



House of Commons
Health Committee

Public health post–2013

Second Report of Session 2016–17



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*Report, together with formal minutes
relating to the report*

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Health Committee

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Contents

Summary	3
1 Introduction	5
Tackling the broader determinants of health—a top priority for Government	5
What is public health and why is it important?	7
A major change in public health	9
Why have we looked at public health?	11
2 Funding	13
Summary	13
Conclusions and recommendations	24
3 The new system	26
Systematically improving public health and addressing unnecessary variation	26
Summary	26
Sector-led improvement	27
Public health outcomes	29
Conclusions and recommendations	31
Politics and evidence	32
Conclusions and recommendations	35
Boundary issues and fragmentation	35
Summary	35
Health and Wellbeing Boards	37
Commissioning of Pre-exposure Prophylaxis for HIV	38
Conclusions and recommendations	38
Leadership for public health at a national level	38
Health in All Policies nationally	39
Cabinet sub-committee for public health	39
Relationship between DH and PHE	40
Relationship between PHE and NHS England	40
Conclusions and recommendations	40
4 Enabling public health teams to work effectively	42
Access to data	42
Summary	42
Conclusions and recommendations	43
The public health workforce	44

Movement of staff across sectors	46
Statutory regulation of all public health specialists	47
Conclusions and recommendations	48
5 Case study: Health protection	49
Summary	49
Conclusions and recommendations	55
6 Case study: Health in all policies	57
Summary	57
Conclusions and recommendations	60
7 The role of the NHS in public health	61
Summary	61
Conclusions and recommendations	63
Conclusions and recommendations	64
Annex 1 – supplementary information about problems with access to public health data	67
Annex 2: Visit to Coventry City Council	77
Formal Minutes	79
Witnesses	80
Published written evidence	81
List of Reports from the Committee during the current Parliament	85

Summary

In her first speech as Prime Minister, Theresa May put reducing health inequalities first on her list of 'burning injustices' that need to be tackled. We agree. Action should go beyond tackling the difference in life expectancy to include the inequality in the years lived in good health between the most and the least advantaged in our society.

We welcome the focus on public health but recognise that reducing health inequality will also need to address the wider determinants of health, such as education, employment, housing, and the environment. This will require cross-Government working. We recommend that a Cabinet Office minister be given specific responsibility for embedding health across all areas of Government policy at national level.

We welcome the move of public health to local authorities in 2013. They are well placed to deliver these same objectives across their communities and in doing so can harness a far wider network of individuals who can help to improve public health.

Local authorities face a number of challenges and have had to cope rapidly with major system change. In addition they face real terms cuts to public health budgets, including last year's in-year cut of £200 million. As a result, they are trying to deliver more with less. Whilst we have seen examples of innovative practice, local authorities are now at the limit of the savings they can achieve without a detrimental impact on services and outcomes. There is a growing mismatch between spending on public health and the significance attached to prevention in the NHS 5 Year Forward View.

Cuts to public health and the services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities.

The new public health system is designed to be locally driven, and therefore a degree of variation between areas is to be expected. However, we are concerned that robust systems to address unacceptable variation are not yet in place. The current system of sector-led improvement needs to be more clearly linked to comparable, comprehensible and transparent information on local priorities and performance on public health. Changes to local government funding, especially the removal of ring-fencing of the public health grant, must be managed so as not to further disadvantage areas with high deprivation and poor health outcomes.

While strong local political leadership can bring enormous benefits for public health, there is also the potential for tension between political priorities and evidence-based decision making. Clearer standards should be introduced and monitored transparently to improve accountability and to make sure that services to underrepresented or politically unpopular groups are maintained at an appropriate level.

We also recommend that local authorities be given greater powers to directly improve the health of their local communities and reduce health inequalities by including health as a material consideration in planning and licensing. We commend the proposals for a tax on the manufacturers of sugary soft drinks and call for further bold and brave cross-Government action to be included in the childhood obesity strategy and life chances strategy.

Commissioning for certain services is divided between different bodies, creating the potential for confusion and fragmentation. Where these boundary issues are identified there needs to be faster progress on resolving them in the best interests of patients and the public. Sexual health provides a clear example of such fragmentation and, in particular, clarity is urgently needed over the responsibility for and funding of pre-exposure prophylaxis, PrEP, for HIV.

We were told of significant problems with public health teams not being able to access the right level of information they need to do their jobs effectively. In some cases these problems may not have been a direct result of the move of public health teams to local authorities, but nonetheless they need to be addressed with urgency. We recommend that the Department of Health review the barriers which exist to greater information-sharing, and that Public Health England and NHS Digital (the Health and Social Care Information Centre) address the specific issues which have been drawn to our attention.

The public health workforce—both the specialist workforce and the wider workforce—is essential to delivering improved outcomes. We heard of the importance of Directors of Public Health as leaders, advocates and facilitators in local systems. Barriers to workforce mobility must be removed, and given that public health specialists may increasingly come from unregistered disciplines, the Government should review the regulation of public health specialists to ensure the protection of the public.

Health protection—encompassing prevention, preparedness and response to outbreaks and other health threats—is a critical public health function. Despite several sets of guidance on responsibilities we heard that confusion, duplication and lack of clarity persist in some local areas. Public Health England must ensure that local areas are clear about their responsibilities and equipped to deliver a seamless and effective response to outbreaks and other health protection incidents.

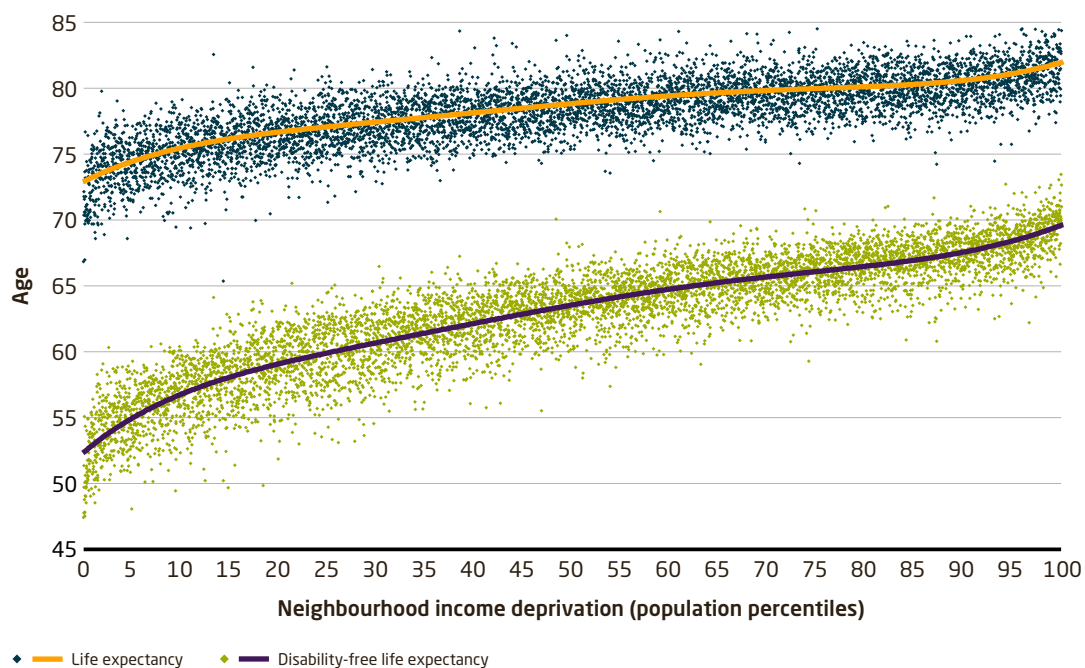
As Simon Stevens, Chief Executive of NHS England, has repeatedly emphasised, the NHS itself—both through NHS Trusts, CCGs, GPs and other service providers and as a major employer—has a critical role to play in public health. We agree but note that this is not yet happening at sufficient scale. The NHS needs to significantly improve its own performance on prevention.

1 Introduction

Tackling the broader determinants of health—a top priority for Government

“If you’re born poor you will die on average nine years earlier than others”

1. In her first speech as Prime Minister, Theresa May put health inequalities first on her list of ‘burning injustices’ that need to be tackled.¹ We strongly endorse this focus on health inequalities, and our report on public health sets out clear actions for the new Prime Minister and her Government to translate this priority into a reality.
2. The difference in life expectancy between rich and poor is well known. Perhaps less well known but equally important—indicated by the lower line of this graph—is the inequality in the years lived in good health.



Source - [Fair Society, Health Lives](#) (The Marmot Review), February 2010

3. But tackling health inequalities and improving public health will not primarily happen in hospitals, even though hospitals receive the lion’s share of health funding. Rather, it requires a whole life course approach, tackling the wider determinants of health in local communities, and through joined-up policy making at a national level. Whilst it was beyond the remit of our inquiry to consider Government policy on issues such as employment, income inequality and housing, we recognise that responsibility for improving public health and tackling health inequality must cross many departments. These policies must also take a long view, as many of the modifiable

¹ [Statement from the new Prime Minister Theresa May](#), Prime Minister’s Office, 10 Downing Street, 13 July 2016

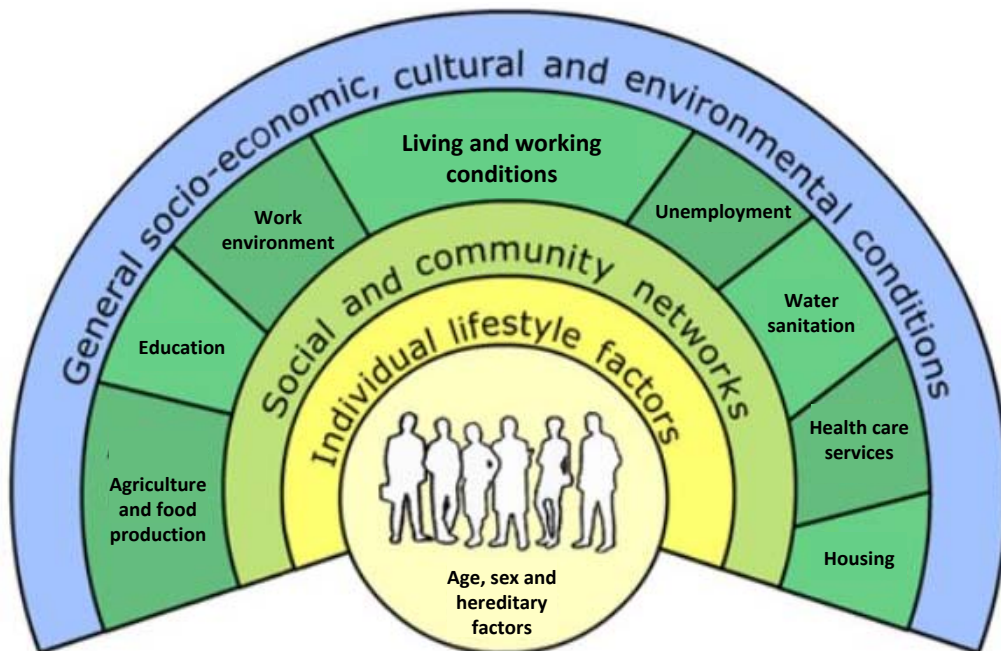
factors which can reduce health inequality will take decades to have a measurable effect. The long-awaited Life Chances Strategy and Childhood Obesity Strategy need to be ambitious and will be a litmus test for the Government’s intent to take these issues seriously.

4. Professor Sir Michael Marmot, a leading expert on health inequality who has written extensively on the wider determinants of health, gave the example of fuel poverty to illustrate this point:

Children develop less well if they grow up in cold homes, there is more mental illness, and, at the other end, there are the excess winter deaths, where somewhere between 20% and 25% of excess winter deaths can be attributed to being in the quarter of homes that are coldest. That is pretty simple. There are three issues here. One is the price of fuel; the second is poverty; the third is quality of housing. If you said, “We are developing a set of policies on housing. What is the likely impact on health and health inequalities?”, we could say, “We have a good enough evidence base to tell you that, if this happens, then that will happen in terms of health inequalities.”²

5. The crucial importance of these wider determinants of health is the reason we welcome the move in 2013 of public health to local authorities. They are well placed to embed the health and wellbeing agenda within their local communities across all the policies for which they are responsible. Whilst recognising the challenges that public health practitioners have faced as a result of the large scale system change resulting from the Health and Social Care Act 2012, we consider that public health should remain embedded in local communities. This report primarily addresses the areas of public health provision covered by the Health and Social Care Act 2012.

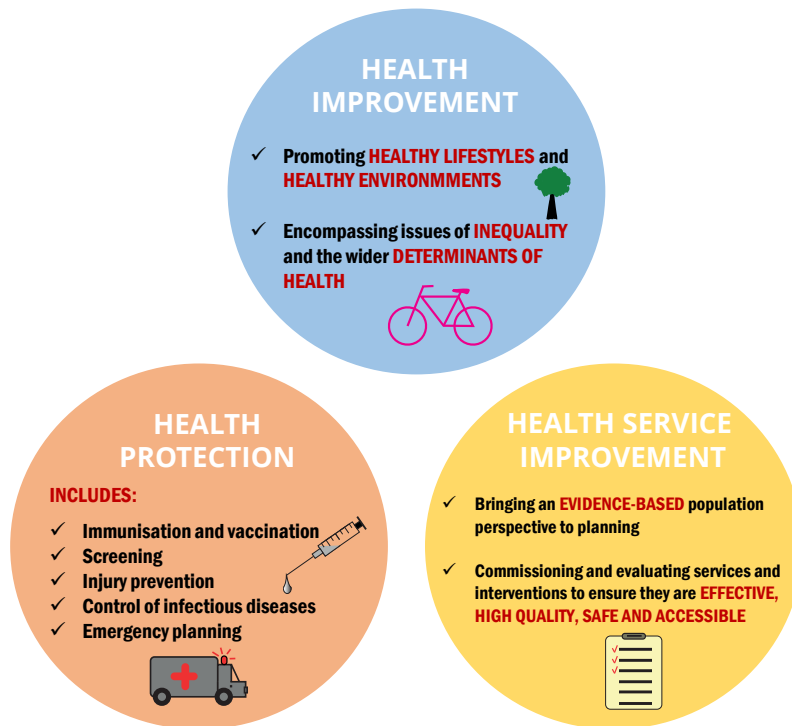
The wider determinants of health



Source - Whitehead and Dahlgren, 1991

What is public health and why is it important?

6. Public health is often thought of as three distinct, but overlapping domains: **health improvement**, which means promoting healthy lifestyles and healthy environments, as well as tackling inequalities; **health protection**, which means prevention, preparedness for, screening and response to infectious diseases and other threats to health; and **health service improvement**, which involves providing public health expertise to inform the effective and efficient planning and delivery of healthcare.



Source - Griffiths, S; Jewell, T and Donnelley, P. (2005) 'Public health in practice: the three domains of public health', *Public Health*, 119(10):907-13

7. Health improvement includes services to encourage people to live more healthily—such as smoking cessation services—but also involves addressing the issues that underpin health, such as housing, work and education. Health protection public health will include the national and local response to a wide range of threats as well as our internationally coordinated response to diseases like Ebola. A public health practitioner involved in health service improvement might, for example, work with commissioners and NHS colleagues across a range of disciplines to help design the most effective diabetes service for their local population.

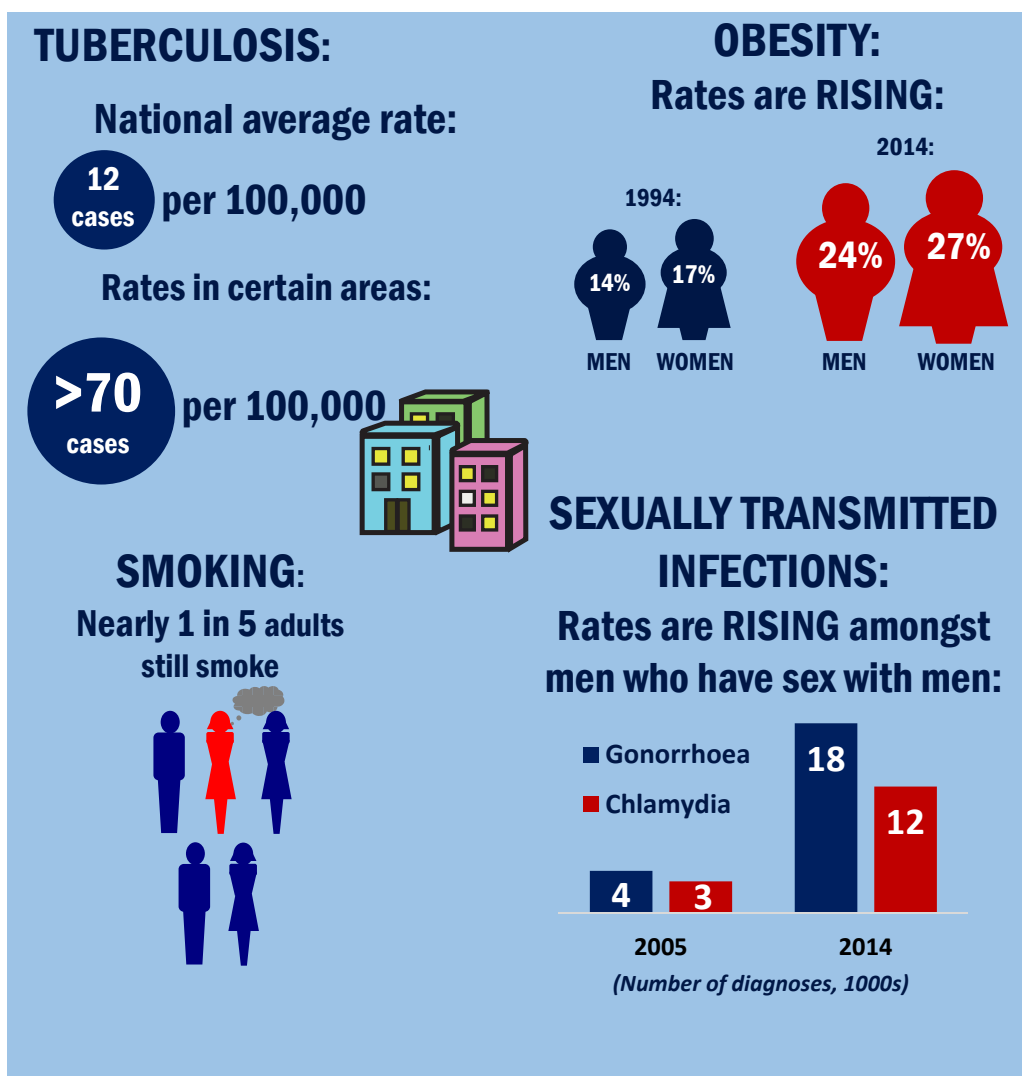
8. There are many challenges which, if tackled effectively, could improve public health and reduce health inequality. Obesity rates continue to rise across England and in particular are continuing to rise in the most disadvantaged children, widening health inequality.³ Although smoking prevalence has fallen dramatically, nearly one in five adults is still a smoker. In the lowest socio-economic groups, the rate rises to over one in four.⁴ If the Government is serious about reducing health inequality, it must be prepared to take action when modifiable risks,

3 Health and Social Care Information Centre, [Health Survey for England](#), 2014

4 ASH, [Smoking Still Kills](#), 2015

such as problem drinking, hit the most disadvantaged communities. It must be ambitious in championing policies to improve the nation’s diet and physical activity, again focusing on those with the greatest need.

