would hope that this will
happen across—

Q325 Chair: I am going to push you further, in that
case. I accept that you, as an independent CMO or as
departmental officials, cannot mandate it, but the
House of Commons can and the Government has to
be clear whether it thinks this should happen and it
should be part of the structure or whether it is simply
left as a matter for local discretion. There is a clear
policy choice to be made. Which choice is the
Government going to make?
Professor Davies: The policy paper that will be
published later this week should make that clear.
Chair: Thank you.

Q326 Mr Sharma: You talked earlier about trainees
who would possibly have jobs. How many trainees
are there?
Professor Davies: I do not have those figures. That is
the report I expect to have at the end of the week.
Chair: Rosie, you wanted to ask about funding, if I
can remind you.

Q327 Rosie Cooper: I do. The public health White
Paper said the total annual public health budget is
likely to be over £4 million. I wonder whether people
on the panel might shed some light on where that
figure was magicked from? Also, what areas of
spending is it intended should be funded from the
ring-fenced public health budget, at local and national
level? I would like to come back on that as well.
Professor Harper: It is £4 billion. I am not sure if I
heard you correctly. Did you say £4 million or £4
billion? It is £4 billion.
Rosie Cooper: I meant £4 billion if I said £4 million.
Professor Harper: I understand. We said in the White
Paper published at the end of November that estimates
at that stage would suggest it would be £4 billion, or
over £4 billion. 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. You have mentioned ring fencing, and it is probably helpful to clarify the different types of ring fencing. Within the total spend for health, there is an element of ring fencing along the lines of £4 billion plus. There is also a ring fencing that is referred to, which I think is the one you are alluding to, that goes out to local authorities essentially to be spent on those health improvement activities—the commissioning activities—laid out fairly clearly in one of the papers that we consulted upon alongside the White Paper on public health. All of this is work in progress. Some of the work will be mandated from the Secretary of State. Much of it will be framed around the outcomes framework that we are currently working on. There will be outcomes that are considered so important at national level that local authorities will deliver them through their own means. We are not saying how things should be delivered, but we are saying what, at national level, we consider important, in the context, say, of inequalities. How do we get this reduction in health inequalities that we are all agreed we should be looking for and that Michael Marmot has been closely involved with for many years now? Those are the sorts of activities that will be included within the local authority ring-fenced part of the budget. Thus, there will be the local authority-determined activities, there will be the activities related to the outcomes framework and there will be a number of mandated services that the Secretary of State feels have to be delivered because of that national importance.

Q328 Rosie Cooper: Do you believe local authorities will have sufficient resources to be able to comply with all those signals and signposts they are supposed to follow?

Professor Harper: That is absolutely the objective. The objective at this stage is to determine what is currently spent and to match that with the priorities that I have alluded to. We are not completely there yet because the elements that I have not mentioned—we might want to discuss them later—are of course around health protection. I have focused on health improvement. Without overcomplicating a very complex landscape, other areas would be expected to be funded out of this ring-fenced budget. However, much of the interest—what we have gleaned through the consultation process, through the listening exercise—is around health improvement activities where there will be a commissioning role, particularly for local authorities.

Q329 Rosie Cooper: Most people would find this all very, very nebulous, but can I ask you a question about the concerns that I and a number of people have, that local authorities might redesignate some of their existing activities as public health activities? In fact, we have had people give evidence who suggested that making roads 20 miles per hour zones around schools is a public health activity.

Professor Harper: That is a risk that we have been made aware of over recent time. It is something that we need to take into account. The very fact that this is being described as “ring fenced” signals the intention. What we need to do over the next few months is work very closely with our key partners to make sure that the sort of risk that you have just alluded to—

Q330 Rosie Cooper: Forgive me. It is down to you to make sure it does not happen. It would be an outrage if public health finances could be moved in that way. I would really like to ask Anita—because, Anita, you know from your previous life how easy this would be—how do you see it? Not that, “We hope we would make sure it did not happen,” but that we—

Professor Harper: I am sorry, at the risk of interrupting, I did not say “hope”. I said “our intention” was, and that is what we are working on. We will be working and already have worked extensively with local authorities and others. Part of the challenge is to identify areas within local authority remits that are legitimately public health. There will be areas of transport—not the one that you identified, 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.

Professor Davies: Could John come in?

Professor Newton: From my experience of working at the moment with local authorities in the transition, most of the ring-fenced budget that will come across to local authorities is currently spent on quite specific items, if you break it down—things like drug treatment services and smoking cessation—and it would be quite difficult to take that money and use it for some of these more general projects. In fact, the NHS spends relatively little on the sort of infrastructure projects that we think local authorities will really want to address. The real win is the strategic and advocacy role of public health embedded in local authorities. That is what we think will make the big difference, not the spend of the specific budgets.

Q331 Rosie Cooper: I absolutely understand the strategic part, but that will go into things like the ideas and the evaluation. The evolution of this will be associated with Health and Wellbeing Boards, but they are powerless. The question I have not yet asked you, is this, I have, as will most people, a problem with the fact that the strategic idea is extremely good but local authorities—councils—are under huge pressure to deliver services to the elderly that they have to deliver and, where they are not required, they are reducing the entitlement of people with moderate needs. They are only dealing with people with severe and critical needs.
Professor Newton: My experience of going round speaking to local authorities—I was talking to the leader of Southampton last week—is that they really welcome the presence of the director of public health on their management boards and they are using that opportunity to look again. Absolutely, Southampton is a good example of where they are making substantial cuts. However, they see public health as something different they can do strategically. In fact, all the arguments around public health getting upstream are that unless you invest in public health they will not be able to make their books balance.

Q332 Rosie Cooper: I understand that. That is where the strategic point is good, but the reality is that we are here today. We have to get to 2013 and beyond and I think there are serious hiccups on that journey. I do not see any real signposts from the Department of Health that they are dealing with the “now”. Without going into much detail—I can give you an example today—Liverpool City Council, when a person goes from a residential home to a nursing home, is, in essence, making a family pay an extra £100-odd for nursing care that is free. They are making the family pay. If they are doing that now, and that is totally outwith the rules, what fun they are going to have with this lot.

Professor Davies: We are designing an outcomes framework—we have consulted on it—which will be used to judge the outcomes, because we are trying not to tell local authorities how they should do their business, and, of course, there will be the health premium, particularly aimed at health inequalities. Would one of you pick up on that?

Anita Marsland: If I may I will go back to your point that I should know from my previous experience. My previous experience was working in Knowsley where we did join up the system. We did that over nine years ago. We found that we were able to reduce health inequalities and that there was much more ownership about some of those very difficult decisions. They are always very difficult decisions and, arguably, even more difficult now than previously. In that authority there was the real strength of working together. We did have a Health and Wellbeing Board all those years ago and we gave it teeth locally. The benefit of this reform is that the Health and Wellbeing Boards will be given teeth.

Q333 Rosie Cooper: What teeth are they? Can we see any? Can you tell me what those teeth are?

Anita Marsland: Now their powers are strengthened in terms of being able to challenge the clinical commissioning groups—

Chair: If we are going all through Health and Wellbeing Boards, we will never finish by lunch-time.

Q334 Rosie Cooper: No, absolutely. I cannot see any teeth that are worth their bite coming out of those powers. They can recommend, talk and do this and that, but they do not have a vote, a power or a veto. What use is all that?

Anita Marsland: They can challenge the clinical commissioning groups in terms of their plans, which will be very helpful. Having experience of working in the system where people genuinely did come together—they did not always agree about things but they came together—the Health and Wellbeing Boards certainly provide opportunity for that debate in some areas where it has not been the case thus far.

Q335 Rosie Cooper: I totally agree that it is an area where debate will take place, but not very much more. Can I very quickly finish by coming back and talking about how local authorities may circumvent your intention? You said you were intending to stop it. My question to you would be: how would you actually prevent them doing it? Also, I have a general question about the extent to which public health is subject to cuts in NHS management and administration. We now know that public health doctors or trainees will not be threatened, but everybody else is. What effect is that having on public health today?

Professor Harper: As to the first part about how we can stop it happening, a number of points have been made already, such as having the director of public health in the right place within the senior structure in the local authority. That will be critical because the director of public health will be the person whose responsibility it is to ensure delivery of those sorts of outcomes that I referred to earlier, but also to produce, on a statutory basis, a report on the health of their population. These are, together, the sorts of things that should help reduce that risk. Over the next two to three months, working towards the autumn, we will be continuing to do this work and in a number of other areas as well around outcomes, around the commissioning lines, the budgetary lines and the health premium that the CMO mentioned earlier. Working with local authorities and with our key partners, we would expect to be able to manage that risk. Of course, that is in the future. That is our intent. That is where we are now and we have quite a lot of work to do to be able to deliver that.

Q336 Rosie Cooper: Okay. What about cuts in NHS management and administration and how that affects public health today?

Professor Harper: The general principle that I know you will be very familiar with is that front-line services, as far as possible, are protected. As far as the rest of the administration is concerned, the whole system is subject, over the next three-year period, 2014–15, to a cut of the order of a third. That will apply equally—

Q337 Rosie Cooper: Except to trainees.

Professor Davies: I will have to come back on this.

Professor Harper: That will apply to the administration of Public Health England and the public health system as well.

Professor Davies: I will know, by the end of the week, the size of the problem. I will do my very best for those trainees because it is my responsibility and it is a waste of public money not to use them. I cannot guarantee people a job. Some of them might not be up to it, of course. I sincerely hope, if they are trained, that they are.
Chair: These are the joys of debate in the House of Commons. We have been going 700 years and we have not got to the conclusion yet. We go on to public health outcomes.

Q338 Mr Sharma: The Department is still working on the details of the public health outcomes framework, but are you able to indicate how the Department is working to refine the framework in response to the various concerns that have been expressed about it?

Professor Harper: Yes, certainly. There are a number of responses that you are alluding to through the consultation on the document that was published alongside or just after the public health White Paper. There was a great deal of support for the general approach. One of the key responses—a number have responded—said that they would like to see an alignment of the three outcomes frameworks: public health, the NHS and social care. That is something we are very mindful of and we are working towards getting as much alignment as is appropriate but recognising that they are there to do different things. The other strong element of the response was the need to focus on health inequalities. These run right through four of the domains that were consulted upon. The fifth domain is health protection and resilience, and we can talk about that separately. Much of what was said was about choosing the right indicators. We included, therefore, in our consultation document, a number of indicators, but they were only ever there to act illustratively and to prompt discussion. As you rightly said, over the next few months, as with the funding and commissioning issues, we are going to be working and engaging with a range of key partners to develop our thinking on the right indicators. We are not there yet.

Q339 David Tredinnick: I would like to mention the domains. My understanding is that there was a consultation document published in December last year which proposed this outcomes framework and the divisions into domains. I would like to focus on what I have down as domain 3, health improvement—helping people to live healthy lifestyles, making healthy choices and reducing health inequalities, for example, by reducing smoking rates and increasing physical activity rates. Over the years I have chaired the Complementary and Alternative Medicine Group here, and have been an officer of it for about 20 years, and I have been part of the Food and Health Forum, but I am not going down that route today. Chairman, I would suggest to you that the key issue here is diet and food consumption. If you really want to improve people’s general well-being you need them to cut back on fat consumption, probably meat consumption and to eat more vegetables. This is something that you need to put up there right at the top of the agenda. I would like you all to comment on that, please.

Professor Davies: You are absolutely right. The science is quite clear; the major cause of obesity and the consequential diseases relating to it is our diet. Physical activity plays a role in our health outcomes but a much smaller role in our overall size. Because it does play a role in our health outcomes, on Monday I launched the four UK CMO’s physical activity guidelines. We do believe that diet is important and the Change4Life campaign and the Responsibility Deal have addressed that quite a bit. It is, again, one of the ways that local authorities can play a role; how they look at the provision of fruit and vegetables in their localities and their shops and how the whole system works locally. We would agree with you that it is very important.

Professor Newton: Yes, that is absolutely right. We know that diet is probably the second biggest cause of health inequalities. There was a recent study published showing that in people who do not smoke, obesity is the next biggest cause of health inequalities, so it is very important. It emphasises, again, the importance of an approach to public health that crosses all sectors of society. If you want to influence people’s diet, the most effective way is through education. I would point to the work of the School Food Trust, for example, in trying to change children’s food culture. There is evidence about how that could be done and there are a number of projects that have illustrated that.

If you are going to tackle something as fundamental as what we eat, you have to take a root-and-branch approach. That is the sort of thing that is easier to do if you are in a larger organisation that can, frankly, punch a heavier weight with all the big partners that you have to deal with, which is an argument for Public Health England. You will see where I am going with this. The other argument is for local authorities who, of course, have such a big role in education.

Coming back to your original point about the outcomes framework, if it does not cover diet and the consequences of diet, it will not be a public health outcomes framework.

Q340 David Tredinnick: From listening to professors of nutrition over a period of time, it seems pretty clear that those who change their diet then get improvements in the functioning of the body; their arteries clean themselves out gradually over time and their metabolism speeds up. That is why I think this is so important.

Chair: Good advice at the beginning of the summer recess.

Professor Harper: I have a very quick comment to follow up the points that have been made. The outcomes framework is a very important part of the new public health system. It is, though, only one part and I think you have already mentioned the Responsibility Deal. Within that there are specific pledges, as you will well know, about reducing salt, reducing trans-fats and increasing physical activity. With the outcomes framework itself, there are, under this particular domain, indicators—for the moment—for further discussion about increasing the number of people of healthy weight. Thus, it is absolutely embedded in the total approach that we are taking, but well recognised.

Q341 Valerie Vaz: You mentioned an advisory group. Who will you have on this advisory group? Are you going to have food manufacturers or alcohol
Q342 Valerie Vaz: I am sorry, do you want me to do your job? I am very happy to do that. Shall we swap?  
Professor Davies: No. I am just interested in the provenance of your question.

Q343 Valerie Vaz: I am asking you a simple question: who are you going to have as your advisory group? We have heard that there are some people who have influence at the Department of Health who should not be part of it. I am wondering who you have on it. It is a simple, straightforward question. Please do not be defensive about what we say.  
Professor Davies: No, I wasn’t. I was interested in your advice.

Q344 Valerie Vaz: This is about public money. You referred to the fact that we are in austerity measures, but nobody asked for this reorganisation and there was a way to evolve all this restructuring very simply. The morale of people in the NHS is at rock bottom. I feel, given the evidence. We have heard from all four of you and it is extraordinary that nobody knows what is going on. It is quite scary because it is a third of the budget and all four of you sit here and say, “I don’t know what is happening,” and, “We don’t know what is happening next week.” It is no offence to you.  
Chair: Let us get back to the membership of the advisory group.

Q345 Valerie Vaz: Professor Davies threw the question back at me. You are here to answer our questions. It was just a simple, straightforward question: who are you going to have on your advisory group? You have taken the decision to pick on infection when there are a huge number of other issues you could have picked on and it seems simple and straightforward for someone at the top of public health to pick something like that.  
Professor Davies: Clearly there will be both academics, who bring one sort of expertise, and practitioners there. I am sorry if it was not proper protocol to ask your advice. Further than that, we have not decided. I want to make it work, which is why I am open to advice.  
Valerie Vaz: I am very happy to advise you then.

Q346 Rosie Cooper: We have heard concerns about the risk in the proposed health premium, that it could act in a regressive way by rewarding wealthier areas, which have the least tractable health problems, and penalising poorer areas. I am an MP for West Lancashire where if you live in one area, you will die 10 years before people living in another area, around three miles away. What policy options is the Department looking at to obviate or mitigate that risk? If you are doing that, what are they? I am not only talking about the grand scale but actually down to, for example, my constituency where I have huge differences in health outcomes.  
Professor Davies: It is complex and I agree that we have to do our best to get it right. David.  
Professor Harper: I can give you the answer that I think you are not looking for, which is where we currently are. It is reiterating what I said earlier about the bigger funding issues. When we consulted on the health premium we had a number of responses, not least those in the area that you have indicated. Our intention is, as I think you are very well aware, to incentivise local authorities to tackle those areas where we can have a reduction in health inequalities. Of course, this is a huge issue and one we have not managed to tackle successfully so far, in spite of the best intentions of a vast array of very capable people. The health inequalities gap is still increasing, and that is not a surprise, given that the health of the more disadvantaged is improving but the rate at which the health status of the better-off groups is improving even more quickly. Thus, the gap is increasing. This is something that is at the heart of the current Government’s strategy for tackling health inequalities. Michael Marmot himself said, at a recent meeting I attended with him, that he was extremely pleased to see how the Government has responded through the public health White Paper, in a strategic sense, to address some of the key issues that he has been talking about for a very long time. How the health premium can be made to work is exactly what we are working on over the next one, two, three or four months. We will publish the shadow allocations, including the health premium, as intended and as reported in the various documents that you have had before you for shadow running of those health budgets from April next year.

Q347 Rosie Cooper: Forgive me, but what I have heard since I have been here this morning is a lot of change, intent, hope and whatever, but very little evidence-based change. All these changes are taking place. You don’t have the evidence to back it up. You are trying to make this work based on a strategic objective that nobody could disagree with; we have never had any disagreement even before this reorganisation. Wouldn’t the amount of money and effort that has gone into all this reorganisation have been better directed at issues such as this?  
Professor Harper: No. I think on public health we have a clear position, and my apologies if it has not come across like that. In the funding and outcomes area, we have consulted. The consultations closed at the end of March. We have been assimilating all the responses, through the listening exercise as well, and we are developing policy. One of the very strong messages is, “Don’t come to us with the answers.” In the responses that we have had the people want to be able to play into the co-production—how these systems will work. That is what we are doing. We have said very clearly that we will be doing that over the next two to three months.
Q348 Rosie Cooper: If I come back to you in three months’ time, you are going to tell me how this policy will affect the differing parts of my constituency.

Professor Harper: Specifically with the health premium. There is a timetable for various pieces of information that we are working on over the next two to three months. With the funding, we will be in a position, we expect, to be able to issue shadow allocations for the start of the next financial year. That is the timetable that we have talked about and that people are working to.

Rosie Cooper: Thank you.

Q349 Mr Sharma: There seems to be some confusion about the extent to which funding for Public Health Observatories has been cut in 2011–12. In an Adjournment debate on 17 May 2011, the Public Health Minister referred to “The Government’s contribution of £12 million to the observatories”. Can you explain to us what changes have been made to the observatories budget this year and exactly how that £12 million figure was arrived at?

Professor Newton: I will come in there, Chairman, if I may. I should say, by the way, that I spoke to the secretariat and it might be helpful if I give you a written comment as well, since there are figures involved, but I can briefly explain now as well.

If I take the overall approach to the funding first, in recent years the Public Health Observatories have received two types of funding from the Department of Health. The first is a core grant to support reasonable health intelligence infrastructure and the second is funding to support specific programmes of work—specific projects, such as the health profiles or the specialist observatories, and many of the other things that you will be familiar with. In 2010–11 these were, respectively, £5.1 million for the infrastructure and £7 million for the specific projects, the specialist observatories. That totals £12 million. That was for last year. I can give you the list of what made up the £7 million.

In this year, 2011–12, the budget committed by the Department to health intelligence infrastructure is the same—£6.5 million—as it was last year. As last year, that budget will be used to support the Public Health Observatories but also to deliver some other public health intelligence functions, such as congenital anomaly registers and health impact assessment gateway projects. It is not only for the Public Health Observatories, but it is there for the Public Health Observatories and it is the same as last year. This year, however, we have asked the Public Health Observatories to work more in an integrated national approach. In fact, in different roles, I have been having that conversation with them for the last two to three years and there was widespread acceptance that the Public Health Observatories should be moving to a national structure. This recognises the change or move away from regions themselves, but particularly regional public health programmes that are not now funded. The requirement, and in fact the experience, is that the observatories have worked extremely well when they have taken national leader roles, things like the specialist observatories.

What we have asked them to do is develop a single integrated work plan and Professor Brian Ferguson, when he was here, indicated that he was working on that. He has been working on it for a year. We asked him for it, in fact, in March this year because we wanted to base this year’s funding on it. He has told me that it will be ready by the end of July. While we are waiting for that programme, we have allocated £4 million to the observatories for this year for the infrastructure function. It is an unspecified amount upfront to the observatories which they have—guaranteed—for the whole year. If, when we have received it, the plan requires more than that for the observatories to deliver it, the budget is available to fund the plan.

We think the move to a national integrated approach will be efficient. For example, each observatory currently supports their own website. In addition, there is APHO’s website. That is 10 websites pointing to largely similar resources, so we think there are efficiencies from this single integrated work plan.

However, I stress that the budget remains the same and it is available to support the observatories if they need it. We are obviously reluctant to support a model that is going to be left slightly out of date by all the other changes happening across the public health system.

In terms of the rest of the money, in other words, the specific projects, the specialist observatories and so on, that is business as usual as far as the Department is concerned. The figure, so far, is that £5.2 million has been confirmed for this year. I should say, by the way, that the £4 million confirmed for this year already would represent a reduction of 23% in the core budget if they receive no more money for the rest of the year. Obviously, if they do receive more money as the year goes down, that reduction would be less than 23%.

In terms of the special projects, the reduction is, as it happens, also equivalent to 23% compared to last year. Some of that is because programmes have come to an end; they were three-year programmes that have reached their end. Some projects have moved; for example, the National Library for Public Health has moved to NICE. The same work is being done but not through the Public Health Observatories, so there is a reduction in the money going to the observatories.

Going back to the original figures, the money that I have mentioned is the money the observatories get from the Department of Health. In addition, in 2010–11, the observatories received £3.7 million from other Government Departments and from other sources such as the NHS Information Centre, making up their total budget.

Q350 Mr Sharma: Can you tell us what the role is of the Working Group on Information and Intelligence for Public Health, which you chair, and can you summarise what it has achieved so far?

Professor Newton: Following the White Paper and the recognition of the significant change to the public health delivery system, there has been widespread recognition—the policy papers published have clearly said this—that information, intelligence and evidence
have to be at the heart of public health. We have been asked to set up a group representing all the different interested parties, including, for example, Cancer Registries, Public Health Observatories, the NHS Information Centre, the Health Protection Agency and the National Treatment Agency, to consider three things: 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. Thus, there are three distinct functions: designing the future, designing the transition and ensuring that nothing gets dropped on the way.

In terms of what we have achieved, we thought the right way to do this was to start with the products—
to decide what the new system needs rather than starting with the structures. We have come up with a draft list of products that we have put out for consultation—I think we have had three weeks of consultation so far—and we have had, broadly, a very positive response. We set ourselves a target of, by September, having agreement from all the parties involved that this is the plan, these are the products and then we will start working on implementation from September. We already have nine draft projects.

Chair: Thank you very much. We have two short questions that I would like to cover and then we need to move on. Rosie wants to ask a question about NICE.

Q351 Rosie Cooper: Absolutely. In your evidence to my colleague you indicated that some of the work of the observatories was being done by NICE. I understand that NICE is supposed to have a continuing role in evaluating public health interventions, but we have recently heard from a member of NICE’s Public Health Interventions Advisory Committee that its workload has reduced dramatically and that, in fact, it has not met since December last year and usually they meet monthly. Everybody is a bit mystified. Can you tell me what is going on? If you are saying some of the work is going to NICE and NICE has not met since last December, here we are, six months later, and there is a bit of a gap.

Professor Newton: I can tell you about the areas in which I am involved, but I will pass over to my colleagues for the more general picture. The work I am talking about is the National Library for Public Health, NICE currently provides the National Library for Health, which covers all the other areas, so it makes sense. In fact, the National Library for Public Health started with NICE, has moved through various places and is now back with NICE. It makes sense.

Q352 Rosie Cooper: Why has this advisory board not met since last December?

Professor Newton: I am a member of the NICE public health reference group, which meets monthly, and is a very active group, but I will hand over to David who may know more, or indeed—

Professor Davies: I do not know anything about their internal workings. I don’t know whether you do.
April 2013 and the new system will be ready to go with the right people in the right places.

Q354 David Tredinnick: Soldiers often talk about “the fog of war”. It is almost as if you are talking about the fog of emergencies. It is the second time today we have heard that at the Department you are having to investigate what different areas in the Department’s purview comprise and how they work. I wonder if you are not dealing with a very difficult situation where it has been very unclear who is doing what out there and a lot of this has been hanging together in a rather haphazard way. Do you think that is fair?

Professor Harper: No, I do not think it is fair, if I may say so, and I am sure Sally Davies will want to comment as well. The system has been tried and tested and has been shown to work extremely effectively in an emergency. By “emergency” we have to be slightly careful. There is a huge spectrum of different emergencies. People consider it everything from a local food-borne disease outbreak as an incident that requires the sort of processes around it that we are very familiar with all the way through to the national emergency where the Department of State, the Secretary of State himself, will hold the ring and bring together the different parts of the system. 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 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, as somebody already mentioned today, the alignment not just at the sub-national level but at the very local level for emergency preparedness. The Secretary of State has already said very clearly that he would like that alignment between the Commissioning Board, Public Health England and, very importantly, between the local resilience fora on the DCLG side of the business.

Q355 David Tredinnick: Thank you very much for that detailed explanation. What plans, if any, are there for the designation of bodies as Category 1 responders under the Civil Contingencies Act 2004?

Professor Harper: 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. We are working through Category 2 responders as we speak. 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.

Chair: At that point, we have overrun, significantly, where we were aiming. Thank you very much for coming this morning. We have enjoyed meeting you and we have enjoyed the debates. We will reflect on what you had to say. Thank you very much indeed.

Examination of Witnesses

Witnesses: 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, gave evidence.

Q356 Chair: Thank you very much for joining us this morning and for sitting patiently through that last evidence session. Could I ask you both to begin by introducing yourselves and your background of interest to these issues?

Dr Scally: Certainly, and thank you, Chairman. My name is Gabriel Scally. I am Regional Director of Public Health for the South West Region. I have been a regional director of public health in England since 1993. In that role, I am employed by the Department of Health, so I am a civil servant, but I am also a director of the Strategic Health Authority for the South West. In the context of what we may be talking about in terms of regulation, I should mention that I have also been a member of the GMC for 10 years.

Professor Maryon-Davis: Good afternoon. My name is Alan Maryon-Davis. I am a public health doctor. I have a background in hospital medicine and general practice, but I have been a public health doctor for over 37 years now, including being a director of public health for an inner city borough in south London. I am also the immediate past president of the Faculty of Public Health, which is the professional body for public health specialists. My role today is to provide a broad overview.

Q357 Chair: Thank you very much. We shall no doubt need that I would like to begin by asking Dr Scally to talk about the background to the work you did on recommendations on professional regulation. What was the remit you were given and the background to the report that you produced? To what extent were you pointed in a direction, or did you feel there was a sense of preference of what the outcome was likely to be?

Dr Scally: I was asked by Sir Liam Donaldson—the former Chief Medical Officer—who was acting in consort with his three CMO colleagues from the other countries of the UK, to undertake this review because there was a general feeling in the public health profession that the current system of statutory regulation was not adequate. My task was to look at the systems and come up with some recommendations, whether they were a continuation of the existing system or proposals for change. I duly reported back to the CMO—by that time, it was Dame Sally Davies—and then my report was published...
alongside the White Paper for consultation in the autumn.

Q358 Chair: In summary, what were the inadequacies of the current system that led to the establishment of your process?

Dr Scally: It had been a view from the early days of multidisciplinary public health that there should be a statutory regulatory framework. However, as part of the move towards multidisciplinary public health, a voluntary register was established. Indeed, that is one of the steps that the Government prefers to see in terms of a move towards regulation of a profession—or, in this case, a branch of a profession—but it was always envisaged that it would move to a statutory footing. That had not happened. The existing system was continuing and was operating, but not in complete consort with the rest of the regulatory system consisting of the GMC and the GDC. There were a number of routes of entry to the voluntary register of the GDC and the GMC and this was causing unnecessary confusion.

Q359 Chair: Was there any evidence that it was leading to prejudices to public safety?

Dr Scally: I am unaware of that, but there have been concerns that the routes were unequal. Some younger professionals seeking to come into public health were choosing to aim for the voluntary register route rather than going through training and qualification because they had a feeling that it was somehow easier and less demanding than going through proper training.

Q360 Chair: Is that a coded way of saying it was easier to get into public health through the non-medical route?

Dr Scally: No. The examination and the structured training route is open to medics and non-medics. Indeed, increasingly, the balance of people going through that route is evening up, if not tipping in favour of non-medics going through the formal training route. It was certainly a view that we needed to look at the whole system and get it much more unified so that there was one route everyone could rely upon to produce highly skilled, highly qualified and regulated public health professionals throughout the country.

Q361 Chair: To be clear, it was your recommendation that there should be a clear pathway to a full, single compulsory regulatory framework?

Dr Scally: I had several recommendations, but to summarise them, the three key ones were, first, that there should be a system of statutory regulation that covered all senior public health professionals—of course, about 80% are doctors or dentists and already covered by statutory regulation—and it should be a universal system of statutory regulation; secondly, that there should be protection of title, that the term “director of public health” or “consultant of public health” should be protected and only able to be occupied by someone who was on a statutory register and the third thing was that I recommended there should be a single predominant pathway to registration, which would be through qualification, structured training and doing the examinations of the Faculty of Public Health. I very much saw the Faculty of Public Health coming to occupy a very central place in the validation of training and training programmes.

Q362 Chair: How do you think those recommendations would change the balance between the medical and non-medical routes? Would that lead to a process of change in what it meant to be a public health doctor, or indeed a director of public health?

Dr Scally: No. I don’t think so. I do not think there would be any detriment to that. Indeed, my view was that it would provide reassurance that all senior public health professions were trained, qualified and regulated to a satisfactory degree. Indeed, having looked at various schemes of regulation for health care professionals, I found that the closest analogy was with the pathologists, where approximately 20% of pathologists occupying consultant posts are non-medical; the medical component of pathology is regulated by the GMC and the non-medical regulated by the Health Professions Council. That was my specific recommendation. That would put us very much on a par with pathologists and provide a very good basis for going forward, particularly, should I say, into an era when senior public health people—of course, the White Paper on public health appeared subsequent to my report—will be employed by local government, perhaps by the NHS Commissioning Board, by the Department of Health via Public Health England and, indeed, in academia. Therefore, one standard statutory regulatory framework, I thought, would fit very well with that.

Q363 Chair: I understand the point about reassurance. I was asking a slightly different question, which is whether you thought the adoption of that framework, as you recommend it, would, as a matter of practical predictive effect, lead to a change in the nature of the public health profession.

Dr Scally: No, I do not think so. All the evidence from our recruitment to the structured training programmes is that we have a good balance between medical and non-medical entrants and a good balance of completion of that programme, and people are coming on to both the statutory registers at the moment and, indeed, the current voluntary register perfectly satisfactorily through that structure. There is usually a five-year training programme involving the examinations of the Faculty of Public Health.

Q364 Chair: You do not see any particular reason to change that balance, nor do you think that your recommendations would lead to a change in that balance.

Dr Scally: No, indeed.

Q365 Chair: Neither an intended or unintended effect.

Dr Scally: I cannot envisage that it would. It operates perfectly satisfactorily in terms of recruitment into the profession at the moment.
Q366 Chair: Professor Maryon-Davis, you were going to offer us independent or balanced advice.
Professor Maryon-Davis: What is more likely to change the balance of the public health profession in terms of medical or non-medical, which I think is what you were getting at, are the new structures that are being put in place under the current system in England; we are not talking about other parts of the UK. That is going to have a much more profound effect on the rebalancing because a large chunk of public health specialists will be working in local authorities, as we know, and that is a kind of alien set-up for public health specialists up till now. That may have the effect of deterring some doctors who would have gone into public health from joining because they may feel that they are moving away from the National Health Service and into this slightly alien territory they are not used to. I think the non-medics will find it much more comfortable working in that sort of set-up. The medical members will tend to move towards the health protection function of Public Health England and, also, the health care public health function you mentioned earlier on—advising on the necessity of coordinating services or service reconfiguration. Therefore, we will start to see a bit of a split in terms of the professional background of public health specialists.

Is that a good or a bad thing? It is hard to say. It should be a good thing as long as there is cross-talk between the different groups. As long as there are good communications across the commissioners, Public Health England and the local authorities, in particular, and hopefully with academia as well, and the information side of things, and there is a continuing critical mass, as it were, and people support each other, that could work okay. Otherwise, there are dangers in fragmentation.

Q367 Chair: I was quite struck, in Dr Scally’s response, that there was neither an intended nor a predicted unintended consequence in terms of changing the balance. This is a pretty profound change that is being proposed. I am surprised that it is neither motivated by, nor anticipated to produce, a change in the balance.

Dr Scally: Chairman, I may have misunderstood your question. I understood your question in terms of my recommendations around regulation. If you are asking me a different question, which is about the overall effect of the public health changes, I agree with Professor Maryon-Davis that there is that possibility. However, as I think perhaps you mentioned earlier, these changes, in so far as they affect public health practice locally, are very much public health coming home.

Neither Alan or myself are probably venerable enough to have worked in the local authority setting—I was a medical student at the time—but you have to remember that there is a long tradition, going back to 1848, of medical officers of health working very successfully within local government. Of course, they operated against a background of protection, in terms of their independence, the inability to sack a medical officer of health without the agreement of the Ministry of Health, a requirement that they should be properly qualified and possess a diploma in public health and that every local authority above a certain population size had to have a medical officer of health. There was a very rigorous system. The good name of medical officers of health ensured that there was a steady flow of medical graduates into public health at that time and that is very much what I hope we will manage to establish in terms of the position and operation of directors of public health at a local level.

Professor Maryon-Davis: May I add to that? Because of these changes and because directors of public health, but also consultants in health protection and other members of the team, are going to be, in the future, in such crucially important roles for the health of their population—they will have responsibility for delivering on various health programmes—it is absolutely vital that they have statutory regulation as described. It is very much an issue of public safety. That is at the very root of it all. You only have to look at what has happened in Germany just recently with E.coli. There have been over 50 deaths there. That could so easily happen in this country.

The directors of public health have a crucial role and responsibility for co-ordinating the response to that sort of outbreak, working with Public Health England. Pandemic flu could hit us again at any moment. God forbid that it happens in the next couple of years while we are in disarray, but it could happen. Again, there is a crucial responsibility. There is cancer screening. I was always very worried when I was a director of public health about cervical cancer screening, about the wrong letters going to women telling them they are okay when they are not okay and that sort of thing. It could easily happen and there would be massive consequences.

Q368 Chair: It has happened.
Professor Maryon-Davis: Indeed. Emergency responses and immunisation are crucially important things which have a direct effect on the health, life and limb of the general public. There is also the role in communicating with the general public, which can go horribly wrong. To my mind, it is absolutely crucial that not only directors of public health but also public health specialists in general enjoy the same statutory regulation as the medics and the dental people. It should be an equivalence. The trends in recruitment are now that there is a preponderance of non-medics coming into the specialty. In fact, the latest figures are 2:1. Therefore, if you look to see that cohort coming through, it is going to play out in terms of the people on the ground.

We must not have a “postcode” public health system. We have to have equivalence across, parity across and we have to have employers, who will be largely local authorities but others as well, confident that they are employing people who are quality assured and are fit and proper—to use the current phrase—to act in those positions of responsibility.

Q369 Chair: David wants to come in, but I want to come back to this question of balance. The figure you gave of a preponderance of non-medics coming into public health is a striking piece of evidence against the background of this having been originally a medical

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qualification. Do you still say that we should be virtually blind to the proportion of medics and non-medics?

**Professor Maryon-Davis:** I am blind to that, but, in terms of the current debate about regulation, it is important to point out that difference.

**Q370 Chair:** It is important to point it out but then to be blind to its consequences.

**Professor Maryon-Davis:** Providing that people who are in those positions are quality assured through a robust system of statutory regulation with the full force of the law behind it, which is the big difference about the statutory regulation, the employers can take comfort from that and so can the public.

**Q371 Chair:** One more go and then I will shut up. It surely goes to the culture of what it means to be engaged as a public health professional if we are moving into a world where less than half, and potentially significantly less than half of them, are medically qualified.

**Dr Scally:** How this will play out remains to be seen. I know, in my own region in the south-west, that we have recently recruited five trainees and none of them are medical. This is the first time in my very long experience that that has been the situation. Public health has moved to incorporate people from a wide range of professional backgrounds, and that has been greatly to its advantage, but in my view, public health would be weakened unless there was a substantial proportion of people from a medical background working within it because of the nature of much of the work that we do. Many of the things that will stop that happening lie around the way in which the new public health system is set up in terms of some of the issues that you have addressed, in terms of the status of the director of public health and of consultants within local authorities and young people in medicine seeing public health as an attractive career option for them.

**Q372 Chair:** One of the issues that the Committee is interested in—way outside this current public health inquiry—is the role of professional regulators through the GMC, the NMC and those bodies. I would have thought it merits further thought—I put it no more provocatively than that—that a new statutory regulatory structure should be established that would be blind to the balance between medical and non-medical input into a new regulatory body or recruits into the work force.

**Dr Scally:** I certainly think, as a system, we should not be blind to it. It lies within the realm of developing a work force plan for public health for the future rather than in relation to regulation, if I may say so.

**Q373 Chair:** Surely the regulator has to own the concept of quality—that it means to be a professional—in that particular profession. If the regulator does not own that concept, who does?

**Dr Scally:** If I can go back to my analogy with the pathologists, the organisation that holds that role is the Royal College of Pathologists, and I very much see the Faculty of Public Health holding that role with regard to quality and advising the regulators as to who should be admitted to the particular register that they operate.

**Professor Maryon-Davis:** A lot will depend on what jobs are out there. Where there are jobs for public health people to advise on commissioning and to advise on the commissioning of clinical services, there is clearly a role for somebody who comes from a clinical background—medical, nursing or an allied health professional. If there are jobs out there to advise on outbreaks of flu or other things, there is a strong clinical or medical element, so that is another role. Employers will play a big part in this in specifying the sort of public health person they may want for a particular job.

**Q374 Rosie Cooper:** I am flying a kite here really, but listening to you, would a local authority be more likely to appoint a doctor to a public health role or a non-medic, in that they would more likely fit in with local authority practices or ways of working?

**Chair:** Habits of thought.

**Professor Maryon-Davis:** It is an interesting thought, if one speculates. A key point in this is pay. Most of us in public health are fighting to make sure that the non-medics and the medics are at the same pay level so that the issue of the cost of employing that person does not come into that kind of judgment.

**Dr Scally:** From my own experience in the south-west, we have 14 directors of public health, 13 of whom are joint appointees between the local authority and the local primary care trust. Having sat through a very large number of appointment panels, the choice, as you have put it, has never been a key deciding factor. It has been who has been the best person for the job, though there is a view among some local authority people that they would prefer a medically qualified person to undertake that role.

**Q375 Rosie Cooper:** I share that thinking, but I am looking forward. Times are going to be very, very difficult and there may be a view that an independent-thinking medic may be more difficult than a public health professional who was more used to the ways of business or local authority working. The choices may just be different.

**Dr Scally:** Most of the people who are non-medical but within the public health fraternity tend to come from some form of health-related background. It is very interesting because it is not, by any manner of means, the medically qualified public health people who are less involved in issues such as the effects of transport on health or housing on health—not at all. There is, of course, that very long tradition of public health people caring passionately about the social determinants of health, and that does not divide, in my long experience, necessarily along medical and non-medical grounds.

**Q376 Rosie Cooper:** But in the future they will be making those choices inside a local authority.

**Dr Scally:** Chairman, if I may say so, in terms of how I choose to spend my time and energy as a regional director of public health, it is orientated very little on the clinical side of the business, except when it goes
wrong, in which case I am called upon to sort things out. It is very much about the determinants of health around smoking, diet, physical activity, transport policies in the south-west, for example, or housing policies and what kind of urban extensions we want to build to house the increasing population. All those areas are absolutely core to my personal practice.

Q377 Mr Sharma: My question is about registration. If registration of non-medical public health specialists is to continue to be voluntary, as the Government proposes, what are the options regarding who should maintain the register and which do you favour?

Dr Scally: Chairman, I have made my recommendation to the Department and the Department is currently contemplating these issues. The current Government position is that regulation should be commensurate to risk, that there is a presumption in favour of voluntary regulation and that more discussion is needed on these questions. I have made my recommendations and I think there is a role in future in terms of the public health work force, for example, for the Royal Society for Public Health and the use of its charter in terms of potential regulation of public health practitioners. Beyond that, I am unable to go.

Professor Maryon-Davis: I would agree. I have argued very strongly for statutory regulation of public health specialists, who are the senior ones. There is a role, potentially, for voluntary registration or regulatory registration of people at public health practitioner level, which is the intermediate level. There are some good reasons for that and it would seem to fit quite well. In that respect, I could see either the current voluntary register taking on that role or the Health Professions Council. There are various models, but that is for practitioners, which is the intermediate level of public health. For the senior people, the public health specialists, as I have argued very strongly, we should have statutory regulation. My concern is that dogma is ruling common sense here at the expense of public safety, which is really the issue.

Q378 Mr Sharma: The Council for Healthcare Regulatory Excellence has argued that it should have the statutory power to recommend a professional group for statutory regulation in the interests of public protection. How much merit would that approach have?

Dr Scally: That is a perfectly valid approach. There is a difference in respect of public health in that about 75% or 80% of current senior public health professionals are currently already subject to statutory regulation, so we are not a professional group coming de novo to the issue of regulation. My report was making the suggestion that that should become 100% of the public health profession, subject to statutory regulation.

Professor Maryon-Davis: To extend the regulation to the non-medics is simply an extension of the statutory regulation, of the current set-up. It would not require huge amounts of legislation to put through. It is a step which I think is important to take.

Q379 Chair: You said, in your previous answer, that you favoured doing it because you felt the public were at risk if it was not done. That harks back to an earlier question I asked Dr Scally, whether there is evidence of risk to the public arising as a result of the non-registered status of non-medics.

Professor Maryon-Davis: Yes. The public needs assurance, and needs to take comfort from the fact that the people who are in charge of the health of the population are fit and proper. Employers need that assurance too. Indeed, if you are employed by Public Health in England, the Secretary of State could do with a bit of assurance.

Q380 Chair: The desirability of assurance is a different thing from evidence of risk of the current position, is it not?

Professor Maryon-Davis: Gabriel will probably be able to answer this better than I can. The risks in the current system are that if, for some reason, the checks, balances and assurances are not there and if there are people who are employed who do not fit the system, that could put the public and the employers at risk, specifically around the issues I mentioned, which were outbreaks of disease, cancer screening and immunisation, where there are decisions that are made by people in positions of responsibility that can affect the lives of literally thousands of people. There could be a communications breakdown, which, again, could affect the lives of these people. The potential risks are huge. It could be tabloid stuff. It could happen tomorrow and it does happen, as you said, and goes on. That is a worry. There needs to be a strong system which provides the sort of assurance that we are talking about. There are risks in there which could be alleviated by having a statutory system where the force of law comes into play in dealing with any issues that arise in terms of falling down on the job, basically.

Dr Scally: I think there is considerable risk. I look back at my own professional career and some of the decisions I have been involved in and taken around, for example, intervening to stop paediatric cardiac surgery in Bristol or on several screening issues, or even things like the sitting of pyres and burial pits for animal carcasses during the foot-and-mouth outbreak. Always at the back of that was that if I made the wrong call on those I would be held to account professionally. That was because a requirement of my post was that I was a registered medical practitioner. One of my fears about the use of voluntary registers is that they are just that, and someone can leave them. This is indeed a problem, I remember, that we confronted in the GMC. When someone got into trouble in the medical profession they merely resigned from the GMC and could go off and practise perhaps somewhere else in the world or in another jurisdiction. The Government’s position on voluntary registration is quite clear. The White Paper in February this year, a Command Paper, stated that: “No stuff will be compelled to join these registers and employers will not be required to employ staff from these registers, though they could choose to do so.” It is not just an issue of the assurance of standards, to make sure the right decisions are made in some crucial
Q381 Chair: Going back to this question of the twin routes into public health, you still propose that two lists are maintained in one register.