9. Further action is also required in other areas of public health. The Prime Minister also referred in her first speech to the need to improve access to mental health services. Our predecessor committee’s inquiry into children’s and adolescents’ mental health services (CAMHS)—amongst others—made the case that to improve public mental health, prevention and early intervention are the most cost effective approaches.⁵ There can be no cause for complacency on infectious diseases, especially in light of the grave risks from antimicrobial resistance. Tuberculosis rates have risen over the past decade (although they have fallen over the past two years),⁶ and national averages mask high rates in some local areas; likewise the emerging risk from multiple drug resistant sexually transmitted infections.



Sources: Obesity: Health Survey for England 1993–2014, Smoking: [ASH/Integrated Lifestyle Survey](#), STIs: [Infection Report](#), Volume 9, Number 22, PHE, TB: Tuberculosis in England, [2015 report](#) – PHE

5 <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf>

6 PHE, [Tuberculosis in England 2015 report](#), 2015

10. Public health matters not only for its role in improving health and wellbeing and in reducing health inequalities but because it is absolutely essential to reducing future demand on an overstretched health service. A ‘radical upgrade’ in prevention and public health was central to NHS England’s 5 Year Forward View.⁷

11. The Nuffield Trust provide the following helpful explanation of why public health matters in reducing demand:

The top three causes of premature death in the UK (heart disease, lung cancer and stroke) are placing a significant burden on the NHS, social care and wider society, but all are largely preventable. The Department of Health (DH) estimates that 70% of the total health and social care spend in England is for the treatment and care of people with long-term conditions such as diabetes and heart disease (Department of Health, 2010a). Yet, many of the behaviours which contribute towards the development of long term illnesses such as these are also preventable, including smoking, excessive alcohol consumption, lack of physical exercise and obesity.⁸

12. Despite the clear economic case for focusing on prevention, spending on public health currently accounts for just over 4% of total health spending. The Health Foundation estimate that the public health budget will have fallen in real terms from £3.47bn in 2015–16 to just over £3bn in 2020–21.⁹

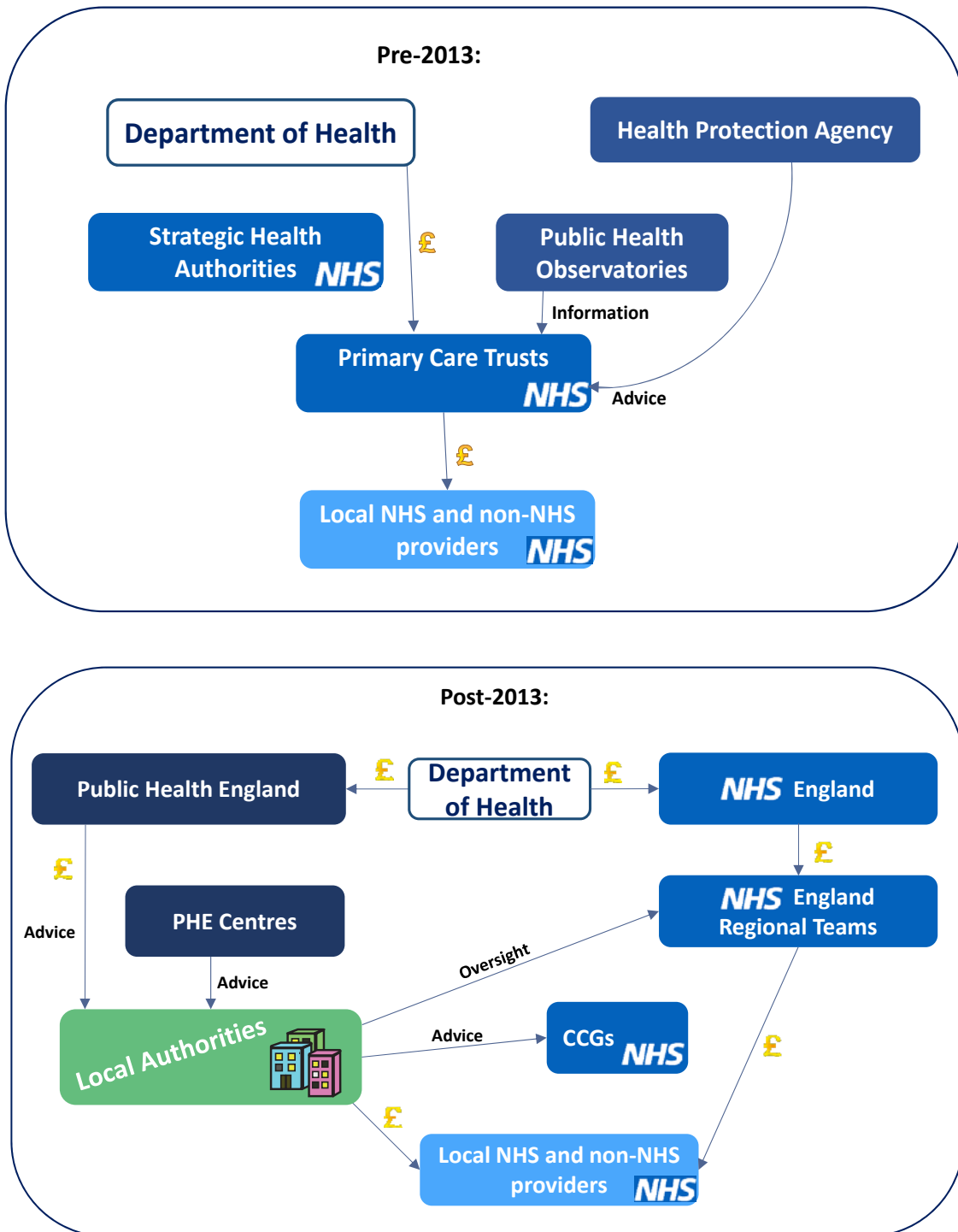
A major change in public health

13. In 2013, much of the responsibility for public health was transferred from the NHS to local authorities—a fundamental change. The public health landscape has also become more complex, with the addition of a new national and regional public health agency—Public Health England—whilst some public health responsibilities remained with the NHS, through NHS England. The Secretary of State retains ultimate responsibility for public health, and has powers to take steps to improve the health of the people of England, as well as responsibility for health protection. The following diagrams illustrate the changes:

7 NHS England, [Five Year Forward View](#), Executive Summary, para 3

8 Nuffield Trust, [Focus on Public Health and Prevention](#), April 2016, p9

9 Health Foundation ([CSR0097](#)) p1



14. In this new public health landscape the role of the Secretary of State remains crucial. The public health responsibilities which remain with NHS England are not set in legislation, but given to it directly by the Secretary of State through an agreement under section 7A of the National Health Service Act 2006 (inserted into that Act by section 22 of the Health and Social Care Act 2012). Public Health England, meanwhile, is an executive agency of the Department of Health, giving it a closer relationship with the Secretary of State than NHS England, which is a non-departmental public body. The Secretary of State therefore retains—in theory at least—a more direct responsibility for public health than he does for the other health functions which are the responsibility of NHS England.

15. Local authorities now have a statutory duty to improve the health of their populations, and from 1 April 2013 they assumed responsibility for a large range of public health services including, for example, services to tackle drug or alcohol misuse. These services may be provided by commissioning services, for example through contracts with NHS, voluntary sector, or private providers. The Department prescribed 6 services—sometimes referred to as mandated services—that all local authorities must provide. They are sexual health services (sexually transmitted infections testing and treatment and contraception); the NHS Health Check programme; health protection; public health advice; the national child measurement programme; and most recently services for 0–5 year olds.

Why have we looked at public health?

16. Public health—although it may be less visible to members of the public than hospitals and GPs—is absolutely crucial to improving individual and population health, reducing health inequalities and the future sustainability of the NHS. While the aim is to extend healthy life expectancy for citizens, it is the period of ill health towards the end of life that increases demand on the NHS and social care. The transfer of public health responsibilities from the NHS to local government was widely supported, but, like all change, it has the potential to be destabilising. We therefore decided to hold this inquiry as an initial ‘stocktake’ of the successes and challenges arising from the evolving new system for public health.

17. The evidence we have received suggests that the relocation of public health to local authorities in England has been largely positive, allowing public health to become integrated into all policies and to take account of the wider determinants of health. We endorse and support the embedding of public health teams within local authorities and commend the many examples of excellent practice presented to this inquiry.

18. Nevertheless, since 2013, those charged with protecting and improving public health have faced significant challenges. These challenges include:

- Variation in performance between local authorities and unclear accountability
- Tension between politics and evidence
- Boundary issues and fragmentation
- Workforce issues
- Poor access to data and information

19. These challenges have been compounded by cuts to public health funding including in-year cuts.

20. There has also been a noticeable contrast in the views of those providing evidence to our inquiry, with some public health professionals being overwhelmingly positive about the changes, and others being much more negative. We recognise that the system is an evolving one, and this initial inquiry will inform an ongoing process of review and support, through which we will hold the relevant organisations to account for addressing the outstanding issues and unacceptable variation presented to us.

21. We held three ‘overview’ sessions examining new public health structures, and supplemented this overview with two case studies into specific areas of public health—health protection

and the ‘health in all policies’ agenda. To build as rich a picture as possible for our inquiry, we supplemented our Westminster evidence sessions with a seminar with leading public health academics, an informal roundtable meeting with 25 public health professionals, and a visit to Coventry City Council. We are extremely grateful to all of those who contributed, as well as to our specialist advisers, Dr Janet Atherton and Professor David Hunter.¹⁰

22. Our report is set out as follows:

- Funding
- The new system
 - Systematically improving public health and addressing unnecessary variation
 - Politics and evidence
 - Boundary issues and fragmentation
 - Leadership at a national level
- Enabling public health teams to work effectively
 - Access to data
 - Public health workforce
- Health protection—‘case study’ 1
- Health in all policies—‘case study’ 2
- The role of the NHS in public health.

10 Dr Atherton declared the following interests: Director, Janet Atherton Ltd, public health and management consultancy; Adviser to Public Health England on local government public health; Associate, Local Government Association working on Sector Led Improvement Programme; Associate, iMPower Consulting Ltd; Associate Member of the Association of Directors of Public Health; Fellow of the Faculty of Public Health; Member of the Department of Health’s Advisory Committee for Resource Allocation (ACRA); Non-Executive Director of Tobacco Free Futures (now Healthier Futures).

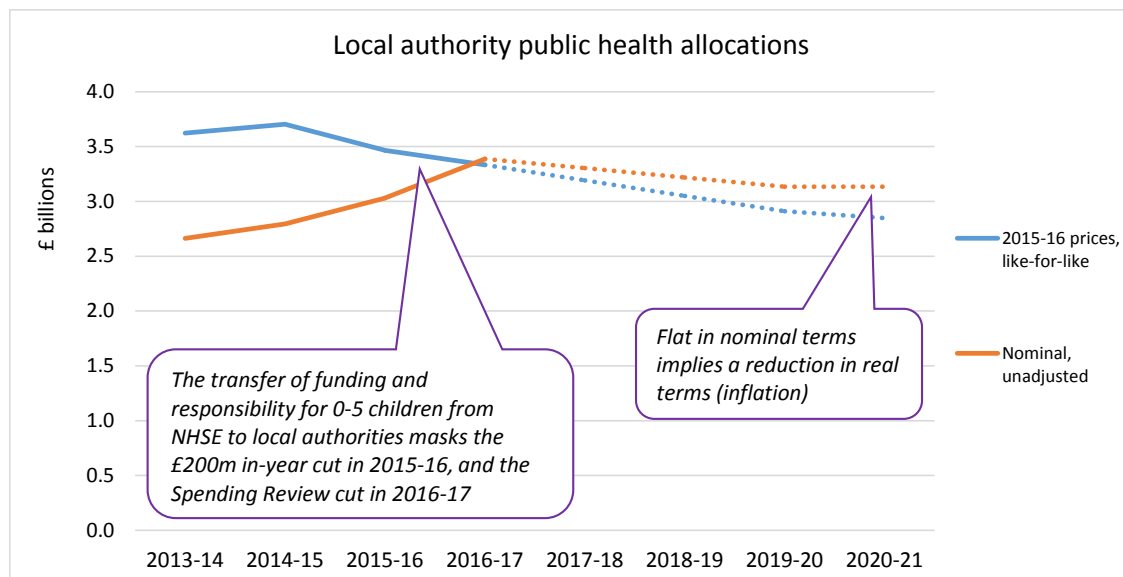
Professor Hunter declared the following interests: Non-Executive Director, NICE (2008–present); Senior Investigator on evaluating the leadership role of Health & Wellbeing Boards, Department of Health Policy Research Programme (2014–16); Senior Investigator on Shifting the Gravity of Spending? Exploring methods for supporting public health commissioning in priority-setting to improve population health and address health inequalities. A fellow on study, NIHR School for Public Health Research (2015–16); Co-Investigator on Commissioning for Public Health: the impact of the health reforms on access to services, health inequalities and innovation in service provision, Department of Health Policy Research Programme (2015–17); Special advisor to WHO Regional Government for Europe and Director of WHO Collaborating Centre on Complex Health Systems Research, Knowledge and Action at Durham University (engaged in a number of consultancies (2015–16); Interim review of the European Action Plan for Strengthening Public Health Capacities and Services; Survey of country capacity to generate, appraise, translate and apply research evidence for health decision-making for WHO EVIPnet; Designing and facilitating short courses in capacity-building in Health in All Policies (HiAP)); Honorary Member, Faculty of Public Health.

2 Funding

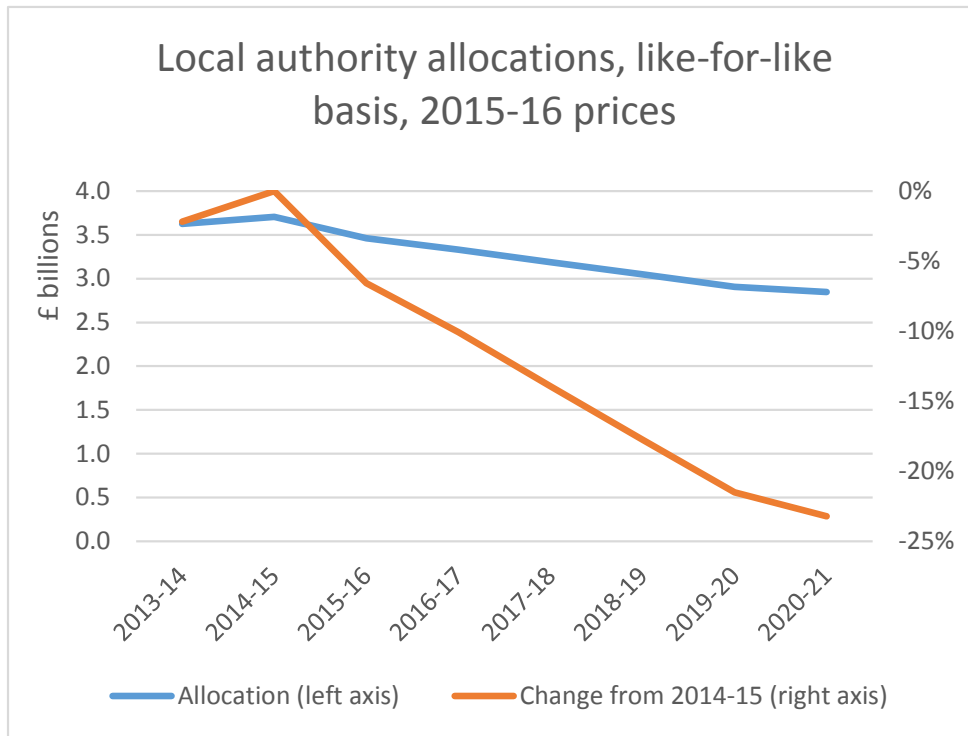
Summary

Local authorities are aiming to deliver more with less, giving rise to innovative practice, but they are now at the limit of the savings they can achieve without a detrimental impact on services and outcomes. There is clearly a mismatch between spending levels on public health - which are set to reduce - and the significance attached to prevention in the NHS 5 Year Forward View.

23. Local authorities are currently allocated a ringfenced public health grant. Public health accounts for some 4% of local authorities' total spending. There are six 'prescribed' or mandated public health functions—services that local authorities are obliged to provide with their public health grant. In July 2015 public health budgets were subject to an in-year cut of £200m (6.7%), and the 2015 Spending Review announced further cuts to the public health budget.



24. The graph below has been adjusted to include the funding for 0–5 services which prior to 2015–16 was allocated to NHS England. It shows the reality of a sharp drop from 2014–15:



25. The cuts are likely to be “significantly front-loaded”, according to the Health Foundation. Real terms reductions in the first four years from 2015–16 (-3.8%, -4.2%, -4.4%, -4.6%) are followed by a lower reduction in 2020–21 of -2.2%.¹¹ This amounts to a real terms reduction from £3.47bn in 2015–16 to just under £3bn in 2020–21.¹²

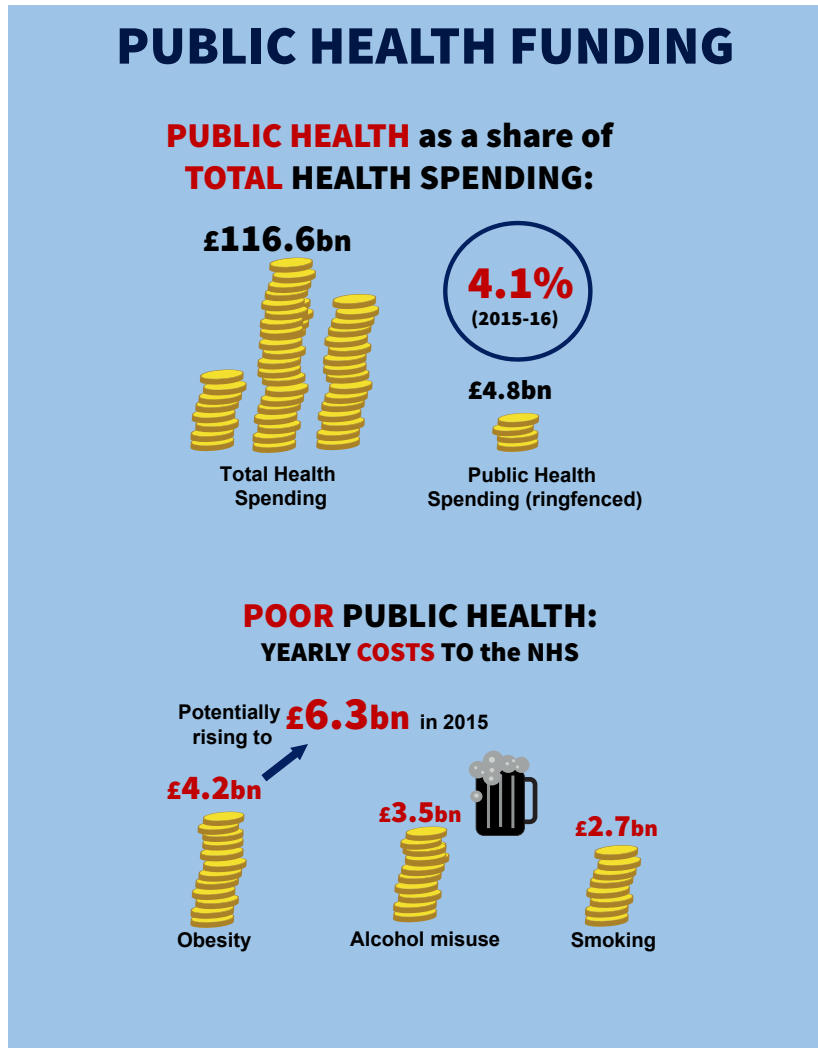
26. Funding allocations for public health activities were originally determined by a baseline audit of spending against public health activities by primary care trusts. There was wide variation in this historic expenditure across the country, ranging from £18 per head in Surrey to £108 per head in Westminster with an England average of £47 per head. This resulted in inequality of funding, as funding was matched to past spending, not need. A resource allocation formula has been devised to match funding more closely to deprivation and need. This formula suggests that Slough was receiving 48% under target, and Kensington and Chelsea was receiving 199% over target. The growth funding in the allocations in 2013/14 and 2014/15 was applied differentially with the aim of bringing councils closer to their target allocation. The most over-target areas received 2.8% growth in each of the years while the most under-target areas received 10% in each year.¹³ However, this reallocation has only resulted in small reductions to variations, and funding cuts have been made on an equal basis without reference to target allocations.

27. Funding sources for public health are likely to change significantly in coming years. In 2018–19 the ringfence will be removed, and central government grants to local authorities will be replaced by funding through retained business rates.

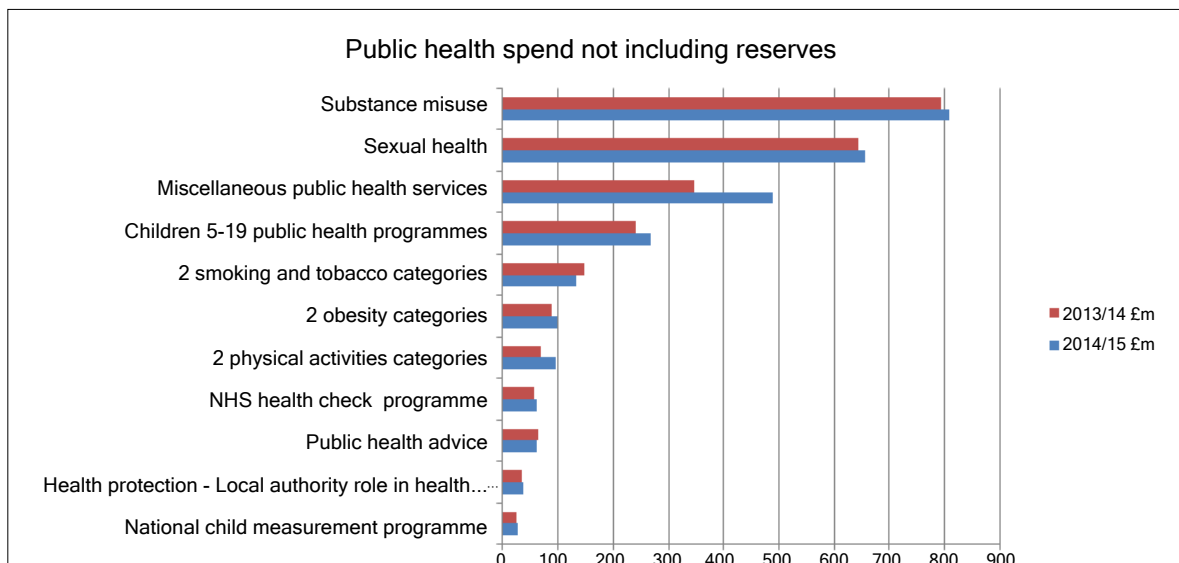
11 Health Foundation ([CSR0097](#)) p1

12 Calculations made by the House of Commons Scrutiny Unit.

13 Department of Health, [Public health Grants to Local Authorities 2013-14 and 2014-15](#)



Note: Health expenditure is measured as a total department expenditure limit, excluding depreciation. Sources: HM Treasury, Public Expenditure Statistical Analyses 2015. DCLG, Local authority revenue expenditure and financing England: individual local authority data – outturn. NAO report: [Public Health England's grant to local authorities](#), Figure 1, p.12



28. Our witnesses had mixed views on whether the removal of the ringfence was a positive or a negative development.¹⁴ There was concern that the formula for adjusting retained business rates should be carefully designed so as not to further disadvantage poor areas and compound health inequalities.¹⁵

29. Some witnesses argued that working within more straitened financial circumstances had the potential to prompt local authorities to be more creative about unlocking resources in other local authority services to achieve public health goals:

One of the reasons that **local government has sustained the level of funding cuts** so far is because of its **ability to innovate and do things in a different way**, which requires **professionals to help politicians** make the different decisions they need to make and run services in a different way.

[Martin Smith, Chief Executive, Ealing Borough Council, SOLACE, Q50]

The decades of **bearing the brunt of cuts** is not great for local government, but the one **positive** to come out of that is that we have become **very good at commissioning and redesigning services** and trying to deliver the same or better with **flat or reducing resources**. We have brought some of those skills to bear in relation to the contract that we took on. There are a number of examples I could give from Hackney, but if I look at one, which was smoking cessation services through general practice, through a **redesign of that service** we have moved from a **19% to a 51% quit rate** in a year, and it costs **the same amount of money**.

[Jonathan McShane, Chair, Public Health System Group/Local Government Association, Q21]

There are **opportunities** to work more closely with **community partners** around the provision of services, which is not necessarily around funding but **doing things differently**. Those are the opportunities that we need to focus on, because **funding is not going to get any better**, from what I can see of the settlements.

[Housing professional, informal session]

14 Q49

15 Q150

30. In oral evidence to us, PHE took a pragmatic view that the system would work with the resources it has:

No reductions in funding are welcome. However, we believe the **9.6% cash reductions in the public health grant** over the next five years, announced in the spending review, are **manageable**. Local authorities have a demonstrable record of **getting more for less** and PHE will support local authorities in this task using our intelligence and expertise.

[PHE, Written evidence, PHP0099]

31. However, NHS England's response in a recent Board Paper clearly illustrate the potential for public health cuts to derail the delivery of the Five Year Forward View:

[...] the Forward View called for a radical upgrade in prevention, and support for wider public health measures. Given the funding pressures in the local authority financed public health services and the need for wider government action on obesity and related challenges, we cannot yet conclude that this test has been met. Much hinges on whether the Government's proposed childhood obesity strategy [which has yet to be published] comprises an effective package of credible actions [...] Absent this, and other linked action, the NHS will be exposed to patient demand and consequent funding pressures over and above that modelled in the Five Year Forward View assumptions.¹⁶

32. Unsurprisingly, our witnesses from local authorities and public health services echoed these concerns, describing the cuts as 'galling', and as sending out a very unhelpful message that seemed to run counter to government policy:

So far...in terms of the efficiencies in the way we have recommissioned, we have managed to cushion a lot of things. **I do not think we can carry on doing that. As we...get into the reductions over the next few years, that is going to start cutting into some of the core services and I fear what that is going to do to outcomes.** There has been a lot of discussion about **sexual health services**. It is quite clear that we are going to have to start making reductions in that area. Some of the areas we would want to protect, such as **early years**, in line with Professor Marmot's recommendations, area also going to start to feel **the squeeze over the next few years**.

[Dr Eugene Milne, Director of Public Health, Newcastle Council, Q147]

If we are serious about what is being said in the **Five Year Forward View**, why would you do that? It **does not seem to tally**, so there is an **incoherence** to it.
[Martin Smith, Chief Executive, Ealing Borough Council, SOLACE, Q49]

It is **irrational to cut the prevention budget** when we are expecting so much of the overall healthcare system **to reduce demand on hospitals** and to close beds and all the other things that need to be done ... clinicians from all the [royal] colleges feel ... that cutting back on prevention in public health is **crazy** in this present context

[Professor John Ashton CBE, President, Faculty of Public Health, Q25]

We welcome the language in the Five Year Forward View about **the importance of prevention** ... but it is **frustrating** when you hear that **rhetoric** and it gets you excited, because you think we are beginning to win the argument and then **funding decisions** are taken that **undermine** that. You have to remember not only that the Five Year Forward View requires **efficiencies** that are hugely ambitious but that Simon Stevens is very clear that it demands that **shift to prevention**, which I assume means **at least maintaining public health spending** but also assumes maintaining **adult social care spending**—and **neither of those things are now happening**. These are not just issues for the services that we are talking about specifically in relation to public health. It is about **the viability of the whole system**.

[Jonathan McShane Chair, Public Health System Group/Local Government Association, Q47]

I am very concerned at **cuts to the public health budget** and cuts to the budget for the areas that I think impact on the health of the public. I am very concerned ... we know that, in general, areas with higher mortality rates, that is, **more deprived areas**, have had **steeper cuts to local government funding**other things being equal, [this] will have **an adverse impact on health inequalities**. Simon Stevens made very clear in his Five Year Forward View the **importance of prevention** ... I looked at a King's Fund report a couple of weeks ago looking at the question of waiting times in the NHS and they said it was pretty simple: demand had gone up, funding was relatively flat, and so **waiting times went up** ... What are you going to do? You can put more money into it, reduce demand or put up with longer waiting times. That is what you have to do ... What we are talking about has **the potential to reduce demand**, so it is, again, joined-up thinking

[Professor Sir Michael Marmot, Director, Institute of Health Equity, University College London, Q94]

33. Witnesses also explained to us that prevention is the first thing to get squeezed, but that this is a false economy.

We have a **sexual health service** to run. We know that most of the money will go on **treatment and the service**; it has to. The service will always demand and pull that, but, if you are **not doing any of the preventative work**, your service will go up and up, and that is just **wasteful money**.

[GP, informal session]

If you started from quite a **low base**, as a number of places did because of this **6.8-fold difference in funding per head**, then the wriggle room when you have **an in-year cut and then these other cuts** means that some of the stuff we all want to be doing, which is **the upstream prevention stuff, gets squeezed out** by things like treatment of drug and alcohol problems or sexual health services. That **does not feel sustainable** in the long run.

[Jonathan McShane Chair, Public Health System Group/Local Government Association, Q46]

On the one hand, you have **the public health services**, like screening, sexual health and so on, but on the other, as Jonathan has indicated, **a lot of public health work**, particularly on determinants, is **broader** than that and there has been a real growth of interest over the last few years in **community development in public health**. That working with community, supporting community leadership, health literacy and all sorts of other initiatives is what is really going to **suffer from a reduction in funding**. That is very worrying.

[Professor John Ashton CBE, President, Faculty of Public Health, Q49]

34. A Director of Public Health explained that because returns on public health preventative investment are often seen as very long term, this makes them particularly vulnerable to cuts:

If places start to **lose**, for example, **action on smoking in pregnancy**, that is going to impact on health not only now and within the next few months but in **70 years' time**, when people who were born with lower birth weight because we did not manage to do anything about the smoking then have heart disease. The outcomes are **spread over a long period**, and in a way that is what makes **public health vulnerable**; it is that you do not necessarily see those immediate changes. You **cannot put an easy number on to that impact**, but it will be there.

[Dr Eugene Milne, Director of Public Health, Newcastle City Council, Q147]

35. Simon Stevens, Chief Executive of NHS England, also emphasised the importance of protecting preventative services to ease pressure on and save money in more expensive parts of the NHS:

At the very least, we wanted the **availability of preventive services to be sustained relative to need**. An area where you get very quick payback, or indeed a **worsening of the situation** if those services are not there, for example, is **drug and alcohol services and sexual health services**. If those services diminish, that shows up as **extra demand in more expensive parts** of the National Health Service within **12 months, not within 10 years**.

[Simon Stevens, Chief Executive, NHS England, Q350]

Some of the evidence that has been provided to the Committee as part of this inquiry is that **many local authorities are cutting back on exactly those services you mentioned—smoking cessation and alcohol services**. Are you concerned about the **reductions** in those services?

[Helen Whately, Committee member, Q351]

To the extent that they have an **impact on downstream demand, clearly, yes.**

[Simon Stevens, Chief Executive, NHS England, Q351]

36. Witnesses from a wide range of different public health services and professional backgrounds also gave examples of the immediate impact of cuts on their services at our informal roundtable session:

As to **the reductions**, they are **incredibly challenging** because they come alongside **difficult cuts in broader local government budgets**. In particular, **the £200 million cut in year** is very challenging...

[Jonathan McShane, Chair, Public Health System Group/Local Government Association, Q25]

When we went over to the local authority in 2014, we were presented with a **wonderful service level agreement** that we would love to deliver, which incorporates **everything we want to do**. However, with **the number of nurses** we have and **the increasing number of schools, population and immunisation** programmes, **we do not have a hope of being able to deliver that**, and now we are being told that we will be cut rather than invested in.

[School nurse, informal session]

In particular, **the local services** based in my local area have seen **a 34% cut** to be managed in a short space of time. **Nobody** is looking after or protecting the interests of **substance misuse services** there.

[Substance misuse service manager, informal session]

I would echo the **variability** we have seen across the country. We have frequent reports of **cuts to services**, which are influencing **clinical delivery**

[Sexual health consultant, informal session]

The move to local authorities **should have improved** our ability to deliver public health services, and initially in many ways it did. Our DPH was really excited. Being able to walk across the floor to the drug and alcohol team, the children centres' team and so on has been wonderful, but, as someone said earlier, in many ways **the timing could not have been worse** because of **the cuts**. Smoking has been mentioned. On the one hand, we have **a reduction in still births**. A toolkit has just come out, and "Stop smoking" is the first plank of that. On the other hand, we are sitting in meetings every week where people say that if we stop the stop smoking services it will save **£70,000**. I am doing a big piece of work on **prematurity**. You have £70,000 and prematurity. There does not seem to be any sense in some of those discussions, but **the council is in an impossible position in terms of what it has to save**.

[Consultant midwife, informal session]

One of our great concerns is about **addiction services**. We have seen great **cuts**. The new system means you can cut services **without people knowing what you are cutting**. Where I work in east London, it has been **a race to the bottom** for **the cheapest service and cheapest provider**. In general hospitals where I work, I have seen **enormous consequences** and an increased burden on our **emergency** department, because there is **not even a nurse or doctor in the building** to prescribe for withdrawals of various medications.

[Psychiatrist, informal session]

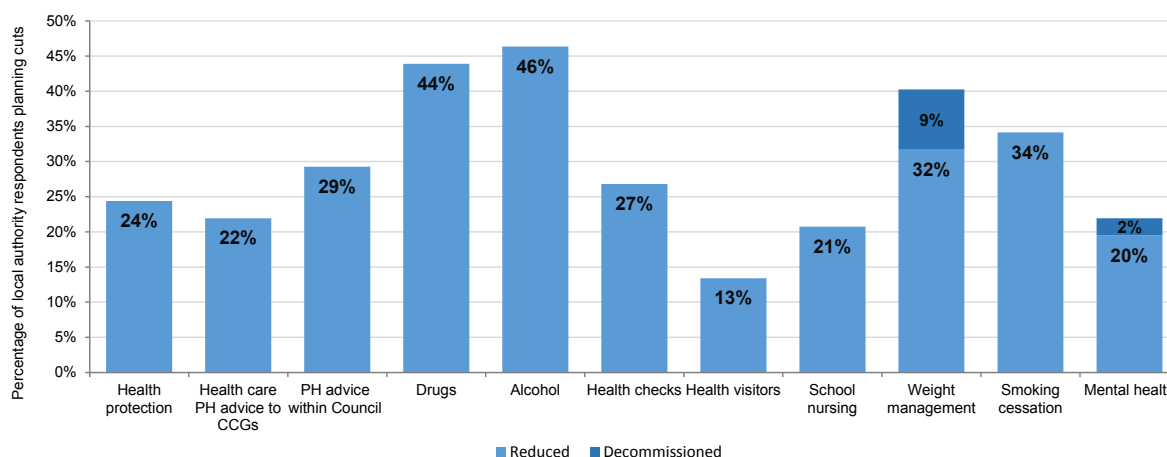
We are **unlucky** enough to be in the borough that has **the highest rates of childhood obesity**, yet we have **less than two full-time equivalent dietitians** working in this area. We have seen cuts to our teams.

[Dietician, informal session]

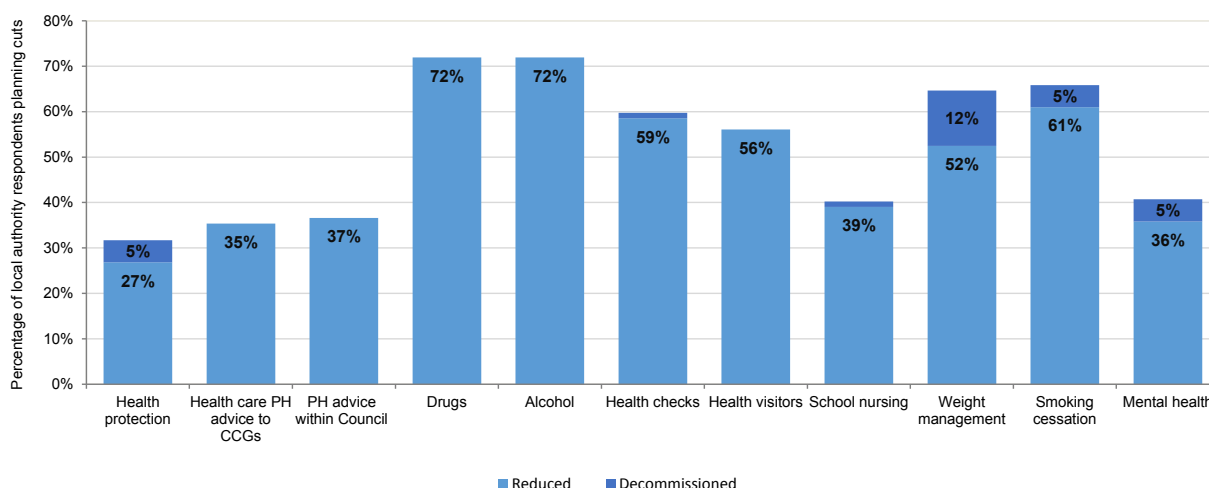
It is becoming clear, if you look at the national picture, that whether **the local authority is prepared** to fund or commission posts going forward for health visiting **depends very much on where you live**. Some areas are looking at **40% reductions in health visiting staff**, which is quite scary. Obviously, there is a sunset clause at the end of 18 months. While the services will be secure until then, it is safe to assume that because of **the cuts in the social care budget** it will **impact upon health visiting** going forward.