Dr Scally: My preference would have been to be able to convince the General Medical Council to take on all of public health, but they were reluctant to do so. They felt they had enough on their plate with revalidation and various other changes in the GMC. That would have been my preference. Having looked at all the options, however, as I think I said earlier, the closest analogy I could find was with the pathologists where the medically qualified pathologists were registered and regulated with the GMC and the non-medical pathologists by the Health Professions Council. That seemed to me the best way forward and is indeed what I recommended.

Q382 Chair: Professor Maryon-Davis referred to the grades of specialist practitioner, and there is a third one.

Professor Maryon-Davis: It is the wider public health work force—health visitors, GPs and a whole bunch of people who do public health. They would not see themselves as necessarily public health people per se.

Q383 Chair: No. One of the surprises I had when I was reading some of the material for this session was that a health visitor is regarded as part of public health. That is another debate. Could you characterise for the Committee the nature of the work that the specialist and practitioner grades do and the implications of those classifications?

Professor Maryon-Davis: The specialists, who have either been through a five-year training programme on top of their basic professional background or who have presented a portfolio, are experienced people and they have presented their experience and been accepted on the basis of that; they tend to be senior people in positions of considerable responsibility. They are either in strategic positions, like directors of public health, or responsible for specific areas such as health protection, for instance, or it might be around health improvement—the three main domains—but they will be in positions where they are dealing with senior people in the hospital sector, in a local authority or in other areas depending on who their employer is.

Basically, they are working at a senior level, making big decisions. They might be in command of quite large budgets and so on and so forth. The practitioners tend to be people who are at an intermediate level, such as health promotion officers or specialists, people working in informatics, people working in health protection but at a lower level, and specialists. What other sorts are there, Gabriel?

Q384 Chair: It is very unlikely somebody would be a qualified doctor and a practitioner.

Professor Maryon-Davis: It is pretty unlikely.

Dr Scally: It is unlikely but not unknown. We should not try too much to demarcate the boundaries here. It is quite clear at the high level of the profession—consultant level, directors of public health level—that those people are highly specialised and work solely within the public health realm. When you get beyond that, the boundaries are more blurred, and I think correctly so. I would like there to be public health people—who think of themselves as contributing to the public health—within the transport or housing departments. Indeed, in my region, we put a lot of money recently into making it possible for people from local government to undertake a certificate, diploma or masters in public health to increase their skills. I firmly believe that we need a spread of public health knowledge and interest across the whole of the public sector.

Q385 Chair: I understand that thought process, but it is, to some degree, in conflict, is it not, with a desire to create a status for public health as an identified regulated profession with all the obligations that go with professional status?

Dr Scally: There is territory to be worked on, particularly around people such as health visitors who have their own regulatory body and framework. As I say, it is no easy demarcation. The demarcation that my report was particularly concerned about was the people who are occupying the specialist professional roles, and it is much clearer there.

Q386 Chair: Your advocacy of compulsory regulation is focused on the specialists, not on the practitioners.

Dr Scally: Indeed, that was the nature of my review and its recommendations.

Q387 David Tredinnick: I want to move on to public health work force strategy. The White Paper of November 2010 sets out the Government’s vision for the public health work force: “it will be known for its expertise, professionalism, commitment to the population’s health and wellbeing and flexibility.” Dr Scally, in your report you concluded that “there should be, as far as possible and allowing for dental public health, a single training pathway for specialist training in public health”. I know we have touched on some of this before. How is this aspiration affected by the proposed new structure of the public health services?

Dr Scally: I do not think the aspiration is affected at all. What we will have to do in public health is look at the competencies that are required of people who go through that training programme. Quite clearly, particularly with the move to local government, there is a requirement for an expanded or a different skill set. I only have to think of the challenges of dealing with local government councillors and the move from directors of public health being an executive board member of a primary care trust to being an adviser to elected members and to a cabinet to see that that is quite a considerable difference and quite a considerable skill set required of people. There will have to be a look at the content of the training, but our training framework is a good, sound one, which indeed is one of the requirements for statutory regulation.
Q388 David Tredinnick: Thank you. What dangers do you see in the cohesion of the public health service work force in the proposed new system?

Dr Scally: I am not sure—

Q389 David Tredinnick: You have a public health work force and we are coming up with a new system. How far could dangers of a lack of cohesion be mitigated by Public Health England taking on the entire work force, for example, and then seconding it out to local authorities and NHS commissioners?

Professor Maryon-Davis: Do you mean dangerous to the cohesion of the profession?

Q390 David Tredinnick: I mean that the cohesion of the public health work force is important. I want to know how, in the new improved system, this is going to work and whether there will be the cohesion that is desirable or whether it will be fragmented. There have been some issues raised, some of which—

Dr Scally: I can see the issue. The biggest threat to cohesion is through the loss of senior people as we go through a restructuring or liberation. I am in my seventh incarnation as a regional director of public health, so I have been through more than my fair share of these. In every serious restructuring affecting public health at a local level, we have lost anything up to 30% of the senior people. I think that is our biggest single threat. There is no sign of that happening at the moment. People are responding.

Professor Maryon-Davis: I would disagree with that.

Dr Scally: Maybe it is just in my region. The Government’s position is that directors of public health and their senior colleagues will be employed by local authorities and that Public Health England will be involved in the appointment process. I know that some public health organisations are advocating that they should all be employed by Public Health England and then seconded in.

Personally, and I must give my personal view here, it would be not good for public health if all directors of public health were employed by the Department of Health and were all part of the one organisation. It strikes me that that would not be a healthy situation in terms of their independence, freedom of thought and practice. Therefore, I would strongly support that the employment should be with local government. When you look at the coherence of the medical officers of health and the power that they held as a group within the country when they acted collectively, they were very coherent indeed.

Q391 David Tredinnick: Do you mean before 1974?

Dr Scally: Pre-1974, yes, indeed.

Professor Maryon-Davis: I am certainly in favour of directors of public health being employed by local authorities. That is the legitimate locus for them, but I think the links with Public Health England have to be pretty strong and, as I mentioned before, the links with the commissioners have to be pretty strong.

Q392 David Tredinnick: The Royal Society for Public Health has told us: “Local government has little experience of the expectations and responsibilities associated with medical/public health training, or of working with postgraduate Deaneries.” Do you think that is a legitimate concern and if so, what shall we do about it?

Professor Maryon-Davis: That is a concern. If you are talking about the training, there are risks in what I would regard almost as the atomisation of public health, going in different directions: local authorities, Public Health England, commissioning, private sector or wherever. There are issues there. Local government currently does not have the mindset and is not set up, as it were, to understand the training programmes.

That can be learnt and that can be acquired and I am sure it is a barrier that can be got around, but at the moment it is a bit of a risk and will need to be addressed. What is important is that trainees coming through the system must be given the opportunity to have experience in a variety of settings so that they build up a broad view of the range of public health.

Q393 David Tredinnick: Thank you. Is there a danger then that in the absence of statutory regulation, the public health work force within local government could become professionally “diluted”? Should councils be obliged or encouraged to take on appropriately qualified and experienced staff?

Professor Maryon-Davis: Yes. On that basis, they certainly should. That is something which I would hope this Committee could make a strong recommendation about because that is a considerable risk in terms of the effectiveness of public health.

Dr Scally: We have to remember that what is envisaged in the transition, and the reason for directors of public health managing the transition, is that public health teams will simply move from their current bases in PCTs to local authorities. Indeed, many of them are already in local authorities. As I said, 13 of the 14 appointments of DPHs in my region are joint appointments. They are already well integrated and have trainees in public health operating successfully within the local authority area. While I can see the theoretical risk to training, I believe that smooth transference will be achieved without too much difficulty.

Q394 David Tredinnick: The Unite union, when they came before us, told us that they feared councils could disperse public health staff across their organisations, leaving those staff without sufficient professional support, coaching, management and mentoring. Is that a risk to the future work force development or is that something you disagree with?

Dr Scally: Were it to happen, it would be, but I do not believe for a moment that it will. Directors of public health have a clear leadership role and I would hope that they would have public health staff working across the different aspects of a local authority but under clear leadership. In fact, I go back to the Health Select Committee report on public health some 10 years ago which pointed out the importance of the leadership role of directors of public health. A key part of their leadership role is to lead that team within the local authority, irrespective of where public health people are working within that local authority.

Professor Maryon-Davis: I agree with Dr Scally, but to help that process along it is important that the
directors of public health have control of their own bit of the budget that they are given, however small it might be. That will help to make sure that there is cohesion within the local authority.

Q395 David Tredinnick: Fine. Thank you for that. I am going to ask lots of supplementarys, but I will have to keep an eye on the clock. How should public health fit into the new systems for clinical work force planning, education and training that the Government is currently developing?

Professor Maryon-Davis: Public health should be an important component of clinical training as well, and certainly there is a lot of interest from some of the clinicians to embed public health within their training. For instance, GPs are very interested in having a public health module within their training programme. The paediatricians are very interested in them having public health, because it is so important for children’s health, as are psychiatrists and others. There is a move, and there is work going on with the Faculty of Public Health in particular, to try to work through training programmes that incorporate an element of public health within clinical training.

Q396 David Tredinnick: How big a danger is it that in the future public health could be less attractive as a career choice for doctors and dentists? I think one of you already said that it is down to the money. Are there any other factors in there? How could you mitigate those concerns?

Dr Scally: I do not think it was down to the money. I do not think it was down to the money.

Professor Maryon-Davis: It is not down to the money, but it is a factor.

Q397 David Tredinnick: Proper remuneration?

Dr Scally: It is a potential factor, yes, and of course people will be concerned. It is very important that we have a public health specialism within medicine that doctors want to go into that can provide them with a fulfilling career. That has a lot to do with how the system is structured and operates locally.

Q398 David Tredinnick: Thank you. The academic public health work force has an important role to play—every one of you will agree—not least in the work of the Public Health Observatories, about which we have had discussion this morning. How satisfied are you that sufficient attention has been paid to the future of this particular strand of the public health work force?

Professor Maryon-Davis: We heard from Professor Newton this morning about the plans for the observatories to be absorbed into Public Health England. My worry is in the transition to that position, because we are seeing what I would call the dissolution of the observatories. We are seeing senior people in the observatories leaving—jumping to academia or taking early retirement—basically because of all the uncertainty and unrest. My main concern is with what is happening during the transition period. Ultimately, the vision painted by the civil servants earlier on, at the end of that process, is a reasonably rosy one, aside from the fact that an Executive agency is still a branch of Government and that the people who work for it are still civil servants. What restrictions will that imply in terms of their independent voice? I do have continuing concerns about that.

Q399 David Tredinnick: I must say that when the representatives of the observatories came before us earlier in the year they presented incredibly well and one got the impression that this was a first-class integrated data-gathering system.

Professor Maryon-Davis: It certainly is.

Q400 David Tredinnick: Now there is a degree of haemorrhaging and there will have to be some major repairs, effectively. Is that right?

Professor Maryon-Davis: That is my view.

Dr Scally: Sir Liam Donaldson caught it quite well when he described the observatories on more than one occasion as the Crown jewels of public health. It would be unfortunate if there were any diminishing in the lustre of those Crown jewels, particularly in terms of their ability to support local directors of public health, local authorities and all of the work that needs to be done to contribute to the joint strategic needs assessments.

Q401 David Tredinnick: I have one final question. You have both, gentlemen, had very long careers by the sound of it. Dr Scally, you said you had been through seven transmogrifications—whatever the word is.

Dr Scally: It is six, I think. I am in my seventh.

Q402 David Tredinnick: That is going right the way back to when you were training. When you look at the landscape now, with particular reference to what we are discussing this morning, is there anything that really worries each of you? Is there something there that you personally would like to get on the record today so that we could perhaps look at it later?

Dr Scally: Not from my point of view.

Professor Maryon-Davis: He is a civil servant.

Chair: Professor?

Professor Maryon-Davis: This is by far the biggest shake-up that I have been through. I have been through as many as Gabriel—probably more—but this is by far the biggest and the most disturbing. We will not rehearse all the stuff about “Why?”, “Why bother?” “Why now?” and all those other things. Given that it is happening, from the public health professional point of view, the most worrying aspect is the potential fragmentation of public health not just as a profession but as a service to the public as well. The Government missed a trick in not having a public health person on the commissioning boards. That was a great mistake, and I think work will have to be done to make sure that that input gets in there. The cross-talk at the local level is important, that the Health and Wellbeing Boards and the commissioning boards—consortia groups—do cross-talk. Public health can play an important part in that, but that has not been worked through yet. We might hear about that coming soon. The biggest worry is the fragmentation. There are concerns that training might also be fragmented and that might cause problems.
We do have to get the regulation right and, as I have tried to say this morning, the time is absolutely right and we have a real opportunity now, especially in the way that the balance is changing in terms of the professional background of public health, to put in place, not at great expense, proper statutory regulation that would address quite a lot of the concerns that have been raised this morning.

Q403 Chair: Could we explore this concept of fragmentation? It is relevant to the debate about regulation too, is it not? You can have a coherent profession that works for a series of different employers and subscribes to a common professional ethic.

Dr Scally: Indeed.

Q404 Chair: Would it be fair to say that one of the arguments you would advance in favour of stronger regulation is that with a variety of employers the regulatory structure would address some of the fragmentation concerns?

Professor Maryon-Davis: The fact that we have a whole multiplicity of different employers adds real urgency to the need for statutory regulation. It is yet another reason why we should go for statutory regulation.

Dr Scally: Indeed. It also places the Faculty of Public Health in a key and vital position as the main professional organisation that is setting the standards for public health against which regulation will operate. The tasks falling to the Faculty and the distributive system of public health increase commensurate to the distribution.

Professor Maryon-Davis: I agree. I think the Faculty of Public Health will have to have a hugely expanded role in helping to mitigate some of the fragmentation concerns that we have talked about in working with the regulators to make sure that that regulation itself is fit for purpose. Yes, I agree. The Faculty’s role is going to be much greater.

Q405 Chair: Pushing you a bit further on the concept of fragmentation, currently, or traditionally, directors of public health have been employed by PCTs and, before that, local statutory health authorities of one sort or another, and they have been employed within the Department of Health. In the future they will be employed through Public Health England and through local authorities rather than through the health service. Why does that add up to fragmentation?

Professor Maryon-Davis: They will be working in a whole variety of different milieux. Some will be working for the private sector, which is going to expand as well, and some will be in academia, as we have heard.

Q406 Chair: Yes. What I am trying to test is your proposition that the world in five years’ time is more fragmented, from a public health perspective, than it was five years ago. It is not immediately obvious to me that that is true.

Dr Scally: I do not think, Chairman, it has to be true, but it could be true if directors of public health moved to local authorities and we did not have the right structures in place to ensure that they remained within a coherent system. What we are trying to create for the country is a public health system that will serve us well for the coming years. It is the systemisation of public health that will ensure we retain coherence. If we do not have a system and we do not have coherence, then the fragmentation could very easily happen.

Q407 Chair: As to the fragmentation, I think I am hearing you say that the danger is isolation.

Dr Scally: Indeed.

Q408 Chair: And that leads to fragmentation, but actually the institutional structure is no more fragmented in the Government’s intended world than it has been. The danger is that the culture in the local authorities is more isolated than the culture in the health service.

Dr Scally: That is right. In terms of professional accountability, the lines are redrawn. For example, I am very clear about the professional accountability of the directors of public health in my region. I sit within the strategic health authority and I have an organisational role then with the PCTs accountable to the strategic health authority, so it is very easy to maintain coherence and to encourage collective activity. If that collective activity falls away, it will be greatly to the detriment of public health because some of the really good things we do are done collectively, like the regional offices of tobacco control and the fantastic work they are doing with smoking, or our office in sexual health about integrating sexual health service approaches across the region. Unless we have a systematic approach to creating a system, then I do fear fragmentation.

Chair: Are there any other questions?

Q409 Rosie Cooper: What would you put into the system today to stop that happening? If directors of public health are not director-level employees at local authorities, that fragmentation will start, will it not?

Chair: I think we were given the broadest possible hint today that that is an issue the Government is going to address in a few days’ time.

Professor Maryon-Davis: The Faculty of Public Health can have an important unifying role across this potentially fragmented service by making sure that the standards are set equivalently across the system, so there are not differences in quality across the system, that the training programmes again use the whole system and not just bits of it and that communications between members of the Faculty working in different settings are there to help to encourage networks at local level, in particular, or the sub-national level and so on. Therefore, the professional body—the UK Faculty of Public Health—does have an important role in helping to mitigate the potential fragmentation that might occur.

Chair: We try to draw these sessions to a close by 1 o’clock. We are three minutes adrift, so thank you very much indeed for your evidence this morning. Thank you.
Tuesday 19 July 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Dr Daniel Poulter
Chris Skidmore
David Tredinnick
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: 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, gave evidence.

Q410 Chair: Welcome to the Committee and thank you for coming. Welcome back to Professor Harper. This is becoming a habit. You are very welcome. I understand, Minister, that you would like to start off with a statement to the Committee, which we look forward to.
Anne Milton: I will not try the Committee’s patience by saying very much, but I have just two things to say. First of all—whether I have to or not is not quite the point—I should mention that my husband is a public health physician, although not working as a director of public health. I feel it is important to have that on the record.

Secondly, I would like to put in context what public health means for me in my ministerial role. I feel incredibly privileged to have responsibility for this. It is important to remember that successive Governments have tried to improve the public’s health. Generally—overall—that has been the case, but the inequalities in health have widened. That is certainly not due to a lack of will on the part of successive Governments. The point is that they have all tried very hard and, in fact, the inequalities have got greater. That is because it is extremely difficult to do something about that and bring about the change that is needed. Thus, for me, this is a real one-off opportunity. We can be quite blasé about the figures surrounding health inequalities but they are truly shocking. If we really take them to heart and consider how they might affect our particular constituents, the fact you might live seven years less if you live in a particular area than another is dreadful. As I say, for me, this is a fantastic opportunity to try and make a dent. We will not turn round the fortunes of everybody in the lifetime of this Parliament, but I hope we set in train the structures and the philosophy needed to start to turn round what is like a great big tanker, and it is going to be slow. That is all I want to say at this stage.

Q411 Chair: Thank you for that. I do not think there will be any disagreement with the sentiment you express from any part of the Committee or indeed much broader than that.

That feeds quite nicely into the first question I was proposing to ask. What is the problem, essentially, that the changes in the structure of public health policy are designed to solve? Does it follow, from what you have said, that your prime motivation in this is to address health inequalities, or are there other issues in public health that you think also lie behind the Government’s proposed changes in the delivery of public health policy?
Anne Milton: Health inequalities sit out there. We are and have continued to become healthier as a population, of course, which is due to diet and a number of other things. However, it is those inequalities we need to address first and foremost. What some of the changes in how we look at public health will achieve and what we have the opportunity of getting is a real understanding that intervention from the health services—in its broadest sense—is insufficient. If you want to improve the public’s health, you have to bring about social and economic change and you need action from a wide variety of Government Departments and different local authorities—from parish level up to Government. There is not one single magic bullet for this. I am besieged by people who feel they have the answer. There is no one answer. One is always faced with a series of tools in the box. What is important is to employ the right tools.

Q412 Chair: It would also be said, would it not, that health inequalities are indeed an issue—and you have identified there are quite a lot of statistics that illustrate they are an issue—but you can solve inequality in any set of circumstances in two ways: one by raising the performance at the bottom of the heap and the other by restraining progress at the top of the heap? I wonder where the Government is. Should we be allowing the best to get better as quickly as possible and then narrow the gap with that, or should we be focusing specifically on inequalities rather than on the average?
Anne Milton: There has always been debate in the public health professions about that. In fact, they would argue that you have to shift the whole cohort to a better point. We want to put a focus on improving the health of the poorest fastest. It is not a matter of necessarily slowing down the improvements in health at the top—the people who are better off, if you like—it is also about speeding up the improvement of the health of the poorest. It is putting the foot on the accelerator for those people and trying to address some of the reasons why their health is poor.

Q413 Chair: Indeed. If that is the objective, to “put the foot on the accelerator”, to use your phrase, for the people for whom health outcomes are poorest, what are the key elements in the changes being
introduced that you think most empower that objective?

Anne Milton: It would be the move back into local authorities because, of course, public health has a proud tradition and history within local government. It is putting it there, for which—and I try to spend as much time as possible going around the country—there is widespread support. I do not think I have heard any dissent on that for that reason. That way you harness action at every single level and for every single—I hate the word “partner”—organisation that can join together to make the difference, because it is not an intervention from the health services alone.

Chair: Thank you.

Q414 Dr Wollaston: I appreciate the delivery and the objective. I think it is widely felt the issue is the independence of directors of public health; Public Health England. Public Health England will be an executive agency and, therefore, still a civil service body. How do you respond to the argument that it would be more independent if it were a special health authority?

Anne Milton: I am not the person to answer that question, Dr Wollaston, inasmuch as it is a technical one. The technicalities of special health authorities and executive agencies are something for officials. For me, what matters is the outcome. You are absolutely right that what we want is something independent and rigorous—whatever structure best achieves that. I understand that the executive agency will give that independence, which I think is very important, and that separation, if you like. It is extremely important, particularly in this area where we are treading on people’s freedoms, sometimes, in the cases of health protection, and stepping into people’s lives a little to improve their health as we do that, that the foundation for any intervention or action we take, or for any advice we give, has absolute public confidence. Therefore, it is important that it is independent and I understand an executive agency is the best way to achieve that.

Q415 Dr Wollaston: I understand those arguments, but the other issue is this: if public health doctors within Public Health England are directly critical of Government policy, how free will they be to make very direct open and public criticisms?

Anne Milton: Professionally, completely free. I do not doubt that they will.

Q416 Dr Wollaston: But will they within a public arena? For example, sometimes people are constrained, if they are working in the Department of Health, from being directly critical of Government policy. What the public want to see is directors of public health and Public Health England being able to directly criticise the Government if they feel policy is not going in the right direction.

Anne Milton: There will be people employed in Public Health England and people employed by the local authorities. Those will be the joint appointments. There are different pressures on both and I think your point is quite well made. If my history serves me correctly, this came up in the last century actually, protecting medical officers of health—or whatever they were called at the time—from local business interests was the issue there, and indeed that would persist. A good example would be, maybe, a seaside town where local people derived some of their income from, say, slot machines, casinos or nightclubs, and the local director of public health being very worried about the impact those are having. So there is that conflict. One of the reasons they will be joint appointments is to make sure we protect directors of public health. The Secretary of State would be involved in any dismissal or any appointment. Within the Department itself, the executive agency, I gather, is what will protect them. But, as you say, it is important. I do not have any doubt that they will be free to express their view.

Q417 Dr Wollaston: For example, if they were critical of Government policy, perhaps in having partnership arrangements with, say, Diageo or drinks companies, would they be free to make those public criticisms?

Anne Milton: Yes, they would be, unless they are part of the civil service and, with the civil service, I am really straying into areas I do not know.

Q418 Dr Wollaston: But that is the point—

Anne Milton: They would not be civil servants, I understand.

Q419 Dr Wollaston:—if they are part of the civil service. They are not going to be, directly, civil servants, but it is not going to be as much independence as they would have if they were a special health authority.

Anne Milton: No. I understand. I don’t know—

Q420 Dr Wollaston: We saw this in the last Government when Professor Nutt was directly critical of Government policy because he was an adviser and sacked. There is a precedent for people being dismissed if they criticise Government policy, but what the public want to see is Public Health England being able to be independent and able to directly criticise the Government’s policy if they feel strongly.

Anne Milton: There are several issues that have now come up. 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. The Professor Nutt thing was completely separate. They were an advisory committee and free to say, think and feel what they wanted. I could not comment on what happened in the previous Government’s time, but I go back to the fact that, from my point of view, and as far as policy is concerned, what is absolutely critical is that independence. What the public has to have is confidence, and the public are, rightly, always very suspicious of what Governments say and vested interests. It could not be more topical at the moment than at any other time. Thus, it is very important that the public have confidence. It is not only the case that
there is independence but that it is seen to be independent.

Q421 Dr Wollasten: You are confident that they would be able to be critical if they felt strongly about it.

Anne Milton: I can certainly ask officials to send you a specific note on the precise differences between executive agencies and special health authorities.¹

Q422 Chair: Given what you have said—and Professor Harper is sat alongside you—and that you have stressed the importance of independence, it would not be unfair to say it flows from that that the choice between executive agency and special health authority would at least be influenced by which gives greater assurance of independence.

Anne Milton: Yes.

Q423 Chair: Against that test, how is it that executive agency status gives more independence than special health authority?

Professor Harper: Good morning. There are a number of different points I would like to make very briefly, if I could, to supplement what the Minister has said. First of all, on the different parts of the new system, if we take directors of public health in local authorities, they will have a right and a requirement to publish, on a statutory basis, an annual report on the health of their population. They will be expressing their view without fear or favour. That is the intention and, subject to the successful passage of the Bill through Parliament, that will be the case. They will be producing their statutory report and will be held to account for doing that. So there is independence there.

With Public Health England, which we have announced will be set up as an executive agency, one of the helpful comparisons is the Medicines and Healthcare products Regulatory Agency. That is an executive agency, staffed, largely, by civil servants as an executive agency, but the vast majority of people would see the MHRA as independent regulators. That perception is vitally important. The governance structure that is set up and the mandate given to them ensures, alongside professional requirements and professional stewardship, that the MHRA is able to act in that independent way as a regulator of those products. The comparison I would draw for the executive agency that will become Public Health England is exactly with the MHRA.

Q424 Chair: Can I push you on that? I have heard the Government say they prefer executive agency. I have heard others say they prefer special health authority. I have not, in truth, heard an argument from either side that justifies their preference. The Minister was saying that she was looking for the greatest possible level of security of the independence. If that is the test, why does that test lead to one conclusion rather than the other, apart from an instinctive preference?

Professor Harper: I might have a very quick go at that and then I am sure the Minister will want to say something more. With a special health authority—this is an NHS organisation—the way special health authorities have worked in the past is that some of them have been very long standing. The intention in the future is that they are time-limited. That is an important distinction. Also, Ministers are very much of the view that this is an opportunity to open up public health to everybody. It is not being driven from the National Health Service. That is a very important feature of the proposals that you are familiar with from the policy statement.

Q425 Chair: Did you want to come in, Minister?

Anne Milton: No. I think Professor Harper has picked up on the point that I made, that it has to be independent and be seen to be independent. That is extremely important.

Q426 Rosie Cooper: Could you describe to me the structure of Public Health England? Who will be on it? I just want a rough idea. Frankly, I understand the distinctions that we are making in here, and I understand the idea of independence, but if you were to go to the general public, they wouldn’t give a tinker’s about any of these detailed bits. They would look at what name appears. With a special health authority, at least half the people on it would be lay people with a lay chair. Would you envisage this being set up in such a way?

Professor Harper: No, Chair, if that question is directed to me. 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.

Q427 Rosie Cooper: People out there will not see that as independent. How can that be?

Professor Harper: If you said who was in the new Public Health England—the organisations or the functions of the organisations being brought together—if we take the Health Protection Agency, there are of the order of 4,000 staff in the Health Protection Agency. Many of them are laboratory scientists working in a very specialist area, and it is very important to protect—

Q428 Rosie Cooper: Can you describe the structure of the executive agency? What do you see making it up?

Professor Harper: The constituent parts, or the functions, coming from the Health Protection Agency, the National Treatment Agency and from those parts of primary care dealing with public health that will not, in the final structure, be in local authorities—so perhaps some of the public health specialists. What is being worked through at the moment is exactly what you are asking about, which is the operating model and the detail of the structure for Public Health England. What we have said, very clearly, is that the chief executive should be in post from the beginning of the next financial year. During that key transition year, the chief executive will be helping to shape the new organisation.

Anne Milton: Could I come in, Chairman? The crucial thing—and you are absolutely right to talk

¹ See Ev 167
about how the general public couldn’t care but they want it to be independent—is that public health for the general public is going to be about the local authorities, be that unitary authorities or two-tier authorities. That is where public health is going to happen. For them, it is about their health and well-being. What matters to the general public is the outcome of it all.

**Q429 Rosie Cooper:** Absolutely. When things are going well, I can see that that model and solution is absolutely fine. The minute you have a real crisis and a difference of opinion, this model may not have the confidence of the public because, in their eyes, it would not be seen to be independent. Everybody who is feeding into it is part of the NHS structure somewhere, however loosely you would describe that, and eventually reporting straight through to the Secretary of State. If you are basing this on independence, this model is not necessarily going to be perceived as giving you the qualities you want.

**Anne Milton:** Things are not going well. That is a point. One of the reasons for these changes is that things have not gone well. I hesitate to point the finger—and I wouldn’t because it is very difficult—but things are not going well. Despite the fact that the overall health of the population has got better, inequalities have got worse. We have problems with alcohol, persistent problems with smoking-related disease and problems with people not exercising enough. Things are not going well. We do not need to set up structures. We need to change that and we need to make sure we have the form to produce the functions we want, which is about improving the health of the local population.

As far as the public is concerned, in the case of public protection—E.coli outbreaks or a terrorist attack or something like that—the public have to have confidence that Government can act. The direct line of sight that the Secretary of State has talked about, and we have talked about, is going to be very important—accountabilities and who is responsible for whatever. In terms of improving public health, much of it is going to happen on a local level, and rightly so.

**Q430 Dr Poulter:** I wanted to pick up on a couple of issues. First of all, as to Public Health England, there is going to be a role here, you say, in regulation. There is also going to be a role, I presume, in setting leadership on some sort of national level in terms of dealing with the interrelationship with these sub-national hubs in the regions and setting some sort of focus for those local authorities in what their agenda should be. Are you envisaging there is going to be that leadership role for Public Health England in actually working to direct policy in some ways for these sub-national regional hubs?

**Anne Milton:** The leadership role of public health professionals is going to be absolutely critical. As a director of public health said to me when we first started out on this, “It feels like Christmas came early,” because public health has tended to be a little bit in the cupboard. Most directors of public health would produce an annual report and it would collect dust on all the stakeholders’ shelves for the next year, when they would write another one. Everybody would maybe read it once. If you had an imaginative council, particularly in two-tiered authorities, they might have one debate on it or a presentation, but that would be it. The leadership role and the facilitative role of public health are going to be critical. We will look both to regional hubs and local areas to do that.

**Q431 Dr Poulter:** To clarify this, we have established that there is a leadership role for Public Health England to set a focus—an agenda—which will be delivered through local hubs and local authorities.

**Anne Milton:** Yes.

**Q432 Dr Poulter:** Obviously, that will be with some local nuancing. Is that correct?

**Anne Milton:** Yes, and quite a lot of local nuancing. As Members of Parliament, we only need to think of our local areas to see how different they are to the one next door to realise how much there should be.

**Q433 Dr Poulter:** Absolutely. It is very clear that the public health agenda in Eastbourne, with an ageing population, would be very different from Bradford, for example, with issues, maybe, with cardiovascular disease. Nevertheless, there is an issue on that and there has been a problem in the public sector sometimes around mechanisms of failure. Let us say, for example, we have identified and acknowledged there are big problems with health care inequalities, but there is a feeling that some of the criteria or problems we have identified with health care inequalities have not been addressed. What mechanisms will there be in place to create change or to improve delivery of public health policy in terms of Public Health England if we continue to fail to meet these challenges we have identified in the public health agenda, particularly around health care inequalities?

**Anne Milton:** I am not sure I am entirely clear what you are asking.

**Q434 Dr Poulter:** For example, there is an issue about dealing with failure in the public sector, and sometimes public sector bodies when there has been a failure, say, on a local council or elsewhere, but I am talking now particularly about replacing the people who have not been delivering what they should be delivering. How are we going to do that in terms of Public Health England if you are having an arm’s length body, which I am not saying is necessarily is a bad idea?

**Anne Milton:** I am going to hand over to Professor Harper to talk about the centre bit. Certainly, 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. You have that democratic accountability, which is, in many ways, a failure mechanism and, as many
ex-local councillors will tell you, can actually be quite effective.

Professor Harper may be able to talk about failure at the centre. I don’t think we will deal with it very well, do we?

Q435 Dr Poulter: This is what I am trying to get at. Anne Milton: It is across Government. I think it is wider than the Department of Health.

Dr Poulter: It is wider than the Department of Health.

Anne Milton: Very much so.

Q436 Dr Poulter: Let us say we have accepted that a key issue for health care is tackling the public health agenda, smoking, alcohol and the health care inequalities you have identified, but we decided that Public Health England is not necessarily helping to deliver some of those objectives. What mechanisms does the Secretary of State have in place, if we do set up an arm’s length body, to intervene and act?

Professor Harper: The key points are about the differences in this context between the health improvement side of public health and the health protection side of public health. What we have done with Public Health England—or the intention of Ministers—is to set up, with a clear line of sight on health protection, delivery through Public Health England. With health improvement, the delivery is through the front line, through local authorities, and there are the local authority mechanisms to deal with failure. That is not a central Government issue. If you take health protection and Public Health England, the main role of Public Health England in health improvement will be to provide, along with organisations such as NICE, that authoritative source of evidence, advice and evidence-based interventions to inform how the local authorities and the DsPH in local authorities deliver what is required to meet the outcomes that are set, centrally, by the Secretary of State.

The Secretary of State will be setting the outcomes framework. There will be a number of outcomes, I have no doubt, that local authorities will want to set for their own purposes, and Public Health England will be providing information and intelligence, through the Public Health Observatories and so on, to help local authorities in the health improvement area deliver what they need to deliver. It is different on the health protection side, and sometimes it is helpful to make that distinction, where Public Health England will be responsible for leading public health emergencies. We can say more, later, about the NHS side of the business if that is of interest to the Committee, but it is quite an important distinction to make.

Q437 David Tredinnick: Following on from the points that have been made, I would like to ask you a little about the status of the chief officers—the new directors of public health. Concerns have been expressed by public health bodies that the directors of public health should be appropriately trained and qualified; they must be of an appropriately senior level; and they should be free to speak out independently. Are you confident that these chief officers will have that status? I am mindful of the fact that the Command Paper says that the Government “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.” What happens if a council says, “We don’t agree with that”? Your Command Paper says the Government “would expect.” It does not say “we intend to require” that the director of public health will be of chief officer status. What are you going to do if a council says, “We don’t agree with that. We don’t think he should have that status”? If they do not agree to it, then you are going to have somebody, I would suggest to you, who does not have the clout to get the job done.

Anne Milton: There are two issues. Public health professionals, both medical and non-medical, have been right to raise the issue of status. The issue is quite important and local authorities are quite smart organisations. Officers in local government organisations, particularly the unitary authorities, are quite sharp. I am very aware of the fact—and I have talked to the Faculty about this—that we are going to need to do quite a lot of skills development of directors of public health to ensure that they can take on that challenge. Therefore, status matters and we would expect them to report to the chief officer—I will come to the point you make—but that in itself, of course, is not enough. We are continuing to look at this and whether we mandate it or not. I think we still have a window on that. In fairness, the more important point is whether they have the skills, because whether they report to the Chief Executive, as I say—although that status is important—in itself is not enough. That is for sure.

Q438 David Tredinnick: Thank you. On that point, we have had a debate in previous sessions about the proper qualifications: should they be medical qualifications or other qualifications? The previous feeling was that they should not just be exclusively medically qualified. My recollection is that we were told there was an increasing number of those not medically qualified. Professor Harper is nodding his head, so my recollection appears to be correct. Another issue is about what happens if everything goes wrong. At the moment a local authority can only have to consult the Secretary of State before sacking its director of public health and social care. Why will the Secretary of State not have a power of veto, which was the case—I think I am right in saying—with medical officers of health before the 1974 reforms?

Anne Milton: If you think that there is power in localism, then localism must prevail. There are going to be a number of safeguards out there to ensure that directors of public health are protected. One is that there is going to be an outcomes framework. If a director of public health is not performing the job for which they were employed, the local authority would want to take action. If we feel they are being treated unfairly because they have given advice to the local council does not want, the proof of the pudding will be on how the local authority is performing against an outcomes framework. There is an annual report in the outcomes framework and I think they are going to...
be two very powerful tools. You also have a body of elected councillors. I accept the fact, Chairman, that I am an eternal optimist, but local authorities are going to want to improve the public’s health and there is going to be the support, in terms of evidence and rigour, from Public Health England. As I say, we want to make sure that directors of public health feel they are free to give the advice they want and take the action they need, but the Secretary of State will have to be consulted if they are dismissed, which is the protection in there.

Q439 David Tredinnick: Chair, I do not propose to proceed on this line any further. I will move on to funding unless any colleague wishes to come in. The Command Paper confirms that the Government intends to ring-fence the public health funding allocation for local authorities. We heard from Professor Harper last week that public health was subject to management and administration cuts but that “front-line services, as far as possible, are protected.” Can you tell the Committee, please, exactly what aspects of public health are being defined as “front-line services”? Could you elaborate on where you see the division between front-line and, shall we say, second-line services?

Anne Milton: I would see it in very simple terms. Front-line services are actions that deliver improvements in public health, or certainly attempt to. Some of the time scales on public health improvements are very long. The money will be ring-fenced—you are quite right—for the first time. Whereas, previously, we have seen money filched away for other things—not necessarily unworthy things, but always public health has been the poor relative and it has been very easy money to take away—now there will be that fence around it.

Q440 David Tredinnick: What I am getting at is this. If you say you are going to ring-fence front-line services but that management will be subject to cuts, somewhere in the middle there is a very vulnerable area of health care provision, if reductions have to be made.

Anne Milton: Health care services and provision is not really in my remit. That is straying. Maybe I am misunderstanding, Chairman. You are looking as if I am misunderstanding.

Q441 Chair: There is quite a simple issue at the heart of this. On the one hand, we have a proposition that the funding will be ring-fenced and, on the other hand, a lack of clarity about what services are required to be delivered. Ring-fencing funding for an indeterminate service seems quite difficult.

Professor Harper: I was going to give an example, Chairman, but having heard the comment, it might not be as useful. To me, it is a very clear example of what I would classify as a front-line service. A consultant in communicable disease control currently employed by the Health Protection Agency will, in the future, one would expect, become part of Public Health England. Up until the creation of the Health Protection Agency, they were providing a front-line NHS service. They have moved into the Health Protection Agency and continue to provide the same service and a proper officer role for local authorities and so on. They are very clearly, to me, front line. There will be, at the other end—if you consider this to be a spectrum perhaps—people involved in the management of public health. Those are the people it is considered, along with all the other management cuts being made, should be subject to those cuts across the National Health Service and the public sector more widely. 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 that I think you indicated.

Q442 David Tredinnick: Thank you very much. Minister?

Anne Milton: I apologise for not entirely understanding it. As Professor Harper says, the bit in the middle and providing support to front-line services is the more tricky area.

Q443 David Tredinnick: I have a last line of questioning about proportions—how the money will be divided up. What proportions of the public health budget do you envisage will be allocated to, (a) local authorities, (b) Public Health England, and (c) the NHS Commissioning Board? How is the cake going to be chopped up, please—or cut up, perhaps I should say?

Anne Milton: “Chopped” and “cut” are the same. We are working on that at the moment and, of course, it has not been an easy task to extrapolate exactly how much is currently being spent on public health. One of the difficulties is that it has been a moving feast because it has not been ring-fenced before. What we are very determined to achieve, in line with everything else we are doing within health, is to make sure, as Professor Harper said and you highlighted, that the maximum is getting to the front line to get the improvement in public health that we want. We need sufficient in Public Health England to ensure that it is adequately resourced to provide the leadership from the centre and the rigour and the evidence base that is needed to assist directors of public health and all those employed in public health locally. But this is a work in progress at the moment.

Q444 David Tredinnick: In a phrase, it is work in progress.

Anne Milton: Yes.

David Tredinnick: Thank you very much.

Professor Harper: May I make one small additional comment, to reiterate some of what I said last time. Over the next few months, particularly as far as the allocations to local authorities are concerned, including details of how the health premium will work, that will be developed so that shadow allocations can be made for the start of the next financial year for local authorities. Alongside that, there is work going on to see how much is necessary
for Public Health England and, indeed, how much will need to be channelled through the NHS Commissioning Board to deliver the likes of immunisation programmes and so on.

Q445 Dr Wollaston: Going back to the issue of ring-fencing, because the definition of public health can be very wide if you look at the Marmot report, what if an authority decided that their top priority was housing? Could they make a decision to divert public health money into housing or other projects?
Anne Milton: What they are going to be judged on is the outcomes framework. Fundamentally, that is the lever. I have been quite impressed with some of the innovative ways of working that I have seen local authorities doing already without a public health budget. If we accept the fact that public health is everybody’s business—and you are right to bring up housing because the association between housing and health is a very long and established one—the outcomes framework is what will drive it. Sadly, we do not have that in front of you at the moment. Within those five domains, that is going to be very important.

Q446 Dr Wollaston: They will be very much constrained within the outcomes framework by your definition of “front line”.
Anne Milton: Yes. The flexibility of local authorities is going to be quite important and I can see differences between unitary authorities, but I can also see unitary and two-tier authorities doing this completely differently. Although responsibility will lie with upper-tier authorities, I can see some devolution of that budget down to the second tier, without a doubt. To improve the public’s health, you have to have a very nuanced system and the idea is that it will be driven locally.

Q447 Rosie Cooper: Can we get to the nub of this, which is that, given a time of constrained financial resources, it is going to be very difficult for local authorities in the next few years. We have had public health academics and people working with unitary authorities who have described 20 mile-an-hour zones outside schools as a public health measure and there is a fear that we will get to the point at which filling in potholes will become a public health exercise because it saves lives. In reality, there will be some measure of local authorities using the public health ring-fenced budget to fulfil their core function.
Anne Milton: Absolutely. I know there is nervousness, but there are two sides to this. There is nervousness but there is also seeing an opportunity to be more imaginative about how you improve the public’s health. The fact is that public health funding is not currently ring-fenced at all and lots of different organisations can try and get at it from the PCTs. In fact some of the PCTs will give money to improve, say, cycle lanes and you could argue that improving the potholes encourages more cycling. The point is that there will be an outcomes framework. That is going to be critical. That, if you like, is central Government’s lever on it and, in many ways, is the protection. At the end of the day, the council will be judged, as councils are judged, through the ballot box if they have not improved the public’s health. Also, there will be a health premium, which will incentivise local authorities—

Q448 Rosie Cooper: Minister, you are not really telling me that public health will be become number 1 on the agenda for local authority elections, that people are going to understand and be into the public health framework, especially as they have Health and Well-being Boards which have no power. Are you going to tell me that we are going to impose this? Could this not be yet another layer upon which the local electorate is theoretically going to make a decision but is so low down on the list of whatever is happening at that particular time it is almost an excuse, in a way? It is a fog.
Anne Milton: Maybe I am more optimistic about the great British public than you are. I think it will and once local authorities have public health in their remit—let me finish—there will be enthusiasm. There is enthusiasm from the local authorities themselves, and it is not only because they can get their hands on some money that they did not previously have. Most people genuinely want to improve the public’s health. This comes at just the right time because there is a change in public mood. There is an understanding that we have to do something to improve the public’s health. To some extent, the drivers of this are going to be local councillors and they will be very powerful in this argument. If I think of my own constituency—an affluent area with small but significant pockets of deprivation—it is already out there rumbing away as an issue. As it says on the tin, local authorities are going to tell me that is going to be upfront and centre. It will be a power to do something about it, I have no doubt they will. I think it does bother people that more than is reasonable of the population—

Q449 Rosie Cooper: Minister, you genuinely misunderstand my concentration on that.
Anne Milton: I am sorry.

Q450 Rosie Cooper: I am not saying public health is not important. It is very important, and very important for the fact that we are all breathing. The problem is that this is complex, it is layered and when people get to elections, as you introduced, the state of the Health Service—and we may disagree about where we are going to end up with the Government’s current policies and Bill—will be more on their mind than the detail of the Public Health Outcomes Framework. That is what I am saying.
Anne Milton: The Public Health Outcomes Framework will not necessarily bother the public. How the councillors perform will do, and the director of public health will produce an annual report which will say how the council is doing. In fact, local authorities take a great deal of notice of the number of services done and their performance, so it will affect the public. What the public want to see is populations given opportunities to become healthier. They do not care—rightly so—about the mechanisms by which we do it. What matters to them are the outcomes. I know you think it is important. I also think that is a vision shared by the local authorities.
Q451 Rosie Cooper: The resources are being reduced.

Anne Milton: They are going to be ring-fenced for the first time. They have never been ring-fenced before. It is a start.

Q452 Rosie Cooper: But we do not know what is going to be inside the ring fence.

Anne Milton: As I say, you will do. It is tedious in the extreme, I know, for many committees to have to sit there and be patient while we say that this is a work in progress, but we need to get it right. In fact, I have been impressed—and I am not always impressed by everything that “government” does—with the time and trouble that is being taken to try and get this right first off, because it does matter.

Q453 Dr Poulter: Picking up on some of the issues around outcomes and the outcomes framework, there are domains that have been identified around health protection and resilience, tackling of the wider determinants of health, health improvement, prevention of ill health, healthy life expectancy and preventable mortality. I understand Professor Harper told the Committee last week that you were “going to be working and engaging with a range of key partners to develop our thinking on the right indicators” for the Public Health Outcomes Framework. What criteria are you using to determine which indicators are appropriate? Professor Harper can go first with that question.

Professor Harper: You are absolutely right that, over the next few months, we will be working with a whole range of key people, including people from academia, practitioners and the people involved absolutely in delivery on the front line. Of course, we have the benefit of the organisations that will be coming into Public Health England to help us develop those indicators. The criteria are very basic and are laid out in a number of different documents. It will be about having something which is meaningful and something which is measurable. It is all very well having an aspirational indicator, if you like, or an aspirational outcome that we are trying to pick an indicator for, but it has to be a measurable—a meaningful—indicator, something that is quantifiable and can demonstrate progress towards reaching the outcome that is being considered.

Q454 Dr Poulter: Clearly, these outcomes are going to be applicable on a local basis, as we have heard, in different local authorities and there is going to be a framework established. Let us say, for example, a local authority were to prioritise clearly one, two or three of those framework criteria but were to ignore, effectively, one or two others. Would that be something you think would be acceptable, in terms of the outcomes framework? Let us say you are a local authority putting in place your outcomes framework—which will be applied locally, but nuanced—and you had your five domains around which you are focused but you effectively ignore some of that outcomes framework and focus on only some aspects of it. What would your view be of that?

Professor Harper: The point I would make is that the nationally-set outcomes framework are outcomes considered to be of the utmost importance for the country—for population health across England. If we take the first domain, as currently indicated in the document you are referring to, I must say that, over the next few months, there could be substantial changes on the back of comments received through the consultation and listening exercise. We will be working further even on the domains, not just outcomes within those domains, and indicators of progress against those particular outcomes.

If we took health protection and resilience, there would be things such as having plans in place to deal with an emergency, which are vitally important, and being able to reduce numbers of cases of tuberculosis. I am picking—the risk in picking—particular outcomes to illustrate the point, and I hope people will understand where I am coming from. If these are considered, when we publish the outcomes framework later in the year, to be of such national importance they need to be part of the national outcomes framework, then the strongest indication is that those will need to feature in any of the delivery plans of any of the constituent parts of the system. Of course, there will be local outcomes frameworks as well and there will be things that are absolutely the responsibility of the local authority, for example, and other delivery organisations within the public health system. Those will be developed and they should be complementary to the nationally-set outcomes framework, which, in public health, should be, as far as possible, aligned with the NHS Outcomes Framework and the Social Care Outcomes Framework.

Q455 Dr Poulter: Do you have any concerns on that basis? I accept what you have said, but there would be money, obviously, going to local authorities directly. Although the money going to local authorities, effectively, be ring-fenced and you have your national outcomes framework and your local outcomes framework, a local authority could potentially divert funding into areas with a funding shortfall rather than those necessarily compatible with the national outcomes framework. That is, a funding shortfall for that local authority, for example, housing or other issues or duties that may be connected with the local authority.

Anne Milton: This is the issue which was raised earlier and alluded to. It does cause some concern. It would be naïve for us to sit here and deny that is a possibility because public bodies have become awfully good at what is commonly referred to as “gaming the system”—dressing something up as something else in order to get their hands on the money, or to achieve targets or whatever. 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. That is a very important message and one that has been heard by local authorities loud and clear. There are wonderfully imaginative schemes out there already which local authorities are using to improve the public’s health. On first appearances, they stray...
into all sorts of areas you would not normally associate with improving the health and well-being of the local population, but they have actually been incredibly effective.

Q456 Dr Poulter: I hope I am not being disingenuous to local authorities—I do not mean to be because we have to assume that public servants are, generally speaking, publicly spirited—but there is a certain amount, and we have seen this, to some extent, with, say, the QOF payments to GPs, of game playing that can occur in order to attract—

Anne Milton: Surely not.

Q457 Dr Poulter: It can happen. If we saw that, for example, a local outcomes framework were to be structured in such a way as to pick up areas of other shortfalls in funding that the local authority felt it may have, what mechanisms are going to be in place centrally to make sure that sort of game playing cannot occur?

Anne Milton: We need to be mature enough, if we do not get it right first time, to adjust it. It is almost impossible in Government to exclude entirely the possibility of unintended consequences of legislation and unintended consequences of something like this. I would not suggest, Chairman, the Committee is being disingenuous to be appropriately sceptical about local authorities, but that is where we have to get this right. That is why we are trying the patience of not just this Committee but others in saying, “I am afraid you will have to wait for the absolute results,” because it is an important work in progress. As you say, public bodies at all levels and in all fields have become very good at gaming systems. From my point of view—this is very personal and, in a way, I feel is an important part of my role—working through DCLG, the Local Government Association, and up-skilling councillors into this very big and new area of work they will have influence and power over is going to be essential because they are quite a significant balance in this as well.

Chair: Talking about gaming the system, Rosie would like to come in.

Q458 Rosie Cooper: My constituency has pockets of great wealth and great deprivation. At some points, if you were to compare them, for the person living in the poor area, the gap in life expectancy is 10 years, which is a very scary fact. I would like to address the health premium question. Minister, last week we asked Professor Harper what the Department were considering doing to reduce the risk that a proposed health premium may in fact operate in a regressive way. He was not able to give us any details. I am looking to you for assurances. What assurance can you give us in this regard?

Anne Milton: What I can give you is political assurance. I have to repeat—not because I do not think you have not heard it but it is important to say it again—that to reduce inequalities in health we have to improve the health of the poorest fastest. The health premium is a way of doing that but there are several issues we have to consider really carefully. We were talking about gaming on outcomes and councils spending money on inappropriate things. With the health premium, it is going to be even more important to get it right. There are several issues. One is in local authority areas where there is a very mobile population. Although they get the health of the local population better, they move out and another lot, with poor health, come in. Thus, the area appears to have done nothing but it has possibly achieved quite a lot. The other issue you have raised is about it being regressive. Again, it is a work in progress and I know the King’s Fund have offered to give us some help and support on this. To get this right and to work—and it could be a very powerful tool, as you rightly say, in areas like yours where you have very big discrepancies—it is very important that we seek every piece of advice we can from a wide variety of experts to make sure we get the gearing on this right to produce the outcome we want. 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.

Q459 Rosie Cooper: When are we likely to get those?

Anne Milton: I think in the autumn. Professor Harper will now come in and correct me if I am wrong on that fact.

Professor Harper: On the health premium itself we would expect to have details of how it will work later this year, but, of course, it will be dependent upon having the outcomes framework agreed. We will have shadow allocations agreed for the start of the next financial year, but the first year of introducing the health premium will be at the end of that first year. Therefore, there will be a year for local authorities to perform against the outcomes framework and then the health premium will be introduced, for the first time, for the second year of the new arrangements.

Q460 Rosie Cooper: In that first year, will you, obviously, be using that to make changes?

Professor Harper: Yes, to improve.

Anne Milton: That will be quite an important year. It will be when we start to see where we can tick a box if it 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.

Q461 Chair: There is a core issue here, isn’t there? It is not really about gaming or the technicalities of the system. The concept of the health premium is to channel money to those areas that have already demonstrated a capacity to outperform other areas. Therefore, I do not fully understand how it can be that the health premium is not regressive. It is a means of channelling resources towards those areas that have already demonstrated a better performance than other areas, is it not?

Anne Milton: It is about progress.

Professor Harper: Yes. The intention is to pay a greater premium for more disadvantaged areas that make that progress.
Q462 Chair: You have bands of areas where there are relative Jarman-style disadvantages, presumably. However, it is still true, is it not, that, as between two areas in the same group, one area demonstrates greater progress than another—presumably by raising the health standards of the most disadvantaged in that area—and wins a health premium and another area does not make such good progress with the disadvantaged and does not get the resources for the future? I do not understand how that does not deliver a perverse outcome.

Anne Milton: That is why it is extremely important. If you measure progress alone—progress as against the absolute improvement that you achieve—it should not mitigate against authorities, as you say, who still have the same problems but have not made the progress that they should. That is why you have to be very careful with it and why talking to organisations like the King’s Fund, who I know have done quite a lot of work on this, is going to be quite important. As I say, there are other issues about transient populations. They have not been raised but I know they are also an issue.

Chair: Thank you.

Anne Milton: Then there is the measuring of it which, in itself—

Q463 Chris Skidmore: I was coming on to the measurement because, obviously, with public health interventions you simply cannot measure them. It has to be a five-year period at the very least, I would have thought. On issues such as sexual health, for instance—where improved screening will probably increase the rates of STI infection and you will have a perverse system where the number of cases would rise—would you penalise areas doing a good job in detecting rates of STIs, or coronary heart disease or whatever incidences are currently hidden? How would the premium work then, because the results over the first two to three years would probably be perverse?

Anne Milton: Absolutely. You are quite right. If you were going to measure the incidence of smoking-related disease, for example, chronic obstructive airways disease, you would have to wait a very long time. There has been quite a lot of research into this because previous Governments have also wanted to demonstrate improvement. As you rightly say, with STIs—and it was a good one to choose—if you start diagnosing them, the rate appears to go up. You would need to look at proxy measures. 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. There is quite a good evidence base. As somebody said to me only this week, one of the mistaken things sometimes about public health is that, almost as an excuse, people say there is not a good evidence base when there is some quite good stuff on measuring those proxy things that demonstrate whether things have improved.

Chair: Thank you.

Q464 Dr Wollaston: I am going to change the subject now to Public Health Observatories. We have heard some serious concern within Public Health Observatories about their funding and also about their future role. Could you give us some undertakings on both those issues?

Anne Milton: Yes, I can. I answered an Adjournment debate—I think possibly from a member of this Committee—or this.

Dr Wollaston: Yes. It was Mr Morris.

Anne Milton: I do not have the details of the current allocations, but I can certainly let you have that. Without a doubt, Public Health Observatories have led the way on a lot of the research and absorbing them into Public Health England is going to be very important. That is where a lot of the rigour, expertise and research have lain. We cannot do this without the evidence. Again, I suppose what I am giving you is a political commitment to their importance. Without doubt, there is an overlap, and certainly, as a new Minister, bright-eyed and bushy-tailed, 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. From my point of view—and I am a neat-minded person and like everything in order—bringing in those Public Health Observatories and harnessing that expertise so that we use it and do not replicate it is going to be very important.

Q465 Dr Wollaston: To some extent they do that already, do they not? They have regional specialists as well.

Anne Milton: Here they do, yes.

Q466 Dr Wollaston: The north-east would, say, focus on alcohol policy. They are not all reinventing the wheel and doing the same things.

Anne Milton: No, they are not. There are other organisations that are doing it.

Q467 Dr Wollaston: But you can give us your commitment to the value that they play and make sure that their role will not be diminished?

Anne Milton: Absolutely, without a doubt. In fact, I would argue that their role will be enhanced. What will arise out of the changes in public health, notwithstanding concerns about the detail and the process, most importantly, is that the sort of work the Public Health Observatories do will now be spread out into the wider world because they are a source of quite a lot of information for a lot of organisations beyond the realms of health.

Q468 Dr Wollaston: You are not intending to concentrate them all within one organisation at the Department of Health in London. They will still have a regional presence.

Anne Milton: Where they will be physically based, I do not know.

Q469 Dr Wollaston: You mentioned that they are going to be spread out.

Anne Milton: What they know and what they say will be spread out. What matters to me is not where
something is physically. As we all know in this day and age, where you are physically is not desperately important. It is how far and wide your message goes that matters.

**Q470 Dr Wollaston:** Although you could argue that, for public health, the information gathering does need to be, to a certain extent, regionally placed. You are better able to...

**Anne Milton:** I do not think there is any right or wrong answer. As I say, where people are physically is not any longer the point. If we have important messages we need to spread out, it does not matter from where they start. What matters is that they get out. The trouble is that a lot of work done in public health has not got out. It has been a little bit of a Cinderella service.

**Q471 Dr Wollaston:** Is it still a work in progress in terms of the structure of how Public Health Observatories—

**Anne Milton:** Yes, the structure and where everybody sits at a desk—where personnel sit and all the rest of it—is all ongoing.

**Q472 Dr Wollaston:** That is all ongoing but you are absolutely committed to their role.

**Anne Milton:** Yes, very much so, and mindful of the fact that we are dealing with people’s lives—travelling arrangements, family arrangements and all the rest of it. We can be very theoretical when we talk about things like this and devise good models but we are dealing with people’s lives.

**Q473 Rosie Cooper:** I would like to ask a question on NICE. They are supposed to have a continuing role in evaluating public health interventions, yet have not met once this year. One question is what that indicates about NICE’s future involvement. However, I would also like, just before that, to ask you a quick question about Public Health Observatories and their funding. My understanding is that they get two sources of funding, core funding and that for commissioned work. In all the assurances we have had about protecting the front line and protecting the outcomes, it appears that both those budgets have been reduced by a fifth—23%. How does all that fit in?

**Anne Milton:** I am going to ask Professor Harper to come in and help me. My understanding is that bit of the budget—I can send you the reference for that because I know I covered this in my Adjournment question. My understanding is that bit of the budget is playing a key role.

**Q474 Rosie Cooper:** Why?

**Professor Harper:** It is because we are going through the transition and the groups that have been set up—not least the group chaired by Professor Newton as you heard last week—are looking at the best arrangement to deliver the functions which are critical to Public Health England and the public health system in the most efficient way.

**Q475 Rosie Cooper:** Are we saying that some of the core funding was spent in previous years in the wrong way or unnecessarily?

**Professor Harper:** Not necessarily. We are saying that now is a good opportunity, with the transition, to take stock, look at the priorities and look at how best to deliver the outcomes we are looking for in terms of information and intelligence. There is a huge amount of consideration of the best way of dealing with this. Retaining part of the core funding at the centre until such time as it is needed or it is recognised where it can be best spent gives the flexibility we have not had in previous years.

**Q476 Rosie Cooper:** Who will decide that? How will that get fed out?

**Professor Harper:** It will be decided through the group and the infrastructure that has been set up—the governance arrangements—where Professor Newton is playing a key role.

**Q477 Rosie Cooper:** It will not be the Department of Health that decides whether they are getting it or not. The budget is there for them to use.

**Professor Harper:** If it is necessary.

**Q478 Rosie Cooper:** So it is not really there for them to use.

**Professor Harper:** If it is considered to be necessary, through all the governance processes I have alluded to, then the money will be made available.

**Q479 Rosie Cooper:** I see. In a previous life I used to work in a retail organisation where the directors’ and associate directors’ bonus payments were referred to as “the Goodwin Stakes” because there were that many hurdles you never got there. Is this going to be anything like that?

**Anne Milton:** We would hope not.

**Q480 Rosie Cooper:** Shall we go back to NICE and their involvement in the future public health agenda?

**Anne Milton:** Yes. They are going to be very important. I understand—my little note tells me—that the Health and Social Care Bill re-establishes NICE in primary legislation. They are going to be an important source. I gather that we asked NICE to review the public health interventions programme in the light of the new priorities. NICE has a critical role to play, particularly if we consider that, although there is quite a lot of evidence on public health and public health...
interventions, we have not always collated and collected all that evidence together under one roof and come out with some good guidance. It is going to be absolutely vital.

Q481 Rosie Cooper: But if it has not met so far this year—

Anne Milton: As I say, we are reviewing how we do public health. NICE needs to consider how it is going to do this in the light of our priorities. There is nothing sinister in it not meeting. NICE continues to play a terribly important part. Its reputation is world wide, so we are obviously going to use it. 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.

Q482 Rosie Cooper: When do you think that will happen?

Anne Milton: I gather the Secretary of State has already commissioned some work.

Professor Harper: Yes. I know this question came up last week, particularly about the Public Health Advisory Board, which has not met. Of course, the executive part of NICE is there, it is working and we have close contact with the staff. They are doing the work. What has not happened is the Advisory Board has not met. Part of the reason for that, having gone back and checked this from last week, is because we have asked NICE, as we indicated, 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.

Q483 Rosie Cooper: Thank you. Minister, how has the Government’s response to the Future Forum specifically changed plans for the involvement of public health expertise in commissioning in the new system? Also, why are seats on clinical commissioning groups not reserved for public health specialists to ensure that the very input you have been talking about takes place?

Anne Milton: I know this is an issue that came up a lot when the Future Forum was wandering around—moving around, not wandering. It sounds like a rather slack attitude.

Q484 Chair: That was an interesting choice of verb.

Anne Milton: Yes. If you talk to any member of the Future Forum, they talk about a frog-march around the country at an enormous rate. Something that has come up with me is the concern that public health advice will be lost to commissioning processes. Heeding public health advice, I have no doubt, will be one of those. With the directors of public health in local authorities—and of course the director of public health is a key part—sitting in those Health and Well-being Boards and bringing together all those different sorts of strands of health and well-being, if they choose to exercise their power, they will be enormously powerful. I would not underestimate it. Power is something that is rarely given to you. It is usually something you claim.

Q485 Rosie Cooper: Why? They do not have a veto. The Health and Well-being Boards have no powers to veto it. They can make recommendations. They can talk to that wall, and many people do quite often, but they do not have to.

Anne Milton: Who talks to walls, if I may ask you a question? Chairman, if I may indulge the Committee Member by asking a question back: which walls and who is talking to them?

Q486 Chair: Can we regard it as a rhetorical question?

Anne Milton: Yes. Maybe it is a rhetorical question. The clinical commissioning groups will need to heed public health advice, as any commissioner would now. You make better decisions if you heed it. The Health and Well-being Boards are going to be critical inasmuch as they can refer back. They have teeth. Certainly within local authorities they will have the power they choose to take. It is significant if they choose to use those powers, so they will be in a position to be able to refer—

Q487 Rosie Cooper: Could you describe those powers, Minister?

Anne Milton: They will be able to refer up to the NHS Commissioning Board if they are unhappy with the clinical commissioning group’s decisions and processes. Heeding public health advice, I have no doubt, will be one of those. With the directors of public health in local authorities—and of course the director of public health is a key part—sitting in those Health and Well-being Boards and bringing together all those different sorts of strands of health and well-being, if they choose to exercise their power, they will be enormously powerful. I would not underestimate it. Power is something that is rarely given to you. It is usually something you claim.

Q488 Rosie Cooper: If the only power that people have is to refer to the National Commissioning Board, then, in the end, the National Commissioning Board is not going to be able to carry out much work because they are going to be completely jammed with people objecting to X, Y and Z because they are not being listened to.

Anne Milton: You have very little—

Q489 Rosie Cooper: I have 30 years of local government experience.

Anne Milton: So do I. I have 25 years in the NHS and as a local councillor. Some of the clinical commissioning groups will make good commissioning plans. I do not think they will all be bad and all end up being referred.

Q490 Rosie Cooper: Come on, Minister. The reality is that, yes, a lot of those decisions will be absolutely superb, but the real critical clinically-required decisions will not necessarily meet the will of the local population. When those decisions are about, there will be some very difficult times. You cannot run away from that. It is going to be very difficult.

Chair: We are probably straying into the effect of commissioning decisions on health care services.
Anne Milton: The only thing I will say—because although it might not have been your intention, you raised the issue of the will of the local people—is this. There is what people want and what people need and there is what people need to have and what people choose to have. They are not necessarily the same things. There will be some tensions—you are absolutely right—and it will be interesting to see how those play out. However, that is a tension that we, as local Members of Parliament, have felt, necessarily, being unhappy with decisions that PCTs have made. This will bring it all under one roof and the Health and Well-being Board, in a way, will be a forum where all that tension is harnessed.

Q491 Rosie Cooper: Can I throw in one very last point? You need to get local doctors involved in the part of the Bill about clinical senates, and that kind of thing. However, if you are going to get local GPs really involved, it is going to cost them time. They have made it very clear that they would be required to be paid to give up that time. Do you see that impacting on the public health agenda?

Anne Milton: Now we are straying into areas in which I do not have the expertise, the clinical commissioning groups. It will take time. There are quite a lot of structures and organisations GPs are currently involved in which I do not think are terribly effective. I could name a number where a lot of time is spent achieving very little. I would hope their time is better spent. Less time is not necessarily worse time. Less time can be better time.

Q492 Chair: May I move the discussion on to the question of the structure of the commissioning of public health services? When this policy started off, 12 months ago, it was attractively simple. The responsibility for public health was going to be transferred into local government and, to some extent at least, it owed its parentage to the old concept of a medical officer of health. As the months have gone by, it seems to me, it has become more and more complicated. First of all, how do we define the function of public health? Secondly, what is the amount of money we devote to it currently and how much are we going to devote to it in the future? Thirdly, who is responsible for the public health budget that started off being conceived as one budget and now seems to me to be broken down into three sorts of budget: the NHS Commissioning Board public health budget, the Public Health England public health budget and that part that actually does end up with local government? I would be interested to hear how you articulate that move from the proposition last year, that we were going to transfer it into local government, to a proposition now that seems more complicated.

Anne Milton: Yes. May I share your disappointment? I like things that are simple and they have to have some fit for me. You are right it is a shame, but probably necessary—and I am convinced that some of it is necessary—if you start from the point of view that all those things which can be commissioned locally should be. I think there are some things we probably have to do from the centre—if you take immunisation programmes—because of their reach. Screening programmes would be another. Public health for those in prison or custody would be something else. We have also sat in, at a national level, child public health services. This is in line with Coalition commitments to early years, to improving or having an impact on the lives of young families. It sits there for now as we drive it forward. If you like, we are almost kick-starting a new service. Certainly, the political will would be there to move everything possible to local commissioning, if we could.

As to Public Health England, one of the difficulties is when one is talking about theoretical things. It is important sometimes to have a check that we all have the same vision in our head—the same picture, if you like. For me, there is quite a lot of clarity in things like immunisation and screening sitting very sensibly at the centre. It is a nationwide and a population-wide thing. I do not think there is much opportunity for local intervention and local discussion, although there might be—

Q493 Chair: Even accepting that, there is a decision that has been made, apparently, that it sits with the Commissioning Board of the NHS rather than with Public Health England.

Anne Milton: Yes.

Q494 Chair: I am not quite clear why that is.

Anne Milton: I see Public Health England, which is the third strand of this, almost providing, in some ways, the direct line of sight for the Secretary of State. That is important. Public Health England has a crucial role on health protection. I hesitate to say that it is the admin organ because we are cutting administration. It is not administrative. It is the policy and the evidence driver of interventions further down the tree. It is the engine room.

Q495 Chair: If it is responsible for making decisions about priorities—even take it as a ring-fenced area of health protection—if the commissioning process for immunisation programmes, for example, is the responsibility of the Commissioning Board, has that not taken most of the budget out of Public Health England?

Anne Milton: No. There must be some budget left. We have talked about Public Health Observatories and we have talked about all the health protection services, so, no, it will not have done.

Q496 Chair: It must have taken a significant amount.

Anne Milton: It must have taken some. It depends what you consider to be significant.

Q497 Chair: May I just ask the question: why is the Commissioning Board being introduced to do this rather than Public Health England?

Professor Harper: If I could use the example of immunisation, one of the concerns expressed, quite understandably, from a number of quarters was about fragmentation of delivery—different parts of the system responsible for different parts of delivery. So far, and this is still work in progress, the suggestion is that the coherence is brought about through the
commissioning route, through the NHS Commissioning Board. However, there will be procurement of vaccines, there will be a vaccine policy and there will be the Joint Committee on Vaccination and Immunisation still providing that essential independent advice to the Department and to Ministers, to the Secretary of State. That will be where the policy is developed, but, of course, we have to recognise—and much of the immunisation programme is delivered through primary care, through general practitioners and some through school programmes—that in order to have that coherence and to benefit from the new system, at the moment the thinking is to have that coherence through the NHS Commissioning Board.

**Anne Milton**: Professor Harper has put much better into words what I was trying to describe. The NHS Commissioning Board has those links with the local commissioning groups. Immunisation is a good one to pick, but it would also apply to screening programmes. There is a natural synergy. I suppose Public Health England, except for health protection services, is not going to be involved in that relationship directly and on a day-to-day basis. It is about providing expertise, evidence, support and leadership.

May I use this opportunity, Chairman, to say that I think political leadership is very important and we do not talk enough about it. There is an opportunity to provide political leadership in an area—and I do not mean this on any sort of party political basis—where there has not been political leadership before.

**Q498 Chair**: May I take Professor Harper back to a phrase he used in his answer. He said “for the moment” it was planned this should go into the Commissioning Board. Was there any significance in that remark?

**Professor Harper**: Simply that, with many of the areas we are talking about today and we talked about last week, they are work in progress.

**Q499 Chair**: That decision remains at the moment—

**Professor Harper**: For the specific areas—I picked only one specific area—those are discussions that are currently underway.

**Q500 Chair**: Thank you. The same applies to all the other allocations of commissioning responsibility, does it?

**Anne Milton**: Yes.

**Q501 Chair**: How much commissioning responsibility for public health services do you think will rest with local authorities outside the six core areas that are identified in the Command Paper?

**Anne Milton**: Did you say how much responsibility?

**Q502 Chair**: There are six core areas defined in the Command Paper as being core areas that local authorities have to be responsible for. My question is: what is the scope of their public health responsibility beyond the six core areas?

**Anne Milton**: I would say, to some extent, they have those areas of responsibility and they have—

**Q503 Chair**: The reason for my question is that, if that is their core area, they have to do that. The risk is, is it not, that any resource currently associated with public health that goes to local authorities that is not in those six core areas gets siphoned off into pothole filling?

**Anne Milton**: Then what is surprising maybe—and I look forward to the Committee’s report because it might shed some light on the fact—is that, currently, local authorities have some responsibilities for the health and well-being of their population, and things like community safety are a health and well-being issue. What is quite surprising is how much local authorities are already spending on 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. What this will do is beef up the pressure—coming back to Rosie Cooper’s point—to apply those more evenly across their population, particularly in areas where there are wide variations in deprivation.

**Professor Harper**: If I understand the question right, Chair, you are referring to what we have called mandated services in the policy statement.

**Chair**: Correct, yes.

**Professor Harper**: Those are services that are considered to be special, for whatever reason. Of course, as the Minister has said, as to the outcomes framework, the broader areas of public health, you will not find, in these mandated services, areas around smoking cessation, for example. Those are very important public health areas and those will absolutely be part of the local authority responsibility. I think the six areas that you were alluding to or that you referred to are simply the mandated services.

**Q504 Chair**: Yes. The reason I have picked them out is, as I read it—if I am honest, I have only read the summary of the Command Paper so far—it defines six core areas and it remains, twelve months on, unclear what services, currently delivered, fall under the heading of “Public Health Services”.

**Professor Harper**: These are services that are considered to be of a special nature.

**Q505 Chair**: I understand that about those six. It is the rest of it that I am interested in.

**Professor Harper**: The rest will be covered, in due course, by the publication of the outcomes framework and all the other areas we have been talking about this morning.

**Q506 Dr Poulter**: On that, interestingly, in these six areas you have chosen “appropriate access to sexual health services.” Why, out of interest, was that chosen rather than, as you raised yourself, the issue of smoking cessation being, maybe, an essential ingredient in some of the criteria? Why, particularly, did you pick and fall upon some of these areas? That is quite specific criteria about sexual health.

**Professor Harper**: Yes. 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—whatever the indicators might prove to be in due course, as we said earlier—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.

Anne Milton: You have a Committee Member, Chairman, who is not convinced. I can tell by his face.

Q507 Dr Poulter: We could debate the key points, but I struggle to follow why this has been something that has been specifically set around sexual health. This is specifically framed, and why I say smoking cessation—

Professor Harper: Across the entire country, if we looked to help public health, if you take the national child measurement programme as another good example, it would not be very helpful if a number of local authorities opted out of that, whereas, according to the Joint Strategic Needs Assessment, and in the light of the outcomes framework, if a local authority chooses to resource, out of the ring fencing, more or less on smoking cessation services, that is about a local decision, which is the way the new system is being set up. It would not be appropriate for a local authority not to do the things that are indicated in this list.

Q508 Dr Poulter: My only concern on this is that it seems to be saying access to sexual health services is an issue out there on its own that is being made crucially important, more so than if you only put the others in the outcomes framework and more so than issues around alcohol awareness and smoking cessation. We know that, if you smoke, you are going to die probably a lot younger than if you do not smoke. That seems to be possibly an imbalance in the Command Paper. I am simply curious as to why sexual health has been chosen and put out there. If you were going to pick out, say, on national statistics, that there is a key issue with smoking cessation, it would seem entirely appropriate for a local authority not to do the things that are indicated in this list.

Q509 Dr Poulter: I do not fully follow what you are saying. Nevertheless, I will move on. I still think there is an issue around the fact that putting sexual health out there gives it a special status and elevates it above other public health issues—which may be covered in the local framework—and there is perhaps a legitimate concern around that, which I do not think is probably the intention at all. However, the other thing I am interested in is the issue around HIV treatment and why that is not necessarily considered part of sexual health.

Professor Harper: It is considered part of sexual health.

Q510 Dr Poulter: It is but it is being treated alongside infectious diseases as an issue. Is that correct?

Professor Harper: It is the HIV treatment not the diagnosis—not the early detection, if you like, which is obviously one of the key features of how we are looking to deal with HIV in the future. Treatment is considered to be an integral part of the NHS business. This is core business for the NHS.

Anne Milton: It is very specialist stuff.

Q511 Dr Poulter: The Commissioning Board is going to commission HIV treatment alongside its responsibility for commissioning treatment for other infectious diseases and I am curious as to why HIV is grouped with infectious diseases rather than with sexual health, which would seem a more logical pairing to me.

Anne Milton: It is both. You could argue both sides. What has been fascinating about this is that I meet one group of people who say, “We would agree with you absolutely,” and I will meet another group, equally qualified and articulate, who will argue precisely the opposite. This is why, maybe, it is quite challenging for us to articulate why we have come to the decisions we have. There are very diverse views. HIV is not exclusively a sexually-transmitted disease, as you know. It sits in both areas and what we have had to do is to come down to a decision on where it sits best. The important thing is that there is not necessarily a right or wrong answer.

Q512 Dr Poulter: If I can continue on that—sorry, Chairman—my concern is that the majority of HIV in this country is sexually transmitted. It is either men having sex with men or is often, with migrant communities who come into the country, by heterosexual transmission. The amount of transmission through drug use is much reduced now we have real statistics.

Anne Milton: It is.
Q513 Dr Poulter: Probably 90% plus is coupled with sexual transmission, which is where I am struggling to follow this. Logically, if it is coupled with sexual transmission, why is it not coupled with sexual health?

Professor Harper: It certainly is not an epidemiological feature of this. This is not the reason it has been put there. It has been put there for a number of other reasons, for example, the length of treatment. There are other factors that are being taken into account for HIV—the way treatment is provided. These are features of HIV treatment that are quite different from, say, syphilis, gonorrhoea or whatever else you might want to consider in sexually transmitted infections. That is the sort of thinking behind separating it. It is the type of treatment, the duration of treatment, where the treatment is best delivered in the new system and how, therefore, the responsibilities will lie. There were a large number of responses during the consultation to these sorts of questions.

Anne Milton: There are different component parts. The big issue is late diagnosis. That is what we are struggling with.

Chair: We have probably covered that. Chris wants to ask some questions about workforce.

Q514 Chris Skidmore: I want to turn, in particular, to the issue of professional regulation. Obviously, within public health, you are going to have to have strong leadership, both locally and nationally, to be able to deliver your outcome objectives and within public health to have staff who are professionally qualified and appropriately registered. From your evidence in paragraph 50, I see your approach to professional regulation remains that it is going to be set out in the professional regulation Command Paper, Enabling Excellence, which was published in February, and provided for in Part 7 of the Health and Social Care Bill. In particular you state: “The Government believes that statutory regulation should be a last resort, where less burdensome regimes are insufficient to protect the public from poor professional practice.”

Since the Command Paper was published in February we have obviously had a number of changes to the Health and Social Care Bill, notably the pause and the advice and recommendations of the Future Forum. I was interested that the clinical advice and leadership group of the NHS Future Forum had specifically recommended that registration should not be voluntary but, instead, should be by an appropriate national body and be compulsory for non-medically qualified public health staff. I think you would also admit, in your evidence at paragraph 49, that that would reflect the recommendations made by the Scally report as well, that it should be compulsory. I was intrigued why, given the Government’s enthusiasm for the Future Forum and all their recommendations, you did not decide to take them up on this particular recommendation.

Anne Milton: We have not decided yet.

Q515 Chris Skidmore: You have anticipated my second point, actually.
Q518 Chris Skidmore: You are not, on record, opposed to statutory regulation.
Anne Milton: No, I am not opposed to it. We would always favour a non-regulatory route, but I am not opposed to it, no.

Q519 Chris Skidmore: In terms of the process, I know the Command Paper, and you have just mentioned that you are welcoming “further evidence from the profession on significant risk to the public,” and “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 autumn.”
Anne Milton: Yes.

Q520 Chris Skidmore: In terms of what is taking place this summer, you are still actively considering taking submissions. Is that through the Future Forum continuing work? Who is involved?
Anne Milton: Anybody who wants to be. This is very live. In fact I saw the president of the Faculty of Public Health yesterday and there are a number of organisations that have already given—

Q521 Chris Skidmore: I am not sure when our report is being published, but I guess you will actively consider any recommendations we will make as part of the autumn strategy.
Anne Milton: Chairman, we will look forward to seeing your report and hope that it is published in time to inform our decisions.
Chair: Our ambition is to get it done when we come back in September. We will see.
Anne Milton: My experience of Government is that the autumn lasts from about September through to Christmas.
Chair: Or indeed to March, quite often.
Anne Milton: Or indeed to March, depending.
Chair: We are now moving beyond institutions towards public health policy.

Q522 Dr Wollaston: I know that, in your opening remarks, you gave the commitment that you wanted to see real improvements in health inequalities. One area that repeatedly comes to mind, because it is so cross-cutting, is the issue of alcohol policy and looking at the impact that that has on public health in everything from the sexual health agenda, teenage pregnancies across the board, indicators for child health, early mortality, suicide, violent crime, and the list goes on. Yet, to my mind, it is quite shocking the Government finds it difficult to introduce evidence-based policies and even today this is reflected in the House of Lords Science and Technology Select Committee report. Also, they highlight the fact that, with the nudging philosophy, in many aspects, whilst it might be evidence base for some nudge policies, for others there is both a lack of evidence or even in some cases evidence that it does not work.
Can I ask you to clarify at what point, if voluntary approaches are not working in industry partnerships, will you review the evidence and then take a regulatory approach rather than a nudge approach?
Anne Milton: Yes, and you are right to raise alcohol because it is one of the more difficult ones. Smoking is easy, to some extent, inasmuch as we do not want people to smoke. With alcohol, we are happy for people to drink a bit, but not too much. There are also two dimensions to alcohol, which you absolutely rightly raise. There is the health impact and then there are the wider societal impacts, which go as far reaching as domestic violence. The harms of alcohol are almost impossible to quantify because they reach so far.
I have had a brief look at the House of Lords report. I am slightly disappointed that they have jumped the gun a bit because, certainly on the Responsibility Deal, we have not got there yet. In fact, I chaired a meeting yesterday where we were discussing exactly the point they are making. The Committee, I am sure, Chairman, will be aware of the Nuffield ladder of interventions.
Your point is at what point we will punch in. 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 wider than industry—are very aware of that. In a way, the regulatory route is a sword of Damocles. The difficulty with things like alcohol is that we are also banging up against European legislation and saying, “If you look at pricing, European competition law.” Therefore, it is not solely in our hands, which is why getting on and doing some voluntary things, if they work—and time will tell—are important because we can do them now and we do not need European agreement.
What matters is how we monitor and evaluate and the robustness of this, and we were talking about the crucial role of NGOs in that. They are absolutely vital. At the end of the day, the NGOs are very good. It is they who will judge whether the monitoring and evaluation is robust enough to stand up and whether we have made a difference. However, we have an unusual and unhelpful relationship with alcohol, without a doubt in this country. We saw it with the Licensing Act. We cannot necessarily import ideas from other countries. We have a relationship with alcohol that harms our health and creates significant problems for law and order.
I apologise for going on, but it is important to realise this is not that simple. You know it is not that simple. I was talking to the Director-General of the World Health Organization about the fact that if you look at guidelines on physical activity—you know, 30 minutes of exercise five times a week, or whatever it is—it is simple and cheap. It doesn’t cost anything but maybe a pair of running shoes and it certainly does not take up much time out of our day. The impact it has on our health is profound, reducing rates of stroke and heart disease significantly, and yet we do not do it. Thus we have a very big mountain to climb, which is where the behaviour change ideas come in.

Q523 Dr Wollaston: Can I take you back to alcohol policy because there is some very specific
Anne Milton: Yes, and it is very useful that you brought up the alcohol network and the Responsibility Deal. We have five networks, food, physical activity, behaviour change, alcohol and obesity. All of them have gone extremely well. Interestingly, the health and well-being at work is absolutely scooting ahead and there is fantastic stuff coming through.

Q524 Dr Wollaston: I am not denigrating the entire thing.

Anne Milton: The alcohol one is interesting and it is important to bring it up.

Q525 Dr Wollaston: As to obesity and alcohol, there are real concerns about them.

Anne Milton: The NGOs are quite happy with the obesity one, but the alcohol one has produced immense tension. There are, without a doubt, people who believe—I feel—that price and price alone is the only thing that needs to happen in order to alter this.

Q526 Dr Wollaston: I don’t feel that. I agree with you, that it is cross-cutting.

Anne Milton: The test of whether voluntary action will work is in that Responsibility Deal and we do not have a lot of time to demonstrate it. At the end of the day, the Government will be judged, as will local councils, on our progress towards what we have said we want to achieve. We start with the voluntary route, acknowledging there are some hurdles, and indeed the Treasury has made some changes. They are small and a lot of NGOs feel they are insignificant but I suppose it sends signals that we will do something. It makes quite clear to industry that this is a ladder and we will climb up it if that is what we have to do.

Q527 Dr Wollaston: Can I ask for a timescale on that, on when you will make that assessment?

Anne Milton: I am happy to get back to you, because again we were discussing this yesterday with some of the key organisations and the NGOs, but my understanding is that a lot of the pledges have been made and they are available on the Department of Health website. We will monitor that at the year end, so it will be spring or early next year. Then we will have a benchmark from which to see progress. I cannot tell you at what point we would have to look at regulation and take the next step up the ladder.

Q528 Dr Wollaston: The alcohol strategy is due to come out in the October. Is that going to commit us to a policy, if we then find in the spring that it is not working?

Anne Milton: The alcohol strategy will lay down exactly what the Government’s intentions are. It will lay down what we will be judged against.

Q529 Dr Poulter: This is a key issue around alcohol strategy. What we are talking about here is a greater demonstration of corporate responsibility. It is a good thing to encourage, but there is not a simple solution. There is a culture in this country, particularly around binge drinking and those sorts of things, which is almost unique to Britain compared with a number of our European neighbours. In terms of achieving that corporate responsibility, it has proven quite difficult. If we look elsewhere, we want to support British agriculture, for example, and we have found difficulty in getting fairer prices for our farmers despite some very active campaigns, sometimes we see that supermarkets do not always show that corporate responsibility, even though there is a demand for it. The concern is, if this nudge theory does not work, about how we are going to act. One of the key issues is around cut-price alcohol in supermarkets and, although I am instinctively against regulation on this, that is probably the one intervention that might be effective in dealing with it. Is that an area, if the nudge theory does not work, where you would envisage some form of legislation coming in later on?

Anne Milton: We will regulate if that is what we have to do. Your point about the supermarkets is very obvious. We recently got into trouble because we applauded, I think it was, ASDA who said they would take promotions out of their fronts of stores. Then Waitrose and one other supermarket, Morrisons, got very upset because they never put them in their fronts of stores. We have to be slightly careful.

The issue of minimum pricing is a European competition issue and it is very live. I have responsibility for European matters and I talk to other Health Ministers in Europe. You are right that our association with drinking is northern European. There is something about the northern European countries. Without a doubt, price alone will not do it, but we will consider regulation if regulation is the route we have to go. I hope we do not. I think the mood has changed a bit. In the short period of time that I have been a Member of Parliament, living in a constituency with a significant night-time economy, certainly the licence trade and some of the retail outlets have become much more acutely aware of what drunken people in the High Street do to their brand, so there is a brand issue out there, which we are clearly tapping into. If I think of the progress that has been made in some of the other networks, it is about corporate responsibilities and retailers and producers feeling they have to tick some of these boxes now.

Q530 Dr Poulter: Thank you for that. Moving on, one of the other key challenges is dealing with the issues about smoking, which I do not want to talk about, but also about obesity and promoting healthy
lifestyles. In health care you may well see local GPs incentivising someone who has had a heart attack, afterwards, to then take up exercise, effective dietary and nutrition mechanisms or go to the local gym as part of their rehabilitation. That is obviously important because it will hopefully improve their long-term chances of survival and recovery from their acute event. However, we often need to get in much earlier than that—before these acute events happen in the first place. On the issues of, for example, promoting healthy living with gyms, fitness and healthy eating, what specifically is the Government looking to do in terms of incentivising the industry, business and people to get engaged with that?

Anne Milton: That raises a huge number of important issues. To go back to alcohol, and it plugs into what you have just asked, one of the issues is that people do not understand how harmful alcohol is. Most people understand that eating too much causes you harm and smoking too much causes you harm. I do not think they always understand that drinking too much does cause harm. There is a major issue on information that we need to address, and that is something Government can do.

There is no one point at which you can punch into changing the way people lead their lives and their understanding both their responsibilities and Government taking action to reinforce that. The work that we are doing on early years and with young families is critically important to this, particularly if you consider Marmot—if you consider the poorest and improving their health the fastest. Some people will never come into contact with the public services. The only time they do is when they are pregnant. You have, sometimes, a once-in-a-lifetime opportunity to have an impact on how they lead their lives when they are very vulnerable to positive messages because they want to do the best for themselves and their children. It might not last and you might not see them again.

The early years stuff is important because what we want to do is make sure young people grow up with the skills they need to make good decisions when faced with what I consider to be a wide array of quite difficult choices. That is about what they eat, what they drink, whether they smoke, whether they take drugs, whether they have unprotected sex, whether they fall pregnant and so on. I am talking quite closely to colleagues in education about what work we need to be doing in schools. There are massive opportunities for local authorities because we always tend to think of schools, but, of course, some of the most vulnerable families and children are not desperately good attenders in schools and you need to think about such things as sports clubs. There is a wide variety of organisations out there that can deliver some of these messages. This is about public health being everybody’s business because in some areas it is faith communities and in some areas it is other community groups. Messages have to be tailored to the population that you are dealing with.