[Health visitor, informal session]

37. A survey commissioned by the ADPH shows that local authorities are planning cuts across a wide range of public health services both in 2015–16 and 2016–17:¹⁷



Source - ADPH; 2015–16



Source - ADPH; 2016–17

Conclusions and recommendations

38. As we concluded in our recent report on the Spending Review, cuts to public health funding are a false economy and jeopardise the delivery of the demand and efficiency savings essential to a sustainable NHS outlined in the Five Year Forward View.

39. Local authorities have managed to make some savings by recommissioning services, but they are at the limit of the savings they can make without adversely affecting the provision of services. Preventative services are likely to be particularly affected including those investments which support long term health and wellbeing.

40. Cuts to public health are a false economy. The Government must commit to protecting funding for public health. Not to do so will have negative consequences for current and

¹⁷ ADPH, [Impact of funding reductions on public health](#), February 2016

future generations and risks widening health inequalities. Further cuts to public health will also threaten the future sustainability of NHS services if we fail to manage demand from preventable ill health.

41. We recommend that the Government sets out how changes to local government funding and the removal of ring fencing can be managed so as not to further disadvantage areas with high deprivation and poor health outcomes. We plan to return to review the variation in funding and outcomes.

3 The new system

Systematically improving public health and addressing unnecessary variation

Summary

The new public health system is designed to be locally driven, and therefore a degree of variation between areas is to be expected. However, we are concerned that robust systems to address unacceptable variation are not yet in place, and sharing best practice is not yet happening at a scale which will systematically improve public health.

42. The public health system is now firmly centred on the principle of localism—local public health strategies designed by local teams, to meet the specific needs of local populations. This means that a degree of variability is inevitable and indeed desirable if it reflects local priorities.

In many ways some **variation** is entirely right and proper because **places are very different**....we are working on what might be called **unacceptable variation**, where there is not a logical reason why things vary...there are some areas where we are sure that we can level up; that the best can help the people who are still learning. The process for doing that is called **sector-led improvement**; the Local Government Association and the Association of Directors of Public Health have done a lot of work on it, and we **support that with our tools and data**.

[Richard Gleave, Deputy Chief Executive and Chief Operating Officer, Public Health England, Q281]

43. We chose two distinct areas of public health as case studies to examine in more detail—health in all policies, and health protection. Subsequent chapters discuss these functions in more detail. We found that both functions were noticeably better developed in some areas than in others. This suggests that while some areas may be making solid progress, a considerable challenge remains to bring the worst performers up to the level of the best. Professor John Ashton of the Faculty of Public argued that:

...there should be **140-plus directors of public health** in teams around the country. It feels to me as though we have perhaps **30 or 40 that are doing quite well**, and there are still some areas that **do not have a director of public health** and do not have the leadership in place. Then you have the ones in the middle that vary a lot.

44. Andrew Furber of the Association of Directors of Public Health gave a more positive view. He said in terms of the proportion that are succeeding, “I would say maybe it is 80:20, or 90:10. There are a handful of local authorities where it is still not working quite as we would hope.”¹⁸

45. One public health trainee who had worked in different local authority areas noted variability, and remarked that in her current posting:

We have **excellent integration with the local authority**; we have been welcomed with open arms; and our specialism is respected. We are **well integrated with our partner organisations**, externally and internally, and I am relieved to be there because it is an **excellent example** of how public health post-2013 has worked really well. My experience of working in other areas is that that **does not seem to be reflective of the wider national picture**.

[Public health registrar, informal session]

46. When we asked about the mechanisms for sharing best practice, and also who holds the ring where a system is failing to deliver improved public health outcomes for its population, we were not persuaded by the answers we received.

Sector-led improvement

47. Local authorities are meant to share best practice with one another and improve their performance through a process called ‘sector-led improvement’ rather than through a central performance management system. In this, local authorities are supported by national organisations—the LGA, the ADPH and PHE:

From our place now within local government, instead of the performance management arrangements we had within the NHS, we are moving ahead on the basis of **sector-led improvement**. **Public Health England** has supported us, as has the **LGA** in establishing the sector-led improvement approach within public health, which does that very thing. It looks at **who is doing well** on teenage conceptions or alcohol, or whatever the issue is, **what they are doing that is working well**, how we can **share** that practice and how we can **avoid reinventing the wheel**. That is the mechanism for doing that.

[Andrew Furber, President, ADPH, Q70]

The LGA—I will put in a plug for the Local Government Association—**support** us with that **and use sector-led improvement**, which **does not exist in the NHS**. That is about us **helping ourselves do the best thing**. It is about **peer review, support and benchmarking**, but it is all **internally** driven. It is a very **powerful** way of getting people involved in things.

[Dr Virginia Pearson, Director of Public Health, Devon County Council, Q129]

48. We also asked how well this ‘sector-led improvement’ was working in the area of health protection, but there was less confidence in the process:

Is there a **national forum** within which these different solutions can be **shared**? The thing that strikes me is that everyone is having to find their way ... Is there a way of **accelerating everyone** to arrive at solutions, even if it is different ones? Do you have a **national space** in which all of this learning can be shared?

[Dr Philippa Whitford, Committee member, Q258]

There is a national forum. The Local Government Association has a **public health conference** every February, for example, and both Public Health England nationally and the **LGA** have a very **key role** to play in making sure we share good practice. I referred earlier to my role as a **peer reviewer**, and the **peer challenge process** for health and wellbeing boards is an excellent process.

[Professor Kate Ardern, Director of Public Health, Wigan Council, Q258]

...we are still working our way through that in terms of **how we share good practice**. But, hand on heart, I **do not think**, nationally, **we are terribly good at that**. We are good at learning it in localities; at **a national level we find that more difficult**.

[Paul Davison, Deputy Director Health Protection, PHE North East, Q258]

Public health outcomes

49. To determine whether improvement is taking place, outcomes need to be consistently and transparently monitored. When we asked about public health outcomes, we were told they had remained broadly stable since the changes:

The public health outcomes framework tracks **149 indicators**. In the last three years **80%** of those have been **level or improving**. There are problems and there are some areas that we are concerned about, but the overall picture is of **continuing improvements in health**. Of course, that is only two or three years in, and many of these indicators you would expect to take some time to change.

[Professor John Newton, Chief Knowledge Officer, Public Health England, Q279]

50. The three areas of concern highlighted by PHE are sexual health, breast feeding, and uptake for two cancer screening programmes. PHE argue that “Nevertheless, it is still an overall positive picture on the outcomes.”¹⁹ However Martin Reeve, a local authority chief executive from London, gave a more challenging view of the data:

If you look at the **public health outcomes for the nation**, the trajectory is as good as, if not slightly better, than under the previous arrangements, but it is **nowhere near good enough**.

[Martin Smith, Chief Executive, Ealing Borough Council, SOLACE, Q10]

51. The Five year Forward View is clear that a step change in public health was required if the NHS was to deliver the ambitious savings set out:

The first argument we make in this Forward View is that **the future health** of millions of children, the **sustainability** of the NHS, and the **economic prosperity** of Britain all now depend on **a radical upgrade in prevention and public health**

52. When pressed on exactly how much savings the radical upgrade of prevention and public health needed to deliver, Simon Stevens put the figure at between £0.5 billion and £1 billion.²⁰

53. We heard of some local authorities measuring outcomes. For example, Shirley Cramer of the Royal Society for Public Health described progress on improving cardiovascular outcomes in Wigan and Leigh:

We say that **public health is long term** and there are long-term outcomes, and of course there are, but we can see some **shorter-term improvements** and we should be **aiming** for those in an ambitious way. Many local authorities are doing that, and we want to encourage that and make sure that **they have the tools and the framework nationally** in order to do that and **to support people in local authorities**.

Shirley Cramer CBE, Chief Executive, Royal Society for Public Health, Q91

54. Coventry reported improvements in physical activity levels, as well as other indicators relating to the broader determinants of health.²¹

55. However on the whole there appears to be a disconnect between the official ambition to deliver significant savings through a radical upgrade of public health and prevention and the lack of rigour in implementing this ambition, with little systematic monitoring of local authorities' progress towards specific public health goals at a national level.

56. While availability of information about public health outcomes has improved, there are 144 separate indicators in the public health outcomes framework, making the data available complex to interpret. A simplified version of this information is also available for members of the public on the My NHS Website. However, it is still difficult for us, as a Parliamentary Committee, to scrutinise and compare the performance of local authorities robustly and objectively.

57. Individual local authorities agree local priorities for public health, and the best outcomes for monitoring them, through their Health and Wellbeing Strategies—but these plans are not subject to external quality assurance, and information about local authorities' performance against local priorities is not collected systematically. Health and Wellbeing Boards are not required to implement their Health and Wellbeing Strategies, and nor are they held to account for delivering them.

58. Public Health England have made it clear that they “are not the performance manager of local government”.²² They did describe a protocol for managing the risk of underperformance which they have developed with the LGA and ADPH, around giving extra support to local authorities which need it, as well as weekly and monthly contact with local authorities. PHE also gave an example of when they had stepped in to influence a particular local authority which was proposing substantial reductions to its service for 0–5 year olds, a proposal that was then

20 Q348

21 Coventry City Council ([PHP0137](#))

22 Q284

withdrawn as a result of PHE's intervention.²³ While it is reassuring that this case was picked up by PHE and acted upon, the mechanism for public accountability and transparency about public health decision making and performance at a local level is far from clear.

59. Ultimate accountability for local authorities' performance on public health now lies with elected members of local authorities, and with the public through the ballot box. However, for accountability to be exercised, the public need a clear articulation of the actions their local authority is taking and their planned impact, underpinned by a benchmarking framework that allows for informed comparison and challenge between local authority areas, to provide a mechanism for closing the loop so that local authorities can be held to account.

60. A return to a centralised system which sets a national public health strategy for all local authorities and enforces progress against it is not likely to be possible or workable, or necessarily desirable. However, as improvements in prevention and public health are crucial to the ongoing sustainability of the health service, it is essential that the contributions local authorities are making towards this national goal are measured and underperforming areas are supported to improve, and held to account if they do not.

61. Prevention is intended to be an important element of local Sustainability and Transformation Plans, and guidance has been issued to local areas setting out national expectations in this area. However, planning in most, if not all, areas is still at an early stage, and it is not clear how rigorously this guidance will be enforced or what will emerge when the STPs are finalised. The funds earmarked to support STPs are likely to be under intense pressure, which is once again likely to marginalise public health.

Conclusions and recommendations

62. There is variation between local authority areas in terms of their public health provision. The system of 'sector-led improvement' is beginning to be used to good effect in some areas, and clearly has potential to deliver performance improvements. However, in our view, this programme needs to be given added impetus and more clearly linked to accountability and performance.

63. Currently local Health and Wellbeing Strategies identify priorities and targets at a local level, but progress against these is not enforced or monitored. Sustainability and Transformation Plans may offer another opportunity to embed public health and prevention targets, but these plans are at an early stage in development. While ultimate accountability for local authorities' performance now rests with the voting public, there is a lack of comparable, comprehensible information on public health performance for the public to access easily.

64. We recommend that local authority directors of public health should be required in their statutory annual reports to publish clear and comparable information for the public on the actions they are taking to improve public health and what outcomes they expect to achieve, and to provide regular updates on progress. While public health priorities may be different for different areas, which is entirely appropriate, they should be presented in a standardised format, and underpinned by a benchmarking framework that allows for informed comparison and challenge. The Chief Executive of Public Health England, in his capacity as accounting officer, should publish an annual report drawing together and analysing local progress towards agreed plans.

65. We also reiterate the recommendation of our recent report on the impact of the Spending Review on health and social care that the Government should set out clear milestones of what it expects public health spending to achieve, and by when.

Politics and evidence

While strong political leadership can bring enormous benefits for public health, there is also the potential for tension between political priorities and evidence based decision making. Clearer standards should be introduced and monitored transparently to improve accountability.

66. Locating public health within local government has also placed it at the heart of local democracy. Many described the boost that political leadership could give to public health which was lacking when the NHS had lead responsibility for the function.

Where there is **good political leadership** it can take you to places you cannot get to **just with evidence-based practice** because of **the links with the local community.**

[Public Health consultant, informal session]

When I went to **Coventry**, when they had a big meeting to celebrate the first two years of being a Marmot city, only—it seemed to me—by chance I met the director of public health. I was entertained to breakfast by the chief executive—a very impressive person—and the leader of the council. They were clearly driving it because the **director of public health cannot** get early child development services and education, transport **and all the other things that need to be lined up, but the chief executive of the council can.**

[Professor Sir Michael Marmot, Director, Institute of Health Equity, University College London, Q81]

There is something for me about the **empowerment** that you have **as a director of public health** working in a body that contains **democratically elected members**. It is an **incredible experience**. I have been born and bred in the NHS, but the work that we do, working with those elected members and **bringing democracy into what we do in public health, is very powerful**.

[Dr Virginia Pearson, Director of Public Health, Devon County Council, Q108]

67. Others raised concerns about politics rather than evidence determining spending priorities, which could be of particular detriment to services for more marginalised or stigmatised groups:

The **bigger issue** is that the groups like **drug and alcohol**, which are not popular and may not be subject to demonstrations on the steps of the county council building, **can get missed**.

[Breastfeeding counsellor, informal session]

One of the main issues is **accountability for and governance** of what **local authorities have to do** for their local populations. I know that a lot of it is about **localism** and being **locally democratically responsive and accountable**, but then you run into problems where you have something that is not necessarily politically palatable or popular, like **providing services to drug and alcohol users and migrant health services**, which **will not get you any votes** and, therefore, are not necessarily high on the local authority's agenda, depending on where you are.

[Public health registrar, informal session]

As you mentioned, **public health doctors are evidence-based**, which is fantastic. That is what doctors believe in and what we go for, but **politicians are not**. Rebecca's point about the £1 investment for a £14 payback was incredibly well made. That seems to be such an easy win, but our **public health colleagues are not winning that argument** with their political colleagues for whom they have to work. If you are in a situation where **highly-trained public health specialists are working incredibly hard** within a **very squeezed budget** to produce excellent advice that is being **ignored**, what is the point?

[GP, informal session]

When things were delivered from **the NHS**, they were done because they were needed and **vulnerable groups were provided for**. It should be led by what is **the right thing to do**. You can involve the **local population and substance misusers** in that area, but if things are **not popular** sometimes they are **not done**. That is not fair; it is not right.

[Public health registrar, informal session]

68. A particular issue was the whether the director of public health was able to give a truly independent view:

You are there as part of the team because **that is how you get influence**, but, professionally, **we do need that independence...** **The public health report is the only report that goes to Devon county council** where it is my report. It is **not** a lead member's report; it is **not** a political report; it is my report and they know that. They are a bit wobbly about... but they have embraced that... **That independence is very important** because things may come up that we are not happy about and we have to have **the freedom to speak**.

[Dr Virginia Pearson, Director of Public Health, Devon County Council, Q112]

A litmus test ... for innovation might be the sort of thing that we did in **Liverpool in 1986**, which was to establish **the first large-scale syringe exchange programme in the world**, which was very **controversial**. If we were back in the 1980s, with AIDS just on the horizon, an **epidemic of heroin injection and high youth unemployment**, which is what we faced in Liverpool at that time, **would a local authority public health director today be able to do that** when it was so **controversial** and when you would see the battle lines drawn up? Somehow there needs to be **the space for directors of public health acting professionally on evidence**, as far as possible, to do that kind of thing.

[Professor John Ashton CBE, President, Faculty of Public Health, Q50]

69. Many services that used to be provided by the NHS—including smoking cessation services, drug and alcohol treatment services, and sexual health services—have been recommissioned by local government. We heard significant concerns about this recommissioning from those involved in running such services, including claims that services were being restricted or were of a poorer quality than previously.²⁴ However we also heard an opposing view that although the changes may have been unsettling for established providers, in fact new commissioning arrangements had resulted in services which delivered better value for money, better matched to local needs than previously, and accessible and appreciated by service users.²⁵

Conclusions and recommendations

70. It is clear that good political leadership for public health has enormous potential to deliver positive change. However, amongst some public health professionals, concerns remain about the tension between evidence-based decision making and political priorities. In particular, concerns were raised about the potential for services such as sexual health and drug and alcohol to be neglected, if felt not to be political priorities, and are unlikely to generate demonstrations on the steps of the town hall. To address these concerns, **benchmarking standards for all local authorities' prescribed public health functions should be introduced, which should be transparently monitored to enhance accountability and provide reassurance that these functions are being maintained at an appropriate level.**

Boundary issues and fragmentation

Summary

Commissioning for certain services is divided between different bodies, creating confusion and fragmentation. Sexual health provides a clear example of this.

²⁴ Informal roundtable session with public health practitioners

²⁵ Q21

71. With a wider range of different organisations now involved in the commissioning and delivery of public health services, complexity and fragmentation was a common theme in the evidence we received. In some cases our witnesses were clear that the system was not ‘broken’, but that it had left them with a greater number of boundaries and relationships to negotiate.²⁶ We also heard that two-tier local authorities face particular challenges.²⁷ Drawing on their assessment of the new public health system, the University of Kent offered the following observation²⁸:

The **new system of public health (PH)** is perceived as being **more complex and fragmented** than that which existed prior to 2013 ... Our findings highlight the **fragmentation of the new system**, and the **continued state of change** as structures and processes evolve, and as roles and relationships are developed

72. Sexual health, screening and immunisation are examples given where fragmentation has been detrimental:

Recent changes have created **a fragmentation** in the commissioning and delivery of **GUM and HIV services**. ... Commissioning integrated **sexual health outside the health service** has meant services have been **uprooted** and relocated apart from each other, increasing fragmentation to the **detriment of patient access and care**. There are indications in **some areas of England** that the continued delivery of existing HIV services will become **untenable** due to these fractures in commissioning there are also concerns that due to this increase in fragmentation, **cervical screening tests** are no longer being routinely provided in local authority-commissioned sexual health services, as responsibility for national screening programmes falls under the purview of NHS England.