Chair: Correct.

Anne Milton: Surely not, Chairman. Therefore, it is quite important there is not an elite flag over sport. We have to be slightly careful. This is about growing up children with the skills they need, and, my goodness, they need some skills. They really do. If you look at what you are faced with, and we have talked about marketing, and you look at the messages they are bombarded with, there is a danger—and it is one of the challenges that we face—that Government is always slightly behind the curve. We are talking about the next form of communication when people have already moved on to the one after that.

If I think of my own children, bringing in a personal point of view—I have a child of 27 and one of 15—the media outlets they have accessed are completely different. The world has changed enormously. We have to keep up to date and we have some quite good vehicles. Change4Life is one which has been important and powerful. It does not look as if it was run by the Government and, therefore, has been quite successful. If I think of advice, the FRANK website has been a very, very successful tool. We are reviewing the content of that. It is for young people to access information on drugs and they trust it and use it. Therefore, we have some good examples of what works. We have to get information out there and then we have to get the support in to help people make better decisions.

Q532 Dr Wollaston: On the very subject of football, which you mentioned, you can spend as much as you want telling young people sensible messages about alcohol, but next year they are going to watch the FA Cup and be bombarded with messages about alcohol, which will be subliminally making the link between sporting success and alcohol.

Anne Milton: You are absolutely right. In fact, when I first became a Minister, I did something during the World Cup, and it was a challenge because the consumption of alcohol, particularly at home—and you only need to look at the mini fridges that are marketed that save you the trouble of having to go to the kitchen to get your alcohol—and the consumption of pizzas rises dramatically. With alcohol we have a major challenge on information. I do not believe that most people even know—and if they do know, they do not acknowledge—the danger alcohol causes them, and I mean young people. We are dealing with a population between the ages of 14 and 25 and the difficulty, between the ages of 14 and 25, is that you feel you are immortal.
Q533 Dr Wollaston: Yes, but we are giving them mixed messages. On the one hand we are talking about the Government having programmes to give people education, and in fact my understanding is that the evidence base is around them having a fairly short-term impact, but—
Q534 Dr Wollaston: Educating young people about the dangers of alcohol has a relatively short-term shelf life. There they go now, outside.
Chair: The bottles are out there ready.
Anne Milton: Are they water or alcohol?
Q535 Dr Wollaston: We are giving them a mixed message. On the one hand we are saying that we want to tell them about how they have to drink sensibly, but the overwhelming amount of marketing that they are being bombarded with, through the FA Cup, linking sporting success with alcohol cannot be right.
Anne Milton: That is why it is everybody’s business. I have made a point of trying to gather information such as what happened in France and what is quite interesting is that if you dig down into the research things don’t necessarily correlate. One of the difficulties with some of these interventions is to demonstrate causality. If you look at some of the legislation that has been passed on smoking—and indeed it is ongoing and in the courts at the moment—with some of the issues around smoking and displays of tobacco at the time at which legislation is passed, of course, a number of other things come into play, and not least that it is widely discussed in the media. Therefore, awareness is raised and it is quite difficult to do. Nevertheless, you are right, and it raises the issue that this is not only a matter for the Department of Health. The Cabinet Sub-Committee on Public Health is there and all the Departments are represented but, more to the point, all the Departments turn up, which is, as the Chairman will know, not necessarily always the case. Thus everybody recognises that it is important and is part of their remit. Maybe on another occasion, the Health Select Committee would like to discuss this further with the Department for Culture Media and Sport when they have perhaps less to do than they have at the moment.
Chair: On that note, there is the opportunity to draw this to a close. Thank you very much. You have certainly convinced us of your passion for the subject. Thank you both very much for coming.
Written evidence

Written evidence from the Department of Health (PH 01)

**SUMMARY**

— The Department of Health welcomes the Committee’s Inquiry and the opportunity to set out its vision for future public health delivery.


— DsPH will have professional accountability to the CMO and managerial accountability to their employing organisation.

— Subject to the Health and Social Care Bill, Public Health England will bring together a number of organisations and functions including those of the Health Protection Agency (HPA) and the National Treatment Agency for substance misuse (NTA).

— The Department of Health is working with all of these organisations to identify the functions that need to transfer and to ensure a seamless transition. As part of this, the Department will ensure continuity of emergency planning, resilience and response during transition to the new arrangements.

— Public Health England (PHE) will be set up as an Executive Agency and will promote information-led, knowledge-driven public health interventions, championing new approaches and providing clear and practical evidence for commissioners in local government and the NHS.

— Work is ongoing to enable the combination of information and intelligence from PHE’s individual parts to form the public health system, nationally and locally

— Secretary of State will provide national leadership, especially for health protection and emergency response, with a clear line of sight down to the front line.

— Local authorities will take on key new responsibilities and be supported by a new ring-fenced budget for public health.

— Secretary of State will set his priorities for the NHS, and at local level there will be a joint strategic needs assessment, and a joint health and wellbeing strategy.

— The Government is still working to prepare its response to the recent public consultation on public health.

— The five domains of the Public Health Outcomes Framework reflect national, local and community level actions that are evidence-based, can be measured, and can be used to hold local services to account.

— We are examining ways of aligning the three current outcomes frameworks to ensure a coherent approach to health, wellbeing, risk and illness

— *Healthy Lives, Healthy People* provided the Government’s response to the review by Professor Sir Michael Marmot, adopting many of its recommendations.

— Funding for public health services will be ring-fenced and a health premium payment will encourage improvements in health and reductions in health inequalities, ensuring maximum accountability to local populations in the process.

— The Department of Health is developing a Public Health Workforce Strategy.

**INTRODUCTION**

1. The Department of Health welcomes the opportunity to give evidence to the Committee on our plans for public health. This Memorandum seeks to cover the issues identified in the Inquiry Terms of Reference.

2. The Government is currently examining the more than 2,000 responses received to the consultation questions posed within the White Paper *Healthy Lives, Healthy People* and related consultation documents.

3. The Government is still working to prepare its response to the recent public consultation. This Memorandum, therefore, reflects the policy set out in the White Paper (rather than the outcome of the consultation).

4. The Department was granted an extension to the deadline for submitting written evidence so that the Committee would benefit from the latest possible position on Public Health, as reflected in the high level DH response to the NHS Future Forum’s report into the current Health & Social Care Bill which was published on 13 June 2011. Any issues regarding Public Health that arise from the more detailed DH response (due in w/c 20 June) which are not fully covered by this Memorandum can be discussed as part of the oral evidence sessions.
The Government’s Vision for Public Health in England

5. The current system for health protection is fragmented. *Healthy Lives, Healthy People* confirms we will:
   - build a stronger, integrated public health system to meet future threats;
   - make responsibilities at a national and local level clear; and
   - create a streamlined public health service to lead health protection and public health effort across England.

6. The Government has set out a number of values and principles which will underpin the new public health system:
   - **Values:**
     - To seek to *prevent* harm and reduce the risks of poor health, by early and effective interventions.
     - To strengthen responsibility—in individuals, families, communities, business and Government—for our health by working together to promote positive actions to improve health.
     - To do what works, on the basis of evaluation and evidence, focussed on outcomes; recognising the influence of the wider causes of ill-health.
   - **Principles:**
     - To establish a clear national strategy and world-class public health infrastructure to deliver improved population health.

7. This will be based on a public health system that puts Local Authorities (LAs) and the NHS in the lead, to drive forward improved public health through:
   - locally-led strategies which link across communities and Government, seeing better health and well-being as key to civic and social responsibility;
   - partnership (reaching across Government, small and medium sized, as well as large, businesses, the charitable and voluntary sectors, pressure groups etc) to create integrated, joined-up strategies and to promote a shared commitment to healthy lifestyles and the development of self-esteem and confidence; and
   - active effort to adapt the environment in which individual people live to make healthier outcomes easier to achieve, reducing potential harm and encouraging healthy choices, especially at key moments in people’s lives.

The Creation of Public Health England

8. Public Health England (PHE) will be key to delivering this vision. It will bring together all the areas of public health—health improvement, health protection, and population health services—into a single, expert delivery organisation to support achievement of this vision across the system. PHE will be charged with driving and securing progress against the outcomes framework set by Ministers, to secure improvements in health and wellbeing, to reduce health inequalities and safeguard the population against existing and future threats.

9. The government’s response to the NHS Future Forum’s report proposes that Public Health England will be set up as an executive agency of the Department of Health, subject to completing the normal government approval processes for establishing new bodies. This will ensure that expert and scientific advice is independent, while at the same time bringing together policy and action to allow a more joined-up approach to health protection and emergency planning. We will explore this further in the government response to the Public Health White Paper consultation.

The Abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

10. Public Health England will bring together the functions of:
   - the Health Protection Agency (HPA);
   - the National Treatment Agency for substance misuse (NTA);
   - the Public Health Observatories;
   - the Cancer Intelligence Network;
   - the National Screening Committee;
   - NHS cancer and non-cancer screening programmes;
   - Cancer Registries; and
   - the current Strategic Health Authorities and Regional public health teams.

11. The Department of Health is working with all of these organisations to identify the functions that need to transfer and to ensure a smooth transition. Critically, throughout the transfer to the new NHS and public
health system, the Government is committed to ensuring that there remain robust arrangements for emergency planning, resilience and response.

**Emergency Preparedness and Response**

12. Arrangements for emergency preparedness and response are to be strengthened and made less fragmented. There will be clear roles and responsibilities for Public Health England, Directors of Public Health and the NHS Commissioning Board, with a defined route for mobilising NHS and public health services to respond to emergencies.

13. The Health and Social Care Bill updates the Secretary of State’s powers of direction during an emergency. In addition, new arrangements provide Secretary of State with a clear line of sight to front line responders through Public Health England and the Commissioning Board.

14. Public Health England will provide public health leadership for emergency preparedness and response and will provide independent scientific and technical advice at all levels. Subject to Regulations being passed it is intended that, within Local Authorities, Directors of Public Health will ensure plans are in place to protect the health of their population, working closely with PHE local units and NHS organisations. NHS funded units will have clearer obligations to prepare for and respond to emergencies and providers will be required to collaborate in local multi-agency emergency planning and response activity.

15. Joint planning and collaborative working will lie at the heart of the health system’s preparedness and response arrangements. Public Health England and the NHS Commissioning Board will work together at all levels to ensure nationally consistent health emergency preparedness and response capability. Senior leaders will be appointed in both the Commissioning Board and PHE to take responsibility for this. They and their teams will work closely together, aligning with wider Government resilience hubs established by DCLG, and the existing Local Resilience Fora which provide the focus of multi-agency planning and response to emergencies. There will be a clear process to develop and test plans based on national and local risks and challenges.

16. These new arrangements will be a significant improvement on the current arrangements. For example in a new pandemic, there will be joint plans in place between PHE and the NHS for the important testing and data gathering that is essential to understand the nature of the new disease in the early stages. The NHS with PHE and Local Authorities will have joint plans in place to establish antiviral collection points, if needed. PHE, as an Executive Agency of the Department—subject to Cross-government/normal approval process—will be able to provide scientific and technical advice and the NHS will have clearly understood mobilisation plans to respond to the additional pressures on hospitals and primary care services. Throughout an emergency, the CMO with PHE will provide the Secretary of State with consolidated scientific advice to inform response and resolution. This means that the new system will give an improved integrated and coordinated response in any future public health emergency.

17. We will manage the transition to this new approach to ensure a continuing robust and effective emergency planning system, including throughout the Olympic period.

**The Public Health Role of the Secretary of State**

18. Secretary of State will provide national leadership. In particular, he will ensure that central government provides effective and efficient health protection capability, underpinned by a clear line of sight from the Secretary of State down to the front line, reflecting the core responsibility of government to protect its population.

19. The White Paper set out the Secretary of State’s role in public health. In summary it is:

- accounting to Parliament and the public;
- ensuring that the overall health and care system works coherently;
- setting a ring-fenced budget for public health from within the overall health budget;
- setting the direction for Public Health England and the context for local public health efforts;
- leading public health across central government, through the Cabinet Sub-Committee on Public Health;
- setting the national Public Health Outcomes Framework;
- holding PHE to account for its part in delivery;
- leading public health work across civil society and with business and brokering partnerships at national level;
- participating in public health work across the UK with the Devolved Administrations and at European and international levels;
- proposing legislation where this is a necessary and appropriate response; and
- commissioning research for public health through the National Institute for Health Research.
THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

20. *Healthy Lives, Healthy People* highlighted that localism will be at the heart of the new system, with local authorities taking on key new responsibilities, particularly, though not exclusively, around health improvement, supported by a new ring-fenced budget for public health. Local authorities will be uniquely placed to tackle the wider determinants of health (such as employment, education, environment, housing and transport): integrating their new responsibility for public health activity with their wider functions, and using their understanding of the local population to consider vulnerable groups in order to improve outcomes for the most disadvantaged. Thus the Health and Social Care Bill requires unitary and upper tier authorities “to take such steps as it considers appropriate for improving the health of the people in its area” (see new clause 2B(1) of the National Health Service Act 2006, introduced by clause 8 of the current draft of the Bill).

21. The intention is that positioning public health within local authorities will present an exciting challenge to local government itself to:

- consider population health and wellbeing as part of the core business of the whole organisation;
- create tailored solutions to meet varying local needs; and
- enable joint approaches involving other areas of local government’s work.

22. DsPH will enable local government to lead this challenge. They will be qualified in the specialty of public health (which includes those from both medical and non-medical backgrounds) and, to ensure that the right calibre of individual is appointed, local authorities will act jointly with Public Health England in making appointments. Ensuring that they continue to have an independent responsibility for the health of their local population is an essential pre-condition for the public health system. We are working with local government to ensure that there is maximum flexibility at local level to enable this to happen.

23. We are aware that there is an important development agenda to achieve a smooth transition to the new arrangements. This will include inducting Directors of Public Health into the ways of local government and, in turn, ensuring that local government leaders have a good understanding of public health and the major new functions they are taking on. How these functions are organised and resourced in practice will be up to the local authorities, but we envisage that the Director of Public Health will act as a key advisor on health to the authority.

ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES/THE ROLE OF HEALTH AND WELLBEING BOARDS, JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES

24. The Government recognises that public health should be at the heart of all commissioning, both at the national and local levels, to ensure that it is focused on the needs of the whole population.

25. At the national level, Secretary of State will set his priorities for the NHS, and the contribution which the NHS is expected to make to public health outcomes through the process of publishing a mandate for the NHS Commissioning Board. This is likely to be supported by documents which will set out more detail, for example on the public health services to be commissioned through the Commissioning Board.

26. At the local level, each unitary and top-tier local authority will develop a joint strategic needs assessment (JSNA) with clinical commissioning groups, which will underpin the production of a joint health and wellbeing strategy. The JSNA is jointly led by the Director of Public Health, the Director of Adult Social Care and the Director of Children’s Services and owned by the local authority. It is used to hold commissioners to account and is made available to them. All commissioners will be under a joint duty to take account of them when fulfilling their role.

27. In addition, we are considering options for ensuring that clinical commissioning groups receive the detailed public health advice they will need to improve population-level health outcomes and reduce health inequalities.

28. Health and Wellbeing (H &W) Boards will provide a focus for agreeing the most important health priorities for the population of the area and for taking action to address these priorities. H &W Boards will need to show their accountability to local people’s needs, in particular how individuals and communities have been empowered to express those needs. We are exploring how the use of the health premium can aid this process by supporting the most disadvantaged.

29. The key benefits of establishing these Boards will be to increase the influence of local people in shaping services through democratically elected councillors and local HealthWatch, so that services can better meet local need, be more joined up for the people using them and improve integrated working. The Government’s response to the Future Forum’s report makes clear that clinical commissioning groups will continue to be groups of GP practices, but we will make a number of changes to provide greater assurance that commissioning will involve patients, carers and the public and a wide range of doctors, nurses and other health and care professionals. Before establishing any clinical commissioning group, the NHS Commissioning Board will be required to seek the views of emerging H & W Boards. These Boards will also have a stronger role in promoting integrated provision between health, public health and social care.
ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

30. The Department published a consultation document on 21 December 2010 which set out the proposed scope of the new public health system, and a range of commissioning routes. Services funded through the public health budget could be provided or commissioned by:

— Public Health England at the national level (for example some national campaigns).
— The NHS Commissioning Board (for example screening programmes).
— Local authorities (for example the majority of health improvement programmes).

31. The Government is considering its decisions with regard to these commissioning routes in the light of the recent consultation exercise.

PUBLIC HEALTH EVIDENCE AND INTELLIGENCE AND THE FUTURE OF THE PUBLIC HEALTH OBSERVATORIES (PHOs)

32. In light of the Government’s commitment to doing what works, PHE will promote information-led, knowledge-driven public health interventions—supporting both national and local efforts. It offers a unique opportunity to draw together the existing complex information and intelligence functions performed by different organisations into a more coherent form.

33. Specifically, the White Paper set out that PHE will have a role in:

— collecting and managing data;
— analysing and evaluating information; and
— providing intelligence about needs, priorities and the effectiveness and cost-effectiveness of interventions.

34. To achieve this, work is already well underway with the PHE Information and Intelligence Working Group. This includes representatives from each of the member organisations of PHE, including the HPA, the NTA, the Public Health Observatories (PHOs), the cancer registries, and other groups whose responsibilities for public health evidence, and information development and distribution, will in future fall to PHE.

35. As recommended by the Future Forum, we are building on existing high quality outputs of these organisations, such as the annual Health Profiles from PHOs, a set of surveillance programmes from the HPA and regional registries of cancer. Our aim is to make evidence more easily available to those who will use it and provide it in a form that makes it most likely to be used.

36. This streamlined and integrated information and intelligence system will underpin everything PHE does, making the best possible use of evidence and evaluation, and supporting creative approaches to public health. It will provide a focus for close work with partner agencies such as the Office for National Statistics, the National Institute for Health and Clinical Excellence and the Information Centre.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

37. Following the recent consultation on our proposals for a Public Health Outcomes Framework, we intend to publish a final framework in the autumn. The Outcomes Framework will have three purposes:

— to set out the shared goals between Government, public health and local government 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 for health improvement and protection, and inequality reduction, at both the national and local level; and
— to provide the mechanism to encourage local health improvement and inequality reduction against specific public health outcomes through the “health premium”.

38. Public health is everyone’s responsibility. Therefore, the Outcomes Framework will be designed to reflect the breadth of contributions all partners should make at the national and local level and across public services. It will also line up with the NHS Outcomes Framework and the Adult Social Care Outcomes Framework (see below).

39. The Government is radically shifting power to local communities, and the Outcomes Framework will aim to include measures that allow us to assess health improvement across all years of life, and (following Sir Michael Marmot’s independent review: see below) to tackle health inequalities explicitly.

40. Our proposals will be modelled on five domains that best represent those high-level goals that we want to achieve through the whole public health system. They reflect national, local and community level actions that are evidence-based, can be measured, and which can be used by the public to hold local services to account. They are:

— DOMAIN 1—Health Protection and Resilience: Protecting the population’s health from major emergencies and remaining resilient to harm.
— **DOMAIN**—*Tackling the wider determinants of health*: Tackling factors which affect health and wellbeing and health inequalities.
— **DOMAIN 3—Health Improvement**: Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities.
— **DOMAIN 4—Prevention of ill health**: Reducing the number of people living with preventable ill health and reduce health inequalities.
— **DOMAIN 5—Healthy life expectancy and preventable mortality**: Preventing people from dying prematurely and reduce health inequalities.

41. The final framework will also describe its relationship to the NHS Outcomes Framework (NHSOF) and the Adult Social Care Outcomes Framework (ASCOF). We have already identified a number of proposed measures that are common to two, or all three, frameworks.

**Arrangements for Funding Public Health Services (including the Health Premium)**

42. Funding for public health services will be ring-fenced for that purpose. The funds will then be used either to:
— commission or provide services directly at a national level;
— fund the NHS Commissioning Board to commission public health services on behalf of Public Health England; or
— make a grant to local authorities for the provision of public health services. Grant conditions will specify that these funds can only be used for the provision of public health services. The provision of a small number of specific services may also be mandated.

43. Work is continuing to understand primary care trusts’ current spend to estimate how much resource will flow through each of these commissioning routes. The Advisory Committee on Resource Allocation has been asked to advise on the design of an allocation formula for local authority public health grants.

44. In addition, we will introduce a health premium payment to local authorities that encourages improvements in health and reductions in health inequalities. The premium will be simple and formula-based, and designed with a group of key partners to keep the administrative costs to a minimum. The premium will be based on elements of the Public Health Outcomes Framework and will be complete enough not to distort local decisions.

45. It will need to reflect accountability to local people, particularly the most disadvantaged in an area. The challenge of measurement must balance the need to act on their behalf in any year with the need to encourage long-term benefits. Critically, disadvantaged areas will see a greater premium if they make progress in improving the health of their population.

46. It will be important to have a detailed scheme agreed and announced during 2012–13 to allow local planning for 2013–14 to respond to the incentive proposed.

**The Future of the Public Health Workforce (including the Regulation of Public Health Professionals)**

47. The Department of Health is developing the Public Health Workforce Strategy as set out in the White Paper. The approach is consultative, through a workforce strategy group chaired by a Regional Director of Public Health. 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 year, and will:
— consider the role of the public health workforce in the context of “Healthy Lives, Healthy People”;
— examine how we will transform the workforce to meet the challenges and opportunities of the future;
— scope the current situation of public health workforces;
— set out how we could deliver a high quality, sustainable specialist;
— workforce with the flexibility to move from one employment area to another; and
— look at the opportunities to support wider public health workforces.

48. It will not make specific proposals for the terms and conditions of service of individual workforces, which are matters for their employers and employer groups. As part of this work, the Department of Health is working with key professional leaders, employers and other partners to ensure that the need for Continuing Professional Development and leadership capacity in the profession is addressed.

49. At the same time as the publication of the public health White Paper, the Department published the report by Dr Gabriel Scally on the regulation of public health professionals. Whilst Dr Scally’s report recommended that non-medical public health consultants should be regulated on a statutory basis, the White Paper indicated a preference for a system of assured voluntary registration.
50. This new approach to professional regulation, set out in the professional regulation Command Paper, *Enabling Excellence*, in February 2011, is provided for in Part 7 of the Health and Social Care Bill. The Government believes that statutory regulation should be a last resort, when less burdensome regimes are insufficient to protect the public from poor professional practice.

51. Assured voluntary registration provides for a system in which unregulated professionals can be registered with a voluntary register which is quality assured by the Council for Healthcare Regulatory Excellence. Professionals will be able through this means to show that they meet high professional standards.

52. The public health White Paper recognised that this is an issue on which the public health profession felt strongly, and has invited views as part of consultation. Any decision to regulate non-medical public health specialists on a statutory basis would need to be supported by clear evidence that these individuals presented a significant risk to public safety that would be effectively prevented by statutory regulation.

**The Government’s Response to the Marmot Review**

53. The Marmot review—the strategic review of health inequalities in England post 2010—was commissioned by the Department and chaired by Professor Sir Michael Marmot. Its remit was to identify the evidence on health inequalities—including on putting evidence into practice—and to advise on possible measures to reduce health inequalities in England in the short, medium and long term (to 2020 and beyond). Its report, *Fair Society, Healthy Lives*, was published in February 2010.

54. The review said that action on health inequalities requires action on all the social causes of ill-health. It adopted a life course approach, stated that there was a social gradient in health, and suggested action that was related to the level of disadvantage (“proportionate universalism”). It set out six policy themes, including on early years and ill-health prevention.

55. The coalition agreement emphasised the government’s commitment to fairness and social justice, and to tackling health inequalities. The *Healthy Lives, Healthy People* White Paper was the Government’s response to the review. It accepted the approach of the review and many of its key principles. It emphasised the importance of improving the poorest fastest.

56. For example the White Paper adopted a life course approach across the social determinants of health and, like the Marmot review, it gave high priority to the early years of life. It reflected a “proportionate universalism”. For example, it committed to an extra 4,200 health visitors to deliver a new model of support to families, building on the Healthy Child Programme, and to a doubling of targeted Family Nurse Partnership support to the most vulnerable first-time young mothers and their children.

57. The further work to address the issues raised by the Marmot review is being taken forward across government, including through the Cabinet Public Health Sub-Committee. The review has also contributed to the work of a number of government social policy committees. In addition, Government strategies, statements and independent reviews have reflected this work, including the Frank Field review on child poverty and the Graham Allen review on early intervention.

**Conclusion**

58. The Government is committed to a new approach to public health. This is rooted in localism and the need to build local solutions through effective working between public health, the NHS, the wider public sector and civil society, supported by the advice and expertise of Public Health England and the local public health system. The drive to reduce health inequalities will be central to everything we do.

59. This localist approach is accompanied, however, by a leadership role for the Secretary of State for Health and Government, and in particular clear central responsibility for protecting the population’s health.

*June 2011*

**Written evidence from Association of Directors of Public Health (PH 02)**

ADPH is the representative body for Directors of Public Health (DPH) in the UK. It seeks to improve and protect the health of the population through DPH development, sharing good practice, and policy and advocacy programmes. ADPH has a strong track record of collaboration with other stakeholders in public health, including those working within the NHS, local authorities and other sectors. ADPH President Frank Atherton is a member of the NHS Future Forum.

ADPH has provided extensive information in response to consultations and inquiries relating to the proposed reforms (available at www.adph.org.uk), and recently produced a Position Statement on the strategy for Public Health in England. ADPH were recently co-signatories to a letter to the Prime Minister highlighting continuing concerns that the proposals, as currently presented, will endanger the effective delivery of public health, undermine existing collaborative work and fragment the specialist public health workforce—already at risk due to management cuts in the NHS.
We welcome the Prime Minister’s recognition of flaws in the proposed reforms in his announcement of 7th June, including commitments to extend professional involvement in consortia planning and commissioning of care; new “clinical senates” consisting of senior medical professionals to oversee integration of NHS services across local areas; and a duty on Monitor to promote integration of care across an area. However we would reiterate that all organisations undertaking commissioning and health/social care planning functions (at national or local level) should be required to consult and take cognisance of specialist public health advice in formulating their proposals; and the board of each such organisation must include a specialist in public health as a full member.

We also note the Prime Minister’s commitment that greater competition will only be introduced when it benefits patient care and choice—however we await further clarification of the details relating to this statement.

1. Overview – Concerns for the Public Health System

We recognise that the proposed reforms raise opportunities for public health and welcome the increased formal role of Local Authorities (LAs) in the health agenda and integration of local DsPH into LAs. However, England needs an integrated system for delivery of public health outcomes, and we are concerned that there is a significant risk that the proposals could have adverse effects on fragmentation:

— of the public health workforce across a number of organisations;
— of commissioning and finance responsibility for public health programmes; and
— and loss of clarity on accountability, particularly in the area of health protection.

LAs should be accountable for improving and protecting the health of their population at all times (with support from Public Health England). However, in order to ensure a coherent system-wide approach to public health, the Health & Social Care Bill should place a statutory duty on all health and social care bodies (including NHS funded providers) to cooperate in efforts to improve and protect health and in responding to public health incidents and emergencies.

2. Specific Issues Identified by the Committee

2.1 The creation of Public Health England

Public Health England (PHE) can only effectively operate as a national public health service if it encompasses all three domains of public health:

— Health protection (infectious diseases, environmental hazards and emergency planning);
— Health improvement (lifestyles, inequalities and the wider social, economic and environmental influences on health); and
— Health services (service planning, commissioning, audit, efficiency and evaluation).

PHE should operate as a supporting organisation which can:

— provide independent scientific evidence-based advice to national and local government, the NHS and the public on all matters relating to the maintenance, improvement and protection of health;
— offer expertise to the National Commissioning Board (NCB) in support of its role in providing national leadership in commissioning for quality improvement, commissioning national and regional specialised services, and allocating NHS resources;
— provide effective, expert and adequately-resourced specialist PH capacity to support the work of local DsPH and their teams;
— provide independent scientific evidence-based advice and guidance to the devolved nations where they are unable to access this locally; and
— generate revenue from external consultancy and academic research funding.

It is unlikely that these aims can be achieved if PHE becomes a fully-integrated part of the Department of Health. It should be established as an NHS body which would:

— facilitate the employment of public health staff by PHE;
— enable pooling of scarce and specialist public health capacity;
— enable the continuance of external income streams that currently support national health protection activity;
— facilitate the separation of science from policy and therefore re-enforce the independence of DsPH and health protection for the populations’ health and protection.

We are also concerned that:

— there is a lack of definition on the role and status of DsPH within PHE—this requires clarification, including in relation to the health protection functions of DsPH locally;
— clarity is required on the mechanisms for public health input to the NCB; and
there must be clear lines of accountability, communication and access between PHE, commissioning consortia, NHS and DsPH working within local authorities.

Specialist public health capacity (including specialists working across the domains of health improvement, health protection, healthcare public health, and public health intelligence/analysis) should be consolidated into PHE. The specialist capacity can then be deployed to provide public health input to all parts of the health and social care system; Commissioning Consortia, LAs, NCB, and NHS-funded provider organisations.

Health protection

Capacity for emergency preparedness and response must be maintained within the new structures—and robust interim arrangements to ensure a stable transition.

Clarity is vital over which part of the system will lead responses to incidents at local and sub-national supra local or regional levels.

There needs to be clear agreement on the roles and responsibilities for DsPH and local health protection units, including assurance that health protection work carried out in second tier local authorities is connected with coordination and planning mechanisms organised at the top tier of local government.

ADPH has been working with the HPA to develop solutions to key local health protection issues. The initial phase of this work was recently completed and the outcomes report has been widely circulated. PHE and the NHS will need to liaise closely with public health agencies in the devolved administrations to ensure that cross border support remains robust in relation to UK health protection issues.

2.2 The public health role of the Secretary of State

We welcome proposed new duties on the Secretary of State (and NCB and commissioning consortia) to have regard to the need to reduce health inequalities. However these duties are narrowly drawn, only applying to the role of the NHS in providing services to patients. The duties should reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer.

There are also no equivalent duties on the Secretary of State or local authorities in respect of their roles in promoting public health.

2.3 The future role of local government in public health

DsPH are the frontline leaders of public health working across the three domains of health improvement, health protection, and health care service planning and commissioning. DsPH must be enabled—through primary legislation—to provide oversight and influence across all these determinants of health within local authorities, the NHS and primary care, and other appropriate sectors and agencies in order to secure the improving health of their population.

DsPH should be jointly appointed by LAs and PHE and should have a contractual relationship with both. However the supporting HR framework and clarification of terms/conditions and accountabilities are urgently needed.

DsPH will need clearly defined responsibilities and powers and the professional status and enablement to express an independent view in order to provide advocacy for the health of the population. This is analogous to the requirement for local authorities to appoint a suitably qualified officer responsible for the proper administration of its financial affairs in section 151 of the Local Government Act 1972.

DsPH will require a well-resourced, professional and co-located Public Health team providing the skills and experience to input to local service planning and commissioning, and to deliver Public Health programmes and advice across the health economy, supported by access to high quality local and national data and scientific evidence base.

ADPH strongly believes that:

— A DPH should be an individual trained, accredited, and registered in specialist public health;
— There should be a statutory requirement for top tier Local Authorities to appoint a DPH with the appropriate professional training and accreditation;
— The DPH should be recognised as the principal adviser on all health matters to the local authority, its elected members and officers, and its Health & Well Being Board, on the full range of local authority functions and their impact on the health of the local population as stated in Annex A of the PH White Paper;
— The DPH should work at corporate/strategic director (top team) level as a full executive member of the corporate leadership team with direct access to the local authority Cabinet and councillors— influencing and working alongside other Local Authority Executive Directors and normally reporting or accountable to the CEO or equivalent;
The professional status of the DPH and ability to express an independent view in order to advocate for health improvement and reducing health inequalities within their local population and act for the protection of the local population—and the independent DPH annual report—must be protected; and

As the principal advisor to a Health & Well Being Board, a DPH should not relate to more than one Board. However, we recognise that where local arrangements lead to a shared Board, then it may be appropriate for one DPH to work to this Board.

DsPH should:

— be appointed jointly by the local authority and PHE, through a statutory appointments process which mirrors the existing Advisory Appointments Committee process for DsPH and Consultants/Specialists in Public Health—and accredited by the Faculty of Public Health (as is currently the case);
— have a formal contractual relationship and role—which could be honorary—with PHE; and
— have their employment terminated only with approval of both the local authority and the Secretary of State for Health.

HR guidance to clarify employment/contractual issues—and professional accountability issues for DsPH and their teams—is urgently needed. There is an immediate and transitional risk of loss of PH professional staff and expertise through uncertainty and staff concerns over the implications of potential transfer out of NHS employment.

Clarification of the resources that will support the DPH role in local authorities is urgently needed.

Funding for DPH and PH team development will be crucial to support effective transformational change.

Health & Well Being Boards/JSNAs

The powers granted to Health and Well Being Boards are weak and there is a risk that health and social care integration may be more difficult to achieve.

The Boards have not been granted sufficient powers to meet the expectation that they will join up commissioning between the NHS and local authorities. The interface between GP consortia and local authorities will be critical in ensuring that services meet the full range of local population health needs. However, while Consortia must consult Boards in drawing up their commissioning plans, there is no requirement for Consortia to have regard to the views of the Board.

Health and Wellbeing boards must have the power to sign-off local commissioning plans, ensuring that they are aligned with the joint strategic needs assessment and address the identified needs of the population.

The DPH should act as a principal advisor to the Health and Well Being Board and as such, a DPH should not relate to more than one Board. However, we recognise that where local arrangements lead to a shared Board, then it may be appropriate for one DPH to work to this Board.

In two tier authorities existing health and well-being partnerships should continue to work together. District Authorities should have specific roles and duties for the improvement and protection of health and the reduction of health inequalities.

The JSNA must:

— be asset-based, wide-ranging and thorough and include qualitative “citizen” views (not just service-user or patient views);
— include preventative and health protection issues; and
— be the basis for all local commissioning.

2.4 Arrangements for public health involvement in the commissioning of NHS services; arrangements for commissioning public health services

Public Health oversight of and input to commissioning will be essential to achieve real improvements in health outcomes and the reduction of health inequalities.

The proposed reforms:

— lack clarity over who will be responsible for providing “local system leadership” and planning services across GP consortia boundaries following the abolition of SHAs/PCTs;
— include few requirements on the governance of consortia;
— do not require GP consortia to promote integration between health and social care—an omission that will be exacerbated by lack of co-terminosity between consortia and local authorities; and
— do not appear to place a duty on GP consortia to promote and protect the health of their local health population.
Locally, the DPH should provide oversight and the Public Health team input to GP consortia commissioning, supported by additional resources and expertise held within PHE. 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.

Specialists working in health services public health possess skills that are highly specialised. The essential role of this group in the commissioning of health services by commissioning consortia (and NCB) has not been grasped in the draft Health & Social Care Bill. The current position is that the Bill requires commissioners to take advice only from those with “professional expertise relating to the physical or mental health of individuals”.

The requirement for commissioners to take advice should be extended to ensure that all organisations undertaking commissioning functions (at national or local level) should be required to consult and take cognisance of specialist public health advice in formulating their commissioning proposals. The board of each such organisation must include a specialist in public health as a full member.

GP Consortia (and NCB) should be responsible for improving inequalities of health outcome rather than just inequalities of access to health services. Clarity is required over where responsibility lies for ensuring GP consortia meet their responsibility for improving outcomes and how consortia are to be held to account for PH outcomes.

The population size of GP consortia should be based on evidence of effectiveness, as should decisions as to whether services are commissioned and delivered nationally, regionally or locally. Consortia should develop structures for stable joint commissioning where these would best serve their population.

GP consortium must be responsible for a defined geographical population which is coterminous with local authority boundaries.

In order to promote coherent response to emergencies, GP Consortia should assume similar responsibilities as category 1 responders under the Civil Contingency Act (that have previously applied to Primary Care Trusts) and be required to have a responsible officer for emergency response.

Commissioners should be required to demonstrate the use of a strategy covering high quality, universal services, targeted services for communities of interest at greater risk especially deprived communities and tailored services for people with multiple and complex needs. This should be underpinned by evidence base, public health intelligence and needs assessments.

There must be clear lines of accountability, communication and access between PHE, GP consortia, NHS and DsPH working within local authorities.

2.5 The future of the Public Health Observatories

The new system must ensure that all those working in public health have access to timely, comprehensive and appropriate data and analysis to inform their decisions and advice.

Reliable data and information are essential to the understanding of health needs, modelling of future scenarios and assessment of impact and efficacy. This is relevant both for service planning and design and for the recognition of and response to hazards and outbreaks.

The reforms could result in disruption of existing flows of data and the loss of analytical expertise. Arrangements for maintenance of the public health observatory function and for ensuring access to health service data at local and national levels need urgent clarification.

2.6 The structure and purpose of the Public Health Outcomes Framework

ADPH welcomes this focus on outcomes, and whilst recognising that many of the proposed indicators are process rather than outcome measures, we feel that this mix of process and outcome measures is appropriate given the long time frames which may involved.

However:

— greater emphasis should be put on ensuring that the Public Health framework is relevant to all sectors—with greater emphasis on linkage across the NHS, Social Care and Public Health outcomes frameworks;

— public health analytical capacity is essential to delivery of public health outcomes and current capacity must be preserved and enhanced; and

— investment will be needed in national surveys relating to health and wellbeing to ensure LA data can be assembled.
2.7 Arrangements for funding public health services (including the Health Premium)

The ring fenced budget

The scope of the ring-fenced budget must be defined clearly and the funds available in the ring-fenced budget must be sufficient to meet the needs for which that budget is intended.

PHE will require adequate resources to immediately and effectively fulfil its wide remit—and vitally to invest in the continuing development of public health expertise and the public health workforce.

In relation to the local ring-fenced public health budget:

— it should be explicit what will fall within this budget, and equally explicit that excluded activities with a bearing on public health will continue to be resourced from other / existing Local Authority and GP commissioning consortia budgets;
— within the LA these budgets should be deployed with flexibility for DsPH to direct resources to best meet the needs of the local population based on the JSNA and Health & Well Being strategy; and
— it should be clarified as to how baseline budgets will be set. We are concerned that public health resources have already and will continue to be lost through the impact of local financial savings—any baseline must not be based on reduced resources.

Resources will also be required to support transition—including funding for DPH and PH team development to support effective transformational change, plus funding an awareness programme to ensure that politicians (national and local) fully understand the DPH role and all key PH functions.

Health premium

The health premium should:

— target need;
— reward relative improvement; and
— identify and reward “value added” activity/outcomes.

We are concerned over potential unintended consequences and that the health premium may create greater health inequalities.

The extent of the health premium is unclear but may not provide significant additional resources. Learning and evidence from existing programmes (such as the Spearhead approach) may provide useful evidence/outcomes to inform development of the health premium. We recommend that a full assessment of Spearhead experience should inform the further development of the health premium concept.

2.8 The future of the public health workforce (and regulation of PH professionals)

ADPH supports the recommendations within Dr Scally’s Report on the Review of the Regulation of Public Health Professionals.

The Faculty of Public Health is the standard setter for all public health practice in the UK.

The title “Specialist in Public Health” should be a protected title, required by statute to be registered.

Statutory regulation of public health specialists is the best mechanism for providing effective protection of the public. The current requirement for statutory registration for public health specialists who are doctors or dentists should therefore be extended to cover those from all other backgrounds. All specialist public health staff (including DsPH) should be appropriately qualified, should be appointed through a statutory Appointments Advisory Committee and should have access to recognised continuing professional development. The training of public health specialists should be planned and delivered through Health Education England and should be consistent with arrangements for training other health professionals.

The independent PHE should act as the employing body for public health specialists, seconding them to other organisations as necessary, to ensure their primary responsibility is to the public. The use of honorary contracts can facilitate this model.

2.9 How the Government is responding to the Marmot Review on health inequalities

The current reorganisation of the NHS and of Public Health significantly underestimate the role of the NHS in addressing health inequalities.

We welcome new duties on the Secretary of State, NHS Commissioning Board and GP consortia to have regard to the need to reduce health inequalities. However these are narrowly drawn and do not reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer. There are also no equivalent duties on the Secretary of State or local authorities in respect of their roles in promoting public health.
The duties are unlikely to be sufficient to ensure that tackling health inequalities is prioritised in the health system. We strongly recommend that the NHS commissioning bodies should be held to account for reducing inequalities in health outcomes.

The proposed new system risks service fragmentation with detrimental impacts on the very areas the reforms seek to improve: quality of services, education and training, patient choice, efficiency and equity, and has the potential to exacerbate any existing postcode lottery in health services.

The “Nuffield Intervention Ladder” should be applied to the Responsibility Deal approach. Robust, time-limited monitoring and evaluation after 12 months will be crucial to assess the effectiveness of voluntary commitments.

3. Additional Issues

Provider and Regulatory organisations

Protecting, maintaining and improving the public’s health require services to cooperate, addressing shared priorities to meet health needs, and making best use of all available resources. A requirement to promote competition will discourage integration and collaboration across the sectors, and should be removed from the draft Health & Social Care Bill. A duty of cooperation should be placed upon service providers and commissioners.

Public health influence within provider organisations should be extended, eg:

— a public health lead working within Trusts;
— provider trusts should work with LAs in improving the health of the population; and
— above a capped level of reserves, an annual proportion of Foundation Trust reserves to be spent on initiatives agreed locally as providing health gain for the population.

Conclusions of a 2010 ADPH survey on Transforming Community Services were:

— in any re-organisation the impact on public health services should be assessed—particularly true for emergency planning and response;
— where possible there should be a named public health lead in community services; and
— public health expertise should be readily available to provider services where no public health lead is in place.

There should be clear lines of public health input into CQC and Monitor:

— public health expertise and input at a high level within the CQC to ensure a strong population perspective in quality regulation; and
— public health expertise and input into Monitor to ensure effective use of resources in support of the prevention agenda health improvement and a reduction in health inequalities.

June 2011

Written evidence from Professor Brian Ferguson (PH 03)

Introduction to Submitter

Professor Ferguson is a health economist by professional background and has been Director of the Yorkshire and Humber Public Health Observatory since its inception in January 2004. He was the elected Chair of the Association of Public Health Observatories from April 2006 to March 2011, and became National Transition Director for the English PHOs from 1st April 2011. He is currently also Co-Director of the Northern and Yorkshire Cancer Registry and Information Service. Professor Ferguson was admitted to the UK Public Health Register in February 2007.

Executive Summary

1. PHOs have been part of the health intelligence system for over a decade and have been successful in generating income and diversifying funding in addition to their Department of Health core funding.

2. PHO outputs and advice are widely viewed as credible, authoritative and independent, and consideration needs to be given to how this will be assured in the new health intelligence system.

3. Recent uncertainties have led to a significant loss of capacity in PHOs and action needs to be taken urgently to stabilise the observatories in preparation for transition of their functions into Public Health England, and to ensure business continuity going forward.

4. Further efficiencies are required across the observatory network to prepare for effective transition, and considerable work is underway to achieve these through the development of a single national work programme.
5. Integration of health intelligence activities is critical if economies of scale are to be maximised in the use of scarce expertise to support the aims of Public Health England.

6. Integration of health intelligence is required to ensure that there is a consistency of approach and sharing of scarce skills and capacity to support decision-makers engaged in both commissioning and public health activities.

**Factual Information**

**Context and key figures**

7. There are nine public health observatories in England, established to be co-terminous with the government office regions. These cover ten NHS strategic health authorities. The longest established PHOs have been in existence for eleven years.

8. The Association of Public Health Observatories (APHO) was the network that brought together all of the twelve PHOs in England, Scotland, Wales and Ireland (North and South). APHO was disbanded by the Department of Health in England on 31st March 2011.