[BASHH]

There is a **fragmentation in screening and immunisation functions** there is a clear **disconnect** within the system between **the commissioners (NHSE/PHE)**, **the local intelligence about providers (GP's and Trusts)** and **the population**.

[ADPH]

26 Q249

27 Q108

28 University of Kent ([PHP0022](#))

Health and Wellbeing Boards

73. The Health and Social Care Act 2012 placed a statutory duty on local authorities to create a Health and Wellbeing Board (HWB) as a committee of the authority. HWBs bring together partners within the NHS, public health, adult social care and children's services as well as elected members and representatives from Healthwatch, in an effort to ensure strategic planning based on local health needs. Local authorities have statutory duties to develop Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Strategies (HWSs) to be discharged through the HWB. These are the principal mechanisms by which HWBs and partners are able to jointly plan and support delivery of improvements to the health and wellbeing of local populations, although they have no powers to ensure the implementation of the HWS.

74. The available evidence indicates considerable variation in the configuration and operation of HWBs.²⁹ Promoting integration across sectors and delivering strong leadership across organisational boundaries have proved to be especially challenging for HWBs, which have very few powers to make things happen.³⁰ Their authority does not lie in having executive powers but in their capacity to influence others through the persuasiveness of their arguments and success in building sound relationships.

75. The evidence we received concerning HWBs and their performance was mixed. Whereas the Public Health System Group maintained that HWBs 'are becoming a key forum where local partners can agree how to harness the sum of local resources to address key health challenges'³¹, NHS Clinical Commissioners gave a less positive view. They believed that HWBs were struggling with achieving 'clarity around the role and purpose of the Board' with CCGs in particular not yet seeing HWBs as 'conducive environments for meaningful discussions about public health'.³² The University of Kent research found that the HWB 'is crucial in ensuring local governance and stewardship' and that Boards 'could play a crucial role in bringing together a fragmented system'. However, they were still considered to be in 'early development'.³³

76. The latest evidence suggests that most HWBs continue to address the challenges they face with variable success. Progress is slow and subject to constant changes in, and demands from, national policy. This can result in Boards losing focus and in trying to do everything, with 'mission creep' a real and present danger.³⁴ A key conclusion to emerge from the evidence is that the majority of HWBs have yet to position themselves as the key strategic forum for driving the health and wellbeing agenda.³⁵ Despite these difficulties, there is cautious optimism about the future of HWBs and their ability to bring and hold the health system together thereby reducing

29 Coleman A, Dhese S and Peckham, "Health and Wellbeing Boards: The new system stewards?" In: Exworthy M, Mannion R and Powell M (eds) *Dismantling the NHS?* Bristol: Policy Press, 2016

30 Hunter DJ, O'Leary C, Visram S, Adams L, Finn R, Forrest A and Gosling J (2015) *Evaluating the Leadership Role of Health and Wellbeing Boards as Drivers of Health Improvement and Integrated Care across England*. [Interim report no. 2: Mapping the configuration and operation of Health and Wellbeing Boards across England](#). Durham: Centre for Public Policy and Health, Durham University.

31 Public Health System Group ([PHP0065](#)) p2

32 NHS Clinical Commissioners ([PHP0084](#)) para 3.6

33 University of Kent ([PHP0022](#)) para 2.16

34 Shared Intelligence, *The force begins to awaken: A third review of the state of health and wellbeing boards*, 2016

35 Peckham S, Gadsby E, Coleman A et al, *Public Health and Obesity in England – the New Infrastructure Examined*. Final report. PRUComm: Policy Research Unit in Commissioning and the Healthcare System. Canterbury: University of Kent, 2016

the fragmentation that threatens it in many places.³⁶ It is generally acknowledged that HWBs have a critical role to play in creating the conditions in which discussions can take place between councils, CCGs and service providers on the future shape of local health and social care systems.³⁷

Commissioning of Pre-exposure Prophylaxis for HIV

77. The recent issue of commissioning of Pre-Exposure Prophylaxis for HIV is another example of the new structures causing fragmentation and confusion. In September, 2014, NHS England announced that PrEP would be put through the NHS England specialised commissioning prioritisation process, and it proceeded through this process for 18 months. In March this year NHS England announced that in fact commissioning of HIV prevention services was the responsibility of local authorities rather than NHS England.³⁸ In response to the considerable concern expressed at this decision, NHS England are now seeking further clarification on the legal position, but the situation has clearly caused confusion and delay, rather than concentrating efforts on the evidence for PrEP and how it can be resourced.

Conclusions and recommendations

78. The new system for public health is more complex following the changes made by the Health and Social Care Act, and fragmentation has caused difficulties in a number of areas. Any system will have boundaries but further large scale restructuring would not, in our view, be advisable. There is a need to address the system boundary issues that have negative consequences and make sure that they are addressed in the best interests of patients.

79. The outstanding issue of who is responsible for commissioning PrEP for HIV needs immediate resolution, and we recommend that NHS England and DH clarify the position without delay.

80. Where boundary issues are identified around responsibilities, PHE should set out the options for them to be addressed in the best interests of patients and the public and ensure that they are resolved without further delay.

Leadership for public health at a national level

There is a need for greater clarity on national public health leadership. We also recommend that a Cabinet Office minister is given responsibility to drive forward strengthened cross-departmental working on public health.

81. Just as the risk of fragmentation exists at local level, with the onus on Health and Wellbeing Boards to provide system leadership, there is also a risk of fragmentation at the centre. Nationally, responsibility for public health is split between the Department of Health, Public Health England and NHS England. There are also arm's length bodies, notably Health Education England (HEE)

36 Shared Intelligence - as above

37 Local Government Association and NHS Clinical Commissioners, Making it better together: A call to action on the future of health and wellbeing boards, 2015

38 NHS England, [Update on commissioning and provision of Pre Exposure Prophylaxis \(PREP\) for HIV prevention](#), March 2016

and NICE, which have a role in public health in regard to workforce training issues and providing guidance on what works and does not work in public health respectively. In addition, the Local Government Association seeks to support local authorities through a series of publications demonstrating good practice and by offering a peer review system to local authorities wishing to assess their performance. In such a crowded landscape, clarity over system leadership at national level is lacking.

82. The University of Kent researchers who have completed a study of the public health system in England told us that directors of public health:

felt poorly supported by national and regional organisations such as the Department of Health, NHS England and Public Health England—a perception echoed by elected members.³⁹

Health in All Policies nationally

83. While embedding health in all policies is being actively encouraged in local authorities, with some impressive projects emerging, as we saw during our site visit to Coventry, the same commitment needs to be given higher priority nationally in central government. However, we were encouraged to hear from the Parliamentary Under-Secretary of State for Public Health that the Government’s life chances and childhood obesity strategies are examples of cross-government working.⁴⁰

84. We have called for bold and brave action if the Government is to tackle health inequalities and improve life chances for the most disadvantaged.⁴¹ When it comes to taking action on public health there are steps, such as introducing a sugary drinks tax on manufacturers of full sugar soft drinks, that only national Government can take and we support this measure and urge the new Chancellor to implement it.

Cabinet sub-committee for public health

85. We received differing views as to the value of having a cross-departmental Cabinet Sub-Committee on Health similar to that which existed until 2012. Overall, the evidence we received did not persuade us that such a sub-committee had been a key driver for change or that it should be re-established. Jonathan McShane from the Public Health System Group and LGA had “no idea how effective Cabinet Sub-Committees are as a way of driving change, but public health is much higher up on the agenda than at any time I can remember”. He added that he would “always be wary of a solution to a problem that sets up a committee”.⁴²

86. This view was echoed by the then public health Minister Jane Ellison MP, who told us that she preferred to work “with a very defined outcome, a policy objective, a strategy or a new policy to deliver”.⁴³ She thought it far “better to meet with a purpose” rather than “talking for its own

39 University of Kent ([PHP0022](#)) para 2.20

40 Q378

41 Health Committee, [First Report of session 2015-16, Childhood Obesity - Brave and Bold Action](#), HC 465

42 Qq 56–57

43 Q379

sake” and “then we can be judged by our output and outcomes”.⁴⁴ Both the Minister and Duncan Selbie, chief executive of PHE, told us about joint working in the area of health and work between the Department of Health and DWP.⁴⁵

87. The Faculty of Public Health suggested that in place of reinstating a Cabinet Sub-Committee, consideration might instead be given to having a Minister for Public Health located in the Cabinet Office.⁴⁶

Relationship between DH and PHE

88. We are aware of potential overlap and duplication between the public health group in the Department of Health (DH) and Public Health England (PHE). The Committee of Public Accounts has previously investigated this relationship and was not convinced that there was no avoidable overlap or duplication of effort.⁴⁷ We are aware that DH is conducting a review of the respective roles and activities of the DH and PHE. The Department of Health has also recently announced an internal restructuring. This may provide an opportunity to reconsider the existing relationship between DH and PHE with a view to using limited resources, both human and financial, more effectively.

Relationship between PHE and NHS England

89. Following publication in October 2014 of the NHS Five Year Forward View, NHS England has assumed a more prominent role in driving prevention within the NHS. As we have already pointed out, much of the success of the Five Year Forward View is predicated on the successful achievement of a radical upgrade in prevention and support for wider public health measures.

90. While welcoming a renewed focus on public health and the NHS’s significant contribution to it, we wish to be reassured that PHE and NHSE are working in tandem on this agenda rather than in a silo-based manner. The partnership between PHE and NHSE over the diabetes strategy is an example of good practice and we hope that such a joined-up approach will become the norm for future initiatives.

Conclusions and recommendations

91. National system leadership is important to signal clarity of purpose and commitment to the local system when it comes to improving health and wellbeing. In order to demonstrate where national leadership for public health lies, and to avoid confusion and the risk of giving conflicting advice to the local system, the Government should produce a clear statement of who does what in respect of the main system leaders, namely, the Department of Health, Public Health England and NHS England.

92. Embedding health in all policies is important at both national and local level. But while there is evidence of progress locally, there is less evidence of such an approach becoming embedded across Government departments. We urge the Government to take bold and brave action through its life chances and childhood obesity strategies in order to improve public health and reduce health inequalities.

44 Q379

45 Qq378–379

46 Q57

47 Oral evidence taken before the Committee of Public Accounts on 19 January 2015, [HC \(2014-15\) 893](#), Qq131–133

93. How most effectively to secure joined-up working across Government is a complex challenge to which there is no single or simple solution. The issue is not amenable to a simple structural fix—building sound relationships is a key step in the process.

94. A Cabinet Sub-Committee on Public Health is unlikely in itself to be the answer to securing more effective joined-up policy to improve health and wellbeing. We consider instead that the strengthened cross-departmental working which is required is more likely to be achieved by vesting responsibility for providing political leadership for public health at a national level in a Minister in the department responsible for coordinating cross-departmental work, the Cabinet Office. We recommend that a Minister in the Cabinet Office be given specific responsibility for embedding health in all policies across Government, working closely with the Minister for Public Health in the Department of Health.

95. Since Public Health England was established, the interface between it and the DH has lacked clarity. We therefore urge the Government to review the relationship between the DH's Public Health Group and PHE. The 'tailored review' of PHE which DH is currently carrying out offers a good opportunity to do so.

96. Likewise we urge NHS England and PHE to clarify how the two organisations are seeking to pool their expertise and resources around public health in order to ensure that the local health system feels adequately supported and not conflicted by confusing messages or requirements.

4 Enabling public health teams to work effectively

Access to data

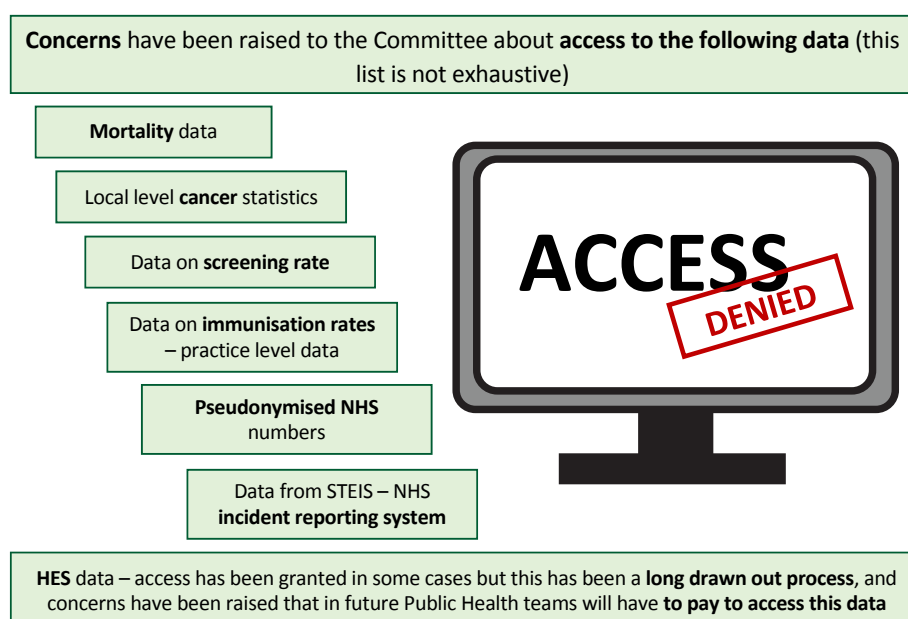
Summary

There are significant problems with public health teams not being able to access the information they need to do in order to do their jobs effectively. In some cases these may not have been a direct result of the move of public health teams to local authorities, but nonetheless they need to be addressed with urgency.

97. In its evidence to our inquiry, PHE acknowledges that there have been problems with data, but say that they are beginning to be addressed:

I completely agree that at the moment **directors of public health do not have good enough access to the data** that they need **to do their jobs**. It is **variable** across the country. Again, it is one of the things that varies, but nevertheless **there is a problem**. It is in two categories. The first is **getting access to data on healthcare activity** for their population. The second is in **getting access to operational data about the public health services** that they commission – things like vaccination and screening services.

[Professor John Newton, Chief Knowledge Officer, Public Health England, Q316]



98. A full list of the data public health professionals have told us they need but currently lack access to is contained at Annex 1.⁴⁸

48 Acronyms used in diagram: STEIS - Strategic Executive Information System ; HES - Hospital Episode Statistics

99. In some cases, data is beginning to flow, but public health professionals report that it has taken nearly three years of campaigning to get it.⁴⁹ When data does come through, there is often a significant time lag, and an inability to link it to other data sets.⁵⁰ In some cases, local solutions have been found, but they have involved very time consuming work-arounds.⁵¹

100. Professor Newton, Chief Information Officer at PHE, told us that PHE would like to see more support from the Health and Social Care Information Centre (now known as NHS Digital) in providing access to local government for data, and in particular he told us that the policy that data linkage can only happen centrally—at NHS Digital—needs to be revisited and reviewed.⁵² He went on to explain that the information strategy published in 2012 was clear that all data linkage must take place within the NHS Digital.⁵³ However, in Professor Newton’s view, NHS Digital “is not yet set up to be able to deliver those services”:

“The situation we have is that the information – **the data – is in one place**, and the **people** who have the capacity and capability to use it **are in another**”.
[Professor John Newton, Chief Knowledge Officer, Public Health England, Q325]

101. The policy of data linkage only happening centrally also causes problems for local area public health teams who want direct access to their local data to be able to carry out ad hoc studies.

Conclusions and recommendations

102. **Our inquiry has identified numerous problems with access to data for public health professionals, which is creating barriers to effective joint working. We are pleased to note that efforts are now ongoing within Public Health England to address these problems.**

103. **Public health teams need to be able to access data in patients’ interests. We were told by PHE’s chief knowledge officer that a change in policy was needed to remove the current restriction that all linkage of health and social care data can only take place centrally, within NHS Digital (HSCIC). We recommend that the Department of Health review these barriers.**

104. **Some areas have managed to access the data they need, and others have not. Some areas also lack the capacity to analyse their data. A co-ordinated national support programme is needed to ensure that until data is easily available to local authorities, all areas at least understand what data they are able to access, and how they can do so.**

105. **PHE identified two types of data public health specialists are having difficulty in accessing—access to population healthcare data, and access to operational data about the services they commission. Annex 1 to this report contains a compilation of the concerns public health professionals have raised to this inquiry regarding access to data, and we ask PHE and NHS Digital to provide a response to us on each point raised. We will revisit this issue to check progress in six months’ time.**

49 Q134

50 Q134

51 Q134

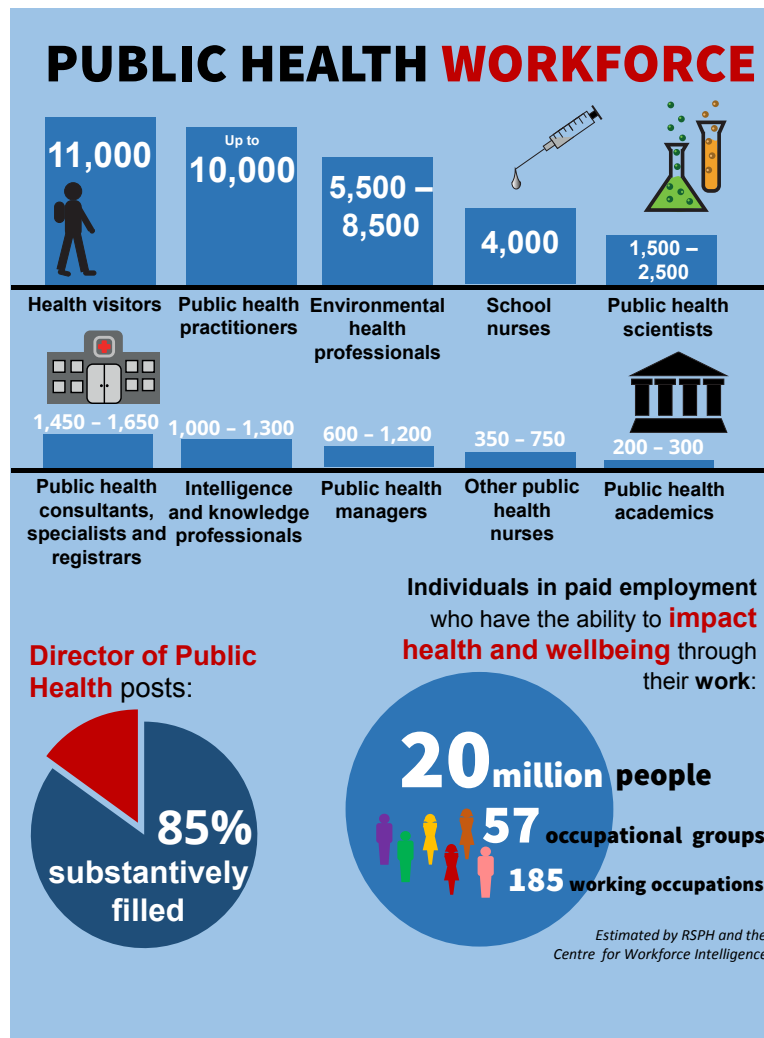
52 Q318

53 Q318

The public health workforce

The public health workforce - both the specialist workforce and the wider workforce - is essential to delivering improved outcomes. Barriers to workforce mobility must be removed, and the Government should review regulation for public health specialists.

106. A well-motivated, skilled and multidisciplinary workforce is needed to improve and protect the public’s health. The workforce has been described to us as a core public health workforce of between 30,000 and 40,000 staff, including public health specialists and practitioners such as health visitors and school nurses whose primary role is to improve and protect public health; and a much wider workforce of around 15 million who have the potential to influence health through their roles such as staff working in the NHS, fire service, and wider local government services.⁵⁴



Sources: Centre for Workforce Intelligence, Mapping the core public health workforce, October 2014, Written evidence submitted by the Public Health System Group (PHP0065), Written evidence submitted by Public Health England (PHP0099)

107. During the inquiry we heard from a diverse mix of this workforce, from those in leadership position to those in frontline delivery roles. Most were supportive of the move of public health to local government,⁵⁵ although some of those in frontline service delivery were less enthusiastic.⁵⁶

108. We heard of the importance of the Director of Public Health role as a leader, advocate and facilitator in local systems and we were told that 85% of Director of Public Health posts now have substantive postholders, similar to the figures before the 2013 transition to local authorities.⁵⁷ Health Education England told us that specialist public health training continues to be a popular choice amongst applicants from a range of backgrounds, including medicine.⁵⁸

109. The Centre for Workforce Intelligence has mapped the core and wider public health workforce through various reports since 2012.⁵⁹ Unfortunately, the commitment in the Department of Health Public Health Workforce Strategy in 2013 to develop a minimum dataset for the public health workforce has not yet been implemented and there is no directly comparable data covering the period of transition to assess how the workforce is changing over time. The 2016 update to the DH strategy suggests that data collection may be tested in 2016, and the Health Education England witness referred to a workforce database being introduced in 2017.⁶⁰

110. The broadly optimistic view presented by both PHE and HEE does not reflect the results of the ADPH survey of the impact of spending cuts presented to us which show that 30% of councils have reduced or are planning to reduce their spending on advice to CCGs and/or within the council.⁶¹

111. The loss of advice on healthcare planning was identified as a threat to the effectiveness of commissioning.

We are a very large trust with 19 different commissioners and five vanguards, and you can imagine that we have to spend an awful lot of time trying to join all that up. One of the stark things, to pick up some of the points that have been made, is that **we have not seen a public health specialist in those commissioning discussions anywhere**. That perhaps says something about the capacity within healthcare public health for the NHS, and that is a weakness of the current arrangements.

[Public health specialist, provider trust, informal session]

112. Beyond public health specialists, many of the witnesses to our inquiry referred to the virtues of engaging a wider range of people in efforts to improve public health—a significant benefit of the move of public health to local authorities. Shirley Cramer explained the potential of engaging the wider workforce:

55 Q108

56 See, for example, written evidence from Julie Hotchkiss ([PHP0012](#)) Ruth Speare ([PHP0036](#)), Jeremy Wight ([PHP0039](#))

57 Public Health England ([PHP0099](#)) para 11, figure 2

58 Q313

59 Centre for Workforce Intelligence, [Public Health Projects](#), May 2016

60 Q314

61 ADPH, [Impact of funding reductions on public health](#), February 2016

These are people in all sorts of **different jobs**. The fire service is a particularly good example, but there is housing, allied health professionals, leisure services and pharmacy—a really **wide range of professionals**. If they have **prevention hardwired** into the work they are doing so that they are **making every contact count**, having that healthy conversation, signposting people, **noticing and helping to enforce prevention**, we would have **an army of people** who would be supporting public health teams in **the prevention agenda** and **helping people stay at home** rather than being in NHS services or in residential care homes....

[Shirley Cramer CBE, Chief Executive, Royal Society for Public Health Q97]

..... In many local authorities where they are making some **real headway** in this area they have been doing this with **lots of different groups**— police services, ambulance services, leisure services, occupational therapists, a whole group of people. In order to do that, we need a number of things that need to happen **nationally**. It is going to happen locally in that that is where we will get the benefit, but there needs to be a **national canvas, a national leadership and a national framework** so that if people in the **wider workforce** want to have a role in public health in the future, or see their **future in a career in public health**, there are some progression pathways and flexibility for them to be supported to do that.

[Shirley Cramer CBE, Chief Executive, Royal Society for Public Health Q97]

Movement of staff across sectors

113. An issue of common concern to many of the organisations submitting evidence, including PHE, the Public Health Systems Group, ADPH and the Faculty of Public Health, was the importance of facilitating movement of staff across different organisations throughout their career to ensure they could gain the breadth of experience needed. At present there are significant regulatory blocks created by differences in terms and conditions between organisations that limit movement. The principal concern is the lack of ability to recognise continuity of service in moves between local government, civil service (PHE) and NHS which is important for a range of employment rights such as maternity and sickness, annual leave and redundancy entitlements. PHSG argues that this issue must be addressed so that “employers know that they are choosing between the best candidates and individuals do not feel constrained in their job choices.”⁶² These problems have been acknowledged by PHE in its recent workforce review, which recommends that PHE

- continue to review what action can be taken at national and local level to remove barriers to mobility linked to terms and conditions of public health staff, and

- in particular, work with NHS Employers, the NHS Staff Council, the LGA, DH and relevant unions to develop a plan for addressing continuity of service.⁶³

Statutory regulation of all public health specialists

114. Public health specialists, including Directors of Public Health, come from a variety of professional backgrounds. Those with medical and dental qualifications are subject to statutory regulation including revalidation, whereas those from other backgrounds are covered by voluntary registration through the UK Public Health Register.

115. The UKPHR explains the essential difference between statutory and voluntary regulation on their website⁶⁴:

“... **the most important factor** for effective regulation is that whoever employs the professionals or commissions their services **takes the requirement to be regulated seriously** and that they will **only look to employ professionals** who have demonstrated they have achieved the **level of competency** required to be on a register.

The difference for **statutory regulation** is that **the disciplinary procedures and sanctions** of the regulator are **underpinned by law**. This means that if a professional is removed from the register it **is illegal for them to continue to practise**. A professional removed from a voluntary register would not appear on the register on enquiry and they may not practise where the employer requires its professional staff to be **independently regulated**.”

116. A commitment was made by the Department of Health in the 2013 workforce strategy to introduce statutory regulation for all public health specialists but in the update published in 2016 they have stated they will not be taking forward legislation.⁶⁵ Professor John Ashton of the Faculty of Public Health Medicine gave the following articulation of the problem:

63 Public Health England, [Fit for the Future](#), May 2016

64 UK Public Health Register, About us - [Frequently Asked Questions](#)

65 Department of Health, [Review of Public Health Workforce Strategy](#), April 2016

The next issue is about **the registration of those who do not have a medical background**. For reasons that are very difficult to understand, the Government have decided **not to have a statutory regulation** for those, and yet we think, from the point of view of public protection standards and equity, parity of esteem and so on, that it should be absolutely clear that the **people who have been through a five-year postgraduate training**, which is what they all do to become public health specialists, **should be seen as being the same**, should be treated the same and they should be **required to do CPD and re-accreditation** and all of that.

[Professor John Ashton CBE, President, Faculty of Public Health, Q59]

Conclusions and recommendations

117. We commend efforts to engage, mobilise and support the wider public health workforce, a group of some 15 million people from a diverse range of professional backgrounds who have the potential to improve public health through their day to day jobs.

118. **Trends in the public health workforce can be adequately monitored only through the speedy introduction of the promised database. This is particularly important given the potential impact of reduced spending by councils on public health staffing.**

119. **Barriers to workforce mobility must be removed, and we are concerned that this issue has not been resolved three years after the transfer of public health responsibility to local authorities. We will review progress in six months.**

120. Statutory regulation is intended to ensure public safety and confidence. We are disappointed that the Department of Health has changed its position on the regulation of public health professionals. **As the Government develops its proposals for reform of professional regulation, it needs to ensure that it has a coherent, straightforward and evidence-based approach to the regulation of public health specialists. We recommend the Department of Health review its current policy in order to protect the public.**

5 Case study: Health protection

Summary

Health protection - encompassing prevention, preparedness and response to outbreaks and other health threats - is a critical public health function. Despite several sets of guidance on responsibilities, difficulty, confusion, duplication and lack of clarity persist in some local areas.

121. The system for health protection is now more complicated than it was before 2013. One local authority public health team told us that in their area, when an Outbreak Control Team was convened to respond to a local outbreak of an infectious disease, some nine different organisations needed to be represented on it.⁶⁶ It was felt that this complexity and scale increased the chances of errors in communication and co-ordination occurring, and could also cause delays in the response to such outbreaks.⁶⁷

CHALLENGES:

Complex system Multiple players/ Uncertainty over **roles and responsibilities**
Reduced response capacity in provider organisations
 Lack of **clarity** over funding

122. Wolverhampton public health teams raised concerns about the fragmentation of health protection, arguing that the separation of public health from the NHS “has led to numerous difficulties including the sharing of and access to data on health protection incidents, engaging with other NHS services, and understanding each organisations role and responsibility for the wide array of health protection issues within their boundary.”⁶⁸

It has... led to examples where either work has been **duplicated** or rather alarmingly where there are **gaps in work** required ...alarmingly there have been examples where **potential significant public health issues in the community** have resulted in more time being expended on **ascertaining whose responsibility it is**, who is to **resource** it, accessing key information and **whether there is the relevant experience and knowledge within that organisation to respond rather than responding.**

66 Local Authority written evidence, [\(PHP0102\)](#) para 3

67 Local Authority written evidence, [\(PHP0102\)](#) Executive Summary

68 Public Health Wolverhampton [\(PHP0098\)](#) para 3.2

Our experience is that we are dependent on good relationships a lot in what is a **fractured and very complex system**; so we are dependent on goodwill. Our experience over the last three years is that there are **capacity issues** with all our partners in being able to respond to health protection issues.

[Ian Cameron, Director of Public Health, Leeds City Council, Q139]

123. Establishing arrangements that work effectively across the complex web of different organisations now involved in delivering health protection requires good relationships. While witnesses were generally positive about the quality of these relationships in their local areas, there was a strong feeling that arrangements for health protection should not be dependent on them:

We are very **clear** in terms of **reports to one another** and there is **dialogue** immediately on any threats that are on the horizon or concerns that might get into the public eye and cause some real anxieties. ...However, if we had not had those **local relationships and networks**, that would be an area of real concern. A system **should not rely on personalities and individuals** to make it work. It should work **whoever is in post** and whoever has been, historically, working in that field.

[Ros Jervis, Director of Public Health, Wolverhampton City Council, Q139]

124. There was also evidence of variation between local areas. While some areas were clear about the challenges posed for health protection by the new system, others, including London and Manchester, reported no difficulty at all.

In **Greater Manchester**, we started work on **setting out roles and responsibilities** as part of the transition process from the NHS into local government. We were able to build on some very **excellent assets** that **local authorities** had already put together around **joining together their emergency planning function**

[Professor Kate Ardern, Director of Public Health, Wigan Council, Q223]

125. PHE regional centres were universally seen to be providing good support to local areas on health protection.⁶⁹

126. Reassuringly, the response to Ebola at both a national and a local level was seen to have worked well.⁷⁰ However, when asked how the new system would cope under the strain of a pandemic, witnesses felt that it would be more difficult than during the last pandemic in 2009.

[In 2009] directors of public health were situated within primary care trusts at the time embedded in the NHS to some degree **directors of public health were able to influence more and call upon NHS resources** at a local system level slightly more easily as part of the flu planning
[Abdul Razzaq, Chair of Association of Directors of Public Health North West, Q192]

We have done a number of exercises....There are differences. Certainly our experience was that there was an issue about **capacity** of the various elements that were needed. Everything ... seemed to speed up in the sense of organisations **suddenly struggling with being able to take various actions**. The message with which I have come away from both our exercises is that **the capacity that is available now has reduced** and so is a **concern** for us. Also, quite clearly, people have come and gone and there are new people. It was clear that those who had experience of 2009 were far more knowledgeable about what happened there, and so, for some, that had gone.

[Dr Ian Cameron, Director of Public Health, Leeds City Council, Q193]

Things have changed since 2009 ... This links to **the capacity issue** ... We **no longer have primary care trusts**. I am not saying that is some kind of Utopian past that we should want to hark back to, but it provided a **single unifying organisation** through the executive power of the director of public health in order to **mobilise NHS resource** at very quick notice. We do not have that any more, so we have to find a way around it.

[Paul Davison, Deputy Director Health Protection, North East Public Health England Centre, Q236]

Community services ... were absolutely **vital** in 2009 ... health protection work carried on, and at the same time in the north-east we had a significant outbreak of measles in the Hartlepool area. We were managing two very significant incidents. As we continued the containment phase, in terms of trying to get antiviral treatment and all the rest of it, there was a lot of work to be done. We **drew on NHS colleagues to come and train them**, and they came into our response centre and did that. I believe that we still could do that, but **how we do that has become much more difficult** because people are in different organisations and in **different parts of the system**.

[Paul Davison, Deputy Director Health Protection, North East Public Health England Centre, Q236]

I also think probably—although this is anecdotal and I have no evidence for it other than talking to colleagues who work in that field—that the **pressure** on them, **the reduction in resource** in those teams and the **increased numbers of targets** that they have to meet have caused them to concentrate much more on their **core business**. When you have an environment where **resources are shrinking**, people concentrate on their core business, and sometimes you **lose those residual skills that are needed** in that response situation.

[Paul Davison, Deputy Director Health Protection, North East Public Health England Centre, Q236]

127. In particular, lack of clarity around CCGs' role was an issue raised by several witnesses.

128. As well as the difficulty associated with forging relationships across more complex systems, specific problems with capacity and funding were also highlighted.

Our experience is that we are **dependent on good relationships** a lot in what is a **fractured and very complex system**; so we are dependent on goodwill. Our experience over the last three years is that there are **capacity issues** with all our partners in being able to respond to health protection issues".

[Dr Ian Cameron, Director of Public Health, Leeds, Q167]

Using the hep A outbreak as an example, **the capacity that providers had to respond very quickly became an issue**, and we are talking about a **small outbreak** there. With the question referring to a flu outbreak, it would be **multiplied**. So, as a very practical example, the capacity at the moment for providers to respond is an issue.

[Dawn Bailey, Health Improvement Principal - Health Protection, Leeds City Council, Q199]

129. Clarity over funding responsibilities was also raised as an issue by witnesses:

Despite the fact that we do have **good working relationships**, we found there was an issue of **who funds what**. While across West Yorkshire we had a memorandum of understanding that said that agency x and y should be responsible for this, when it came down to the nitty gritty of who funds the **vaccines**, who funds **practice nurses** to do x and y, who is going to **pay for the security, the admin and the bus driver**, that is where it undoubtedly got trickier for us...

[Dr Ian Cameron, Director of Public Health, Leeds, Q170]

In my area, I **underwrote the cost** ... just to make sure that the **funding issues did not delay all the action** ... and we want to get to a state where the number of grey areas is reduced in the future.

[Dr Ian Cameron, Director of Public Health, Leeds, Q183]

Where there is an **outbreak of vaccine-preventable disease**, whose **responsibility** is it to lead and to write the cheque for a group of immunisers to be provided to immunise rapidly a population of university students, as we had when we had two linked cases of meningitis W? **The system is not clear** about that but ... the relationships that we have and the commitment to serve the populations that we are there to serve meant that we mobilised and did that. In that circumstance, it was **NHS England that underwrote it** ... We are having different people underwriting; so there are gaps in there...

[Dr Dan Seddon, Public Health Consultant, Screening & Immunisation Lead for Cheshire and Merseyside, Q229]

130. Responding to these concerns, PHE told us that some of the problems raised by witnesses around health protection responsibilities pre-dated the 2013 transfer to local authorities.⁷¹ They also described their ongoing efforts since then to clarify the situation:

We are aware that it is **an ongoing problem**. We were aware at the time. In 2013, we worked with the Department of Health to produce **clear guidance**, we felt, for local government, the NHS and Public Health England as to **who does what in the circumstances of any outbreak**. In principle, **Public Health England** runs **the outbreak response**. **The NHS** delivers **the clinical aspects** of that outbreak response, and **local government** has to absolutely assure itself, through **the director of public health**, that that is being **done properly**.

[Professor Paul Cosford CB, Director of Health Protection and Medical Officer, PHE, Q301]

As we went through into 2014, we were aware that some places felt that was **less clear** than it needed to be. So we did a piece of work with all local health resilience partnerships and asked them **to assure themselves that they had arrangements in place**, and we produced some further guidance in 2014. It is still the case that, sometimes, in **the complexity of dealing with outbreaks**, it is difficult to be exactly sure **who is going to respond in what way**, and that gets dealt with at the time.

[Professor Paul Cosford CB, Director of Health Protection and Medical Officer, PHE, Q301]

131. Concluding, Professor Cosford, PHE's Director for Health Protection, said "I do not see a reduction in the quality of the response to outbreaks as a result of the 2013 changes. I do see that there is still a need for us to work on clarifying some of the roles and responsibilities so that it can be made smoother in certain circumstances."⁷² Professor Cosford argued that the response to health protection will always be prioritised by Public Health England, but it may be at the expense of other areas of work particularly if the incident is large or prolonged.⁷³ We also heard that for the first time, health protection is now going to be included in NHS England's national 'Who Pays' guidance, in an attempt to clarify the funding situation.⁷⁴

132. Dr Ian Cameron, Director of Public Health for Leeds City Council, articulated the need for clearer, more coherent national guidance and support as follows

There have been **enough incidents** of different types and nature across the country for there to be, by now, a common set of issues. From my viewpoint, it is about **collating those incidents** and saying what **the key issues** are and **who is responsible for what**. Whether that is done at **a local level**, which could be done under the health and wellbeing board, or for the local health resilience partnership to get agreement, or whether there should be something done on **a wider level** that comes down and says "No, this is who should be responsible for what," is a judgement call. But, to me, when I am having conversations with people out with our area, it is clear there are **issues**, whether it is TB, hepatitis, or whatever, that are **not fully resolved**. Personally, that seems ludicrous in health protection incidents, where the **funding has in the main been sorted out and we can get on with responding**. I think there is more work to be done, and, as I say, there is a big enough experience now of different types of issues to try to get a **collective view**."