9. PHOs receive core funding from the Department of Health: in 2010–11 the total allocation was approximately £5.12 million (less than 10p per head of population). PHOs have been extremely successful in generating additional income and diversifying their funding sources: in 2010–11 the PHOs received some £11 million in addition to their core funding (approximately £7.5 million from other parts of the Department of Health and £3.3 million from other sources).

10. In 2011–12 the Department of Health core funding has reduced by approximately 23%, to £3.94 million. The total funding estimate from the Department of Health in 2011–12 is approximately £9.68 million: this includes funding for the specialist observatories, for the National Drug Treatment Monitoring System (NDTMS), and for significant projects such as Health Profiles.

11. In June 2010 the PHOs in England employed some 300 whole time equivalent staff, through host organisations which are either in the NHS or university sectors. Staff are not solely analysts, but include public health consultants and specialists, and senior managers with considerable experience of change management in the NHS and beyond.

12. As at 1 May 2011, the loss of capacity across the PHO network was approximately 20%. Approximately 75% of this capacity loss in PHOs during the last year is accounted for by information analysts and public health consultants or specialists. Of the posts that remain in PHOs, around 40% are fixed-term or temporary posts, and on current working assumptions these posts would not be renewed (approximately 80% ending this financial year).

**Core role and functions of PHOs**

13. 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.

14. For many years the PHOs have operated a lead area model so that individual PHOs have developed niche expertise in particular topics such as diabetes, cardiovascular disease, alcohol and sexual health. PHOs are almost unique as organisations that signpost knowledge across the public health spectrum.

15. The PHOs operate as an efficient network in the delivery of key national products. Notable examples include the annual local and sub-national health profiles, the national library for public health, the health inequalities intervention tools, programme budgeting tool and factsheets, and the local basket of inequalities indicators.

16. Within the context of national lead responsibilities, a number of PHOs now host national observatories in the following specialist areas: learning disabilities (North East), child and maternal health (Yorkshire & Humber), obesity (South East), and injuries (South West).

**Peer review / quality assurance**

17. During 2009–10 a robust peer review process was undertaken across the nine English observatories, supported by Local Government Improvement and Development (previously the Improvement and Development Agency (IDeA)) using its well-validated methodology in local government. This process was completed in June 2010, and a summary report of lessons learned was prepared for the APHO Steering Group in July 2010.

18. Findings and recommendations from the peer review process were taken forward in each region by the Regional Director of Public Health and PHO Director.
The Continuing Contribution that Observatories Can Make

19. Public health intelligence is not just about making data publicly available, it is about interpreting the data to ensure that the right conclusions are drawn and the best decisions made. PHO analysts have highly specialised training in both public health and analytical skills. This is critical expertise within the health intelligence infrastructure that will be needed by Public Health England.

20. Public health intelligence is also about understanding local and community level variations and the local social and economic contexts that impact on health. PHOs, with their strong local links backed by knowledge of a huge variety of often complex data sources, are able to provide the right information to the right people at the right time. Public health consultants and specialists, and senior managers skilled in health intelligence, are in scarce supply.

21. PHOs have an excellent understanding of national and local health intelligence needs. They have developed generic tools and provide tailored intelligence for Joint Strategic Needs Assessment and local commissioning of services. Such tools and expertise will be invaluable to Health and Well-being Boards and NHS Commissioning Boards in their work to improve health outcomes.

22. PHO data and intelligence are used by Directors of Public Health in their annual reports. It is vital that Directors of Public Health have access to tools such as the Local Authority Health Profiles. These are regularly used to assess progress on key public health indicators locally.

23. New commissioning organisations will also need access to appropriate tools to inform commissioning decisions and monitor public health performance. The PHO GP Practice Profiles have proven to be invaluable in this respect.

24. PHOs, through their lead area work, have developed tools for measuring and evaluating public health outcomes on key public health issues for all England, at local area level. Examples of these are:
   - Local Alcohol Profiles.
   - Child Health Profiles.
   - Health Inequalities Intervention Toolkit.
   - Sexual Health Balanced Scorecard.
   - Local Authority Tobacco Profiles.
   - Diabetes Community Health Profiles.
   - Community Mental Health Profiles.

25. The PHO disease prevalence models at PCT, Local Authority and GP practice level also underpin commissioning decisions for the highest impact killer diseases and are vital sources of information for reducing mortality and morbidity and tackling health inequalities.

26. Programme budgeting tools, including the PCT Spend and Outcome tool and programme budgeting atlases, link public health outcomes with spend. These are another set of vital tools to ensure that sound commissioning decisions are made and health outcomes improved.

27. PHOs are the repositories of rich knowledge bases, largely through their development of interoperable websites and themed observatories. They are also the custodians of the National Library for Public Health—an integral part of NHS Evidence—and the Health Impact Assessment (HIA) Gateway, which provides information and resources for those commissioning or conducting HIA.

28. PHOs have forged links with social care (for example, in end of life care, and in the creation of an adult social care data set) and are in a strong position to model, advise and resource the development of more robust social care intelligence, which currently lags behind health and health care intelligence.

29. PHO intelligence is used by health professionals and public health practitioners to influence behaviour change in local populations and in health settings. The robust intelligence provided by PHOs is important in helping to ensure that interventions are properly targeted, with outcomes measured and evaluated. This will support the ladder of interventions approach advocated in Healthy Lives, Healthy People.

Support for the PHOs

30. The following quotes provide an indication of how valuable the observatory functions are perceived:
   - “In the past decade Public Health Observatories have become indispensible to the infrastructure of promoting and protecting the nation’s health.” [Sir Liam Donaldson, Chief Medical Officer 1998–2010].
— “The information that the public health observatories produce is important in ensuring that whoever commissions services commissions for the population, not just for GPs’ lists.” [Diane Abbot MP, speaking at the adjournment debate in the House of Commons on 17 May 2011].

— “Anybody who has an interest in public health knows how important the observatories are.” [Anne Milton MP, Parliamentary Under-Secretary of State for Health, speaking in response to the adjournment debate in the House of Commons on 17 May 2011].

— “APHO helps us tell a powerful local story. The red dots (in local health profiles) have more significance in our work with council leaders than reams of numbers.” [Local Government Improvement and Development].

WAYS OF WORKING AND EFFICIENCIES

31. PHOs operate as a network that shares expertise, knowledge, operating standards, methodologies and best practice. They take a “do once and share” approach through the delivery of lead area outputs. They support and train the local public health intelligence workforce and have close relationships with analysts at local level.

32. However, all of the observatories recognise the need for further efficiencies and considerable strategic rationalisation work is currently taking place around data, methods and knowledge management.

33. In some regions, leadership and resources are already shared across different health intelligence functions. Examples of this include shared directors between, and/or co-location of, PHOs and Cancer Registries, or where PHO and Quality Observatory functions are co-located and delivered using shared resources.

34. PHOs have continued to move forward in anticipation of the need for further efficiencies as Public Health England develops. Examples of areas to be explored further with partner organisations include:

— lead areas / specialist observatories: further development and alignment to national priorities;
— aligning the NDTMS function with PHOs in areas where this is not currently the case;
— avoiding duplication by undertaking single analysis of national datasets;
— sharing of public health leadership and other resources across sub-national intelligence functions;
— a more efficient website and knowledge dissemination infrastructure;
— further development of joint local working across all health intelligence functions to support NHS commissioning;
— co-ordination of professional development, training and workforce capacity across health intelligence functions nationally, sub-nationally and locally; and
— opportunities to innovate through the appropriate and responsible linkage of different datasets.

WEBSITE USAGE

35. The individual PHO and APHO websites have been key communication vehicles for products, training and other activities undertaken. Examples of website usage statistics are:

— GP practice profiles: 20,000 unique page views per month since launch;
— sexual health balanced scorecard: over 5,000 unique page views in quarter 1, 2011;
— local authority child health profiles: approximately 5,000 downloads in quarter 1, 2011; and
— local alcohol profiles: over 122,000 page views since September 2010 launch.

PHO FUNCTIONS IN THE NEW HEALTH INTELLIGENCE SYSTEM

36. PHOs have been working together on a single work programme across the network, focusing on key outputs to support Public Health England and the NHS Commissioning Board around priorities in the NHS and Public Health White Papers. Providing health intelligence to support different outcomes frameworks is central to this work programme.

37. PHO directors are hugely committed to ensuring that there is further integration of health intelligence functions at sub-national level, in order that scarce skills are used effectively and intelligence is delivered to local decision-makers as efficiently as possible.

38. PHOs produce population health intelligence and health care intelligence throughout pathways of prevention and care. In many cases this involves close collaboration with clinical networks and the production of outputs that support commissioning decisions (for example in cardiovascular disease and diabetes). There is considerable scope to develop health intelligence products with clinical networks in the new system.

39. Work to date with Public Health England colleagues has been extremely positive in helping to identify observatory functions that will be required going forward, even though the system design work remains at a relatively early stage. Observatories will continue to play whatever role is required to shape the design of the future system and ensure that key products and capacity-building activities are central to that system.
40. PHO directors fully understand the substantial financial pressures on all government funds and the need for all services to show efficiencies. However, they are also acutely aware of the need to retain critical expertise in the public health system through this period of transition. A firm commitment to funding until Public Health England goes live—with no further cuts during financial year 2011/12—would enable the observatories to:

- maintain an excellent public health intelligence service to a nationally agreed work plan;
- retain critical expertise;
- deliver significant efficiencies in provision of local, sub-national and national intelligence and analytical services;
- prepare staff and other assets of the PHOs for transition into Public Health England as required; and
- support Public Health England and other emerging NHS structures with their current intelligence needs at least until new local and national structures are in place.

RISKS

41. Since the capacity to deliver a co-ordinated single work programme has been eroded significantly, locally responsive work in some regions has diminished considerably as a consequence. This is a risk to health intelligence capacity locally and sub-nationally.

42. One of the key perceived strengths of the observatories is their ability to provide independent scientifically credible advice. In a number of places this derives partly from the strong links that exist with academic institutions. For example, the observatory network is integral to the work of the Public Health Research Consortium. Public Health England will need to draw upon objective health intelligence (both data and evidence) if its advice and outputs are to have the maximum impact.

43. It is imperative that observatories and other health intelligence bodies are able to continue to work to support their local Directors of Public Health, local government and commissioning organisations in the new system. Scarcely health intelligence capacity must be safeguarded from further losses.

44. As evidenced in paragraph 9, PHOs have been successful in generating significant additional income, and indeed have competed for several years in an increasingly congested health intelligence market. It is unclear in the proposed Public Health England model how this entrepreneurial element of observatory functions will be protected.

45. Given the current “pause” and various listening exercises, there is a significant risk that continuing uncertainty will further de-stabilise observatories, particularly—but not exclusively—in areas where there are university hosts. The current funding climate across the public sector is such that, where hosts have no assurance of future funding, observatory staff will increasingly face redundancy.

46. Three observatories have faced a particular risk of closure since December 2010. In the London Health Observatory, staff have been at formal risk of redundancy since 1st December 2010, and two university-hosted PHOs (North East and North West) have been vulnerable to complete closure given that it has not been possible to provide a firm commitment to funding for a sufficiently long period.

47. Inability to recruit to posts as staff leave observatories poses a significant risk to business continuity. This must be addressed as a matter of some urgency, in particular given the loss of any central funding to enable the co-ordination and efficient working of a dispersed geographical network.

48. PHOs have been successful in some parts of the country in extending their reach beyond traditional public health audiences, in particular to NHS commissioners with locally funded programmes of work. There remains a risk that there is an artificial divide between health intelligence support to commissioning and support to public health and local government. A more sensible approach is to ensure that there is closer integration of commissioning and public health functions with health intelligence capacity organised in an efficient way to support both functions.

RECOMMENDATIONS

49. There should be no further cuts to PHO budgets in financial year 2011–12.

50. Funding for PHOs should be confirmed until Public Health England goes live, with host employers being given a minimum of six months’ notice of any decision not to continue funding.

51. Consideration should be given to how the independence of scientifically credible evidence can be ensured as Public Health England evolves.

52. Integration of health intelligence activities at sub-national level is essential to ensure the efficient organisation and delivery of advice, outputs and capacity-building activities.

53. Such integration is required both to ensure more efficient working between health intelligence bodies, and to ensure that there is no artificial divide between commissioning and public health.

May 2011
Written evidence from the National Treatment Agency for Substance Misuse (PH 04)

INTRODUCTION

1. This paper is the National Treatment Agency for Substance Misuse’s (NTA) formal written submission to the Health Select Committee inquiry into Public Health.

2. It considers the issues and implications of government proposals from the perspective of alcohol and drug treatment in England.

3. The NTA is a National Health Service (NHS) special health authority, established to improve the availability, capacity and effectiveness of drug treatment in England. We aim to help people overcome their addiction and regain their lives.

4. We are sponsored by the Department of Health, but work closely with and are accountable to other government departments which are partners in the drug strategy including the Home Office, Ministry of Justice, Department of Work and Pensions, and the Department for Education.

5. The NTA works in partnership with a range of organisations and agencies at national and local levels including government departments, local drug treatment partnerships (the bodies that commission drug treatment), drug treatment services in both the NHS and voluntary sector, service users and carers.

6. The arms length body review,1 published in July 2010 announced that the NTA would be abolished as a statutory organisation and its functions would be transferred to the new Public Health Service by April 2012.

EXECUTIVE SUMMARY

The NTA welcomes the opportunity to give evidence to this inquiry. Drug and alcohol misuse is a major public health issue that also cuts across many other areas of policy and practice, both national and local.

The 2010 Drug Strategy tasked the NTA to support the development of a recovery-based drug treatment system, and build a role to improve the provision of services for severe alcohol dependence.

Recovery from drug addiction benefits public health and cuts crime, as well as delivering value for money for the taxpayer. Every pound spent on treatment delivered £2.50 worth of benefit to society, mostly by cutting crime but also in reduced health and social costs.

We believe the creation of Public Health England at a national level, to support and oversee local commissioning arrangements for drugs and alcohol services, is the best vehicle for taking forward the government’s ambition of recovery for people dependent on alcohol or drugs.

This ambition will also require work across housing, employment, education, children services, families, criminal justice, and communities as well as treatment services.

Transferring the NTA’s critical functions into Public Health England (PHE) will provide expert support for local authorities as they exercise their new alcohol and drug commissioning responsibilities.

KEY FACTS

— Drug treatment cuts crime (preventing millions of crimes a year) and therefore delivers benefits for society and communities as well as individuals.

— The wider public health benefit to society (reducing drug-related deaths and preventing the spread of blood-borne viruses) is as significant as the personal gain for patients (207,000) in treatment.

— There is a legitimate cross-government interest in drugs, for which the Home Office has lead responsibility but in which MoJ, DWP, DfE, DCLG and Cabinet Office all have an interest as well as DH.

— Government spending on drug treatment alone (£800m pa) represents value for money, because every £1 invested generates £2.50 worth of savings (HO research 2009, endorsed by the NAO 2010).2, 3

THE 2010 DRUG STRATEGY

7. The government’s 2010 Drug Strategy4 set out a new ambition for anyone dependent on drugs or alcohol to achieve recovery and lead a drug-free life. Its overarching aims are to reduce illicit and other harmful drug use, and increase the numbers recovering from their dependence.

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1 Department of Health (26 July 2010) Review of arm’s length bodies to cut bureaucracy.
8. The strategy outlined plans to create a system that not only gets people into treatment for dependency, but also gets them into recovery and off drugs for good. The mechanism for achieving this transformation anticipated changes proposed in the government’s reforms to the NHS and healthcare system. This envisages effective action at local authority level led by local Directors of Public Health (DsPH), coupled with a streamlined national public health service, Public Health England (PHE).

9. As part of this programme the National Treatment Agency for Substance Misuse (NTA) will cease to exist as a separate organisation in 2012, and its key functions will be transferred to PHE. In the meantime, the Drug Strategy tasked the NTA to support the development of a recovery-based treatment system, and build a role to improve the provision of services for severe alcohol dependence.

10. The transformation from a treatment system to a recovery system demands a culture shift among practitioners and providers, which accepts that treatment is only the first step on the road to recovery. Achieving long-term recovery requires substantial change across the sector, including greater engagement with housing, employment, children’s services, families, and communities. This challenge was enshrined in a public consultation on a new national framework for the field, entitled Building Recovery in Communities, which closed last month.

11. The landscape in which drug treatment and recovery services operate is thus poised to change dramatically. With a new direction of travel at strategic level, and different delivery arrangements on the ground, key decisions about the size and shape of the system are moving from a national stage to a multitude of local theatres.

12. In the wake of the government’s listening exercise on the NHS, the NTA welcomes the opportunity to give evidence to this inquiry. Drug and alcohol misuse is a major public health issue that also cuts across many other areas of policy and practice, both national and local.

13. We believe the creation of PHE at a national level, to support and oversee local commissioning arrangements for drugs and alcohol services, is the best vehicle for taking forward the government’s recovery ambition. Transferring the NTA’s critical functions into PHE will provide the immediate expert support (provision high-quality data, analysis and interpretation of the evidence base) for DsPH as they exercise their new alcohol and drug commissioning responsibilities.

14. We know that realising the coalition government’s new ambition of recovery for anyone dependent on alcohol or drugs will require work locally across housing, employment, education, children services, families, criminal justice, and communities as well as in treatment services. That is why it makes sense in principle to give new alcohol and drug commissioning responsibilities to Local Authorities, operating through DsPH and supported by Health and Wellbeing Boards (HWBs). This arrangement has the potential to improve the joint working required to tackle the wider physical, mental and social needs of alcohol and drug misusers necessary for achieving recovery.

The Nature of the Problem

15. About a third of the UK population admit to taking drugs at some stage in their lives, but few people go on to develop problems. There are an estimated 320,000 heroin and crack cocaine users in England, and an unknown number of other people whose misuse of dangerous drugs poses problems not only for themselves but also for society. Almost 1.5 million adults are significantly affected by a family member’s illegal drug use.

16. Although the Drug Strategy is committed to reducing all illicit drug use, most treatment and recovery services focus on overcoming dependency, the most serious manifestation of drug misuse. Drug dependency is a health disorder with social causes and consequences. In medical terms, it is a chronic condition characterised by relapse and remission.

17. However, it does not fit the popular medical stereotype of diagnosis, treatment, and cure, since there is no instant remedy. Many services are provided by the NHS, but increasingly they also come from the voluntary sector, with clinical expertise provided by specialist GPs and addiction psychiatrists.

18. While any problem drug use has serious consequences, cocaine and heroin are the most damaging illicit drugs in terms of their health impact and social cost. The government acknowledges that drug dependency is a key factor in crime, family breakdown and poverty, which together cause misery and pain to individuals, destroy families, and undermine communities.

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DRUGS AND PUBLIC HEALTH

19. Drug misuse is associated with significant public health harms, although the public health system in England has a good track record of addressing them.

20. Up to 10% of all new HIV infections worldwide occur through injecting drug use, and current or former injectors are also particularly vulnerable to the hepatitis C virus. The HIV rate among English injecting drug users (IDUs) is currently less than 2%, and new diagnoses in the UK are the fourth lowest in Western Europe.8, 9, 10

Nevertheless, NICE estimates that the combined crime and healthcare costs of each IDU adds up to £480,000 over their lifetime.11

21. About a third of IDUs report an abscess, open wound, or sore as a result of risky and un-hygienic injecting practice. Estimates of the annual healthcare costs associated with injection site infections range from £15—£47 million per year, mostly in hospital admissions for treating MRSA and severe bacterial infections.12

22. Heroin users run a high risk of premature death through overdose, particularly through injecting.13 This pattern is found worldwide, and in many countries (including the UK) deaths from drug misuse account for as many deaths as road traffic accidents among males. Research also shows that addicted prisoners are at increased risk of drug-related death in the weeks immediately after release.14, 15

23. So if public health is about preventing disease, prolonging life and promoting health, then tackling dependency on dangerous drugs is a classic public health issue. Successive governments have recognised the risk to society of spreading blood-borne viruses through injecting, the prospect of premature death from overdose, and the damage individuals do to their health and well-being by misusing drugs.

24. However if clinical need was the only criteria for investment, drug misuse would not be top of the healthcare priority list. The annual toll from drug-related deaths—1,700—is relatively small besides, say, the 115,000 people who die every year from smoking-related diseases. The case for tackling drug dependency rests also on the wider social impact of drug misuse.16

DRUGS AND SOCIETY

25. According to research endorsed by the Home Office, problem drug use costs society £15.4 billion a year, of which £13.9 billion is attributed to crime committed by drug dependent offenders.17

Crime

26. Addicted drug users commonly commit acquisitive crimes such as shoplifting, burglary or robbery to fund their habit. Some also take up other economically motivated crimes such as prostitution, while others resort to begging. The illicit drugs market often uses violence to regulate itself, and the fact that drugs can reduce inhibitions and increase aggression means that drug use is linked to anti-social behaviour and violent crime. Factor in drugs law offences, drug driving and money laundering, and drug misuse contributes significantly to the crime burden and policing costs of any local area.

27. Between one-third and a half of acquisitive crime is estimated to be drug related. Recent research (2008) which matched anonymised data from the Police National Computer to information in the NDTMS, showed that the total number of crimes committed almost halved following the start of treatment.18

Safeguarding vulnerable children

28. Parental substance misuse is a significant risk factor for children. About one in every hundred babies are born each year to women with serious drug problems.19 About three out of every hundred children under 16 have parents with problematic drug use (although not all these children will be actually living with their

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parents). The problem drug use of other family members such as a parent’s new partner, siblings, or other individuals within the household also put children at risk of significant harms, including prejudicing their educational attainment.

Families and communities

29. Serious drug problems profoundly impact on the family members and carers of drug users. A drug problem often hits family finances and can lead to feelings of anxiety, worry, depression, helplessness, anger and guilt among family members.20 The stigma associated with drug addiction within the family often means that affected family members are reluctant to seek professional help.

30. Drug misuse also fuels welfare dependency, worklessness and social exclusion and has a negative impact on local communities who face a rise in anti-social behaviour and higher levels of crime. Deprived areas usually suffer most, frequently becoming a focus for drug dealing that can fuel a cycle of decline and lead to heightened levels of fear and intimidation among local residents.

A cross-government response

31. Reducing both the problems caused by illicit drugs misuse and the adverse health and crime outcomes associated with it has been a key policy goal since the threat of HIV/AIDS came to public attention in the 1980s. While the Home Office has lead responsibility for drugs policy, and the Department of Health pays for healthcare and treatment services, other departments have a legitimate interest in aspects of the subject—notably MoJ, DWP, DfE, DCLG and Cabinet Office. The rationale for creating the NTA as a special health authority in 2001 was to ensure that NHS funds were spent on providing services whose primary benefit was crime reduction. Currently the Inter-Ministerial Group on Drugs, chaired by the Home Office drugs minister, exercises cross-government scrutiny of all strands of the Drug Strategy.

TREATMENT AND RECOVERY SERVICES

32. Addiction is treatable, but no single treatment is appropriate for everyone. For example, substitute prescribing is recommended by doctors as the first-stage treatment for heroin addiction, but is not available for cocaine addiction. Good treatment attends to the medical, psychological, and social needs of patients with a balance of pharmacological and psycho-social interventions. Drug workers seek to get addicts better and to help them become free of dependency. They also support addicts to be active citizens, take responsibility for their children, earn their own living, and keep a stable home. Hence treatment is the first step on the road to recovery.

33. The Government currently spends about £800 million a year to ensure a balanced range of drug services in the community in line with the evidence of what works. About 70% of the funding comes from the centre through the pooled treatment budget, the rest is supplied locally by Primary Care Trusts (PCTs) and Local Authorities. In addition about £200 million is made available for alcohol treatment directly through PCTs. There is separate funding for treatment in prisons.

34. Provision is currently commissioned by 149 local partnerships, originally called Drug Action Teams but increasingly known as Community Safety Partnerships, representing health, local government, police and probation. Under the government’s plans, the commissioning role will migrate to Local Authorities supported by Health and Well-Being Boards.

35. The Government has indicated PHE would have a ring-fenced budget of at least £4bn to allocate to the expanded public health role of local authorities.

36. An investigation by the National Audit Office in March 2010 acknowledged that treatment delivers value for money for the taxpayer. It cited the Home Office research finding that every pound spent on treatment delivered £2.50 worth of benefits to society, mostly by cutting crime but also in reduced health and social costs.21

37. Three-quarters of the public believe drug treatment is a sensible use of taxpayers’ money, as long as it benefits individuals, their families and communities. But if they have to choose, most people say the greatest benefit of drug treatment is that it makes their communities safer and reduces crime.22

May 2011

22 Findings from an NTA commissioned MORI survey of public opinion in 2009.
Supplementary written evidence from the National Treatment Agency for Substance Misuse (PH 04A)

BACKGROUND ON THE NATIONAL DRUG TREATMENT MONITORING SYSTEM

The National Drug Treatment Monitoring System (NDTMS) began as a research project in Manchester in the late 1980s. Clinicians completed a form on all new clients, and sent it to researchers at the University who entered information onto a database. This mechanism successfully tracked changing drug use patterns among those seeking treatment. During the 1990s this reporting system was taken up by the Department of Health (DH) and rolled out to the rest of England as the Regional Drug Misuse Database. The data was published annually as a national statistic.

After 1997, the government wanted a mechanism to measure the manifesto commitment to double the number of people being treated. The Regional Drug Misuse Database did not count how many people were treated, only the number of new clients entering treatment. The proposed solution was a second form that all services would return for each client seen. DH commissioned a new database from Serco in 2001, now formally called the NDTMS.

Problems soon emerged around the considerable burden imposed on treatment providers by the additional reporting requirements. Few completed the forms, and compliance fell below 50% in 2001-02. Statistics were estimates that often bore little resemblance to the reality, leading to a loss in confidence in the system throughout the field.

A new arms length body, the National Treatment Agency (NTA) was formed in 2001 to manage the drug treatment system. The NTA had its own information requirements but these were not met by the existing NDTMS system of paper forms. In addition, the NTA needed information closer to real time—not the 18 months it took to turn paper forms into statistics.

By 2003, NDTMS had effectively collapsed with a loss of credibility and compliance. The NTA took over responsibility and decided on a radically different approach, basing all data capture on a clinical data-set that would be embedded in front-line clinical systems. In effect, this changed NDTMS into a (nearly) real time administrative system that produced statistics as a by-product.

To support the collection of data from around 2000 different clinical services, the NTA worked closely with clinical software providers to embed the dataset. The NTA also produced a simple web-based data capture tool which was aimed at smaller clinical providers with no clinical systems.

The immediate impact was greatly improved compliance. Confidence in the statistics (now produced monthly, one month in arrears) returned, and commissioners adopted NDTMS as the source of data for contract monitoring. The system was increasingly used for performance management ratings, underpinning Healthcare Commission ratings for drugs services.

Over the next few years the system improved still further, as the combination of publishing a data-set and running an in-house software accreditation scheme encouraged new software suppliers to enter the market with innovative products. Today nearly all treatment providers have commercial clinical systems.

NDTMS is now one of the most comprehensive data sets in daily use in the NHS. While the volume of data collected centrally has grown significantly, the strategy of embedding the standard into routine clinical record keeping has mitigated the impact on clinical services. Compliance is close to 100%, although there are some gaps because not all independent or voluntary sector providers of residential services supply returns. However the scope of the system has been extended to cover alcohol treatment and young people’s substance misuse services, and plans are underway to include data from the prison estate.

June 2011

Written evidence from the NHS Confederation (PH 05)

INTRODUCTION

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services.

We are pleased to submit evidence to this inquiry. We have consulted extensively with our members throughout the NHS and public health reforms and our submission aims to address the issues they identified.

1. EXECUTIVE SUMMARY

— We strongly welcome Healthy Lives, Healthy People’s aim of making public health a top priority in both health services and local government. We believe the reforms provide a major opportunity to improve the health of the population. In particular we welcome the increased priority given to ensuring closer joint working between local government and the NHS, as well as addressing the root causes of poor health and well-being. However, we believe the Government must rethink a significant number of its proposals to avoid unintended consequences.
— It is crucial that the new public health system is—and is seen to be— independent, impartial and evidence-based. In particular:

— The public health advice currently provided to government by the Health Protection Agency (HPA) and public health observatories needs not only to be independent but also to be perceived as independent. It will be difficult for Public Health England (PHE), a government department, to achieve this.

— With responsibility for public health being transferred into local government and PHE, it will be important for public health professionals to retain their ability to speak independently. This should not be compromised by whoever is their employer.

— More thought needs to be given to how the research and scientific advice functions currently within the HPA could remain independent from government. In addition, thought needs to be given to how PHE could be enabled to hold research grants. The HPA generates much of its own funding through commercial and international contracts and research grants. Once these functions become part of PHE they will no longer be seen as independent and the HPA's ability to generate these funds will be compromised. If solutions cannot be found, it is likely to cost the Department of Health more to bring these functions within PHE than it would to leave the HPA as an independent organisation.

— Commissioning consortia constitutions will need to set out how they will engage public health professionals to connect independent public health expertise with the commissioning process. Adequate funding for this is required and Local Government will need to support public health teams to engage with consortia.

— Our members are concerned that local authorities may not have enough money to commission and deliver all the public health services that they will be responsible for. While the public health budget will be ring fenced, we emphasise that it is not easy to define “public health” and therefore to identify public health activity and spend accordingly. Adequate funding is particularly important, given the impact on the rest of the health service if public health needs are not met.

— We are deeply concerned about unintended consequences that are likely to result from the Government’s plans to use a health premium to reward those areas that reduce health inequalities with extra money. We fear that this may not fairly reward progress and may lead to areas where there is most need losing money. Our submission sets out a number of suggestions to help ensure the new funding system better reflects local circumstances and avoids unintended consequences.

— We are also very concerned that it is unclear how safeguarding of vulnerable children and adults will work in the new system. We argue that responsibility for this should be transferred to local authorities along with their new public health responsibilities and the government should ensure that safeguarding is part of the three outcomes frameworks in an explicit and coherent way.

— We strongly support the decision to give greater priority to improving public mental health. The public health outcomes framework must mirror the priority given to public mental health in the public health white paper and PHE must be given explicit responsibility for improving public mental health and well-being.

— Accountability of the constituent parts of the new public health system, including Public Health England (PHE), commissioning consortia and health and wellbeing boards, must be improved. In particular, commissioning consortia should be accountable both to PHE and to local health and wellbeing boards.

— We are concerned that people’s needs could fall between the gaps unless the way in which the different elements of the new system will work together is improved. Potential solutions include:

— Commissioning services such as immunisation or sexual health as packages rather than fragmenting their commissioning as currently suggested.

— Agreeing how decisions will be taken across populations within and across local authority and commissioning consortia boundaries.

— Establishing specialist subgroups of health and wellbeing boards responsible for integrated child health and safeguarding services, and clarifying how these will be commissioned.

### 2.0 The New National Public Health Service

#### 2.1 The public health reforms strengthen the role of the Secretary of State in public health by abolishing the Health Protection Agency (HPA) and the National Treatment Agency for Substance Misuse and establishing a new national body, Public Health England (PHE), which will be a government department. The reforms also reduce the autonomy of public health bodies and professionals and increase political involvement at national and local government levels. We believe PHE should have similar accountability mechanisms to other parts of the health system. Therefore we recommend that PHE should:

— be required to comply with Nolan principles of public life and have a properly established board, which meets in public and publishes its board papers;
— be accountable to health and well-being boards through the director of public health; and
— support health and well-being boards as they develop their capacity to produce Joint Strategic Needs Assessments and health and well-being strategies collaboratively.

2.2 The HPA delivers an internationally respected, integrated health protection service, conducts research and provides independent scientific advice. The HPA generates approximately £140 million of non-grant-in-aid income annually. Approximately half of this funding is sourced commercially, through contracts with companies and organisations in the UK and abroad. The HPA is also currently eligible for government funding for research through the Medical Research Council, the EU and other bodies. This externally-funded activity contributes to the HPA’s preparedness and response capacity. Under the current plans PHE, as a government department, will no longer be seen as independent and this will compromise its ability to secure commercial work. The loss of independence will also leave it ineligible for research funding. This is likely to mean the health protection functions will cost the Department of Health more to provide as part of PHE than if the HPA remained as an independent organisation. Furthermore, during a public health crisis the advice provided to government not only needs to be independent from government but also needs to be perceived to be independent. In the new system it will be difficult for PHE, a government department, to be seen as independent. We recommend that:
— a robust and credible solution is found to maintain the independence from government of the scientific research, advice and intelligence currently provided by the HPA and public health observatories; and
— a solution is found to allow PHE to hold a research grant from grant-making or commercial bodies.

2.3 PHE will need to be able to mobilise resources and coordinate complex multi-agency responses (for example, the response to swine flu) across the NHS and local authorities. There are currently 26 Health Protection Units (HPUs) in tier two of local authorities and approximately 150 directors of public health in tier one. We recommend:
— PHE should agree clear roles and responsibilities for emergency preparedness and response at national, sub-national and local levels. This must include connection and coordination of the work of directors of public health with that of the HPUs.

2.4 The valuable research work currently carried out by public health observatories and the HPA must be incorporated into the new system. If this can be achieved in a way that connects sub-national/regional intelligence gathering with work done locally this will help maintain and value the public health skills required at local levels. We recommend:
— public health specialists should continue to have access to the public health data held within the NHS, the Office of National Statistics and local authorities; and
— data collection requirements are relevant and able to measure health inequality outcomes within and between areas but are kept to a minimum to avoid over burdening service providers.

2.5 We are concerned that during the transition to the new system, expertise could be lost and public health services, including arrangements for handling public health emergencies, could fail to deliver. We recommend:
— the Government clarify as quickly as possible the future home for all remaining public health functions currently performed by PCTs;
— local authorities are given an indication of future public health budgets sooner than 2012-13 to help plan for transition and staff recruitment; and
— interim arrangements should be developed to safely maintain existing capabilities for handling public health emergencies.

3.0 THE FUTURE ROLE OF LOCAL GOVERNMENT

3.1 We welcome the strengthened role of local government, which is uniquely placed to work across sectors including education, leisure, transport, housing and economic development. However we are concerned that local government accountability arrangements in relation to their public health responsibilities are not sufficiently robust. We recommend:
— local authorities are made accountable to PHE for their delivery of public health outcomes, as local authorities’ public health functions will be funded by PHE; and
— the government introduce a duty for local authorities to reduce health inequalities, given the crucial impact local authorities can have in this area. Currently only the NHS commissioning board, commissioning consortia and Secretary of State for Health have duties in the Health and Social Care Bill 2011 to reduce inequalities in relation to their role within the health service.
3.2 By bringing together all the key players, health and well-being boards could improve integration between different services locally. However their powers and responsibilities are not sufficiently clear. We believe the boards should have freedom to focus on the issues of greatest local importance but should also be accountable for their decisions. It will be important for health and well-being board decisions to be guided by independent evidence and look beyond short-term political considerations. We also recommend that:

— health and well-being boards should comply with the Nolan principles of public life, meet in public and publish board papers to ensure there is transparency in their decision making;
— commissioning consortia should be accountable both upwards to the NHS Commissioning Board and locally to health and well-being boards for delivery of their part of the local health and well-being strategy; and
— clear and consistent advice, guidance and training is provided to support health and well-being board members in taking on their new roles to improve the health of the local population.

3.3 Independent, impartial and evidence-based input from highly trained public health specialists will be crucial to the success of the new system. By moving to local authority employment, public health staff lose the protection provided by the NHS Constitution and the right to whistle-blow. Our members strongly believe that:

— provisions are required to ensure public health professionals retain the ability to independently assess and report on public health. They should be able to make evidence based statements which may not coincide with the views of their employers.

4.0 Commissioning

4.1 More thought needs to be given to how the different elements of the system will work together as a coherent whole. The reforms suggest that in many areas services will be commissioned by multiple bodies. For example, three different bodies will commission elements of the immunisation programme, and local authorities will commission sexual health services but the NHS Commissioning Board will commission HIV services. This could easily result in services that do not meet people’s needs as they fall through the gaps between the different commissioners. As the skill set required to commission these services is the same, duplication of effort and inefficiency is also likely. We recommend:

— immunisation, sexual health and other public health services are jointly commissioned as a package between commissioning consortia and public health departments within local authorities; and
— more clarity is provided about how the various parts of the system will work together to commission services that are joined-up and easy for the public to access.

4.2 Public health and mental health services have developed effective ways of working together through joint appointments and collaborative commissioning initiatives. The Total Place pilots also demonstrated the potential of integrated working beyond health and social care. We recommend:

— the government provide more information on how place-based budgeting could operate in the new system; and
— localities are supported by PHE to develop integrated and joined-up working, in the new structures, for example by sharing learning from integrated commissioning models.

4.3 In some areas, commissioning consortia may have a different geographical footprint to the health and well-being board. This will make it difficult for consortia to commission on a population-wide basis in collaboration with local authority colleagues. We recommend:

— consortia boundaries should have a rational relationship with local authorities for both planning and public health purposes; and
— the government puts in place clear arrangements for making decisions that need to be taken across a larger population than consortia will cover but should be taken as locally as possible, for example, disabled children’s services. We believe there are two potential options for achieving this. The Government could charge consortia with coming together to take decisions that impact on populations that are greater than the areas they service. Alternatively it could ask the NHS Commissioning Board to take on this broader coordination role. It is important that this is resolved quickly.

4.4 It is vital that commissioning consortia and the NHS Commissioning Board engage and receive support from public health professionals to inform commissioning decisions. Adequate funding is required to achieve this. We recommend that:

— consortia constitutions should set out how they will engage public health professionals in the commissioning process. Local Government will need to support local public health teams to do so.
4.5 Primary care delivers a large proportion of health improvement interventions so its performance is crucial. Under the current proposals, PHE will fund the public health elements of the Quality and Outcomes Framework (QOF). But the NHS Commissioning Board will be responsible for both negotiating changes to the QOF and monitoring GP performance. We recommend:

— wherever possible the NHS Commissioning Board should delegate responsibility for managing GP performance to consortia so that they are able to manage primary care locally; and
— the NHS Commissioning Board is required to consult PHE on changes to the public health elements of the QOF to help ensure these complement other incentives on public health. Dialogue between the NHS Commissioning Board and PHE is required to ensure that changes to the QOF are negotiated in line with the rest of the GP contract and are managed so as not to disenfranchise GPs, given their vital role in public health.

5.0 Public Mental Health and Well-Being

5.1 The public health white paper presents the most comprehensive understanding of mental health within national public health policy to date. We strongly support the increased priority given to improving public mental health. To give the best chance of delivering on this key aim, we recommend:

— The public health outcomes framework must mirror the public health white paper’s focus on public mental health and overlap with the objectives of the mental health strategy, the education white paper, and the NHS outcomes framework. We support the idea of “well-being” as an outcome measure.
— The new system puts more emphasis on meeting the physical health needs of people with mental health problems and the psychological needs of people with long-term conditions in order to reduce health inequalities.
— The findings of Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system are fully implemented.

5.2 To ensure progress towards making public mental health and well-being a priority throughout the system, PHE will need to support emerging leaders of new organisations to develop partnerships and understanding of public mental health. We recommend:

— PHE be given explicit responsibility for improving public mental health and well-being through research, sharing evidence and good practice, developing guidance and providing funding and support for joined up commissioning and implementation;
— PHE develops and integrates training and awareness-raising on improving public mental well-being for front line professionals, to enable early intervention;
— Health and well-being boards support employers to incorporate and implement staff well-being initiatives and approaches.

6.0 Children’s Public Health

6.1 We believe the Department for Education’s remit for child health has been diluted and the approach to child health in the NHS reforms is fragmented. In the public health white paper there is also limited focus on the health of young people.

6.2 Commissioning children’s health services is often a complex, interdisciplinary and interagency process and in the new system it is not clear which commissioners will do what. In general, child health professionals do not consider the current system to work effectively enough and they are concerned that the new system will be less effective in meeting children’s needs. We recommend:

— the government clarifies how PHE, local authorities and the NHS will commission and deliver appropriate services for children and young people, including which commissioners will be responsible for which elements of children’s health services;
— specialist sub-groups of health and well-being boards are established in line with local requirements, with responsibility for ensuring integrated child health and safeguarding services are provided;
— public mental health and well-being is addressed in schools and initiatives target groups of children and young people who are most at risk; and
— the government clarifies how the new health visiting service will work. The health visitor service needs to be a multidisciplinary service and health visitors must be integrated with other teams of public health professionals.

6.3 We want to ensure the progress made in safeguarding the most vulnerable in society over the past few years is not lost as the reformed system develops. There is very limited reference to safeguarding in the reforms. It is unclear which organisation or officer will have responsibility for continuing to develop local safeguarding systems within and across different services. As commissioning consortia boundaries may not be coterminous with local authority boundaries, it is also not yet clear how local safeguarding boards will work across NHS and local authority services. There should also be recognition of the need for specialist skills and...
planning to ensure training for named and designated professionals is an integral part of workforce development. We recommend:

— The processes that are currently working well should be replicated or retained in the new system. For example, networks for named and designated professionals in the NHS to learn from each other, discuss issues of common interest and develop new local guidance should be maintained and supported locally; and

— As the public health service transfers to local government, safeguarding and particularly the commissioning of the designated professional role should be transferred as part of this, with the funding explicitly identified within the public health budget.

7.0 Public Health Outcomes Framework

7.1 We support the shift to measuring public health through outcomes and welcome the overlap between the public health, social care and NHS outcomes frameworks. However there is often a time lag between implementation of public health initiatives and achieving health improvements. We recommend:

— outcome indicators monitor the impact on key determinants of health such as housing and employment over long periods; and

— the overlap between the public health and NHS outcomes frameworks need to more clearly articulate the role of public health in NHS services.

7.2 We are concerned about the lack of overlap or alignment of the various outcomes frameworks or cross referencing to other guidance. For example, the proposed Public Health Outcomes Framework contains one element on safeguarding specifically targeted at children under five years of age, the proposed Social Care Outcomes Framework contains one element on adult safeguarding and the NHS Outcomes Framework has no element relating directly to safeguarding. We recommend:

— the government ensures that safeguarding for both children and vulnerable adults is part of the three outcomes frameworks in an explicit and coherent way.

8.0 Funding Public Health Services

8.1 Our members are concerned that local authorities may not have enough money to commission and deliver all the public health services that they will be responsible for. While the public health budget will be ring fenced, we emphasise that it is not easy to define “public health” and therefore to identify public health activity and spend accordingly. Adequate funding is particularly important, given the impact on the rest of the health service if public health needs are not met.

8.2 Extra funding for more deprived areas is to be welcomed. However, we are deeply concerned about unintended consequences that are likely to result from the Government’s plans to use a health premium to reward those areas that reduce health inequalities with extra money. We fear that this may not fairly reward progress and may lead to areas where there is most need losing money. We are concerned that areas with high levels of population movement—which are often the most deprived—could unfairly lose funding due to slower progress. We also note that high levels of deprivation can be found in pockets of more affluent areas as well as across whole boroughs. The health premium would work very differently in different areas, and a one-size-fits-all approach will not be appropriate. In addition, if the current approach to funding allocations continues, this could mean areas that succeed in reducing health inequalities are rewarded by the health premium but may be simultaneously penalised by a reduction in their overall public health funding allocation due to the improvement in their deprivation indicators. We recommend the Government:

— review the health premium mechanism and evaluate it as it is put into practice;

— take local circumstances into consideration through proportional benchmarking of local areas with similar levels and patterns of deprivation, population movement and demography;

— develop other levers and incentives to catalyse action to reduce health inequalities across sectors; and

— work to avoid unintended consequences from the interaction of the health premium with other funding mechanisms.

9.0 Public Health Workforce

9.1 Public health must continue to be seen as a specialism and providing statutory regulation for senior specialists and voluntary regulation for practitioners would contribute towards ensuring this. Continuous professional development is required and public health specialists will need to remain connected to academic public health research. We agree with the recommendation from Dr Gabriel Scally’s review, that specialist public health professionals should be subject to statutory regulation and the Health Professions Council could act as the professional body for this function. Qualified public health consultants with medical and non-medical backgrounds must be part of the regulatory system. Voluntary regulation is appropriate for public health practitioners.
10.0 RESPONSE TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

10.1 We are pleased that the public health white paper aims to address five out of six recommendations from the Marmot review. However it does not respond to the recommendation for a healthy standard of living for all. As the public health outcomes framework is a cross government one, it will be important for other government departments to consider how they can help improve health. Our members believe that decisions about public sector services should be informed by evidence of the potential impact on public health. We are concerned about the risk that cuts to services may adversely affect the health and well-being of poorer communities and affect public engagement initiatives. We recommend:

- when central and local government look for savings, they take into account the impact on public health and avoid increasing health inequalities.

May 2011

Written evidence from the Health Protection Agency (PH 06)

SUMMARY

1. The Health Protection Agency (HPA) welcomes the opportunity to contribute to this inquiry.

2. In preparing its response to the white paper, “Healthy Lives, Healthy People”, the Health Protection Agency identified positive benefits for public health that will flow from the proposals but also some issues and risks that need to be considered and addressed in order that the benefits are fully realised.

3. Since publication the HPA has been working with partners, including in particular the Department of Health (DH) and the Association of Directors of Public Health, to fully understand the implications of the proposals and how they will be implemented.

4. We welcome the Government’s commitment to public health and remain of the view that overall the white paper proposals present a positive opportunity to develop and improve the wider public health system in England, and indeed to create a world-leading public health system that will begin to address the important issues raised by the Marmot Review.

5. To realise this vision the proposals must embrace a whole system approach to public health and remain of the view that overall the white paper proposals present a positive opportunity to develop and improve the wider public health system in England, and indeed to create a world-leading public health system that will begin to address the important issues raised by the Marmot Review.

6. We also, however, remain concerned about some aspects of the implementation that we believe are still unresolved and carry risks for the future success of Public Health England (PHE), and so the wider system, which we would invite the Committee to consider.

7. These key issues are:

(a) Independence: there is a risk of losing independence (or perceived independence) in PHE as currently envisaged.

(b) Expertise: there is a risk of losing critical scientific and public health expertise.

(c) Clear Roles and Responsibilities: the nature of the local relationships between PHE (especially local units) and Directors of Public Health in local authorities.

(d) Emergency Preparedness, Response and Resilience Capability: maintaining, and strengthening, emergency preparedness, response and resilience (with particular concern about the timing in relation to preparedness for the London 2012 Olympic and Paralympic Games).

(e) Operating Model: the need for PHE to be established in a way that will encourage a culture and ethos that focuses on the needs of the population, a sense of unity within the public health community, and supports career paths to develop rounded public health professionals.

DISCUSSION

8. The white paper “Healthy Lives, Healthy People” set out a vision for a public health system for England that aspires to be one of the best in the world—building on the existing excellent public health expertise across the range of public health bodies. The vision is a cohesive public health system based on locally led delivery supported by a new national expert public health service, PHE.

9. The realisation of this vision through the devolution of responsibilities and budgets to local authorities and the implementation of PHE will arise from three key founding principles:

(a) empowering communities to address their own particular needs and giving them the tools and support to do so effectively;

(b) integration of public health services from national to local level, with national expert centres supporting the delivery of excellent public health services at the local level to achieve improved outcomes, and
10. PHE will bring together expertise in high quality epidemiology, intelligence and information analysis from across public health, including the Public Health Observatories, Cancer Registries, the HPA’s national epidemiology centres as well as local and regional public health departments across the health service. The synergy between these groups will create the opportunity to develop new ways of working, allow greater effectiveness and efficiency, and substantially improve and develop the evidence and knowledge base for effective public health interventions. Working closely with local authorities and the NHS will lead to greater impact in tackling the causes of ill-health and poor wellbeing, as well as strengthening the national emergency response capability.

11. PHE will also inherit a proven model of national expert HPA centres working to support local delivery in a seamless, consistent, science-driven and quality-assured system.

12. Together, these will create an organisation with the knowledge, capacity and authority to lead the public health system and support local innovation to deliver real improvements in the health of the public. Local communities, supported by this national expert body, will be empowered to build a stronger healthier country.

**Independence**

13. Independence (real and perceived) of scientific and public health advice to government, at national and local level, is essential if it is to be seen as credible within the scientific community and by partners and stakeholders; if it is not seen as credible it will not be effective. Equally when giving advice to the public, independence is one of the most significant factors determining how the public will receive and respond to that advice.

14. The HPA has, over the 8 years of its existence, developed a reputation with the public, the public health profession, and with the scientific community, for the provision of effective, high quality, and evidence-based public health advice. This confidence of the public in the HPA and its advice has been tested and confirmed in surveys. The independent status of the agency and its statutory right to publish its advice have been an important element in ensuring that confidence.

15. We believe it is essential that PHE builds on that reputation and maintains the same level of public and professional confidence across its wider range of public health responsibilities if it is to be an effective leader and deliver health improvement through supporting people to make better choices about health risks. If PHE is viewed as part of a department of state we believe that its independence, and therefore its credibility, will be seen as seriously compromised. PHE needs to have a distinct identity from the Department of Health and have its independence guaranteed in its constitution. It is notable, for example, that the significant loss of public confidence and trust in the advice of “government scientists” following the BSE incident was partly because they were seen to be part of the government establishment and “not independent”. This was one of the original drivers behind the establishment of the independent HPA and we are not aware that this requirement has changed.

**Expertise**

16. The HPA has also built up an internationally respected body of scientific expertise which should be transferred to PHE as part of its core capacity. That expertise derives in part from, and is funded to a significant extent by, the research and commercial activity that is an integral part of the HPA. Critically the staff involved provide a significant part of the agency’s response capacity in incidents. This has been amply demonstrated in many incidents, most recently by the UK response to the Fukushima nuclear reactor incident where the staff developing advice for the UK were those supported by research and commercial activity. Without this, in future PHE will either have substantially higher costs to the taxpayer or substantially reduced expert capability.

17. The HPA has been able to recruit and retain the highest quality of expert staff because of its reputation, the integration of research and commercial activity into its core business, and the ability of its staff to be influential with the scientific community, with government and with the public.

18. As a part of a government department these attributes will be at risk in PHE. PHE’s ability to compete for research funds will be severely reduced as the major funding bodies, such as the Medical Research Council, do not fund Government departments. The academic sector cannot fill the gap because, as noted above, it is essential that the expert capability is embedded in PHE to be available to directly support the frontline in real time.

19. In addition, it will be far more challenging to engage successfully in commercial activity both in terms of the willingness of prospective clients (including foreign governments) to trade directly with the UK Government and in respect of maintaining the necessary flexibility and responsiveness of structures and support systems within the environment of a Government department.

20. If there is also a perception that expert staff will be constrained in how they communicate and offer advice, both to the public and within the scientific community, by being within a government department of state, then PHE would cease to be an employer of choice for this calibre of expert. This would inevitably
reduce the capacity of PHE to deliver its core public health responsibilities and also damage “UK Plc” in terms of its scientific capacity and its international reputation for high quality science and translating research into successful frontline practice.

**CLEAR ROLES AND RESPONSIBILITIES**

21. It will be important to ensure clarity of roles and responsibilities for the organisations involved in delivering effective public health. A key element of the new public health service will be the transfer of some responsibilities and resources to the Local Authority to ensure delivery of agreed public health outcomes. Local Authorities will depend on the PHE (mainly through local PHE Units) to provide the right expertise and resources to support them in their role.

22. We believe the new public health system will be made stronger if each local authority is given statutory responsibility for the health of its local population, discharged through a properly qualified Director of Public Health (DPH). DsPH have this responsibility now in their PCT role and it is a significant tool in advocating for the health of the population.

23. Similarly, the current statutory responsibility of the HPA to protect the health of the population should be transferred to PHE along with the mutual duty of cooperation with other bodies with health protection responsibilities. PHE, with its specialist expertise, will therefore be responsible for identifying and leading the response to health protection incidents, including setting up Outbreak Control Teams. At a local level the local PHE Unit Directors will be acting on behalf of the DsPH, but will be professionally and managerially accountable via the national PHE structures to deliver this response function (giving the line of sight to SoS). PHE will be responsible for informing DsPH and keeping them updated, and the DsPH on behalf of their local authorities will wish to be assured that the response is being undertaken appropriately.

24. Our experience of outbreaks and public health incidents confirms that many (indeed most of the more complex incidents) cross local authority boundaries and require both coordination and leadership beyond the local authority level, and the seamless application of the specialist expertise currently available in Health Protection Units and the HPA national centres.

25. We are also conscious of the need in a national emergency for the Secretary of State to have a clear line to direct the response through one organisation, from national to local.

26. There needs to be a clear partnership between PHE (nationally and locally) and DsPH that ensures consistent, evidence-based support is available from the national to the local level to support local public health action.

27. This partnership would be facilitated if DsPH were formally part of PHE (for example by having a joint appointment with PHE and the local authority).

28. Ensuring clear responsibility for the population’s health nationally and locally will support the government’s aim of protecting the population with a clear line of sight from the Secretary of State to the “frontline”.

**EMERGENCY PREPAREDNESS, RESPONSE AND RESILIENCE**

29. Our response to the public health white paper highlighted the critical need to ensure emergency preparedness and response systems and resources are maintained both during the transition and in the new health system.

30. Considerable work has been done by the Department of Health, and key stakeholders, to mitigate this risk and there is emerging consensus on many aspects of how this function should be delivered across the health system and across government but there is not yet clarity.

31. The HPA is currently a “Category 1 Responder” under the Civil Contingencies Act. This is an important part of national capability for emergency response because it confers a duty on the agency to identify and prepare for health risks, to cooperate with others involved in emergency response and to warn and inform the public; but it also confers a duty on others to cooperate with the HPA.

32. The mutual duty to cooperate is not currently replicated under the proposed Health and Social Care Bill and we believe that it is important that PHE is designated as a Category 1 Responder to ensure that this capability continues in the new arrangements.

33. We remain concerned about the impact on Olympic preparedness of the pause in the progress of the Bill and the consequent delay in implementation of PHE.

34. Changing key elements of the Olympic response weeks before the start of the Games, and after the Games-time daily operational response has started, adds significant risk to a key national priority. The inability to live test the new system before implementation adds to the overall risk.
35. We are aware that a programme of work is underway within DH to address this issue but we feel this remains a risk until there is greater clarity about the proposed arrangements.

Operating Model

36. The framework within which PHE is established will have a significant impact on its culture and be a major determinant of both its success and its sustainability.

37. As noted above we believe establishing its independence and close partnership working with local authorities will be important to ensure it can be effective. This will enable PHE to provide leadership to the whole public health system, using its expertise and evidence to focus attention and action on those issues which will deliver the maximum benefit to people and communities across the country.

38. Showing how it is accountable to the public (as well as to parliament) will also be critical. The Parliamentary Committee on Public Administration looked at the government’s own tests for Arms length Bodies and set out recommendations on when public bodies should be established outside departments of state as Arms Length Bodies or Executive Agencies and described the importance of public accountability. We believe these arguments apply very directly to PHE.

39. PHE will also depend for its future on a dynamic exchange of specialist staff across the public health system including the NHS, and the training of the specialists of the future will depend on free movement of staff and trainees across organisations.

40. Variations in staff terms and conditions of employment between different parts of the public health system will be a barrier to this free movement and will therefore compromise the future development of the workforce. They should therefore be avoided unless there is a strong justification for introducing them.

Conclusion

41. We invite the Committee to consider these questions and encourage it to advise government to establish PHE in a way that will safeguard both its independence and its expertise and which will bring greater clarity to local roles and responsibilities and minimise any impact on emergency preparedness.

42. Further, and more detailed, information on these issues is included in our response to the white paper, “Healthy Lives, Healthy People”, and similar comments that have been made in the responses of many other professional scientific bodies such as the Wellcome Trust and the Faculty of Public Health. We would be happy to elaborate on any of these comments if that would be helpful.

June 2011

Supplementary written evidence from the Health Protection Agency (PH 06A)

At the Inquiry session on Tuesday 7 June you asked how we thought the local units of Public Health England (PHE) will work. As I explained, the local working for PHE is still being thought through and is not yet clarified. However the Health Protection Agency (HPA) already has a working model for our local units and I thought it might help the Committee’s consideration of PHE if I explained a little about the work of our Health Protection Units (HPUs)

The HPA has 26 HPUs as frontline delivery units working in the (current) nine regions of England. Each HPU consists of a mixture of specialist doctors, nurses and scientific staff. They each cover a defined local population with around one to three million people. Collectively, HPUs deal with over 4,000 significant public health incidents each year as well as working proactively with partners on a wide range of health issues.

Their primary function is providing advice to health professionals, patients and the public on reducing the impact of health risks such as communicable diseases and environmental hazards. This includes advising on the clinical management of cases of communicable disease, advising and arranging preventive treatment (“prophylaxis”) for people who may have been in contact with communicable diseases and leading on infection control measures in outbreaks. Some vignettes to illustrate the work of HPUs are shown below.

HPUs also advise on local strategies to reduce communicable disease such as immunisation programmes and the development of, for example, better sexual health services. HPUs are supported by the national and regional teams of the HPA to provide consistent, evidence based advice across the country and HPU staff have a direct connection to the scientific expertise of our national centres. HPUs are managed locally by a Director who is accountable to a HPA Regional Director, working within a national quality and governance framework.

When it was established in 2003 the HPA inherited over 120 small local teams from the NHS. Since 2003 the agency has reviewed the configuration of HPUs to ensure the best balance between local presence and maintaining a critical mass of expertise in the unit to ensure effective working and resilience. This has resulted in amalgamating the original 120+ units to the current configuration of 26 units.
TB Control – National to Local

At a local level, HPUs are notified of cases of TB that require some specialist action because, for example, they are in a school or health care setting with a risk to others.

The HPU will organise an outbreak control team and will assess the risk to other pupils, patients or staff. If the risk is considered significant the HPU, working with PCTs and the NHS, will organise testing and vaccination of those at risk and treatment for anybody found to be already infected.

As part of continuing innovation in health protection the HPA can now, through its laboratory network, offer specialist testing to identify different individual strains of the bacteria that cause TB. This allows us to recognise where different cases of TB are in fact linked to each other and may need more investigation. As with all our work this laboratory information feeds directly to the HPU who can then carry out the follow up investigations on the ground.

At a regional level, specialist epidemiology teams pull together the information about TB in their region and this helps HPUs, Directors of Public Health and clinicians plan the most appropriate services for their population.

At a national level the HPA collates all the surveillance information about TB and this allows the agency to monitor changing trends and spot new problems. The national teams are also the repository of all the international science and evidence collected about TB to ensure all our work, from national to local, is based on the best science.

Responding to Individual Cases of Communicable Disease

HPUs are contacted whenever a case of meningitis occurs in their local population. Their job then is to assess whether there is any risk to other people who have been in contact with the patient. HPU staff will speak to the patient and if necessary their friends and relatives to identify who has been in close contact with the patient. The HPU, working with the hospital or GP and the PCT, will then arrange for those people at risk to be prescribed a course of antibiotics to reduce the risk of them developing the illness.

Similarly HPUs are contacted about cases of measles. They will then speak to the GP and family to identify contacts of the case and offer advice about vaccination if they are not fully immunised against measles. The HPU will arrange for testing kits to be sent to the family to help confirm the diagnosis and importantly they will also assess whether there are any particularly vulnerable people involved and at risk. If so, they will arrange for protective immuno-globulin treatment to be made available from their regional centre for the local GP to administer to the contacts.

Responding to Major Incidents – The Litvinenko Affair

When Alexander Litvinenko died from poisoning with polonium-210 there was immediate concern about the possible health effects from polonium contamination in locations around London. The local response was led by the HPU who were able to work with the police and quickly adapt the skills normally used to investigate infectious disease incidents to help identify people who might have been exposed to polonium and assess their risk of health effects. This process allowed the HPU staff to interview and assess a very large number of people in a relatively short time, to identify over 700 people who needed further testing, to arrange the testing and report results back to patients.

Throughout this process the HPU was directly supported by experts from the agency’s national radiation centre in a collaboration that demonstrated the unique value of an all-hazards expert organisation.

I hope you, and your Committee, find this information helpful and I would of course be happy to elaborate on any issues should the Committee wish.

David L Heymann
Chairman
13 June 2011

Summary of Key Points

1. Public Health England—We support the proposal that Public Health England (PHE) is created as an independent, arms length body, with its function, accountabilities and relationship with Health and Wellbeing Boards specified on the face of the Health and Social Care Bill.

2. Directors of Public Health—In the long-term Directors of Public Health (DsPH) should be directly employed by local authorities, fully integrated in the senior management structures as key local leaders on public health. However, we recognise that in a minority of cases some DsPH could be seconded from PHE or another NHS body to local authorities on a temporary basis.
3. In common with other senior local authority officers, DsPH will have a duty to provide independent professional advice to elected members and to the Chief Executive. It is neither appropriate nor necessary for there to be national prescription of local accountability arrangements for DsPH.

4. We consider that their primary accountability to the council does not preclude DsPH having regional or national responsibilities in the wider public health service and for health protection.

5. Public health funding—The continuing uncertainties about the level of funding, the proportion that will go to local government and the scope of the public health grant are contributing to a high degree of insecurity that may undermine the new arrangements.

6. We strongly recommend that ring-fencing should be a temporary transitional measure with the aim of incorporating it into the RSG settlement within two years.

7. Outcomes framework—We propose a single shared outcomes framework to establish a minimal national data set, enabling HWBs the flexibility to identify and act on local health and social care priorities. The shared outcome framework would need to balance short-term and longer-term outcomes. Furthermore, we need to set outcomes for geographical areas, not people. Healthy and wealthy people tend to move from poorer areas to healthier areas, to be replaced by other poorer people with poorer health.

8. Local accountability of commissioning—HWBs need the power to “sign off” all plans—including GP commissioning plans, the NHS Commissioning Board’s plans for local commissioning and strategic local authority plans—that have a health impact to ensure that they give adequate consideration to health improvement.

9. A system that does not actively promote localism will not achieve the move from a top-down national approach to one which local areas identify and address their health and social care needs particular to their area.

LG GROUP RESPONSE TO SPECIFIC QUESTIONS

Should Public Health England be an arms length body?

10. The Local Government Group (LG Group) has consistently said that there is a worrying lack of any reference in the Bill to Public Health England, its role and budget. As a result there has been inadequate debate and a lack of clarity regarding the relationships and lines of accountability between PHE, local authorities, the NHS Commissioning Board and GP consortia.

11. The LG Group pushed for an amendment at the Commons Committee stage to put Public Health England onto the face of the Bill so that the nature of its business, functions and relationships could be openly debated and its role in the new health structure plain for all to understand and agree.

12. For the purposes of clarity, we support the proposal for PHE to be an independent, arms length body with clearly defined functions, remit and terms of reference. This would also enable public health employees to be seconded from to local authorities as part of transitional processes. However, we envisage that in most areas, Directors of Public Health (DsPH) will be directly employed by local government: it will only be in the minority of local authority areas where transitional arrangements will need to be put in place (see para 13 for further consideration of the role of PHE). PHE’s role, function, accountability and relationship with other components of the health system will need to be clearly stated on the face of the Bill.

Should the public health workforce be seconded by PHE England to local authorities?

13. In the long-term the LG Group promotes the full integration of the public health workforce within local government, in order for it to be fully accountable at local level and recognised as a valued part of the local government workforce. We envisage that in most areas this will happen within the timescale for implementing the Health and Social Care Bill. DsPH and other public health staff will be TUPEd across to preserve their existing terms and conditions of employment.23 However, we recognise that in some areas there will be a need for interim arrangements to provide security and clarity. In those cases, we see secondment from PHE to local authorities as a temporary arrangement, lasting no longer than two years.

14. We are currently discussing with all the major national public health stakeholders how to ensure a safely managed transition that avoids the loss of vital expertise, and an early resolution of complex resourcing issues. We hope to reach agreement in the near future.

15. There are resource implications for local authorities if the public health workforce continues to be employed outside local government. If PHE became the employer, then the vast majority of the resources for public health would be retained at national level. This is against the localist spirit of the public health White Paper and could work against DsPH having primary accountability to the local authorities and the population which they serve.

23 Transfer of Undertakings (Protection of Employment) Regulations.
Should DsPH be appointed at director level, accountable to the chief executive with access to senior cabinet members?

16. Many senior officers within local authorities—Directors of Finance, Directors of Adult Social Care, Directors of Children’s Services, and Chief Environmental Health Officers—have a statutory duty to offer independent professional advice to elected members. In practice the vast majority feel free to give impartial and independent advice to the chief executive and members of the council and cabinet. This is an essential component of the culture of constructive challenge that exists within councils. Indeed, the governance structure of councils is built on challenge throughout the policy making process from the leader and cabinet to the scrutiny function.

17. Ultimately, all senior employees of the council are answerable to the chief executive and have access to the leader, cabinet members and overview and scrutiny members. The DsPH place in the structure does not preclude this. It is not appropriate or helpful for central government to tell local government how to organise itself.

18. 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.

Should there be a requirement for DsPH to be trained and registered?

19. As with other professions in local government, we would expect DsPH to be properly accredited and trained. We support a system where the Faculty continues to register non-medically trained DsPH.

20. There are currently around 480 professional bodies representing staff working in local government. Local authorities will want to ensure that DsPH are fully trained, members of a recognised professional body and committed to continuous professional development.

21. We are concerned about how public health professionals transferring to local government will access training and continuous professional development. We believe for these purposes they should be considered a continuing part of the NHS and not subject to any levy as may be the case for private healthcare companies.

What should be the overall size of the public health budget and what proportion should go direct to local government?

22. We need urgent clarification of the overall public health budget. Establishing a reliable and realistic baseline for NHS expenditure on public health is proving challenging. The continuing uncertainty about the overall level of funding for public health, the proportion that will go to local government and the scope of the public health grant is contributing to a high degree of insecurity at local level that may undermine the new arrangements. It also makes it difficult for shadow health and wellbeing boards (HWBs) to identify the resources available to them to support local joint health and wellbeing strategies (JHWS) and the degree of flexibility they have in deploying resources. The BMA has estimated that the real cost of public health is around £5 billion—substantially more than the £4 billion quoted by the Secretary of State.

23. HWBs, in bringing together ring-fenced funding with other budgets, are best placed to oversee the budgets for public health given their responsibility for ensuring the coordination and integration of services to improve health and address health inequalities.

24. Local authorities already make substantial contributions to public health through mainstream plans and services—social care, early years, housing, environment and leisure, for example. But whatever the final public health budget, it is important that it adequately matches the responsibilities that are being passed to local authorities. This must be seen in the context of the unprecedented reduction in local authority resources—an average 28% reduction in the Revenue Support Grant from 2011-12—2014-15. It will be challenging for local authorities to make new commitments to public health if they are not adequately resourced to do so. Anything less would be a set up for failure.

What is the Local Government Group view of the ring-fence?

25. The imposition of a ring-fence is at odds with a truly integrated approach to addressing shared priorities and making the most of resources. However, we accept the short term and pragmatic need for public health funding to be ring-fenced to ensure that the total amount is transferred from PCTs and local authorities. We strongly recommend that ring-fencing should be a temporary transitional measure with the aim of incorporating it into the RSG settlement within two years. Furthermore, we propose that the grant be made with as few conditions as possible as this will enable local authorities’ maximum flexibility in how they use the grant. Such freedom will enable them to develop local solutions which make best use of local assets and resources to meet local health challenges identified in the JSNA and JHWS. The more conditions there are on the use of the grant, the less flexibility councils will have for innovation.
Health Premium—what are your main concerns?

26. In principle, the intention to reward progress in reducing health inequalities and improving health outcomes through the “Health Premium” is a good one. But there are many practical difficulties with this approach and several unanswered questions.

— Who will set the qualifying criteria?
— Will the Health Premium relate to achievement of national or local outcomes?
— Which local authorities will be eligible to receive the Premium? Will it be awarded to all local authorities that achieve their outcome targets or for a proportion that are the highest performing?
— How will we ensure that the Health Premium does not measure outcomes for individuals rather than health outcomes for areas? A common feature of deprived areas is that healthier and wealthier individuals move to more affluent areas to be replaced by poorer people with poorer health. How will the Health Premium take account of population change?

27. Financial rewards need to be balanced with resources to support communities that have the least assets and the greatest challenges in relation to health improvement. Government needs to work with the local government sector to ensure a flexible, localist, fair and transparent process for agreeing the criteria for incentives.

Explain your proposal for a single outcomes framework?

28. The LG Group has consistently argued for a single outcomes framework to achieve a number of priorities:

— 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.

29. There is a degree of alignment between the outcome frameworks but we feel that a single outcomes framework would represent a real commitment between local and national government, health, social care and public health to shared outcomes.

30. We envisage that a shared outcomes framework would establish a minimal national data set, enabling HWBs flexibility to identify and act on local health. The shared outcome framework would need to balance short-term outcomes, for example in reducing delayed discharges, with longer-term outcomes for reducing health inequalities and improving mortality and morbidity rates.

What are the challenges of measuring outcomes?

31. We need to set outcomes for geographical areas, not people. Healthy and wealthy people tend to move from poorer areas to healthier areas, to be replaced by other poorer people with poorer health.

32. 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. The area based break down of information may be complicated by the lack of coterminosity between local authorities, the areas covered by GP commissioning consortia and the areas covered by service providers. We have pressed for the Health and Social Care Bill to require the NHS Commissioning Board to consider boundary issues in the approval process for GP consortia.

Will there adequate public health input to GP commissioning?

33. We have called for stronger powers for HWBs to ensure that commissioning plans—including GP commissioning plans, NHS Commissioning Board plans for local services and strategic local authority plans—give adequate consideration to health improvement. HWBs need to have the power to “sign off” all plans that have a health impact. If, in the view of the HWB, strategic plans do not adequately address the public health needs identified by the JSNA and JHWS, they should be able to refer them back to the originator for further consideration and revision.

34. There is a risk of a dislocation between commissioning for public health and healthcare. The creation of the NHS Commissioning Board and PHE at national level, and GP consortia and HWBs at local level may lead to a separation of functions, which could detract from a coordinated approach and result in commissioners and providers of health services no longer being seen as agents of health improvement. HWBs have a vital role in ensuring that health providers and commissioners make an effective contribution to improved public health outcomes. But in order to fulfil this role, they will need the autonomy, authority and resources.

Public health commissioning—is there a serious risk of fragmentation?

35. The proposals create unnecessary and potentially damaging fragmentation—for example in children’s public health. There appears to be no clear rationale for the NHS Commissioning Board to be responsible for
children’s public health for the under 5s while local authorities are responsible for children’s public health from five to 19. School nursing, early years support and health visiting need to be coordinated at local level and it makes no sense for local authorities to commission some but not all of these services. A more sensible approach is for local authorities to be responsible for children’s public health throughout their childhood.

36. The relationship between PHE and local authorities will be important in the new public health landscape and it is still very unclear how this will work in practice. The White Paper proposes that PHE will be responsible for coordinating and commissioning public protection services and functions while local authorities will be responsible for the commissioning and coordinating health improvement services. However, there is a high degree of overlap between the two. This is best illustrated by considering responsibility for emergency preparedness and responsiveness. There is some conflict between the statement to “devolve public health leadership” on emergency preparedness and response and in the same section being seen as a “…core role that national government should perform”. We urge the Government to consider how national and local roles can be defined and coordinated. We propose that PHE be required to work in partnership with HWBs, attending as and when appropriate. Currently, there is no requirement on PHE to cooperate with HWBs.

37. The White Paper refers to the need for sub-national structures for PHE and for local authorities to set up their own supra-local structures to commission some services. We strongly recommend that PHE develops its plans for sub-national structures in partnership with local authorities so that they can be aligned with supra-local arrangements made by neighbouring authorities.

Where is the line between the national and local commissioning?

38. We believe in the principle of subsidiarity: commissioning health and public health services at the most locally appropriate level. A system that does not actively promote localism will not achieve the changes needed: to move from a top-down national approach to one which local areas identify and address their health and social care needs particular to their area. However, we accept there that may be a case for national coordination and commissioning specialist services with national or regional footprints but believe these should be the exception.

June 2011

Written evidence from the UK Faculty of Public Health (PH 58)

About FPH

1. FPH represents the specialist public health workforce in the UK. We are committed to ensuring that public health operates at the very highest of professional standards, underpinned by a strong evidence base. We work closely with a wide variety of organisations and sectors, including government, to promote and deliver lasting improvements in health and wellbeing.

2. FPH has submitted comprehensive responses to the Government’s proposed reforms in Healthy Lives, Healthy People. It was also a leading signatory on a letter to the Prime Minister outlining concerns around the proposed reforms (all available from www.fp.org.uk). Our position has been formed through extensive consultation with our members and other public health and health organisations.

Summary

3. The emphasis given to public health in the white paper and the Health and Social Care Bill is welcomed. Public health—through its three domains of health improvement (including people’s lifestyles, inequalities in health and the wider social influences of health), health protection (including infectious diseases, environmental hazards and emergency preparedness) and health services (including service planning, efficiency, audit and evaluation). All three domains need to be addressed actively by the public health system if the public’s health and wellbeing are to be protected and improved—reaching every corner of the community, at every lifestage. If supported by sufficient resources, public health interventions can improve and extend the lives of many thousands of people, saving the NHS—and society—millions of pounds.

However, FPH is gravely concerned that, if implemented without significant amendment, the proposed new arrangements will put the health of the public at risk through:

— undermining public trust and confidence;
— disrupting the public health system and services, including the ability to effectively respond to an emergency or epidemic situation; and
— fragmenting the public health workforce.

24 FPH defines public health as the science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society. www.fph.org.uk This definition was used by government in Healthy Lives, Healthy People.
4. A model for a new public health system in England which mitigates these risks:
   — places responsibility and accountability for protecting and improving people’s health firmly with local authorities at all times;
   — establishes Public Health England as an NHS body or executive agency providing independent and trusted advice, and employing all public health specialists;
   — embeds all three domains of public health throughout the system, including commissioning;
   — positions the qualified and registered director of public health as an influential, strategic leader responsible for managing the ring-fenced public health budget, and providing public health advice and expertise locally, including to commissioning consortia;
   — ensures that local authorities are supported by expert, embedded public health teams;
   — secures the continuance of public health training alongside other medical specialities to ensure the long-term viability of the profession;
   — ensures effective public health practice through a detailed understanding of the local context, dependent upon good working relationships, built on trust and mutual respect; and
   — supports a sustained period of stability to enable the new system to deliver the ambition of the reform.

Public Health—Everybody’s Business

5. In the era of the NHS, public health intervention has developed from its roots in the sanitary revolution to deliver a much broader range of health improvements. These include the clean air acts, improvements in road safety, tobacco control and the smoking ban of 2007, screening and immunisation programmes, health service planning, and commissioning and emergency preparedness.

6. To maintain momentum and reduce health inequalities, it is essential that public health measures are sustained, developed and enhanced, that they are properly resourced and that they are led with authority and expertise.

7. In an era of austerity, a firm government commitment to public health makes sound economic sense. There is a wealth of evidence to demonstrate that effective public health interventions can reduce the need for expensive health and care services. Public health expertise within the health services is also essential if the escalating costs of low benefit health technologies are to be controlled and health services commissioners are to have the knowledge to implement the most effective and lowest cost services.

8. The Government also needs to maintain and develop its health protection services at national and local level. Protecting the public from infectious disease, environmental hazards and disasters is a matter paramount to the protection of public safety. It would be negligent and reckless not to maintain the expertise that exists and develop it further in the face of future risks including new and pandemic infectious diseases, environmental threats and climate chaos.

9. The new system must also provide the expertise and infrastructure needed to assess risks to health, trends in ill health and health needs. For example, assessing the risks of alcohol to young people, reviewing trends in common and emerging diseases and addictions, and recognising the benefits of new drugs, medical procedures and vaccines. Public health expertise in this field has, for example, recently devised new risk stratification approaches to treating heart disease and identifying people at highest risk from diabetes, alcohol problems and frequent admission to hospital.

10. Public health is everybody’s business—but it requires specialist knowledge and leadership to be effective, to save lives and to reduce disease, disability and dependence.

Protecting and improving people’s health and wellbeing—an effective public health system for England

11. Ensuring the health and wellbeing of people, protecting their health, and reducing health inequalities requires an effective and resilient public health system, one which integrates all three domains of public health (health protection, health improvement and health services). The system also requires defined responsibilities and clear accountabilities, effective levers for change, and a sound and trusted evidence base.

12. FPH supports a model for a new public health system that gives local authorities (LAs) responsibility and accountability—at all times—for protecting and improving the health of their communities. This includes preparing for and responding to emergency and epidemic situations. The current government proposals on responsibility for ensuring co-ordinated action to protect the public—particularly in the event of another Bunsfield Depot Fire or E.coli outbreak—are unclear. This puts people’s health at significant risk. There must be a clear delineation of responsibilities for health protection at the local, sub-national and national levels, including those of the LA, the DPH, the NHS and any local outposts of Public Health England (PHE).

13. It is also vital that with incorporation of the Health Protection Agency (HPA)—currently a Category 1 responder—into PHE, the health protection function at all tiers (local, sub-national and national) is robustly maintained in the new system (and throughout transition) to ensure public protection.
14. In this new model, PHE would provide expert support and advice to LAs. Employing a large body of registered public health specialists, PHE would second many of them out to be embedded in LAs (working as part of the DPH’s team) and other organisations, where public health expertise is essential, including national and local commissioning bodies.

15. Ensuring public and professional trust and confidence in the expertise PHE provides is vital. Creating PHE as an NHS body or as an executive agency, at arm’s-length from the Department of Health (DH), would establish it as an independent, authoritative source of public health expertise whilst still providing the Secretary of State [SoS] with a clear line-of-sight. This would also allow the health protection function to continue essential grant/commercially funded research work—which will not be possible if as proposed it becomes a DH directorate. An independent PHE would be protected to some extent from political or other influence, perceived or actual.

16. Devolving responsibility for improving people’s health and wellbeing, and reducing inequalities to local level should not absolve government from its responsibility for this. We welcome the expressed duty within the Bill for the SoS to have regard to reducing inequalities. This should encompass the full range of interventions, including regulation, and should involve a multitude of approaches simultaneously. For example, implementing a 50p minimum pricing regulation on alcohol at the same time as undertaking public awareness campaigns on the harmful effects of excessive alcohol consumption, to ensure maximum impact.

### A strategic leader for health

17. Public health specialists are trained and qualified to assess the health needs and aspirations of their population. They work across the three public health domains, and make decisions that affect the health of tens of thousands of people. DPHs are the strategic leaders for public health in their area, providing—through their annual report—indepent analysis of the health needs of their local population and, equally important, a critique of how well those needs are being met and what more is required. It is vital that these functions continue in the new system. The Bill currently states that the DPH should produce an annual report on the health of their population but there is no explicit duty for it to also describe their health needs and extent to which these are being met. This should be rectified.

18. It is essential, particularly from a public protection perspective, that public health specialists, including DPHs, are trained and registered to specialist level in public health. Currently, the Bill does not does not require a DPH to be qualified. This needs to be rectified urgently in order to safeguard the public.

19. It is critical that the DPH is placed in a position of influence and authority within the LA, is directly accountable to the LA CEO, and has direct access to cabinet/councillors. They should be the principal advisor on all public health matters to the LA, including its elected members and the Health and Wellbeing Board (HWBB)—on which the DPH should have a statutory appointment), across all aspects of LA activity.

20. To ensure the SoS has a “direct line-of-sight” to specialist public health expertise at the local level, DPHs should have a contractual relationship with PHE. They should be jointly appointed by PHE and the LA, through a statutory appointment process (such as that which currently exists) and should only be sacked with the approval of both the LA and the SoS. This is important to ensure that only those public health specialists that are appropriately trained, registered and experienced are appointed—and to ensure that their ability to provide authoritative professional advice is not compromised.

### Understanding and meeting the health and wellbeing needs of local populations

21. Understanding the health and wellbeing needs of local communities requires an in-depth analysis and assessment of those needs. The joint strategic needs assessment (JSNA) should provide this, underpinning the commissioning of all local services relevant to health and well-being and informing the development of local health and wellbeing strategies.

22. An effective HWBB is pivotal to the success of the new local system. There is, however, a real danger that HWBBs as currently proposed by the Bill will be little more than talking shops for the well-intentioned. If real improvements in health and wellbeing, and reductions in inequalities are to be made, and outcomes achieved, they must be given the authority to challenge and sign-off local commissioning plans, ensuring that they are aligned to the JSNA, local health and wellbeing strategies, and address the actual health needs of their communities.

23. The NHS reform programme proposes that the commissioning of health services becomes the responsibility of GPs, through the formation of local commissioning consortia. GP organisations have acknowledged that commissioning health services for entire populations rather than individual patients requires public health skills, expertise and knowledge. It is critical that public health expertise informs all commissioning decisions—and that commissioners have access to timely, reliable and relevant information and analysis. To meet this need, there must be a registered public health specialist, on the Board of every health commissioning organisation—including the NHS Commissioning Board, able to access additional expertise from local and national experts when this is needed. There should also be a duty placed on commissioning organisations, including GP consortia, to work with DPHs and their public health teams on all commissioning decisions to ensure the health needs of their communities are met. It is also important that commissioning
24. In the new system, and in the period of transition towards it, measures should be taken to enhance integration, reduce fragmentation, and enable the commissioning of entire, seamless pathways of cost-effective care, ensuring that people get the health services they need, when they need them. FPH’s Health Services Committee has produced a comprehensive paper on the scope and impact of public health inputs to commissioning available at: www.fph.org.uk.

**THE RING-FENCED PUBLIC HEALTH BUDGET AND HEALTH PREMIUMS**

25. FPH welcomes the protection of public health funding at national and local level. It is important in these financially challenging times that public health initiatives and interventions which will save money in the longer-term are properly invested in now.

26. However, in order to achieve its wide-ranging vision for public health, government has estimated that only 4% of the total NHS budget to public health—around £4 billion according to the white paper—is required. This figure significantly underestimates the financial resource that will be needed. There is also a real risk that the budget will be viewed as the source of funding for all the additional public health responsibility given to LAs. Clarification on what exactly the ring-fence budget at local and national level will fund, how much will be top-sliced for use by PHE, the NHS Commissioning Board and consortia, and how much will be available for each local authority is needed urgently. As a minimum, the ring-fenced budget must include sufficient funds to support the transition of public health teams and DPHs to LAs.

27. This will need an urgent recalculation of the ring-fenced budget, from a realistic baseline, to resource adequately all those functions—spanning all three domains of public health—which it will be required to fund, now and in the future.

28. The DPH should be responsible for managing the ring-fenced budget. As the specialist trained and qualified in the three domains of public health, their expertise and knowledge will enable them to make sound judgements on the allocation of public health funds, based on the JSNA and the health needs of their communities.

29. A “health premium” has been proposed to incentivise and reward those areas which achieve improvements in the health and wellbeing of their communities. FPH is concerned that in fact the health premium will act as a perverse incentive, penalising those areas—in most likelihood those areas with the greatest disadvantage, the highest levels of population “churn”, and generally the least resource—which are not able to achieve great strides in improving their local population’s health. This will result in greater health inequalities. Careful consideration must be given to the calculation and allocation of this premium. FPH has responded to this issue in full in its response to Consultation on the funding and commissioning routes for public health available at www.fph.org.uk.

**THE FUTURE OF THE PUBLIC HEALTH WORKFORCE**

30. Since Healthy People, Healthy Lives was published in 2010, FPH has been made aware of a loss of public health posts throughout England—in particular, public health posts being cut as part of management cost savings in the NHS—and that posts are not being recruited to if they become vacant, seriously undermining the profession’s capacity at a time when so much is expected of it.

31. It is important now, more than ever, that public health continues as an attractive specialty to both doctors, dentists and individuals from backgrounds other than medicine, providing equity of pay and career options. Public health is a competency based specialty and this must be maintained in line with other specialties. There is concern that, for example, LAs do not have the training structures or workforce plans in place to support the development and assessment of the necessary public health competencies across the workforce.

32. It is also vital that in the new system, specialty registrars undertaking public health training have access to the full range of public health experience and settings (such as local health protection units, provider trusts, local authorities) in order to fully develop their specialist public health competencies.

33. To ensure public and profession confidence, public health training must continue to be organised and provided alongside that for other medical specialities with similar arrangements for recruitment, standard setting and quality assurance. FPH’s comprehensive position on this is set out in its response to Developing the healthcare workforce available from www.fph.org.uk.

34. FPH strongly supports the statutory regulation of all public health specialists. The Government’s steer in Healthy People Healthy Lives is that this is not necessary. This is extremely concerning, particularly from a public protection perspective (see point 18 above). Doctors and dentists working at specialist level are already required to have statutory registration to ensure the public and their employer are safeguarded. It is therefore logical that public health specialists from backgrounds other than medicine and dentistry, who are not currently statutorily regulated, should be subject to the same level of statutory regulation, including a requirement for revalidation. FPH recommends that the Health Professions Council should take on the regulatory role, building
on the work of the existing (voluntary) UK Public Health Register and maximising opportunities for efficiency and economy of scale.

35. In order to protect the public and employers, all appointments to public health consultants and specialists posts in the NHS are currently made on the advice of a statutory Advisory Appointments Committee. The system works well, paralleling that for consultants in other medical specialties. To maintain public and professional confidence it should be extended to cover all new public sector employers.

36. LAs must also support the continuing professional development needs of public health specialists and practitioners working within them. FPH has responded in full to the Review of the regulation of public health professionals available from www.fph.org.uk

The Future of Public Health Intelligence and Research

37. The new system must ensure that there is access to timely, reliable, appropriate and relevant public health information and intelligence, which has been assessed, analysed and interpreted, to inform decision-making. Public Health Observatories (PHOs) and cancer registries are vital to providing this important function. Public and professional confidence is maintained in the intelligence provided, as they are viewed as independent from government. Incorporating PHOs into PHE will put this trust at risk unless PHE is established with an appropriate degree of independence, ideally as an NHS body.

38. PHOs also support significant areas of research through grant funding. If PHE becomes part of DH, as proposed, incorporation into PHE would prevent PHOs from doing this.

39. Current government funding to PHOs has been significantly reduced. This is concerning as it has serious implications for the collation, assessment, analysis and provision of vital public health intelligence. Without the research or evidence base, decision-making could be seriously compromised.

40. PHE must ensure that the comprehensive intelligence gathering and analysis function currently provided by PHOs and cancer registries continues and is strengthened in the new system.

41. High quality public health teaching and research addressing all three public health domains, and close working between academics and those working in the field, are crucial to success in protecting and improving health and wellbeing. The reforms pose a danger of fragmentation of this relationship; in particular LAs do not have a strong research tradition.

42. The opportunities to build and strengthen relationships presented by the new system must be capitalised on by all within it including PHE, funders, academics, universities, LAs and services providers. The formation of the new National Institute for Health Research School of Public Health could, potentially, be an excellent vehicle for bridging the divide between public health research and practice. Appropriate funding will be required to ensure that evaluation of evidence and research in public health is not sidelined during the current difficult financial climate.

43. PHE should support the wide dissemination of all information relating to public health research, development and innovation and will require the resources to do so.

44. In the short time since the extension of its remit to cover public health, NICE’s work in the field has become widely respected and highly valued. FPH is keen that this should continue and be developed further and we wish to highlight our concern at an apparent erosion of the NICE remit: there has been an apparent deletion of some work programmes and a delay to NICE publishing reviews of a number of important public health issues. The reasons for this are unclear and we would like to be reassured that any adaptations to the work programme are rooted in a professional assessment of priorities. Guidelines suspended as of end May 2001 include reducing infant mortality among those living in disadvantaged circumstances, social and emotional wellbeing for vulnerable children at home and others.