[Dr Ian Cameron, Director of Public Health, Leeds, Q215]

133. However, differences remained amongst our witnesses from different areas about which were the most appropriate local forums for health protection to be led from. Local health resilience partnerships were mentioned as one option, and another recommended structure was for health and wellbeing boards to assume responsibility through establishing a Health Protection Committee reporting directly to the main board. One witness pointed out that in his locality, that would not be a good use of resource, as it could lead to PHE local health protection consultants having to attend some 48 meetings per year.⁷⁵

Conclusions and recommendations

134. The system within which the health protection function is now delivered is complex. Despite PHE's efforts to provide guidance, in some areas there is still uncertainty over roles and responsibilities, and lack of clarity over funding arrangements. A further concern raised by several witnesses is the shrinking capacity in provider trusts to provide additional, timely support during outbreaks.

72 Q304

73 Q310

74 Q309

75 Q257

135. Health protection is a critical public health function, and more work needs to be done at a national level to support local areas to deliver a seamless and effective response to outbreaks and other health protection incidents. This work should begin with an audit of local arrangements, including a review of capacity in provider trusts, and the development of a national system to collate and disseminate lessons learned from incidents. We will review PHE's progress on this work in six months' time.

6 Case study: Health in all policies

Summary

A major reason for transferring public health to local government was to enable wider health and wellbeing considerations to be taken into account across the full range of social policy areas which can have an impact on health. In the context of reduced funding, it is crucially important that the right policy levers and tools are in place at a national level to enable local authorities to do their job as effectively as possible. We commend the recent proposals to introduce a tax on the manufacturers of sugary soft drinks, which will be an important weapon in public health's armoury. Local authorities need health to be a material consideration in licensing and planning, and we recommend that this change should be introduced.

136. A major reason for transferring public health to local government was to enable health considerations to be taken into account across the full range of policy areas which impact on health—the 'health in all policies' agenda.

Local government is **the right place** for public health. Health is about more than medicine and wellbeing about **far more than clinical input**. In local government we can **influence** the wider determinants of health: **housing, leisure, education, social services, environmental services, transport planning** etc. The challenge now is to make sure we do this.

[Dr Andrew Howe, Director of Public Health, written evidence, PHP0103]



137. As highlighted above, in some local authorities very good progress has been made, with modest positive impact on public health outcomes already being seen, but in others, less headway has been made.

“...it is clear already that there is **a shift in the perception within councils** of how health and wellbeing change can be effected. I am **optimistic** that we are seeing **developing opportunities to influence future health** through decisions on **urban space, transport, housing** and so on.”

[Eugene Milne, Director of Public Health, written evidence]

“I have worked in a locality where **the CCG, the police and crime commissioner, and the local authority** have **different priorities** and different five year plans with different objectives **for exactly the same population**. If leadership from those different elements **can come together and work more strategically** and we can mirror that on an operational basis, that will create some integration.”

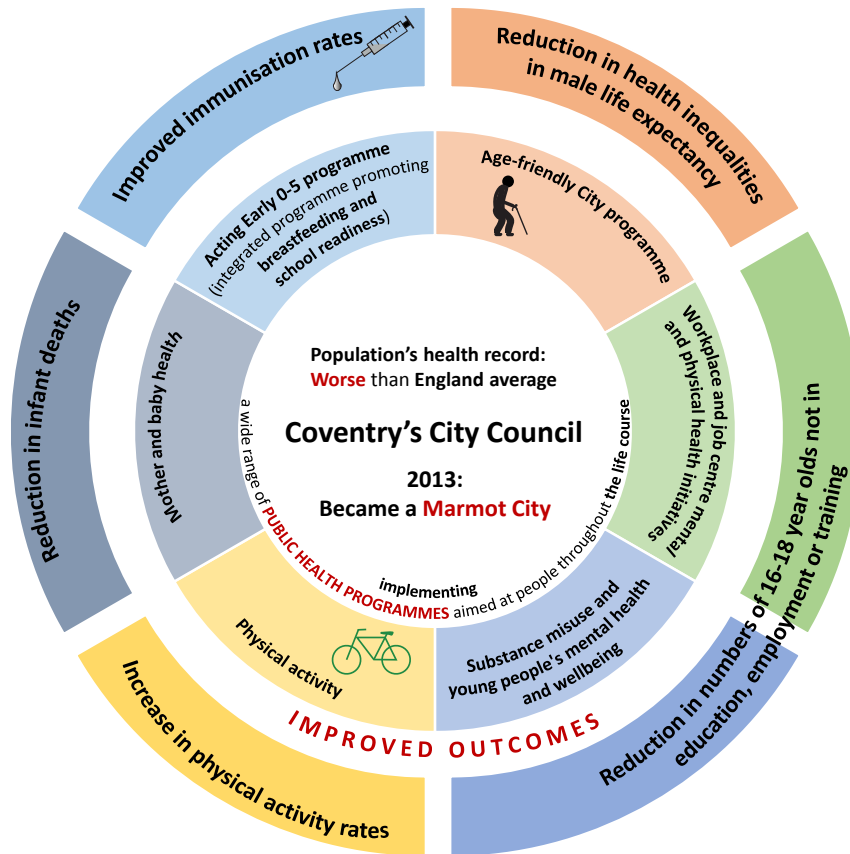
[Drug and alcohol treatment service director, informal session]

“Within **an acute trust**, I see an enormous amount of **variability**. There are some areas where they have been motoring and doing fantastic things with **the benefits of working within the local authority** but there are others where **progress has been really slow**.

[Public health director, acute trust, informal session]

138. We visited Coventry City Council, which has been held up as an area where progress is already being made in embedding health across all policies. We were impressed by the variety of initiatives we saw and heard about there. These initiatives included interventions across the life course—ranging from an integrated programme for 0–5 year olds, through to improving young people’s mental health and wellbeing, supporting working age people, and redesigning Coventry as an age-friendly city. Some interventions were universal—including the drive to improve physical activity across the whole city—and others were targeted at specific populations—for example the MAMTA project aimed at supporting new parents in the south east Asian community. Further details of all the initiatives we visited can be found in Annex 2 of this report and with

the written evidence submitted to the inquiry.⁷⁶ Coventry also supplied information suggesting that they are already seeing some improvements in outcomes—both specific health outcomes (for example vaccination coverage) and also outcomes relating to the wider determinants of health—for example the number of young people in education, employment or training.⁷⁷ The following infographic shows the initiatives we visited and heard about in Coventry, but is not an exhaustive list of all the work they are doing in this area.



139. The recent announcement of a tax on the manufacturers of sugary soft drinks was hailed by many witnesses as a positive move at a national level, which will support action at a local level. However witnesses told us that despite public health now being embedded within local authorities, it was still harder than it should be to influence planning applications for the benefit of health:

76 Coventry City Council ([PHP0136](#))

77 Coventry City Council ([PHP0137](#))

When we are looking at **licensing**, we have a constant headache over the **spread of availability of alcohol outlets** in the city. We devote a lot of time to trying to support **regulation** in those areas. I would very much like us to have more **formal public health input** to some of the broader determinant decisions that at the moment we really do not get in early enough for.... If you look at the way ...**road planning** decisions are taken, the way in which **benefits are monetised** tends to **neglect the utility of some groups**. For example, a **cycle journey** tends to be considered of **less economic value than a car journey** and there is **no utility attached to a journey by somebody who is retired**. That seems to me to be very foolish.”

[Dr Eugene Milne, Director of Public Health, Newcastle City Council, Q121]

“It would be beneficial if **health and wellbeing** was seen as a **material consideration in planning applications** that the planning process is considered in its own right ...it could make **a real impact** rather than us trying to fudge it with some of the other four licensing objectives that we have... They do not have to be onerous—there are some **quick, mini-health impact assessments**—but they need to be seen to be **systematic**, so not ad hoc just when you can persuade them to be undertaken.”

[Ros Jervis, Director of Public Health, Wolverhampton City Council, Q122]

Conclusions and recommendations

140. It is crucial that health considerations are taken into account in all areas of local government policy. Despite the increased potential for public health teams to influence other policy areas from their new position within local authorities, which we have heard is going very well in some areas, the current planning process continues to be a major impediment. **We urge the Government to be bold, and make good on its commitment to health in all policies, by enshrining health as a material consideration in planning and licensing law.**

7 The role of the NHS in public health

Summary

As Simon Stevens, Chief Executive of NHS England, has repeatedly emphasised, the NHS itself - both through NHS Trusts, CCGs, GPs and other service providers and as a major employer - has a critical role to play in public health. This is not yet happening at sufficient scale.

141. Although public health teams have moved from the NHS to local authorities, the NHS—both its commissioning organisations and providing organisations—still has a major role to play in the delivery of improved public health. For CCGs, this role might involve planning services to ensure they meet local health needs, and redesigning service specifications to ensure vulnerable sub-groups within that population are able to access services. Within NHS organisations it can include getting health professionals actively involved in promoting healthier lifestyles to the patients they see for other reasons—the Making Every Contact Count initiative is an example—as well as wider initiatives to promote health amongst NHS staff, and the communities they serve.

142. Public health professionals working in provider organisations attended the Committee’s roundtable, and were unanimously of the view that the NHS was not doing enough in this area:

The NHS is a **huge organisation** and it has got off **lightly** a little bit, in relation to **the preventative agenda** in the past few years. I would like to see **a prevention and public health strategy** being something that all big trusts have to undertake. With a little bit of **specialist public health input**, that could make a huge difference.

[Medical director, mental health and community trust, informal session]

143. Eugene Milne, DPH in Newcastle, put it in similarly strong terms:

One great difficulty we see at the moment is the sense that **prevention is no longer the responsibility of people practicing in the NHS**. I know that is **not universal**, but it is an issue for us. Although the Five Year Forward View makes some real commitments in the direction of secondary prevention, it is **not strongly carried through into the guidance** that is being put into place now. My feeling is that there is an awful lot of **perception** across public health practitioners generally that, for example, **“Tobacco is no longer our problem, it is in the local authority now and we do not need to do that”**. We need to emphasise the necessity for people in the NHS to continue to be **active players** in prevention with us.

[Dr Eugene Milne, Director of Public Health, Newcastle City Council, Q125]

144. The NHS must get involved in the prevention agenda “to a much greater extent than they are at the moment...if it is going to get anywhere near to dealing with the financial challenge it has in the next few years...”⁷⁸

145. Health Education England described work that it was doing to support the ‘Making Every Contact Count’ initiative by providing information and training to health professionals. This initiative is designed to encourage all health professionals to see health promotion and prevention as part of their everyday work.

146. As well as the potential for NHS staff to improve the health of their patients, the NHS is a major employer and as such has the potential to improve the health of its own staff, as Simon Stevens described:

The NHS as an employer, as **the biggest employer in Europe**, has a responsibility to **put our own house in order** when it comes to workplace health, which traditionally we have not done. This year, which we are now in, we have the **world’s biggest incentive programme for employee health** in our health system, with up to **£450 million** of incentives tied to **improving workplace health** for nurses, therapists, ancillary workers and others across the NHS.

[Simon Stevens, CEO, NHS, Q390]

147. However, despite these positive initiatives, we felt that in evidence to us, Simon Stevens and other senior leaders placed insufficient emphasis on the role that the NHS itself must play in public health, and we are concerned about how this may play out in practice. When we asked whether NHS trusts should have a strategy committing them to pursue the public health agenda, rather than viewing it as no longer their business, Simon Stevens agreed:

Simon Stevens: Yes; I absolutely agree that it **continues to be their business**, and if you think about what we are doing, as Duncan said earlier, through the local implementation process for the Five Year Forward View, we are focusing, in all 44 of the communities that have come together in England to do this, on **the health and wellbeing gap as well as the care and quality gap, and the financial sustainability and efficiency challenge.**

[Simon Stevens, CEO, NHS, Q390]

148. Sustainability and Transformation Plans may be a potential mechanism to lock public health targets into the delivery of improvements to local health systems, and guidance has been issued to local areas highlighting the need to factor public health into their plans. However with plans only just being finalised, it is too early to say whether this guidance has been built into plans effectively. We have a concern that of the three gaps referred to by PHE in its evidence to us—the health gap, the efficiency gap, and the care gap—the health gap risks being marginalised by the focus on the efficiency and care gaps. While the new STPs being planned have prevention as a central part of their remit, the focus at present is largely appears to centre on the issues of funding and the deficits in the social care sector arising from public spending cuts in local authority budgets.

149. Simon Stevens and Duncan Selbie told the Committee that it was a positive development that some NHS Trusts now employ their own directors of public health. However, the evidence we received from people in these positions was that not enough is being done to embed public health across the NHS as a whole.

Conclusions and recommendations

150. We were concerned to hear that despite the importance attached to prevention and public health in the NHS 5 Year Forward View, following the move of public health to local authorities, there is a growing sense that prevention is no longer the responsibility of people practising in the NHS. We heard this view from public health specialists working both in local authorities and in the NHS. This issue must be addressed urgently.

151. We have recommended that the Government should set out clear, measurable milestones of what it expects public health spending to achieve, and by when. Locally, this needs to be underpinned by clear information for the public on the actions local authorities are taking to improve public health, underpinned by a benchmarking framework that allows for informed comparison and challenge. **The system of enhanced public health accountability must be extended into the NHS, forming part of a broader national strategy to systematically and demonstrably implement the radical upgrade in public health called for in the Five Year Forward View.**

152. **The NHS has an important role to play in prevention, and developing the skills of its workforce to deliver preventative advice as part of routine care is central to that. We will follow up progress on this issue when we next review the public health system.**

Conclusions and recommendations

Funding

1. Cuts to public health are a false economy. The Government must commit to protecting funding for public health. Not to do so will have negative consequences for current and future generations and risks widening health inequalities. Further cuts to public health will also threaten the future sustainability of NHS services if we fail to manage demand from preventable ill health. (Paragraph 40)
2. We recommend that the Government sets out how changes to local government funding and the removal of ring fencing can be managed so as not to further disadvantage areas with high deprivation and poor health outcomes. We plan to return to review the variation in funding and outcomes. (Paragraph 41)

Systematically improving public health and addressing unnecessary variation

3. We recommend that local authority directors of public health should be required in their statutory annual reports to publish clear and comparable information for the public on the actions they are taking to improve public health and what outcomes they expect to achieve, and to provide regular updates on progress. While public health priorities may be different for different areas, which is entirely appropriate, they should be presented in a standardised format, and underpinned by a benchmarking framework that allows for informed comparison and challenge. The Chief Executive of Public Health England, in his capacity as accounting officer, should publish an annual report drawing together and analysing local progress towards agreed plans. (Paragraph 64)
4. We also reiterate the recommendation of our recent report on the impact of the Spending Review on health and social care that the Government should set out clear milestones of what it expects public health spending to achieve, and by when. (Paragraph 65)

Politics and evidence

5. Benchmarking standards for all local authorities' prescribed public health functions should be introduced, which should be transparently monitored to enhance accountability and provide reassurance that these functions are being maintained at an appropriate level. (Paragraph 70)

Boundary issues and fragmentation

6. The outstanding issue of who is responsible for commissioning PrEP for HIV needs immediate resolution, and we recommend that NHS England and DH clarify the position without delay. (Paragraph 79)
7. Where boundary issues are identified around responsibilities, PHE should set out the options for them to be addressed in the best interests of patients and the public and ensure that they are resolved without further delay. (Paragraph 80)

Leadership for public health at a national level

8. National system leadership is important to signal clarity of purpose and commitment to the local system when it comes to improving health and wellbeing. In order to demonstrate where national leadership for public health lies, and to avoid confusion and the risk of giving conflicting advice to the local system, the Government should produce a clear statement of who does what in respect of the main system leaders, namely, the Department of Health, Public Health England and NHS England. (Paragraph 91)
9. Embedding health in all policies is important at both national and local level. But while there is evidence of progress locally, there is less evidence of such an approach becoming embedded across Government departments. We urge the Government to take bold and brave action through its life chances and childhood obesity strategies in order to improve public health and reduce health inequalities. (Paragraph 92)
10. A Cabinet Sub-Committee on Public Health is unlikely in itself to be the answer to securing more effective joined-up policy to improve health and wellbeing. We consider instead that the strengthened cross-departmental working which is required is more likely to be achieved by vesting responsibility for providing political leadership for public health at a national level in a Minister in the department responsible for coordinating cross-departmental work, the Cabinet Office. We recommend that a Minister in the Cabinet Office be given specific responsibility for embedding health in all policies across Government, working closely with the Minister for Public Health in the Department of Health. (Paragraph 94)
11. Since Public Health England was established, the interface between it and the DH has lacked clarity. We therefore urge the Government to review the relationship between the DH's Public Health Group and PHE. The 'tailored review' of PHE which DH is currently carrying out offers a good opportunity to do so. (Paragraph 95)
12. Likewise we urge NHS England and PHE to clarify how the two organisations are seeking to pool their expertise and resources around public health in order to ensure that the local health system feels adequately supported and not conflicted by confusing messages or requirements. (Paragraph 96)

Access to data

13. Our inquiry has identified numerous problems with access to data for public health professionals, which is creating barriers to effective joint working. We are pleased to note that efforts are now ongoing within Public Health England to address these problems. (Paragraph 102)
14. Public health teams need to be able to access data in patients' interests. We were told by PHE's chief knowledge officer that a change in policy was needed to remove the current restriction that all linkage of health and social care data can only take place centrally, within NHS Digital (HSCIC). We recommend that the Department of Health review these barriers. (Paragraph 103)
15. Some areas have managed to access the data they need, and others have not. Some areas also lack the capacity to analyse their data. A co-ordinated national support programme is needed to ensure that until data is easily available to local authorities, all areas at least understand what data they are able to access, and how they can do so. (Paragraph 104)

16. PHE identified two types of data public health specialists are having difficulty in accessing—access to population healthcare data, and access to operational data about the services they commission. Annex 1 to this report contains a compilation of the concerns public health professionals have raised to this inquiry regarding access to data, and we ask PHE and NHS Digital to provide a response to us on each point raised. We will revisit this issue to check progress in six months' time. (Paragraph 105)

The public health workforce

17. Trends in the public health workforce can be adequately monitored only through the speedy introduction of the promised database. This is particularly important given the potential impact of reduced spending by councils on public health staffing. (Paragraph 118)
18. Barriers to workforce mobility must be removed, and we are concerned that this issue has not been resolved three years after the transfer of public health responsibility to local authorities. We will review progress in six months. (Paragraph 119)
19. As the Government develops its proposals for reform of professional regulation, it needs to ensure that it has a coherent, straightforward and evidence-based approach to the regulation of public health specialists. We recommend the Department of Health review its current policy in order to protect the public. (Paragraph 120)

Case study: Health protection

20. Health protection is a critical public health function, and more work needs to be done at a national level to support local areas to deliver a seamless and effective response to outbreaks and other health protection incidents. This work should begin with an audit of local arrangements, including a review of capacity in provider trusts, and the development of a national system to collate and disseminate lessons learned from incidents. We will review PHE's progress on this work in six months' time. (Paragraph 135)

Case study: Health in all policies

21. We urge the Government to be bold, and make good on its commitment to health in all policies, by enshrining health as a material consideration in planning and licensing law. (Paragraph 140)

The role of the NHS in public health

22. The system of enhanced public health accountability must be extended into the NHS, forming part of a broader national strategy to systematically and demonstrably implement the radical upgrade in public health called for in the Five Year Forward View. (Paragraph 151)
23. The NHS has an important role to play in prevention, and developing the skills of its workforce to deliver preventative advice as part of routine care is central to that. We will follow up progress on this issue when we next review the public health system. (Paragraph 152)

Annex 1 – supplementary information about problems with access to public health data

Difficulties in public health teams accessing data to enable them to work effectively has emerged as a recurring theme in this inquiry. We have been told that Public Health England is working to resolve these issues.