The Public Health Outcomes Framework

45. The focus on outcomes is welcome—though FPH notes that many of the proposed indicators are process rather than outcome measures. FPH would support this mix as some allow adverse outcomes to be predicted and intervention to be made at an earlier stage. For example, improvements in outcomes such as life expectancy involve a significant time lag.

46. Three separate frameworks have been developed by government—NHS, social care and public health. It is important that there is linkage across all three frameworks to ensure an integrated system. FPH had previously supported the notion of one comprehensive framework encompassing all three areas. FPH has provided a comprehensive response to Transparency in outcomes—proposals for a public health outcomes framework available at www.fph.org.uk

Government, Marmot and Reducing Inequalities in Health

47. The Government’s aspiration to tackle health inequalities is welcome, and its proposal to follow a life-course approach in accordance with the Marmot recommendations. However, Marmot also proposes major
economic, educational and environmental interventions on which the Government is silent and in some policy areas the direction of travel is contrary to the major policy recommendations of the Marmot report.

48. The principal policy recommendations were to:
   — give children a good start in life;
   — increase opportunities for young people and school leavers;
   — improve health in the workplace;
   — reduce inequalities in income between the rich and poor;
   — improve physical environments and housing; and
   — reduce the gradient of ill health between rich and poor by targeting health improving interventions.

49. In reality, government cuts in LA area based grants have, in some areas, led to the closure of Surestart and children centres; loss of the Future Jobs fund has restricted job opportunities for young people, and there is currently the highest ever level of unemployment of under 25s. Current economic policies are widening the gap between the incomes of the richest and poorest in our society; the implementation of measures to improve workforce health remain sporadic and under resourced, and reliant on good will or the business decisions of private industry; environment and housing budgets are also being squeezed, and measures to reduce the gradient of ill health across society through targeted health promotion and health services interventions are patchy and inconsistent.

50. As a first step towards addressing this, the duty placed on LAs to reduce health inequalities, echoing that to be placed on NHS commissioners and the SoS, is welcomed.

June 2011

Written evidence from the Royal Society for Public Health (PH 65)

SUMMARY

The Royal Society for Public Health (RSPH) is pleased to have the opportunity to submit its response to the Committee’s inquiry. This response complements the oral evidence provided to the Committee on 17 May 2011 by its vice-chair, Dr Fiona Sim.

1. The creation of Public Health England within the Department of Health

   RSPH believes that it is imperative to preserve the independent voice of public health and, in particular, public trust and confidence in that independent voice. In times of specific challenge to the public health, for example, a serious outbreak of disease that requires public cooperation in order to control it, this trust is essential; and history indicates that this is most likely to be achieved by an independent body rather than by an arm of government. We would favour Public Health England being set up separately from DH, perhaps as a Special Health Authority or through another appropriate solution.

   We would add that we anticipate that, at times, it would be advantageous to ministers, for PHE to be an entity that is separate from government.

2. The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

   These bodies provide expert, independent advice and action nationally. Any proposal to abolish them must be accompanied by feasible effective alternative ways of ensuring the services are sustained to the high standards attained by the existing bodies.

   Clearly the answer to this question is closely linked with the organisational arrangements for Public Health England. If it is decided to incorporate the functions of these two agencies into PHE, once again, we would state that these services are best provided as part of an independent public health body, and not within DH.

3. 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)

   The proposal to incorporate the bulk of the public health function within local government has merits and risks. We are enthusiastic about the exciting potential for health improvement that could be driven forward by close integration with other existing local authority responsibilities, eg for leisure services, the built environment, schools, etc.

   But on the other hand, the risk is that public health may be subsumed and of low priority within local government, which, since 1974, has had only limited responsibility for public health.

   As far as the appointment of directors of public health is concerned, the majority are already hold joint appointments between local government and the NHS (in a PCT) and so the precedent is set for local government appointments. However, substantive appointment in local government presents new challenges,
with examples already surfacing of DsPH being appointed who are accountable to a director of adult social care, who in turn is accountable to the chief executive—for the DPH to be a third tier post in local government causes great concern for the ability of the public health voice, however competent, to be heard at the highest level of decision making within the local authority. This problem could be addressed by an expectation that the DPH will have the right of direct access to the Council on matters within his/her area of responsibility. It is worthy of note that the Medical Officer of Health, until 1974, had such access as well as the freedom to publish a comprehensive annual report on the health of the population. We would support the restoration of such an arrangement.

Regarding health & wellbeing boards, if they are to have a useful role, they must have executive powers—as “talking shops” they are likely to achieve little.

4. Arrangements for public health involvement in the commissioning of NHS services

We are very pleased to note that the Committee has recognised the gap in the government’s White Papers (both on the NHS and on Public Health) concerning the public health contribution to health care improvement and delivery.

GP or Clinically led Commissioning Consortia will need public health expertise if they are to achieve be effectiveness and efficiency in commissioning. Whilst GPs recognise the important role to be played by public health in commissioning health and social care, they themselves do not, with few exceptions, have the knowledge and skills required to perform the public health function. It is essential that the leadership within Consortia have enough awareness of public health, so that they can identify and obtain appropriate and adequate public health support for commissioning.

Examples are emerging of piecemeal approach to public health input to commissioning: for example, Consortia engaging a part-time information analyst in order to support a needs assessment exercise, or a public health specialist in order to support decision making in regard to high cost treatments. What is essential for the proposed commissioning model to be effective, is a systematic approach to public health involvement in all relevant components of commissioning.

As arrangements for Consortia become clearer, it will be essential to incorporate the costs of public health involvement as a core cost of effective and efficient commissioning, and not, as is currently of concern, an optional extra, which may or may not be affordable.

5. Arrangements for commissioning public health services

The government’s proposals as set out currently are very complex and open to misinterpretation, with responsibility both for commissioning and providing various public health services apparently lying with different parts of the NHS, Consortia, PHE and local authorities.

Unless there is clarity, it is likely that public health services will fall through the net with potentially disastrous consequences.

For example, the government’s recent consultation document on the Public Health Outcomes Framework contained numerous examples of potential confusion of roles and responsibilities across the breadth of public health service provision. The most coherent solution may be for PHE to commission public health services, but this might lead to an unhelpful, ineffective, “one size fits all” approach, so it will be imperative to establish partnerships with local commissioning Consortia to ensure local needs are met.

6. The future of the Public Health Observatories [PHOs]

The PHOs are an incredibly valuable and respected source of information about the health of the population, from national to local level. By provision of useable information, as distinct from raw data, they are a valued resource for local DsPH and their teams, and if abolished many of their functions would need to be recreated. However, what is also relevant about the PHOs is that they work closely with their main “customers” working in local public health departments (currently mainly public health specialists and analyst working in PCTs), who themselves have the knowledge and expertise required to ask the appropriate questions of the PHOs, to search the PHO information effectively, and crucially to interpret and then utilise that information. For commissioning Consortia to be effective in future, in working with PHOs (or their successors), the Consortia will need access to local public health expertise to ensure appropriate utilisation of PHO information to meet their needs.

7. The structure and purpose of the Public Health Outcomes Framework

We welcome the concept of an outcomes framework for public health. The consultation document contained examples of “good” indicators—that is, evidence-based and likely to be achievable with focussed, coordinated, local interagency effort. However, as well as these, it contained numerous examples of outcome measures which were at best aspirational and at worst either impossible to measure or to achieve, or both. We had concerns about the sheer number of measures, and the prospect of a small number being selected at a local
level, while on the other hand the prospect of all being mandatory would be unrealistic. There is a need for local discretion so that public health issues of greatest local priority could be tackled.

Despite its stated life-course approach, we 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), in all of which there are evidence-based public health interventions, the outcomes of which could be included in the framework.

8. Arrangements for funding public health services (including the Health Premium)

We believe that ring fenced funding will only be effective if tied to local outcomes. To ring fence a budget called “public health” is inviting a very broad definition of public health services, which may have little resemblance to what we would normally understand to be public health services—eg leisure services or road safety measures. So ring fencing of itself, without further definition of what is meant by public health services and what outcomes are expected for the stated investment, is of limited value. Further, 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”. It is difficult to reconcile this with a positive response to the Marmot Review on health inequalities.

9. The future of the public health workforce (including the regulation of public health professionals)

There is currently practical concern about the continuity of training of public health specialists during transition to local government and beyond. Local government has little experience of the expectations and responsibilities associated with medical/public health training, or of working with postgraduate Deaneries, and so this is likely to be a challenging exercise in many locations.

For the specialist workforce, since 2003 regulation has been through the General Medical Council for doctors, General Dental Council for dentists and the UK Public Health Register for public health specialists from most other backgrounds. The Scally report (Nov 2010) recommended statutory regulation for all public health specialists. If this is to be implemented, it is likely to require primary legislation, which may not be a high priority for government. We have submitted a proposal to government, in response to the White Paper and Scally report, to establish a framework for Chartered status, which we feel would helpfully strengthen voluntary regulation through UKPHR, without the need for new legislation.

What is perhaps at least as important as the detail of regulation is the requirement for employers to appoint only people who are competent to do the job to positions such as director of public health. Until now, there has been Guidance to the NHS as a whole, regarding the appointment of Consultants in the NHS, which, for public health, has included the requirement to appoint only those individuals who are registered with one of the approved regulators—in practice mainly GMC, GDC and UKPHR. It will be imperative for that guidance to be extended to local government if standards are to be maintained.

Through RSPH qualifications and training, we continue to support the professional development of public health practitioners at all levels, and, with our track record of innovation in training and qualifications in order to keep up with the pace of change, we intend to continue to do so.

10. How the Government is responding to the Marmot Review on health inequalities

Having accepted the recommendations of the Marmot Review, we would hope that the government would honour the commitment to ensure they are implemented. A number of concerns have arisen so far in terms of policies and actions that are more likely to contribute to widening the inequalities gap—for example, regarding partnerships with private sector companies on major public health issues such as alcohol and obesity, the 2012 Olympics, the impact of fees on access to higher education, etc.

A cross-government commitment to tackling inequalities must be achieved, and action by government not shied away from, particularly concerning issues where the public is in favour of government action, such as we have seen in regard to smoking control legislation.

June 2011

APPENDIX

THE ROYAL SOCIETY FOR PUBLIC HEALTH

ROLE AND KEY FUNCTIONS

1. The Royal Society is a fully recognised OfQual Awarding Body, with almost 100,000 individuals qualifying each year in a wide range of public health technical and applied courses. These are delivered through a network of just under 1,600 approved training centres. The RSPH offers 51 awards, with new qualifications currently in development designed to support priority areas identified by the White Papers, “Equity and Excellence: Liberating the NHS” and “Healthy Lives, Healthy People.”
2. The RSPH is also a nationally and internationally recognised certification and accreditation body. Approved by the UK Accreditation Service (UKAS), the Royal Society quality assures and certifies many public health related activities, ranging from food packaging production lines to the Department of Health’s Information Standard.

3. Support for up to date, evidence-based professional practice is at the heart of the organisation’s work and the RSPH offers the following services to public health professionals:
   — Two peer reviewed Journals, one focused primarily on support for practitioners.
   — A comprehensive conference programme each year.
   — Study days and training support.
   — Regular electronic briefings by email.
   — A comprehensive website with Member-only update areas.
   — Organisational awards for good practice.
   — Network meetings and support.
   — Qualifications ranging from health promotion and nutrition to pest control and asbestos removal.
   — Discounted professional indemnity insurance.

4. The RSPH hosts a number of independent or semi-independent public health organisations, such as the National NGO Forum for Health (comprising 107 national health charities in England), the Health Equalities Alliance, and the Radon Council. The Royal Society also provides administrative support for and hosts the Academic Network in Health Promotion and maintains the “Shaping the Future” database, initially funded by DH. This latter initiative is part of a shared enterprise with the Faculty of Public Health (FPH), the UK Public Health Register (UKPHR), and the Institute for Health Promotion and Education (IHPE).

5. Operating across the four countries of the UK, the Royal Society also maintains a national network of university partners, which has resulted in a range of initiatives from taught doctoral programmes to specific work on health protection. The RSPH also has a place on the Board of the International Union for Health Promotion and Education (IUhPE) and is leading a major component of the European Commission funded project to identify health promotion competencies and accreditation arrangements, initially in Europe, but with the intention of global application in due course.

6. The RSPH has been active in stimulating debate during the consultation for the recent White Paper, “Health Lives, Healthy People”. Two major consultation events were held in conjunction with the Faculty of Public Health, and the Royal Society led the consultation day for the NHS Confederation. The RSPH’s formal response to the White Paper has been submitted, as have individual commentaries on some of the supplementary papers (eg outcomes and ring fencing).

Written evidence from United Kingdom Association of Cancer Registries (PH 95)

1. The English Cancer Registries welcome the proposal for the cancer registration and intelligence functions to move into Public Health England (PHE). This provides an opportunity to develop the current regionally based services into a single comprehensive national cancer registration and intelligence service within PHE.

2. The establishment of PHE will draw together existing public health information and intelligence functions including cancer registries, the Public Health Observatories (PHOs), and relevant parts of the health Protection Agency (HPA) and will work to eliminate gaps and overlaps and to develop the specialist public health intelligence workforce.

3. At the same time, it will be important that the existing strong links between cancer registries, the National Cancer Intelligence Network (NCIN), the National Cancer Screening Office and the regional cancer screening quality assurance reference centres are further strengthened within PHE. Cancer diagnosis and treatment, whether the cancer is detected through screening or symptomatic presentation, is co-ordinated by cancer networks with patients managed across many disparate but linked organisations. The cancer registries and cancer screening quality assurance reference centres have developed well established data collection and monitoring systems that underpin these complex patient care pathways. It is important that these processes and data flows are not disrupted in the migration to Public Health England.

4. Cancer Registries have a longstanding surveillance function, which sits well with PHE. The regional registries work as part of an integrated, local health intelligence community, supporting local PCNs, cancer networks and other stakeholders in a strong, effective public health surveillance role. More recently registries have had a growing role in supporting the planning and monitoring of NHS cancer services at national, regional and local levels, supporting PCNs, cancer networks, provider Trusts, SHAs and the National Cancer Programme. Both roles will remain vital. Registries (and NCIN) will therefore need to work both with PHE and with the NHS (Commissioning Board, cancer networks, GP commissioning consortia and provider Trusts). Cancer Registries have developed sophisticated systems to collect and quality assure key information from multiple sources on all cases of cancer diagnosed in the English population. These data collection processes are complex,
need to be secure, and must often be customised to individual providers. At present this can only be achieved within the information governance framework of the NHS.

5. As the only available source of reliable, population-based information on which cancer incidence, prevalence and survival rates are based, cancer registries have an essential role in the implementation and monitoring of key national initiatives which aim to improve the quality of care and survival prospects for cancer patients. Cancer registries also undertake a range of public health surveillance and health protection functions. Cancer registration information is used to:

— monitor trends in cancer incidence, prevalence and survival over time and among different areas and social groups;
— evaluate the effectiveness of cancer prevention and screening programmes. For example, population-based data are required to monitor the effectiveness of the existing NHS Cancer Screening Programmes for breast, cervical and colorectal cancer and to inform the design of new programmes (e.g. screening for ovarian cancer);
— evaluate the quality and outcomes of cancer care, through the provision of comparative data about treatment patterns and outcomes;
— evaluate the effect of environmental and social factors on cancer risk and support other investigations into the causes of cancer. Cancer registration information has been used, for example, to investigate cancer risks in relation to power lines, landfill sites and mobile phones;
— investigate differences in cancer incidence, survival and access to treatment among social groups and thus contribute to programmes aimed at reducing inequalities in health outcomes;
— support the work of cancer genetic counselling services for individuals and families who have a higher risk of developing cancer; and
— support recalls of specific groups of cancer patients, for example women who were treated for Hodgkin’s disease with radiotherapy and may have an increased risk of developing breast cancer.

6. The work of registries in partnership with NCIN will underpin two of the key elements of the health reforms in relation to cancer and cancer services: the information revolution and the focus on outcomes. Information from cancer registries will be vital for the monitoring of progress on the Government’s commitment to “save 5000 additional lives per annum by 2014–15”.

7. The National Audit Office Report (NAO) report “Delivering the Cancer Reform Strategy”, the “Improving Outcomes; a Strategy for Cancer” and the recent Public Accounts Committee report on Cancer have all highlighted the importance of high quality information about cancer care and outcomes and the need to improve on the current situation. All three reports identified key gaps in cancer information, including incomplete and inconsistent data on how advanced patients’ cancers have become at the time they are diagnosed (stage of disease) and the lack of timeliness of cancer registration and outcomes data. The Public Accounts Committee report (March 2011) emphasizes many of these points, and makes a further recommendation that “The Department should develop a cancer information strategy which includes common standards for the quality and timeliness of data on cost, activity and outcomes”.

8. The English Registries are already working on several significant developments which will deliver:

— a quality assured, consistent, timely and complete national database of all cancers diagnosed in England, including information about stage at presentation;
— a high quality cancer intelligence and analysis service to support high quality patient care, policy development, public health surveillance, monitoring of outcomes, needs assessment, commissioning of services, patient choice, clinical audit, peer review of cancer services, epidemiology and health services research; and
— National Statistics on cancer incidence and survival (published via the Office for National Statistics) which meet national and international requirements and standards.

9. As part of the cancer registry modernisation programme, the regional registries are moving from their existing separate databases to a single national cancer registration service based on the system currently used by the Eastern Cancer Registration and Intelligence Centre (ECRIC). Registries will also be adopting the same processes, systems and working practices to ensure a consistent, timely, quality-assured, data set. This migration will be complete within two years.

10. Improving the collection of staging data is being given a very high priority by registries:

A National Staging Panel has been established to provide guidance and support to registries. A workshop held on 10 June 2011 indentified the priorities for action to ensure a standardised approach across the registries.

11. A target has been set for all of the English registries to achieve 70% completeness of staging data within the next two years. This level of completeness is already being achieved by one of the English registries, the Eastern Cancer Registration and Intelligence Centre (ECRIC). The 70% target was adopted following the National Audit Office Report last year on the Cancer Reform Strategy and the subsequent Public Accounts Committee (PAC). In reply to the PAC, the Department of Health wrote: “The Department acknowledged that
improving such data was a priority and committed to improve the collection of staging data to the levels achieved by the Eastern Cancer Registration and Information Centre within two year”.

12. The reason for the target being 70% rather than 100% is that there a number of cancer sites where staging does not apply, for example tumours where there is no formal or generally accepted staging system (such as primary central nervous system tumours, leukaemias) and those cancers where the primary site is unknown. In addition some patients are not formally staged by clinicians (where this will not affect clinical management) eg where a patient dies quickly without being investigated fully and therefore the additional information that is needed to decide on the stage of their cancer is not available. The variation in the number of unstaged cases across different cancer sites reflects the aggressive nature of some cancers. Taken together these groups make up the 30% of all cases recorded by the cancer registries which are not staged. There are also a very large number of basal cell carcinomas, a very common skin cancer, which does not metastasise (i.e. spread to distant organs) and is not staged clinically. In-situ malignancies which are strictly speaking stage 0 (and so could be counted as staged) are excluded from the denominator of the 70% target.

13. Cancer registries are working closely with providers of cancer care to secure the information required for comprehensive staging data on each case. The active support of cancer networks and of commissioners is very important in ensuring all providers are engaged with the process. Clinical teams discuss and agree a patient’s stage at the Multidisciplinary team (MDT) meeting in order to determine the appropriate treatment. This is not, however, always recorded in a systematic way, the information may not be in an electronic form, or all the salient information may not be available at the time of the MDT meeting. This makes the straightforward collection of clinical stage by cancer registries difficult.

14. There is now a requirement in the NHS Operating Framework for NHS Trusts to provide data (including staging data) to their regional cancer registry, which is a major step forward. Cancer registries, however, have no sanctions and little leverage over NHS providers and are dependent on the commissioners of those services to ensure the data are provided in a timely way. This would also be an issue with non NHS providers of cancer care. It will be essential that contracts with all providers require the standard dataset to be submitted to cancer registries and that this is monitored by commissioners.

15. Cancer registries are currently permitted to receive and process confidential patient information under section 251 of the NHS Act 2006. It is vital that this permission continues following the transition of cancer registries into PHE.

16. As well as undertaking the core functions funded by the Department of Health, cancer registries currently carry out commissioned work which is funded from a variety of other organisations, including NCIN (eg to undertake programmes of work with national clinical reference groups in their lead cancer site areas), cancer networks and research bodies. This is an efficient way of making use of the specialist data and skills within registries. It is important to ensure that the ability to undertake externally commissioned work will continue within PHE.

17. The challenging agenda for cancer registries over the next few years is made even more so by the current uncertainty over the transition from the existing situation to the new arrangements within PHE. Registries have within the past week received confirmation of funding for 2011–12 but there is currently no commitment beyond that. The current proposals state that cancer registry functions will transfer into PHE but there is as yet no clarity over the organisational structure of PHE or the human resources process for the transition. There is a real danger of losing staff with scarce specialist skills during the transition period. This would potentially delay the planned essential developments to the national cancer registration and intelligence service and jeopardise the provision of vital information required for monitoring trends in cancer incidence and survival.

*June 2011*

**Supplementary written evidence from United Kingdom Association of Cancer Registries (PH 95A)**

When giving evidence on 7 June 2011 to the House of Commons Health Committee for its inquiry into Public Health, I was asked to provide written clarification as to why cancer registries are working towards a target of recording stage (how advanced a patient’s cancer is at diagnosis) for 70% of cases, rather than for 100%.

The 70% target was set following the Public Accounts Committee’s (PAC) report, *Delivering the Cancer Reform Strategy*, which recommended that “The Department should ensure that staging data is complete and timely in at least 70% of cases in each region by the end of 2012”. This was based on the National Audit Office report on the Cancer Reform Strategy which highlighted that, for cancers diagnosed in 2007, the completeness of staging data varied between registries, from 15% to 70% of cases.

The highest level of recording of stage information is currently achieved by the Eastern Cancer Registration and Information Centre (ECRIC) and in response to the PAC report the Department of Health committed to improve the collection of staging data to the levels achieved by ECRIC within two years.
The target has been set at 70% as experience from ECRIC has shown that there are around 30% of all cancers that cannot be staged. There are several cancer sites where staging does not apply; for example tumours where there is no formal or generally accepted staging system (such as primary central nervous system tumours and leukaemias) and cancers where the primary site is unknown. In addition, some patients are not formally staged by clinicians when this would not affect their clinical management. There are other cases where the patient dies so soon after presentation that they cannot be investigated fully; this means that the additional information that would be needed to determine the stage of their cancer is not available. Staging is also not possible for those cases for which the only source of information available is a death certificate indicating cancer as a cause of death.

ECRIC has shown that it is possible to stage around 95% of cases for more than 40 types of cancer. However, for the reasons given above, the best achievable target across all cancers is 70%. It is this ambitious target that the Department of Health has agreed must be met by all the cancer registries. Once achieved, it will take the data quality collected in England to a level that is at least as good as, if not better than, anywhere in the world.

The cancer registries recognise the importance of collecting complete and timely staging data and are committed to achieving the 70% target by the end of 2012. However, as I said in my evidence, achievement of this target also requires healthcare providers to ensure that staging information is captured by their clinical teams and information systems and is then transmitted to the registries. The requirement in the NHS Operating Framework for NHS Trusts to provide data (including staging data) to their regional cancer registry is a major step forward. However, it is essential that commissioners of cancer care, in their contracts with providers, require that staging information is submitted to the registries and that they are prepared to take action if providers fail to do so.

I hope this gives you the clarification you require.

David Meechan
Co-Chair, UK Association of Cancer Registries
June 2011

Written evidence from the Marmot Review Team (PH 134)

We urge the Health Select Committee to look at wider cross-sector Government policies when considering the Government’s response to the Marmot Review and its action on public health. Health equity in all policies is crucial, as are the social determinants of health—experience in the early years, education, income, housing, employment conditions and environmental conditions—which are largely responsible for inequalities in health.

Also of particular concern, are the 28% cuts over four years to the budgets of Local Authorities,25 which are at the front line delivering the services necessary to create the social conditions in which people can take control of their lives and their health. Reductions in public services as a result of cuts will impact most on those who rely most on them for early years provision, education, employment, and improving environmental conditions, including housing. The most vulnerable will suffer most and without new action, health inequalities will likely widen. In addition, research by Core Cities shows that, generally, the more deprived local areas are receiving a bigger proportionate cut in their budgets than the less deprived,26 which will widen health inequalities still further.

1. THE FUTURE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

We welcome a stronger role for Local Authorities in leading action on health inequalities as they are best placed to orchestrate the partnerships necessary to address the social determinants of health at the local level. This was clearly set out in Fair Society Healthy Lives.27 Health and wellbeing boards represent a good opportunity for partnership working.

(a) Role of Health and Wellbeing Boards

Health and wellbeing boards should have a clear leadership role across Local Authorities and need sufficient power and resources to ensure improvements in health, population health and health equity. They should be given the power to lead in addressing the social determinants of health and ensuring joint commissioning. At present the potential of health and wellbeing boards to protect equity and health is unclear, as are the ways in which they will link with other parts of the Local Authority and the extent of their influence over commissioning decisions. The role of health and wellbeing boards should encompass:

— Ensuring local agencies consider health equity in all their policies.
— Joint commissioning for reducing health inequalities.

Scrutiny and accountability for health inequalities (in conjunction with GP consortia).

Developing partnerships with local people and communities and across the Local Authority and beyond (consortia, acute trusts, community services, private sector, police, housing, transport and other community organisations).

Work with other local authority boards and departments to develop shared plans and targets for action in the social determinants.

We would like to see health and wellbeing boards having a statutory power and duty to intervene to reduce health inequalities. Health and wellbeing boards should, with commissioning organisations including Local Authorities, be accountable for reducing health inequalities.

Health and wellbeing boards should include representatives from a broad spectrum of relevant local agencies, such as Voluntary, Community and Social Enterprise Sector (VCSE). Scrutiny functions and accountability mechanisms are currently underdeveloped. It is essential that Local Authority overview and scrutiny powers are robustly exercised and independent of the health and wellbeing boards.

(b) Joint Strategic Needs Assessment (JSNA) and the joint health and wellbeing strategy

We welcome the partnership approach to the JSNA and the joint production and commitment to a Health and Wellbeing strategy which is based on the JSNA. The JSNA process has developed since its inception in 1997. It is now a well understood, embedded process enabling partners to work together to increase knowledge of, engage with and plan services for their population. However the JSNA process still has the capacity to further improve. For example, the current JSNA process does not fully encompass the broad range of social determinants, and therefore their effects on health are not documented and analysed to a sufficient degree. The consultation conducted as part of Fair Society, Healthy Lives also highlighted some difficulties and reticence in agencies sharing information. Guidance should be issued to clarify information and intelligence exchange between key partners to inform and enhance joint protocols and planning. Rectifying these deficiencies would make it clearer and easier to identify pathways to improving health equity.

(c) Directors of Public Health

To ensure that public health and reducing health inequalities are priorities for Local Authorities Directors of Public Health (DoPH) must sit at the highest level in a Local Authorities, as suggested by the White Paper. This is not currently happening in all Local Authorities, undermining sustainable leadership on the determinants of health inequalities. It is important that directors or public health are made directors within the Local Authority—many are being made deputy directors to directors of adult social services.

2. ARRANGEMENTS FOR COMMISSIONING NHS AND PUBLIC HEALTH SERVICES

Given the range of commissioning organisations under the proposed system, great care must be taken that public health and health inequalities advice and information is represented at every level and within GP consortia. There is a risk that new commissioning organisations/commissioning organisations with extended remits will not have the skills and capacity to commission action to reduce health inequalities effectively. The wealth of knowledge around local health and the social determinants of health that currently exists within PCTs must not be lost.

Local voluntary organisations have the potential to contribute to community empowerment, social integration and cohesion. If this potential is to be fully realised it requires that in commissioning services from VCSE both service commissioners and VCSE have greater capacity and knowledge. Building capacity is essential to ensure the widest range of service providers. Many VCSE do not currently have the capacity to bid as service providers and will struggle to survive the local government funding cuts, restricting their ability to bid for and provide services.

(a) Health information and HEIA

Health intelligence and health information must be central to the needs assessments undertaken by all local organisations, including health, social care, housing, leisure, and planning. These functions are currently under pressure due to budget restraints, however, without them the ability to commission on an informed basis will be lacking and the JSNA process could be destabilised. The growing evidence base on interventions which can improve public health and reduce health inequalities must be at the heart of NHS, central and local Government commissioning. Fair Society, Healthy Lives provided an overview of relevant evidence, but this evidence base must continue to be assessed and updated as new evidence emerges.

Health equity impact assessments should be used extensively across local (and national) government to ensure positive impacts on reducing health inequalities. For individual interventions, assessment findings should be discussed within the team responsible including the management lead. To ensure that activities are having a positive effect on public health and that the health and wellbeing boards are functioning optimally, accurate and timely data and appropriate outcome indicators are essential.
(b) Public health in NHS commissioning / GP consortia

Each GP consortia should have a health inequalities/public health lead that sits on its management team. They should work closely with DsPH to ensure that effective strategic commissioning is taking place across a locality, based on need and evidence.

Commissioning organisations should have a statutory duty to be represented on, and to participate in, health and wellbeing boards, and have joint responsibility for public health and health inequalities. Through their health inequalities and public health leads, this should help provide relevant and accurate public health advice in conjunction with the locality DsPH. The acute sector should also be represented on health and well-being boards.

We are concerned that where GP practice catchment areas are likely to no longer be geographical, it would make it very difficult for GP Consortia to “know their populations” in order to commission and target services based on population need and therefore effectively address health inequalities. GP registered populations undermine population needs assessment and hence a social determinants approach.

To ensure that GP consortia are focused on the social determinants of health, population needs assessment should be integral to their work and the definition of quality should include the population health outcomes of each socio-economic group in a geographic area. There needs then to be a formula to attribute GP practice responsibility for delivering this quality outcome. There are precedents—building on the experience of QOF may be a useful mechanism for achieving this shift to improved population health

(c) Arrangements for commissioning public health services

The commissioning of public health services should be undertaken through the health and wellbeing board underpinned by the evidence of the JSNA with a duty for all partners to co-operate and contribute in securing agreed health improvement. There should be a presumption of local commissioning through the health and wellbeing boards unless a clear case can be made for Public Health England to commission.

For all services commissioned, indicators of equity should be developed and monitored. The health and wellbeing board should be held accountable for these. All commissioning decisions should include a health equity impact assessment.

3. The Structure and Purpose of the Public Health Outcomes Framework

The final Outcomes Framework should include guidance on which agencies and sectors should be involved in delivering improvements associated with each of the proposed indicators e.g. police in issues around crime. See, for example, Annex 2 of Fair Society, Healthy Lives. The guidance should extend to monitoring roles and the make-up of the Health and Wellbeing Boards. Local discretion is key to the choice of actions and indicators that need to be prioritised and hence to make up of the Boards.

To ensure that the collection of any indicator is meaningful, mechanisms must be put in place to ensure that all members of Health and Wellbeing Boards must:

— know what indicators are being reported on.
— know how the data has been collected and by whom.
— know what their contribution is to particular priority topics and indicators—this may not always be obvious.
— ensure that achievement of indicators is included within the JSNA process to enable them to drive change.

The inclusion of a criterion specific to health inequalities (criteria 3) is welcome as is the criteria around impact on defined groups (criteria 5). However, the inclusion of other criteria could well lead to perverse incentives that would result in a widening of health inequalities (eg by taking short term measures that are disproportionately successful among the most advantaged). In addition to the existing criteria, this suggests the following criteria:

— “Does this indicator have the potential to widen inequalities? If so, can mitigating action be taken?
— Can the social distribution of the indicator be monitored?

These would facilitate more in depth discussion than criteria 3 alone and include groups across the social gradient above and beyond those addressed in criteria 5.

Key areas which seem to be missing or have limited coverage are:

— Quality of early years service provision.
— Developing the capabilities of individuals and communities.
In terms of specific indicators, the greatest omission is the commitment to including an indicator of well being as it becomes available. The Prime Minister has asked ONS to develop an indicator and collection of the necessary information will begin shortly. It is desirable to include this indicator once sufficient data are available from this source.

4. ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INC. THE HEALTH PREMIUM)

Given the importance of enhancing population health and reducing inequalities in health, the current level of funding is too low and should rise to 7% of the health budget as recommended in *Fair Society Healthy Lives*. The White Paper quotes the figure of £4 billion funding to be available to Public Health England. This is close to the current proportion of funds available to public health from within the overall health budget (approximately 4%). Ring fencing is an important protective mechanism, particularly as new organisations and partnerships form and develop. However, the proposals suggest that Local Authorities will be able to divert funds to plug other deficits, which would undermine efforts to improve overall health and reduce health inequalities.

To achieve these aims, funding must be directed across the social gradient in such a way that it is proportionate to need. Evidence shows that health inequalities are driven by the social determinants of health. Therefore, a partnership approach is critical, however successful partnership working is very challenging and evidence of successful partnerships in delivering on this agenda is sparse. Allocation of lead responsibilities potentially muddies the waters and promotes silo thinking. Equally important is the funding of other mainstream local services. Funding received through the Standard Spending Assessment for local authorities should also be focussed on the social determinants of health, and spent on a similar proportionate basis if health inequalities are to be addressed with sufficient scale and intensity.

The health premium will exacerbate health inequalities as it is much more difficult for deprived areas to make the same inroads into health improvement as less deprived areas. The health premium should take into account that increased efforts are required to reach the same outcomes in deprived populations, therefore there should be upfront funding, not related to performance, to aid organisations working with these populations.

5. THE FUTURE OF THE PUBLIC HEALTH WORKFORCE

The Scally report rightly emphasises the need for quality and accountability of the public health workforce. However, the public health workforce is not a homogenous group. To tackle the social determinants of health a whole range of expertise is required. It must be ensured that accreditation is not too narrowly focused as to prevent individuals with expertise on the social determinants of health, as opposed to the provision of health services, from being included. To ensure true advances in population health, the profession needs to be focussed on the whole range of social determinants, and to adopt a life course approach.

The UKPHR is currently equipped to provide voluntary regulation and we see no reason for this not to continue. The current Faculty of Public Health training scheme should be reviewed with regard to:

- The content and number of competencies that have to be fulfilled—this is also relevant to voluntary registration by portfolio.
- The types of placements available to specialty registrars.
- The professional backgrounds of the current cohort of trainers.
- The above issues create limitations which prevent people gaining experience and knowledge in the social determinants of health. Closer working with Local Authorities should make inroads, but much more work needs to be done to broaden the traditional medical model of public health training.

6. THE FUTURE OF THE PUBLIC HEALTH OBSERVATORIES

The Public Health Observatories perform a valuable independent role. They provide an important information and analysis function not undertaken anywhere else in the Department of Health or the NHS, and the information they provide locally is essential in taking forward the health inequalities agenda. For example, the Marmot Review Team commissioned the London Health Observatory to produce local inequality indicators based on the recommendations of the Marmot Review, and a number of Public Health Observatories were involved in writing the Review (South-West, North-East, North-West, East-Midlands, Yorkshire and the Humber). With the shift from PCTs to Local Authorities and other changes to the health system, there should be a review to establish what is needed from Public Health Observatories to ensure they are useful at the local level, and agreements should be established between the Observatories and Health and Wellbeing Boards.

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PHOs could provide the population based analysis of health and health needs which are needed to inform the activities of GP consortia. A review would help to ensure use of local data in their work and in the development of JSNAs.

7. **How the Government is Responding to the Marmot Review on Health Inequalities**

We are pleased that the Government’s Public Health White Paper responds explicitly to *Fair Society, Healthy Lives*. It recognises the central importance of reduction of health inequalities, it emphasises the life course, and it has explicit recognition of actions needed on social determinants of health. The White Paper takes up five of our six recommendations and endorses our call for proportionate universalism. This is to be welcomed. However, the White Paper does not accept our sixth recommendation: “Ensure a healthy standard of living for all”. This 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.

We urge the Health Select Committee to look at wider cross-sector Government policies when considering the Government’s response to the Marmot Review and its action on public health. Health equity in all policies is crucial, as it is the social determinants of health—from education to housing to employment conditions—that are responsible for inequalities in health. For example, the White Paper accepted the Marmot Review recommendation to “Create and develop healthy and sustainable places and communities”, which contained a specific recommendation to improve the energy efficiency of housing across the social gradient, yet Government policy does not reflect this.

Families living in cold housing, or who are “fuel poor”, tend to be those who suffer from social and economic disadvantage. Fuel poverty and cold housing have a negative effect on physical and mental health, for children, teenagers and adults. The best way to tackle this, and ensure reduced carbon emissions, is to improve the energy efficiency of homes. Yet the latest Comprehensive Spending Review suggests that the Warm Front programme (providing grants to eligible households to improve either home insulation or heating systems and recently piloting systems for hard to treat properties) will be phased out from 2013–14, completely removing central government funding to improve energy efficiency.29 We recommend that this programme should not abolished, but should be adapted to ensure that it is progressive, and effectively tackles inequalities.

In conclusion, we urge the Health Select Committee to look at wider cross-sector Government policies when considering the Government’s response to the Marmot Review and its action on public health.

Cuts to the budgets of those at the front line delivering the services necessary to create the social conditions in which people can take control of their lives and their health are of concern. Reductions in public services as a result of cuts will impact most on those who rely most on them for early years provision, education, employment, and improving environmental conditions, including housing. This will widen health inequalities still further.

*June 2011*

**Written evidence from the British Medical Association (PH 171)**

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine all over the UK. It has a total membership of over 145,000.

**Executive Summary**

— Placing Public Health England (PHE) within the Department of Health undermines the independence and thus the credibility of public health advice. Our preferred solution is that all public health specialist staff would be identified and transferred to a single public health agency, which would be an NHS organisation and would include all three domains of public health practice—health protection, health improvement, and public health support for commissioning.

— There is an urgent need for measures to prevent loss of the current specialist workforce and to provide protection for newly qualified specialists.

— Arrangements for the Health Protection Agency (HPA) should preserve the independence upon which its scientific and technical credibility are founded. Its ability to engage in income generating activities should be protected.

— The Secretary of State must retain statutory responsibility for protecting the health of the population. To this duty should be added a responsibility for improving the health of the population. The public health specialist workforce should be seen as the critical mechanism through which this responsibility is discharged.

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Close links between local government and the public health specialist workforce are essential in protecting and improving the public health. The current joint working arrangements have proven effective in this regard. The qualifications, status, seniority of the Director of Public Health (DPH) and the resources at the disposal of that office are key in securing effective delivery. We are concerned at the current proposals fail to provide the appropriate paradigm for effective public health delivery in a reformed system.

The proposals leave education and training and academic public health extremely vulnerable.

The essential role of public health specialists in the effective commissioning of healthcare services has been completely overlooked in the Department’s proposals. Public health specialists, working with GPs and other healthcare providers, should play a central role in commissioning healthcare.

There is an urgent need for an agreed definition of the scope of “public health services”. Public health specialists will be central in the commissioning of public health services.

Public Health Observatories represent a valuable health intelligence resource and should be protected during the transition. The scope of their responsibilities and their relationship with higher education and the wider public health sector should be defined for the new system.

The public health budget must be mapped to the definition of public health services. We are concerned at the adequacy of the proposed budget and that control over it should be invested in the office of the DPH. We believe the theory behind the health premium is problematic.

Statutory regulation of all public health specialists is essential for public protection.

**Development of the Current Proposals**

The reforms to the public health service are the largest in a generation and are occurring as the entire NHS is being reformed. This has had several important, and deleterious, consequences.

We would argue that inadequate attention is being paid to the public health reforms by Ministers, Department of Health officials and parliamentarians. We would observe that this arises because attention and time is being focused on the commissioning reforms within the NHS.

The relationship between the reforms to public health and the wider NHS has been complicated by the overlapping timescales of the reforms. Many important aspects of the changes to the delivery of public health form an integral part of the Health and Social Care Bill. This includes the Secretary of State’s duties around the protection of public health; the role of the Director of Public Health; the role of local authorities in exercising public health functions and; the reforms to the commissioning of health services. Nonetheless, they form part of the consultation on the Government’s public health proposals, which was ongoing during the period the Bill was being debated. It is impossible to respond to such a consultation on the future of public health without commenting on issues which were at the same time the subject of legislation.

The order of these reforms leaves the public health workforce in limbo. The organisations that currently employ public health specialists (Strategic Health Authorities, Primary Care Trusts, the Health Protection Agency, Public Health Observatories) are having budgets cut prior to their being disbanded. There is no clarity over the future structure or form of the future public health system. This uncertainty is having a huge impact on the specialty which is being exacerbated by the pause.

Historically, reorganisations such as those in 2002 and 2006 have meant that senior consultants have left the specialty in large numbers. This pattern is likely to be repeated, while in the meantime posts left vacant are not being filled on a substantive level; and those specialists who are about to finish their training are having serious difficulties in finding a job. This situation will worsen unless clarity of future form and function of the public health system is achieved very soon.

We believe that the best way to relieve the uncertainty felt by the public health workforce would be to allow them to maintain their NHS contracts, or to have an integrated contract package including an honorary NHS contract in the same way as medical academics based in universities. These would have additional benefits around training and career progression as well as ensuring the independence of public health.

**The Creation of Public Health England Within the Department of Health**

1. The Government’s plan to place Public Health England within the Department of Health causes several interrelated and unnecessary problems. With other elements of public health being transferred to local authorities, and possibly other bodies such as the NHS Commissioning Board or Commissioning Consortia, such a move will lead to the fragmentation of public health.

2. To stop this fragmentation, the BMA’s preferred model is that all public health specialist staff would be identified and transferred to a single public health agency, which would be an NHS organisation and would include all three domains of public health practice—health protection, health improvement, and public health support for commissioning.
3. This model is essential to ensure that public health advice remains free from political interference and is perceived by the public to be free from such interference. Much of public health is concerned with getting the public either to change their behaviour or informing them of health risks. Therefore, it is fundamentally important for public confidence in public health advice that those giving that advice are known to have both the expertise and the independence to speak authoritatively and without political interference.

4. This model has several additional benefits. These include providing a structure that supports robust emergency planning and response, attainment of critical mass of specialist expertise with advantages in efficiencies and collaborative working, and the ability to deliver co-ordinated training and career progression.

The Abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

5. The transfer of the Health Protection Agency (HPA) to the Department of Health would entirely negate its ability to generate additional income. Currently, only approximately half of the HPA's annual budget of £360 million is from the Department of Health. The rest is self-generated through research grants and commercial activity. However, becoming part of the civil service will bar the HPA from these income strands. The money generated from other sources funds specialists, and pieces of work, integrated with work funded by the Department of Health. If the HPA loses its ability to generate extra income, it will also lose staff, capacity and capability. In addition, much valuable research work could be lost or have its value reduced.

The Public Health Role of the Secretary of State

6. It is vital that the Secretary of State maintains statutory responsibility for protecting the health of the population. This responsibility is currently discharged through the entire 'Public Health System', including the Chief Medical Officer (CMO), the DsPH and the HPA. Any changes to the public health system must either fully maintain or entirely replace this relationship. To this duty should be added a responsibility for improving the health of the population.

7. In order to carry out the role, the Secretary of State, and the system over which they preside, needs to be fully cognisant of all three domains of public health—health protection, health improvement and healthcare public health (HCPH). It is only by delivering through all three domains in a cohesive and coherent manner that he or she can fulfil their public health duty. This is because many public health activities require input from all three domains.

8. For example, an effective plan to deal with seasonal flu requires input from: health improvement—to influence the public behaviour around personal hygiene and increase uptake of vaccines; health protection—to monitor the spread and virulence of the virus and institute appropriate interventions; and healthcare public health—to ensure the effective commissioning of services required in response to a health challenge and to mitigate the effects of the challenge on related health services.

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)

9. Local government has always played a central role in the delivery of activity that impacts on the public health and a strong case can be made both for very close working links between public health specialists and local government and for basing director level staff within local government. This is currently achieved by making DsPH joint appointments between PCTS and LAs. Indeed, the BMA, among other public health organisations, expressed an initial conditional welcome to the idea that local public health teams would be located within local authorities.

10. The conditions for supporting moving the public health specialist workforce into local authorities are tied to the status and independence that public health will be afforded. Whilst we are aware of many examples of local authorities who embody integrated public health approaches and which would make excellent homes for a public health specialist workforce, we are also aware of local authorities who seem to place little value in public health as a health specialty. The importance of recognising that public health specialists operate within essentially a professional model and not an administrative or managerial model must be understood.

11. It is our view that the DPH must report directly to the Chief Executive Officer and have the right of access to elected members. The role of the DPH will be a facilitative and brokering one to shape the culture and practice of local government to deliver services in ways that support the health and well being of the local population. The importance of the DPH is derived not from the size of the budget or the staffing of the department but from the nature of the task. We are concerned to hear reports that some local authorities wish to have their DPH report to, for example, their Director of Adult Social Services. This does not give the DPH the required status to be effective.
12. It is our view that all public health specialist posts, as a minimum, need to registered, either with the GMC or with the UK Public Health Register (UKPHR) and be competitively appointed through an advisory appointment committee (AAC). This is to ensure that those responsible for providing vital advice of a technical nature are appropriately qualified to do so and that the public can be assured of that competence. Ideally, we would like to see statutory regulation of all specialists in public health, as recommended by the Scally Review.

13. The DPH, while being accountable to the local authority, should be removed from office only with the agreement of the Secretary of State. This reinforces the Secretary of State is discharging his or her public health responsibilities through the office of the Director of Public Health.

14. We are particularly concerned about the place of academics in public health under the new arrangements. We would draw the Committee’s attention to the reports by the Medical Schools Council on Medical Clinical Academic Staffing Levels in Medical Schools. The latest, published on 23 May 2011, reported a continued year on year decline in staffing levels in public health. Overall, there has been a 21.7% drop in public health academics since 2000. This masks a massive 76.9% drop in lecturers since 2000 from 57 to just 13 in 2010. Despite this decline, medical schools also reported difficulties in recruiting posts. Little consideration seems to have been given to this group and the role that they play in encouraging doctors into the speciality, and of the potentially complex tripartite relationship they will need to have with a university, the NHS and a local authority.

Arrangements for public health involvement in the commissioning of NHS services

15. The BMA was concerned by the almost total absence of reference to public health support for commissioning (or health care public health (HCPH)) in either Liberating the NHS or Healthy Lives, Healthy People.

16. The HCPH specialist workforce is essential to secure excellence in clinically-led commissioning. It has undergone specialist training and provides the critical competences, essential to sustain health services within a cash-limited system, of:
   — Assessing health needs of populations, and how they can best be met using evidence-based interventions;
   — Supporting commissioners in developing evidence-based care pathways, service specifications and quality indicators; and
   — Providing a legitimate context for setting priorities using “comparative effectiveness” approaches and public engagement.

17. This workforce should be retained within the NHS, as part of the commissioning function of the reformed NHS. Commissioning Consortia need to have ready access to HCPH, along with other skilled support staff. At present there are approximately 250 HCPH doctors across England. They are augmented by a larger number of public health specialists who currently work in commissioning organisations and who incorporate elements of health care public health within jobs that also include health protection and health improvement roles. It is vital that this workforce is employed in a manner that preserves its utility and provides cohesion and continuity. We do not believe that local authorities will see the support of health care commissioning by commissioning consortia as part of local authority business, and accordingly we would counsel that the health care public health workforce requires an alternative home that secures its expertise within the NHS family. The DPH must be given a responsibility to ensure that the commissioning of healthcare on behalf of the local populations is aligned to the identified needs of that population.

Arrangements for commissioning public health services

18. There are a broad range of services that can fall under the banner “public health”, from the commissioning of social marketing campaigns to national programmes such as cancer screening and the delivery of the childhood immunisation schedule. As currently envisaged by the Government, these services would be divided between Public Health England, local authorities and the NHS Commissioning Board, though it is not yet clear where responsibility would lie. There is a need for an agreed definition of the scope of “public health services”.

19. What is clear is that any commissioning of public health services must involve public health specialists. Therefore, we would expect public health consultants to be a functioning part of National Commissioning Board, commissioning consortia and local government, and that these should be statutorily required to take cognisance of public health advice

The Future of the Public Health Observatories

20. Public Health Observatories (PHOs) are currently critical in the benchmarking of local authorities performance. If the Government’s vision of judging the success and failure of local authorities is to be successful this work needs to be continued.
21. Yet the future of PHOs is very uncertain, because of uncertainty over their funding. The Association of Public Health Observatories (APHO) has lost all its funding whilst the core funding for the PHOs themselves is down around 30% in 2011–12. Perversely, the pause in the reforms is likely to exacerbate the PHOs’ problems, as it means that the creation of organisations from which they can receive funding is now delayed. PHOs are already losing staff, but unless something is done very soon PHOs will reach a point from which it is hard to see them recovering for some time, if at all.

22. Like the HPA, currently PHOs receive their core-funding from the Department of Health but also receive additional money which would be denied them if they were to become part of the Department.

23. Public Health Observatories are part of a wider, yet diminishing, public health research infrastructure. The BMA welcomes the commitment to public health research in Healthy Lives, Healthy People\(^{10}\). Despite this commitment, there is no mention of how to protect and enhance the academic public health workforce needed to lead on such research and to educate the public health specialists of the future. Without good quality research there will be no way of assessing the impact of the Government’s proposed changes. As noted earlier in our evidence, the number of clinical academics in public health has declined significantly in the last decade, and many of those that remain fear for the future of their specialty and for public health research in general. Specific measures and close working with the higher education sector are needed to tackle this major workforce issue.

The structure and purpose of the Public Health Outcomes Framework

24. We believe that it is important that local areas are given autonomy to allocate their resources according to local priorities, whilst recognising the tension between the localism agenda and the need for national priorities to be resourced and addressed. As such, we would support the idea of there being both core indicators and locally decided indicators which would be selected from a national basket.

25. As described, the outcomes framework suggests that there will be national collation of data and evidence to support reporting against these indicators. Experience from previous approaches has illustrated that performance reporting places a significant burden on local areas in the collection and extraction of data. It is essential, therefore, that the local Director of Public Health has adequate public health specialist support at a local level to support this delivery.

26. Since it is unlikely that there will be co-terminosity of commissioning consortiums with the local government resident population, if the outcomes framework is to be deliverable, the DPH must be able to hold commissioning bodies to account independently for their performance in relation to a particular population in order to ensure delivery.

Arrangements for funding public health services (including the Health Premium)

27. The idea of a ring-fenced public health budget is seen as an attractive counter to the raiding of such “soft” budgets. We are concerned that there remains a lack of clarity over what services fall to be funded from the public health budget and how these monies will be routed from the DH to service providers. Yet this is absolutely vital in assessing the adequacy of the budget in relation to the infrastructure it is required to support and the services it is intended to deliver. We contend that the DPH should have final control over these monies and be accountable for their use.

28. We would argue that the baseline year for funding should be 2009–10. In part, this is because in subsequent years public health budgets have suffered in order to support acute healthcare expenditure. It is important that where service providers can deliver public health improvements at no or marginal cost through modifications in service delivery, that these are not automatically charged against public health budgets, e.g. the offering of brief interventions on alcohol in acute settings. The cost benefit of most public health interventions exceeds that of many poor value clinical treatments offered in the acute sector and this structural imbalance needs to be addressed.

29. We believe that the theory behind the health premium is problematic. There is the potential to learn from reward elements provided under funding systems such as Local Area Agreements. The payment of the premium will be based on historical activity and so it is difficult to see how it will support innovation and development in public health approaches. To be effective, it must be directed not at simply supporting good health status in areas where health is already good, but at a true reduction in health inequalities. It must reflect the number of people whose health has been improved, as well as the extent of the improvement. It will not support effective public health action in some high need areas. For example, it is hard to envisage how it might account for population migration or churn, which describes the movement of people to a neighbouring, more affluent region, as they themselves become richer and healthier. Since these emigrants are often replaced by a poorer and unhealthier population 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.

\(^{10}\) 4.84 et seq Healthy Lives, Healthy People, Our strategy for public health in England.
The future of the public health workforce (including the regulation of public health professionals)

30. The BMA believes that the public health specialist workforce is stronger for its multi-disciplinary nature and that the regulation of all public health specialists, medical and non-medical alike, to the same standard is essential for the safeguarding of patients and the public. We also support the recommendation that there is no substantial change in the roles of the General Medical Council, the General Dental Council and the Nursing and Midwifery Council in respect of public health.

31. Public health professionals make substantial and fundamental decisions about the health and well-being of the population. These have intended positive effects but can have unintended negative effects too. Poor public health practice can do real harm. Therefore, not to demand statutory regulation for non-medical public health specialists, whilst at the same time demanding it for professions such as chiropodists and arts therapists, fails to appreciate the significant role that public health specialists have in shaping the health of the entire population.

32. Central to the role of professionals is the necessity of establishing and maintaining the respect of the public, and this is particularly true in an occupation that spends much of its time giving health advice. Professional regulation has an important role in establishing and maintaining public credibility of the specialist workforce.

33. Statutory regulation is also vital to ensure the continuation of public health as a specialty. We have been informed that some local authorities may wish to appoint Directors of Public Health who are not qualified public health specialists. Such appointments could well be dangerous to the health of the public and would certainly be disastrous to the continuation of specialist public health. The BMA therefore believes that the advisory appointments committee (AAC) process should be used to appoint specialist public health roles, including the Joint Director of Public Health (JDPH).

34. Irrespective of where public health will be based in the future, unless action is taken now to stem the unsustainable level of public health job losses, including those in academia, we have a real concern about whether there will be a viable public health workforce left. For example, one PCT, which previously had 11 public health consultants and a DPH now has an Acting-DPH and six public health consultants. The public health department has also lost a number of administrative support staff and the public health pharmacist is about to take voluntary redundancy.

How the Government is responding to the Marmot Review on health inequalities.

35. The Marmot Review presented the case for the impact of social determinants on health backed up by such a wealth of evidence that its findings cannot be denied. Importantly, similarly to the Stern Review on the economics of climate change, the Marmot Review showed the staggering costs of doing nothing. Leaving aside all moral considerations about the 2.5 million years of life potentially lost to health inequalities by those dying prematurely each year in England, the British economy simply cannot afford for Government not to tackle this issue.

36. Much of the rhetoric coming from Government has been encouraging, including some of the language in the Public Health White Paper. The setting up of a cross Cabinet sub-committee on public health is also welcomed. Yet words alone will not solve these deeply entrenched issues, and so far, although a limited amount of time has passed, there has been little in the way of concrete action. This is of particular concern those who remember the shelving of the Black Report and Wanless Reports by previous Governments.

37. Additionally, while there has been great interest, by both local authorities and PCTs in developing local plans to implement the Marmot Review recommendations, such implementation is made more difficult by steep cuts in funding to local government—which have been more marked in more deprived areas.

June 2011

Supplementary written evidence from the British Medical Association (PH 171A)

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine all over the UK. It has a total membership of over 145,000.

Summary
— Public Health England (PHE) should be a specialist health authority.
— The public health specialist workforce should be employed in that single NHS body and deployed to various bodies as appropriate.

The Shape and Scope of Public Health England

1. The BMA acknowledges that, in proposing to make PHE an executive agency of the Department of Health (DH), the Government has accepted the concerns of the public health community on the need for freedom from political control as a cornerstone of independent and credible public health advice.

2. However, whilst this is a welcome step in the right direction, it does not go far enough. We recommend that PHE be a special health authority within the NHS and believe that there is a strong case for this. Executive agencies, whilst being semi-independent are constitutionally part of their parent body. Special health authorities on the other hand, are independent bodies and hence have a greater assurance of freedom from political interference.

3. As currently envisaged by the Government, we believe that PHE will fail to deliver on the Government’s vision of a truly integrated national public health service. Instead, the current proposals are more likely to result in a fragmented and disjointed public health system, a contraction of the public health workforce, and no clear focus for whole system public health leadership.

4. The BMA believes that the creation of PHE as a special health authority, directly employing the entire public health specialist workforce and encompassing all three domains of public health (health protection, health improvement, and public health support for health services commissioning) could help ensure a world class integrated public health system. The danger of not doing so is that PHE will only have a limited focus and will not provide the necessary whole system oversight of public health activity required for the co-ordination and effective delivery across the system.

5. A “public health system” requires not only a mechanism to delegate responsibility but also an overall co-ordination of efforts, whole system oversight and performance management of public health delivery, such as is currently delivered through the NHS. Without this the “system” will struggle to deliver.

6. The Government wishes PHE to be an Executive Agency in order to provide a clear line of sight for the Secretary of State to act in issues such as pandemic flu. We are unclear as to how the proposals will improve upon the present situation. The Government’s plans will not deliver the anticipated control. PHE will only have an indirect relationship with Directors of Public Health and no relationship with the frontline public health staff, currently employed in Primary Care Trusts (later to be employed by local authorities) who will be carrying out the necessary work. The failure to appreciate this may well arise from the misapprehension that it is the Health Protection Agency (HPA) workforce that currently deliver health protection at the frontline. This is not so. The HPA has principally an advisory and surveillance role, whilst front-line health protection is delivered primarily by PCT and local authority staff.

7. Our preferred model is for the public health specialist workforce to be employed by a single central NHS body and deployed to various relevant organisations, including the new clinical commissioning groups, the National Commissioning Board and local authorities. This model has a number of strengths over and above suggestions that public health specialists should be directly employed by the organisations for which they will be working.

8. Firstly, having a single employer will enable flexibility and responsiveness by allowing public health specialists to be deployed as per local and national need without the barriers of contractual status or organisational silos. This would enable effective and rapid response to health protection incidences such as the outbreak of e-coli in a particular region, by facilitating the redeployment of all relevant staff to the effected region more or less seamlessly.

9. Secondly, it is likely to be more efficient in terms of maximising the output of the public health specialist workforce. It is important to recognise that the public health specialist workforce is small (relative to the need for public health expertise). Consequently, many public health consultants are contracted to work on multiple projects in different domains of public health practice over the course of a year or at the same time and for various bodies. It therefore makes little sense to restrict the scope of such practice, for example by assigning public health specialists to one particular local authority. It would be more efficient for them to be employed directly by a single central agency and deployed to various organisations as necessary. The inter-dependencies and the synergies between the three domains of public health have the potential to produce an end result that is far greater than simply the product of three parallel streams of work. Having the entire public health specialist workforce employed by a single central agency would make the most of this synergy and maximise economies of scale.

10. Thirdly, by having a single NHS body as the sole employing body for public health specialists, the public health specialist workforce would be relatively free from political control and able to maintain their professional independence. This credibility is threatened where specialists are under, or are perceived to be under, direct political control when working within the DH (even within an Executive Agency), or locally, within local government. If PHE is to be considered as the lead organisation in the new national public health service, it must be established as a truly independent body—as a special health authority. In order to ensure the required independence from political control, PHE should act as the employing body for public health specialists, seconding them to other organisations as necessary. The use of honorary contracts can facilitate this model. This is important as the primary responsibility of the public health specialist is to the interests of the population whom they serve at any time.
11. Fourthly, such arrangements would build on the strengths of existing practice concerning Public Health Registrars and Directors of Public Health. Public Health Registrars are currently employed by Deaneries through the vehicle of Primary Care Trusts (PCTs) and then deployed as part of their specialist training to various organisations to enable them to have experience of all three domains of public health. This is mandatory if they are to complete their specialist training and gain a Certificate of Completion of Training (CCT) in public health, but also to enable them to be well rounded and effective public health consultants. A single central NHS public health agency could mirror this practice and ensure access to coordinated training and career progression. Public Health Registrars are the future leaders of public health and all efforts must be made to ensure that they have access to the development and experience that they need under the reformed public health system.

12. Directors of Public Health have established effective joint-working and, in the best examples, truly multi-sectoral working at local level. In doing so, they have: assumed managerial and budgetary control of local authority staff and programmes that impact on public health; been appointed to executive level posts within council senior management teams, and done this from a position within the NHS. Their independent position protects their professional credibility and affords them a true advocacy role on behalf of their populations. This clearly demonstrates the feasibility of our preferred model. It would be unfortunate for this good work to be cast aside by the new arrangements.

13. The BMA recognises the merits of having a single central agency as the hub for national level health protection and fully support this approach. However, we have concerns that the current proposals do not address the need to establish and maintain an effective health protection workforce at the front line (i.e. local authority level). In addition, we are concerned that the other functions of PHE such as those of the National Treatment Agency for Substance Misuse and public health observatories will be overlooked and poorly resourced as PHE becomes in all but name the national functions of the Health Protection Agency (HPA).

14. Public health is a holistic specialism and one cannot prioritise one domain of public health over the others. Moreover, many public health activities require input from all three domains. For example, an effective plan to deal with seasonal flu requires input from; health improvement (to influence the public and increase uptake of vaccines); health protection (to monitor the spread and virulence of the virus) and healthcare public health (to ensure the effective commissioning of services). This underscores the need for PHE to encompass all three domains of public health and for it to have meaningful relationships with front-line delivery.

15. If public health specialists are to retain the public’s trust and confidence, it is of the utmost important that when they speak and provide recommendations, they are doing so on the basis of their specialist knowledge and not under the coercion of politicians. This professional credibility and public confidence can only be sustained if PHE is established entirely outside the DH as a special health authority.

The Public Health Workforce

16. The Government has consistently expressed its view that the public health workforce is central to delivering the health service of the future. However, this is not reflected in the situation in many PCTs. Indeed, on the day that the Government published its update to Healthy Lives, Healthy People, the specialist public health workforce in South West Essex PCT received letters informing them that their jobs were at risk as the PCT has made the decision to further cut specialists post from four to two. Last year the PCT had six public health specialists.

17. This is happening despite the existence of guidance from the DH that specifically excludes public health consultants from management cuts. Contrary to this guidance, the consultants have been told that the whole of public health must subject to the same running costs and efficiency gains as the rest of the system and that public health has not been disproportionately effected.

18. To say this fundamentally misunderstands the role of the public health specialist—viewing them as managers and not clinicians. It was precisely to counter this misapprehension that the DH produced the clear guidance mentioned above recognising that public health specialists are clinical posts. Therefore, the only way in which public health could be said to not have been disproportionately effected by these cuts would be if all other clinical posts in South West Essex PCT, from orthopaedic surgeons to paediatric nurses, were also being subject to a two-third reduction in their numbers.

19. Although the situation in South West Essex is worse than in many areas, it is by no means the only part of the country in which PCTs are looking to reduce public health posts. Often, this is done by not filling empty positions—this is shown by the fact that the number of posts that the Faculty of Public Health was asked to approve in the first quarter of 2011 was 80% down from the same period in 2009. The lack of available jobs for public health trainees that the CMO alluded to in her recent evidence to the Health Committee should therefore be seen as a symptom of this underlying problem. In the meantime, newly qualified public health consultants face an uncertain future, with two-thirds of the 67 trainees who qualified in the last 12 months yet to find a substantive post. Unless something is done to ensure that the public health system returns to business as usual soon and starts to fill empty posts, we may lose this generation to public health.

July 2011
Written evidence from the UK Public Health Association (PH 181)

The UKPHA is an independent, UK-wide voluntary association and a multidisciplinary membership organisation. Through our membership we bring together individuals and organisations from all sectors, who share a common commitment to promoting the public’s health.

We seek to promote the development of healthy public policy at all levels of government and across all sectors. We act as an information platform and aim to support those working in public health both professionally and in a voluntary capacity.

Our three core principles of public health are:
- Combating health inequalities—working for a fairer, more equitable and healthier society.
- Promoting sustainable development—ensuring healthy environments for future generations.
- Challenging anti-health forces—promoting health-sustaining production, consumption and employment; collaborating with businesses to promote socially responsible and healthy products and services.

Our work centres around the activities of our Special Interest Groups:
- Health & Housing.
- Alcohol & Violence.
- Food.
- Child Public Health.
- Health & Sustainable Environments.
- Pharmacy & Public Health.
- Public Mental Health.

Question 1: the creation of Public Health England within the Department of Health

The UK Public Health Association has long argued for the creation of a Department of Public Health. In our publication “Releasing the potential for the public’s health” produced in collaboration with the NHS Confederation and the Local Government Association in 2004 we stated that:

It is now time for a clear statement of Government responsibility for public health and for new arrangements for political leadership to achieve it. This requires a fundamental commitment to health as a public not just an individual good, a willingness to end the injustice of intensifying health inequality, investment in local capacity to improve public health, and a strengthening of local governance to improve the health of local communities.

“Releasing the Potential for the Public’s Health”: Summary and recommendations
http://www.ukpha.org.uk/media/4333/releasing%20the%20potential%20for%20the%20public’s%20health.pdf

Sixteen key recommendations were made the most notable and applicable to this enquiry being Numbers 4, 5 & 6:

4. The Government should commit itself to the transfer of responsibility for public health from the Department of Health to, or with, other government departments, and consider as a matter of urgency how to ensure the most effective leadership and coordination of public health action. The position of Public Health Minister should become a Cabinet-level post, provided with the resources required to work towards the fully engaged scenario, and its funding should be considered a cross-Governmental responsibility.

5. The Government should review the title, role and remit of the Chief Medical Officer (CMO) to ensure there is proper emphasis on and support for the health agenda as well as health services. For health issues, the CMO should be responsible to the Public Health Minister and have dual accountability to him/her and the Department of Health.

6. The Government must ensure that the policies and programmes of all Departments of State are subjected to a process of health impact assessments and inequality “proofing”, overseen by the new Public Health Minister and his/her team.

The health of the public must be the overarching and defining role of any government. Public health is about creating healthy resilient and robust individuals and communities. The National Health Service has long since lost its preventative zeal and is in reality a National Sickness Service (Wanless 2004). Therefore the UKPHA remains firmly committed to a Department of Public Health of which the NHS is a significant player, but no more so than the Treasury, Work and Pensions, Transport, Environment and Business. We applaud the setting up and development of the Cabinet Sub-committee on Public health but cannot understand why this major responsibility of government continues to languish in the shadows of the NHS.
Ev 164  Health Committee: Evidence

Question 2: the abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

The critically important roles that both of these Agencies perform rely heavily upon close cross-sectoral collaboration. It is imperative that the coordinating multidisciplinary function that they perform across the health social and environmental sectors is strengthened and developed. It is not yet clear if the new arrangements and structures will provide both the scope and flexibility for such development. Clear lines of accountability both operationally and in policy terms will be essential not only for the professionals involved but for the public as a whole.

Question 3: the public health role of the Secretary of State

Please see response to question 1 above.

Question 4: 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)

As called for in the document referred to above the UKPHA strongly believes that the responsibility for the public’s health should be firmly rooted in local government. As we would wish the case to be with central government we believe there should be cabinet level responsibility within local authorities and that all departments/directorates should be accountable to this level for the health impacts of their policies and activities. Therefore those officers charged with accountability for the public’s health should be appointed at Director level and accountable themselves to the Cabinet. The role of Health & Wellbeing Boards will be crucial in forging the partnerships essential to the success of the Boards, not only with the voluntary, private and public sectors but with communities themselves. JSNAs are an important point of collaboration and contact but need to become much more informed by local communities and to take an asset mapping approach. Traditionally the local authority input has been drawn from social care directorates but it is of paramount importance that a cross-Council approach is taken bringing housing, planning, environmental health, leisure and recreation etc into the process.

Question 5: arrangements for public health involvement in the commissioning of NHS services

Preventative strategies and interventions must be acknowledged and recognised within the NHS commissioning process. Therefore there must be a requirement for a wide ranging level of public health expertise to inform and agree commissioning decisions.

Question 6: arrangements for commissioning public health services

If public health is to become a central function to local government responsibilities, policies and actions, then the Health & Wellbeing Boards should be key to the process. Clearly their input should be led and defined by the accountable leader, the Director of Public Health.

Question 7: the future of the Public Health Observatories

Research, data collection and analysis together with the active dissemination of such “intelligence” are key to ensuring the promotion of health, the prevention of disease and the prolonging of life. It is therefore essential that the PHOs are managed and coordinated to perform a high quality local, supra-local and national function.

Question 8: the structure and purpose of the Public Health Outcomes Framework

The Outcomes Framework has a unique role to play in encouraging and motivating performance which will address the wider determinants of health. Given the breadth of these determinants it is important that there is flexibility built into the system to allow for “sub-groups” of indicators to signal improvement in specific categories. For example in looking for an outcome of “health promoting housing”, sub sets of indicators could include thermal efficiency, affordability, structural integrity, state of repair, crowding, etc. Similarly health promoting neighbourhoods could include, availability of green/environmentally diverse open space, pedestrian and cycling facilities, “home zones” availability of local shops and community “gathering” spaces etc.

We emphasise again that there should be a category indicator of ‘climate change’ with its own subset of indicators such as reducing the impacts of heatwaves; extreme weather events, water shortages etc.

We welcome the inclusion of air pollution as an indicator. 29,000 premature deaths per year are attributable to poor air quality in the UK—around 5% of all annual UK deaths—with a loss of life expectancy of up to nine years in the most polluted areas. The most vulnerable in our communities are the worst affected, with children, the elderly, those with existing health problems and underprivileged communities disproportionately impacted.

There is a very real concern that children are not getting a high enough profile in PH service and the relationship between PH and children’s social care is not being explicitly mentioned and we therefore also propose that a health and wellbeing indicator for children/families should be included.
Question 9: arrangements for funding public health services (including the Health Premium)

We can only repeat what was stated in our response to the Public Health White Paper: Patterns of deprivation vary in different parts of England. The social gradient needs to be assessed and understood in terms of trends as well as in terms of current “incline”. There will be an obvious need to reward areas that will make a real difference in the most deprived communities but gradated and incremental change will also need incentivising and rewarding across the whole social gradient. Such subtleties of approach will require sophisticated and responsive management to achieve public health outcomes which will begin to redress health inequalities. We are concerned that the health premium could seriously skew what has to be a nationally coordinated but locally driven endeavour to systematically reduce health inequalities.

Question 10: the future of the public health workforce (including the regulation of public health professionals)

At the local level, the proposed Health and Wellbeing Boards, the Joint Strategic Needs Assessment and the proposed Health and Wellbeing Strategies have the potential to support genuinely integrated and sustainable approaches to health and wellbeing. It will be essential to ensure that the Joint Strategic Needs Assessment (JSNA) is not only concerned with “health needs” of a given community. Equal consideration should be given to jointly coordinated asset mapping in partnership with local communities as an integral part of building and recognising social capital.

To succeed and truly benefit the public’s health the proposals contained within the White Paper will require a strong and flexible multi-disciplinary public health workforce drawn from across all professions and sectors and able to work effectively across partnerships and organisational boundaries. We support the view that local government is best placed to manage such a workforce given its role and influence over many of the wider determinants of health and wellbeing, and where the needs are more specifically clinically based to commission such services as appropriate.

The UKPHA believes that a public health “fit for purpose” for the 21st century requires a loosening of the traditional roles and boundaries associated with a medical model of delivery. It is essential that the energy, creativity and excellence vital for the health and wellbeing of populations is drawn from as wide a background as possible with an implicit recognition and valuing of the diversity that this will demand. We cannot see how such a workforce could be satisfactorily managed and developed with the GMC as the Regulator.

The UKPHA recognises the need for a Regulatory Review, and believes that as things stand all public health specialists and consultants should be on statutory registers.

However, we consider that the Review should lead to an all-encompassing exploration of potential future career pathways combined with a comprehensive searching for answers on how do we establish a genuine functional public health system at the same time as creating a cross-sectoral workforce developed and equipped with the many tiered competencies necessary to deliver it.

Question 11: how the Government is responding to the Marmot Review on health inequalities

The acknowledgement of the urgent need to address health inequalities is very welcome indeed. However, because of the complexity of the underlying issues we are concerned that there will be a focus upon achieving equity of access to services and the NHS (important as it is) rather than a systematic root and branch approach to addressing the wider determinants of health exemplified in the Marmot Review. Again we refer to the need for each department of government to be accountable to their senior minister and through him/her to the Secretary of State, for the impact of their policies and initiatives on health. This period of economic austerity poses a severe threat of increasing inequality and poor health to the most vulnerable in our society. Strenuous efforts must made to join-up a highly silo-ed government function at both the local and national levels with a common purpose of improving the public’s health

Endnote

Regrettably we are unable to answer these questions in greater depth as owing to a severe cut in funding, the UKPHA is now operating with a skeleton staff (the remaining paid personnel will cease to be employed by the Association on 30 June 2011).

June 2011
Supplementary written evidence from Professor John Newton (PH 192)

1. Following my appearance in front of the Health Select Committee on Tuesday 12 July, I committed to providing further information to you in writing. This note is intended to:

(a) Provide you with the background on the Information and Intelligence working group; and
(b) Provide information on the transition of PHO functions into Public Health England (PHE), and funding of PHOs for the coming year.

**Information and Intelligence working group**

2. Following publication of the Public Health White Paper, the Department of Health set up a new PHE I&I Working Group, charged with taking forward design of PHE’s future Information and Intelligence function. The group includes representatives from each of the constituent organisations of PHE, as well as the NHS Information Centre. The key roles of the Information and Intelligence Working Group are:

— design the future state of the I&I function within PHE;
— oversee transition of existing I&I functions and, where appropriate, workforce, into PHE during 2011–12; and
— ensure essential functions are protected during 2011–12 through transition arrangements.

3. The Information and Intelligence Working Group have met fortnightly since 2 February 2011. The workplan for the Group has been based on three phases:

— Phase one (February to 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 to 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.

**Public Health Reforms: Implications for Public Health Intelligence**

4. The purpose behind the reforms to the public health system as it applies to public health information and intelligence is to achieve an integrated, well-organised and efficient use of scarce and expert resources. We need a national, comprehensive and integrated high quality public health intelligence system to ensure that we have a health improvement and protection surveillance and analysis function that effectively supports commissioning across public health and healthcare services.

5. Experience demonstrates that where intelligence functions are embedded and integrated within organisations and systems, they provide a responsive, timely and efficient function that assists delivery of public health functions and outcomes. Formation of PHE is an opportunity to create a national public health service whose output is health not health intelligence and advice.

6. It is in the interests of the public, that organisational barriers do not artificially hinder the effective working of an intelligence function and we therefore expect to build on existing best practice of joint and close working where this delivers better services for the public. Examples would obviously be in the management of an outbreak, between PHE, local authority and NHS, but also cancer registries continuing to work with cancer networks and centres.

**Public Health Observatories**

7. There are currently nine Public Health Observatories (PHOs) in England based within NHS regions. Each PHO has an important role in supporting local public health bodies with information, analysis and skills to enable better decision-making, leading to better health. PHOs have increasingly worked together to produce key national outputs like Health Profiles and the Indications Reports.

8. It is clear that functions of PHOs will be a significant and much valued component of PHE, integrated with delivery at a national and local level. The immediate task is to continue to deliver first class public health intelligence within budget, at the same time as preparing for transition to a new integrated model.

9. A new Interim Operating Group has been set up to simplify the relationship between the PHOs and the Department. This group now carries out the functions that were provided by the Association of PHOs.

**PHO Funding**

10. In recent years, the nine PHOs have received two types of funding from the Department of Health: a core grant to support regional health intelligence infrastructure, and specific funding for commissioned work (such as the specialist observatories or Health Profiles). In 2010–11 these came to £5.1 million and £7.0 million respectively making a total of £12 million.
11. So far, for 2011–12, £4 million has been allocated as core funding to PHOs. This represents a 23% reduction compared with last year, if no more funds are allocated in year. This is 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.

12. We have asked the PHOs to seek efficiencies by working more closely with each other and with partners such as cancer registries to eliminate duplication of effort and cost. Experience (for example from the South West) is that the three PHOs who have merged with cancer registries are substantially more efficient and effective.

13. So far this year, the Department of Health has commissioned £5.2 million worth of work from PHOs. This again represents a 23% reduction compared with last year. This reduction is due to the completion of certain time-limited projects and general pressure on central budgets for programmes in support of policy objectives.

14. In 2011–12 the budget committed by the Department to the public health Intelligence and Information programme is £6.5 million, this is the same as last year. Of this money, £5.1 million has been specifically allocated to PHOs.

15. As last year, the funding will be used to support and stabilise the PHOs, but also to fund other health intelligence priorities (such as congenital anomaly registers). This year it will also need to fund some new health intelligence requirements as a result of the move to a new public health delivery model (for example measurement of public health outcomes and additional support to local authorities).

16. We are closely tailoring the resources available to the PHOs to priorities at national and local levels, whilst recognising the changing landscape within which they operate. We have instituted a quarterly review process with each Public Health Observatory in order to discuss any emerging pressures and we are working across policy areas within DH to ensure the total contributions are directed towards our greatest priorities.

17. We have asked the Transition Director for PHOs, Brian Ferguson, to finalise the style workplan for all PHOs by end of July 2011. If this workplan sets out critical work that requires additional core funding over and above the £4 million core grant already allocated, we will make this available.

18. It is too early in the financial year to confirm the exact amount of funding that the PHOs will receive in 2011–12, however, our best estimate in this year indicates this will be in the region of £9.17 million.

19. It is inevitable with change on this scale that individuals become uncertain about their futures. We have consistently reassured staff that we value their work and that their functions are important going forward. It is not possible for us, at this stage to state with any certainty the implications for individuals, except that we wish them to continue with their important work throughout the coming months and into next year.

20. We look to the PHO Directors and Regional Directors of Public Health to provide leadership locally to the staff required to deliver these important public health functions and to ensure that they are enabled to continue delivering their roles.

Professor John Newton  
Chair of the PHE Information and Intelligence Working Group  
Regional Director of Public Health South Central: lead for information  
18 July 2011

Supplementary written evidence from the Department of Health (PH 01A)

The Department of Health strongly believes that an executive agency is the best model, balancing the need to maintain a direct line of accountability to the Secretary of State, with the need to ensure PHE becomes a trusted organisation, known for its objective and expert advice. In reaching this decision, we have taken on board comments from a number of stakeholders including the Health Protection Agency, as well as adopting the recommendations of the Future Forum.

PHE staff will be civil servants. As Professor Harper said during the evidence session, a good comparator for PHE is the Medicines and Healthcare products Regulatory Agency (MHRA). This is an executive agency, staffed largely by civil servants, but the vast majority of people would see the MHRA as an independent regulator, operating with a high degree of operational autonomy. Another example of an executive agency seen as a standalone expert body is the Met Office, which is an executive agency of the Department of Business, Innovation and Skills.

It is very important that the public have confidence in PHE. PHE will be run by a chief executive and it will be essential that he or she builds a culture within the organisation that ensures that national and international organisations have confidence in its advice. To assist with the development of this culture, the Department of Health, as part of its engagement process over the summer will 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.
The differences between a Special Health Authority and an executive agency

Executive agencies are defined units headed up by a chief executive and are part of a government department. Executive agencies typically deliver a service and operate with a degree of autonomy from Ministers. Ministers do not concern themselves with the day-to-day running of executive agencies but are directly accountable to Parliament and the public for the overall performance of the agency. They are established administratively and do not have a separate legal personality from the Secretary of State. Executive agencies publish their own annual report and accounts and their accounts are consolidated into those of the parent department.

A Special Health Authority is an NHS body set up under powers in the National Health Service Act 2006, and the functions and operation of the body are determined in secondary legislation and in directions. A Special Health Authority is a corporate body, with a separate legal personality from the Secretary of State and the Department. 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. A Special Health Authority exercises the functions of the Secretary of State in relation to the health service and the Secretary of State may direct a Special Health Authority as to how it exercises its functions. However, the Authority is liable for any errors or omissions in the exercise of those functions. Staff are employed by the Authority not the Department, and are not civil servants. A Special Health Authority is funded by an annual allocation from the Department and publishes its own accounts.

In addition to the differences outlined above, there is one key difference that means that a Special Health Authority would not be an appropriate model. PHE will have UK-wide responsibilities for some highly specialised health protection functions such as radiation protection and will therefore need an organisational form that can operate across the devolved administrations. An executive agency model allows for this whereas a Special Health Authority is normally established in relation to England only (or occasionally England and Wales only).

Prescribed public health functions for local authorities

The Chair and Dr Poulter raised some helpful questions relating to the six prescribed functions for local authorities that were mentioned in Healthy Lives, Healthy People: update and way forward. It might be helpful to explain the background behind the decision to identify these core areas and to set this decision in the context of the wider responsibilities conferred on local authorities by the Health and Social Care Bill. The committee will want to note that the list of prescribed steps and services will not define what is 'important': local authorities will provide many important public health functions that we do not intend to mandate.

Our broad intention is for health protection to sit at a national level and for health improvement to be devolved to a local level. The Bill inserts new section 2B into the National Health Service Act 2006, which gives local authorities new duties in relation to the improvement of public health. From 1 April 2013, each local authority must take such steps as it considers appropriate for improving the health of the people in its area. The relevant clause lists a number of example steps that may be taken by local authorities such as providing information and advice, providing services or facilities for the prevention, diagnosis or treatment of illness and providing services or facilities designed to promote healthy living. There is a proud history of public health within local government and we must devolve decision making on health improvement as far as possible.

Be that as it may, there are some circumstances where it is appropriate to be more prescriptive. Clause 15 inserts new section 6C into the NHS Act 2006 and confers two regulation-making powers on the Secretary of State. The first enables the Secretary of State to require local authorities to exercise any of the Secretary of State’s public health functions, and the second enables the Secretary of State to prescribe the steps that a local authority must take in the exercise of its public health functions. The general effect is that this would enable the Secretary of State to prescribe steps, including services, functions and facilities relating to both health protection and health improvement, which must be taken or provided by local authorities.

Decisions on whether to prescribe steps or services have been guided by the following principles:

— whether a service or step needs to be provided in a universal fashion if it is to be provided at all;
— whether the Secretary of State is under a duty to provide the function; and
— whether a step or service is critical to the effective running of the new public health system.

In addition, we have considered the duty as to promoting autonomy under clause 4 of the Bill, which would apply to the Secretary of State when he makes these regulations. This requires the Secretary of State, (so far as is consistent with the interests of the health service) to act with a view to securing that a person exercising health service functions is free to exercise those functions or provide those services in the manner it considers most appropriate, and that unnecessary burdens are not imposed on such a person.

Professor Harper quite rightly referred to the National Child Measurement Scheme. This is an example of a service that must be provided in a universal fashion because sustaining a high participation rate within every area is essential to ensure a complete picture in terms of the national prevalence of child obesity and to ensure consistency of approach. Dr Poulter also asked about sexual health services. Examples of the aspects of sexual
health services that we intend to mandate include open-access contraception services and, open access, confidential STI testing and treatment services. The former is a duty of the Secretary of State with elements that would be delegated to local authorities and the latter is a health protection function.

**Powers of Health and Wellbeing boards**

During the evidence session, Rosie Cooper asked about the powers of the Health and Wellbeing Board. Firstly, it is important to highlight that the proposals relating to Health and Wellbeing Boards are about elected local authority members, representatives of HealthWatch and local commissioners having real, strategic influence over commissioning decisions, ensuring a joined up and coherent approach to health and social care. They are not a forum for one commissioner or elected member to over-rule another commissioner’s decision. It is right that Health and Wellbeing Boards do not have an absolute right of veto over commissioning plans of Clinical Commissioning Groups, as that would undermine their autonomy and give local authorities the ability to block commissioning decisions, without being accountable for the results. However, the Health and Wellbeing Board will have the collective duty of developing a joint strategic needs assessment and joint health and wellbeing strategy setting out their local health and social care priorities, and all commissioners (both NHS and local authorities) will have to have regard to the joint strategy when developing their own commissioning plans. Clinical Commissioning Groups will be required to involve the Health and Wellbeing Board when developing their commissioning plans, and the Health and Wellbeing Board will have the power to give the NHS Commissioning Board its opinion on whether a Clinical Commissioning Group’s plan takes proper account of the local joint health and wellbeing strategy.

The NHS Commissioning Board’s annual performance assessment of each Clinical Commissioning Group will include an assessment as to how well the group has performed its duty to have regard to joint strategic needs assessment and the joint health and wellbeing strategy. In doing so, the NHS Commissioning Board must consult the relevant Health and Wellbeing Board as to its views on the Clinical Commissioning Group’s contribution to the delivery of the joint health and wellbeing strategy. In this way, the Health and Wellbeing Board can raise concerns about how well the Clinical Commissioning Group is delivering its contribution, which may cover the effects of some of the clinical commissioning group’s commissioning decisions. In exceptional circumstances, the NHS Commissioning Board could use its powers to intervene where a clinical commissioning group has failed to discharge a function, and the health and wellbeing board may draw its attention to this.

**Funding arrangements for public health observatories**

There are two types of DH funding for public health observatories (PHOs):

- **core funding**: funds for PHO to deliver a national and sub-national work programme. These funds will contribute to overheads such as staffing, accommodation and IT.
- **commissioned work**: money paid for specific pieces of work, currently commissioned by the Department of Health.

In Professor John Newton’s letter to the Committee dated 18 July 2011, he set out the relative values of each of the two sources of Department of Health funding for PHOs (EU 166). The table below summarises the funding arrangements for the 2010–11 and 2011–12 financial years.

<table>
<thead>
<tr>
<th>Type of funding per financial year</th>
<th>2010–11</th>
<th>2011–12</th>
</tr>
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<tbody>
<tr>
<td>Overall budget for public health intelligence (ie PHOs plus other infrastructure), from which the core grant for PHOs comes.</td>
<td>£6.5m</td>
<td>£6.5 million of which potentially £5.1 million is available to PHOs (indicatively assigned for the whole year). Other costs are for Health Profiles, The National Library for Public Health, the Health Impact Assessment Gateway.</td>
</tr>
<tr>
<td>Core grant for PHOs from the Department’s overall budget for public health intelligence.</td>
<td>£5.1m</td>
<td>£3.9 million (This may increase up to £5.1 million should this be required by the work plan)</td>
</tr>
<tr>
<td>Commissioned work from PHOs from different parts of the Department.</td>
<td>£7.0m</td>
<td>£5.2 million (This may increase should the Department identify additional requirements)</td>
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Both the core funding and several PHO commissions originate from Department of Health’s public health intelligence budget, which also funds other non-PHO work including the Congenital Anomaly Registers. So far, the Department of Health has committed to providing the PHOs with £3.9 million of core funding in 2011–12. The Department of Health has secured the same level of core funding as last year (£5.1 million) from the overall budget for public health intelligence, should this be required. Professor John Newton’s letter set out the importance of the integrated work plan in determining whether all this money would be committed to the PHOs, as opposed to funding other public health intelligence, including transition costs associated with the move to the new system.
The indicative budgets confirmed to the PHOs for the core funding from the Department of Health were reduced by 30% in accordance with finance protocols. The balance was held back by the Department in order to provide assurance that delivery in the 2011–12 financial year would be achievable in the reduced budget. Quarterly financial reviews are now in place for PHO directors to review finances with the Department and where necessary additional funding will be agreed. These reviews are carried out by Professor John Newton’s public health Information and Intelligence team. The next reviews will be at the end of October 2011 and will finalise any additional payments. So far, we are not aware that the reduction of funding has had any adverse impact on PHO delivery.

The Department of Health has so far also commissioned work to the value of £5.2 million from the PHOs in 2011–12, though this may increase during the year. This funding covers the Child and Maternal Health Observatory, the National Obesity Observatory, the Learning Disability Observatory and Health Profiles amongst others.

August 2011