Some witnesses who described problems with access to public health data have submitted further written information giving extra detail about the type of information they require and the problems they are having accessing it. These are compiled in the table below. The information has been anonymised.

What data?	Why is access needed?	Data holder	Why access is currently problematic	Was there access pre-2013?
Anonymised hospital activity data	Hospital activity data (inpatient, outpatient and A&E) would be used to contribute towards the Joint Strategic Needs Assessments and would be a key component in informing the Public Health advice to Clinical Commissioning Groups.	HSCIC/ Commissioning Support Units	PHE have sourced Hospital Episode Statistics (HES) on behalf of Local Authorities from the HSCIC. However, this was done with little consultation with local teams who generally do not have the resources to warehouse and manage the dataset as it covers the whole of England. A web-based national system, similar to the Primary Care Mortality Database (PCMD) would be a more efficient solution and reduce duplication across the country.	This information was readily available to PH teams in Primary Care Trusts.

What data?	Why is access needed?	Data holder	Why access is currently problematic	Was there access pre-2013?
Anonymised cancer incidence data	To identify hotspots of cancer incidence within the local authority. This information would contribute towards the Joint Strategic Needs Assessments and would help inform targeted interventions.	Public Health England	PHE will not provide access to anonymised data at record level, which means Local Authorities have to submit individual requests each time we need to data in a slightly different way & PHE have to calculate the rates themselves, which they have limited capacity to do.	The information was much easier to access prior to 2013.
Vaccination and Immunisation uptake data	To identify uptake of vaccination and immunisation across the borough, and assist with fulfilling the Public Health role around assurance for various aspects of health protection. Some data is available at CCG or GP Practice level, but this is insufficient for population monitoring, targeting areas of low uptake and preventing outbreaks.	NHS England	Direct access to the information has not been agreed and standard data flow has not been established. Vague 'IG' concerns have been cited as reason data cannot be provided.	The information was much easier to access prior to 2013.
Anonymised cancer survival data	Hospital activity data (inpatient, outpatient and A&E) would be used to contribute towards the Joint Strategic Needs Assessments and would be a key component in informing the Public Health advice to Clinical Commissioning Groups.	NWCIS/ NCIN	NWCIS are currently undertaking a piece of work looking at cancer survival at a national and local level, but this may take some time to come to fruition and we using relatively old data when discussing how well our residents are doing post diagnosis. We have received data on request (takes some time) from NWCIS since 2013, but it is limited due to the confidentiality issues that arise in allowing access to personal data.	This information was much easier to access prior to 2013.

What data?	Why is access needed?	Data holder	Why access is currently problematic	Was there access pre-2013?
Demographic information available via an extract from the NHS Patient Register	The data provides a postcode level population denominator, based on GP registrations; essential for calculating rates for non-standard geographies, it assists with the production of local level (ward, SOA) population estimates, and apportion data as appropriate. It also enables us to calculate GP Practice level rates, deprivation scores, etc. and has in the past strengthened responses to ONS consultations on national population estimate methodologies. The GP Patient Register has also been used in the past (with appropriate ethical approval) to undertake population wide epidemiological surveys of health-related behaviour and risk factors. Results of which have been used locally to set priorities and target resource. In addition, information held on the Patient Register could potentially help with specific pieces of work; a recent example being identifying new entrants to the UK to assist with latent TB screening.	NHS England	Public Health has not been allowed access to a full non-anonymised version of the GP Register. Individual or postcode level information has not been agreed	This information was readily available to PH teams in Primary Care Trusts.
Access to patient postcode across all datasets	As a general point that applies to all datasets, the absence of patient postcode on data that LAPH teams can access impedes local analysis. Without a postcode, many data records/local data cannot be allocated to defined local areas or new electoral ward boundaries, meaning rates for local areas cannot accurately be calculated.	Various	Full postcode is classed as person identifiable data and has not been made available to LAPH teams since transition	This information was readily available to PH teams in Primary Care Trusts.

What data?	Why is access needed?	Data holder	Why access is currently problematic	Was there access pre-2013?
Anonymised mental health services data	Mental health service data (MHSDS/MHLDDS, IAPT) would be used to contribute towards the Joint Strategic Needs Assessments and would be a key component in informing the Public Health advice to Clinical Commissioning Groups.	HSCIC / Commissioning Support Units	The CSU have advised that only commissioners with Accredited Safe Haven status (ASH stage 1) are able to receive data and that although MHMDS is pseudo data they have to treat it as though it is 'clear' due to its sensitive nature.	Data sets have evolved and developed but what information did exist was readily available to PH teams in Primary Care Trusts.
Breastfeeding initiation data	Monitor breastfeeding initiation rates across the borough and be used within the Joint Strategic Needs Assessment and Early Years performance data.	NHS Trusts	Local data flow – Local hospitals used to supply data to local PCT Business Intelligence Teams. However, when PCTs were abolished this data was no longer available to some Public Health teams. NHS England were publishing the data until Q1 2015/16, but no data has been released since.	This information was readily available to PH teams in Primary Care Trusts.
Reporting at administrative scales (county, district and ward). Service provision needs individual level data from the National Drug Treatment Monitoring System (NDTMS).	To consider the characteristics of people in substance misuse treatment in the county to order to inform needs assessments and commissioning decisions. To assess whether locally commissioned substance misuse treatment services are meeting the needs of service users.	Public Health England (PHE)	PHE have concerns over the provision of individual level data because of confidentiality. The only personal information that was ever previously provided was age, gender, ethnic group and partial postcode.	Yes, via the regional NDTMS team

What data?	Why is access needed?	Data holder	Why access is currently problematic	Was there access pre-2013?
Hospital Episode Statistics – Inpatient, Outpatient and Urgent Care	To monitor patterns of disease and support and improve the local responsiveness, effectiveness and value for money of commissioned public health and NHS services. It is also used to support the statutory 'core offer' of public health advice and support to local NHS commissioners, the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and other functions of the Health and Wellbeing Board. It is more specifically used to undertake longitudinal analyses of patterns the incidence and prevalence of health risks and diseases, demand and access to treatment services, health outcomes monitoring, and support the programme of health needs assessments, health equity audits and health impact assessments within local area.	Health and Social Care Information Centre	Whilst permission has been granted for local authorities to access this data the process has been problematic. Current arrangements for public health access to pseudonymised HES data are due to close on the 31st of August 2016, with no clarity around a future arrangements for local authority public health access and any associated costs leaving local authority public health teams in limbo and unable to access this information in the longer term. Due to the delays outlined above the short-term access our Council will have will amount to less than three months limiting the ability of the Public Health team to fulfil its statutory obligations or plan for the use of this information to improve health and wellbeing locally in the longer-term.	Yes – via Secondary Uses Service data feeds within Primary Care Trusts.
Mortality data (PCMD) including cause of death	<ol style="list-style-type: none"> 1 Suicide audit 2 Identifying mortality rate for CVD in most and least deprived quintiles 3 Identifying leading causes of death (and compare to England) 	HSCIC	<p>N3 access no longer available</p> <p>IGLevel 2 toolkit not in place in our LA</p>	Yes (public health mortality file). We could link postcodes to IMD data too.
Cancer stats at a local level e.g. survival rate at 5 years	Public health surveillance. Continuing to monitor what we have had in past	National Cancer Intel. Network?	It is not published at a lower level (e.g. CCG or LA)	Yes, via H&SCIC Indicator Portal

What data?	Why is access needed?	Data holder	Why access is currently problematic	Was there access pre-2013?
HES data for one year free of charge to LA PH teams	PHE indicated that they would provide access. May or may not be useful	HSCIC	Means completing data sharing framework through H&SCIC and a further (different) data sharing agreement which identifies need for N3 or IG Level 2 toolkit.	PCT Information Team would have had access to secondary care data and we would have been able to put in information request if required. Local CSU is not so accommodating
Data from STEIS – NHS incident reporting system	----- -----	-----	----- -----	-----

What data?	Why is access needed?	Data holder	Why access is currently problematic	Was there access pre-2013?
Child health information – that is, all data held within the child health information system, including immunisation	<p>This would help us to:</p> <ul style="list-style-type: none"> I) monitor population health trends II) enhance support provided to the NHS via the 'Core Offer' III) conduct more insightful needs analysis to inform commissioning interventions which promote public health IV) identify escalating health issues and particularly for screening programmes, fulfil requirement of the Director of Public Health to provide assurance on screening 	NHS England	Information governance rules and also the fact that we do not commission these services, this means it is hard to convince partners to share the data, resulting in lengthy bureaucratic processes to try and get data, if at all.	Yes
Mental health treatment data	As above	MH trust	As above	Yes
GP records	As above	GPs/ CCG	As above	Yes

What data?	Why is access needed?	Data holder	Why access is currently problematic	Was there access pre-2013?
Maternity data	As above	NHS Trust	Information governance makes it almost impossible to share health related identifiable data for so called 'secondary usage purposes' and it's not always straight forward to do this for primary patient care purposes. Even when sharing using pseudonymised data as proposed in our example above it is very difficult to share data. This is despite regulations that suggest using pseudonymisation for secondary usage sharing purposes is possible	Yes
National screening programme data	As above	PHE		Yes

What data?	Why is access needed?	Data holder	Why access is currently problematic	Was there access pre-2013?
Ability to link data	<p>In addition to the previous examples, this enables us to provide a much more detailed analysis. For example, by linking mortality data to maternity data we have been able to demonstrate locally increased risk of infant mortality generated by the following factors; age of mother, smoking, late booking in pregnancy and obesity. We have recently enquired about sharing pseudonymised (non-identifiable) mortality data for the purpose of linking to hospital and social care data, a project which could add tremendous insight into understanding the potential interventions points for health and social care, to improve outcomes for the patients and reduce premature death. However, the current information governance regime makes this almost impossible to do without spending months seeking assurance from ONS to be able to share this data.</p>	<p>Various including local providers, HSCIC, ONS, CSUs, Councils, other government departments</p>	<p>Information governance makes it almost impossible to share health related identifiable data for so called 'secondary usage purposes' and it's not always straight forward to do this for primary patient care purposes. Even when sharing using pseudonymised data as proposed in our example above it is very difficult to share data. This is despite regulations that suggest using pseudonymisation for secondary usage sharing purposes is possible.</p>	Yes
Out of Area service recharges	<p>Only first part of the postcode provided and IG sited for not sharing data. Not possible to prove that this resident has used the service</p>	<p>Various providers</p>	<p>As above</p>	Yes

Further comments received:

“The local information service provided by Public Health England is limited and cannot meet all requests for public health data at the local level.” [Public Health Epidemiologist]

“The lowest level that the published health profiles currently go is local authority (districts/unitary level), which does not provide sufficient detail to consider how plans and developments can help improve health overall and reduce health inequalities because conditions vary within area.” [Planning officer]

“we are becoming increasingly concerned that, although local authority public health teams have had their budgets cut, it look like we are going to have to start paying to access essential public health data” [Director of Public Health]

Annex 2: Visit to Coventry City Council

On Monday 23 May 2016 the Health Committee visited Coventry City Council in connection with their inquiry into public health. The following Members and staff attended:

Committee members

Dr Sarah Wollaston (Chair); Rt Hon Ben Bradshaw; Julie Cooper; Dr James Davies; Emma Reynolds; Paula Sherriff; Maggie Throup; Helen Whately; Dr Philippa Whitford

Staff

Huw Yardley, Clerk; Laura Daniels, Committee Specialist; Victoria Carpenter, Committee Assistant

The Committee were generously welcomed by the Lord Mayor of Coventry Councillor Lindsley Harvard, Cabinet Member for Public Health Councillor Kamran Caan, the Chief Executive Dr Martin Reeves and the Director of Public Health Dr Jane Moore. The Committee are extremely grateful to them for this welcome and for their time, and also, in particular, to the many other members of Coventry City Council's staff, service providers, and service users, who very kindly gave their time and expertise to help the Committee understand in more detail the work being undertaken there to improve public health and tackle health inequalities.

Why Coventry?

Coventry City Council's population has a health record that is generally worse than the England average. Deprivation is higher than average and around a quarter of children live in poverty. The Council became a Marmot City in 2013 committed to implementing the six policy objectives of the Marmot report on health inequalities. The transfer of public health services to local government in 2013 provided Coventry with an opportunity to continue to broaden the ownership of the health inequalities agenda. Coventry committed to delivering rapid change in health inequalities by 2015 and was one of seven cities in the UK invited to participate in the UK Marmot Network and become a Marmot City.

Being a Marmot City has brought together partners from different parts of the Council and from other public sector and voluntary organisations whose decisions and activities have an impact on health. The Marmot principles have all been embedded into the core functions of the Council and its partners. Improving health and reducing inequalities in Coventry is not only a priority for the NHS and public health – it is a priority for everyone who is working to improve the lives of people in the city.

In keeping with the Marmot principles, the Council is pioneering an approach to Health in All Policies (HiAP) which the Finnish government invented some years ago and which is at the centre of WHO Europe's health strategy Health 2020 to which all 53 member States, including the UK, are signatories. The HiAP initiative in Coventry has the support of the LGA, PHE and ADPH.

Since Coventry became a Marmot City there has been progress in outcomes across health and across society. There have been improvements in school readiness at age 5, health outcomes, life satisfaction, employment and reductions in crime in priority locations. A number of innovative projects and initiatives have been set up which are starting to yield positive results for the people

of Coventry. Information on progress towards improving outcomes in Coventry is available here: [http://www.parliament.uk/documents/commons-committees/Health/Written_evidence/Coventry-City-Council-\(PHP0137\).pdf](http://www.parliament.uk/documents/commons-committees/Health/Written_evidence/Coventry-City-Council-(PHP0137).pdf).

Who the Committee met and what they heard about

The Committee were initially welcomed by a variety of people involved in health and wellbeing in Coventry, including Members, the Chief Executive, the Executive Director for People, the Director of Public Health, Coventry & Rugby Clinical Commissioning Group, the Police Service, and the Fire Service. The Committee then visited the following initiatives:

- **Acting Early 0–5 Programme – Acting Early Champions Workforce Development Day** [Key partners including: Coventry City Council, Midwives, Health Visitors, Childrens Centre Workers]
- **Acting Early 0–5 Programme – Discussions with key partners & parent leaders** [Key Partners including: Coventry City Council, UHCW - University Hospital Coventry & Warwickshire; CWPT - Coventry & Warwickshire Partnership Trust; Grapevine Charitable Organisation & Parent Leaders]
- **MAMTA – A Child & Maternal Health Service** [Key Partners including: Coventry City Council; MAMTA and MAMTA Service users; FWT – Foleshill Women’s Training]
- **Age Friendly City, Supporting Older People** [Key Partners including: Coventry City Council; Coventry University; Coventry & Rugby CCG; Age UK; Fire Service; Coventry Older Voices]
- **Young Person’s Substance Misuse & Early Intervention Service** [Key Partners including: Coventry City Council; Compass - Young Person’s Substance Misuse & Early Intervention Service]
- **Promoting Emotional & Mental Resilience** [Key Partners including: Coventry City Council; Coventry & Rugby CCG; Senior and Primary Schools; Police; Children’s Safeguarding Board; Coventry University]
- **Health, The Workforce, The Economy** [Key Partners including: Coventry City Council Solihull & Metropolitan Borough Council; CWLEP – Coventry & Warwickshire Local Enterprise Partnership; Coventry & Warwickshire Chamber of Commerce; Department of Work & Pensions/Job Centre Plus]
- **Social Mobilisation – Coventry On The Move** [Key Partners including: Coventry City Council; Coventry University; Grapevine Charitable Organisation]
- Full background information on all of these initiatives is available here: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/public-health-post2013-structures-organisation-funding-and-delivery/written/35331.html>.

Formal Minutes

Monday 18 July 2016

Members present:

Dr Sarah Wollaston, in the Chair

Dr James Davies

Helen Whately

Andrea Jenkyns

Dr Philippa Whitford

Draft Report (*Public health post-2013*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 152 read and agreed to.

Summary agreed to.

Annexes 1 and 2 agreed to.

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

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

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

[Adjourned till Tuesday 19 July at 2.00pm.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 9 February 2016

Question number

Jonathan McShane, Chair, Public Health System Group/Local Government Association, **Julie Wood**, Chief Executive, NHS Clinical Commissioners, **Dr Andrew Furber**, President, Association of Directors of Public Health, **Professor John Ashton CBE**, President, Faculty of Public Health, and **Martin Smith**, Society of Local Authority Chief Executive

[Q1-75](#)

Tuesday 1 March 2016

Professor Sir Michael Marmot, Director, Institute of Health Equity, University College London, and **Shirley Cramer CBE**, Chief Executive, Royal Society for Public Health

[Q76-106](#)

Andrew Howe, Director of Public Health, London Boroughs of Barnet and Harrow, **Dr Virginia Pearson**, Director of Public Health, Devon County Council, **Dr Eugene Milne**, Director of Public Health, Newcastle City Council, and **Ros Jervis**, Director of Public Health, Wolverhampton City Council

[Q107-164](#)

Tuesday 24 May 2016

Dr Ian Cameron, Director of Public Health, Leeds City Council, **Dawn Bailey**, Health Improvement Principal – Health Protection, Leeds City Council, and **Abdul Razzaq**, Chair of Association of Directors of Public Health North West

[Q165-221](#)

Professor Kate Ardern, Director of Public Health, Wigan Council, **Paul Davison**, Deputy Director Health Protection, North East Public Health England Centre, **Dr Dan Seddon**, Public Health Consultant, Screening & Immunisation Lead for Cheshire and Merseyside, and **Dominic Hardy**, Director of Commissioning for Wessex, NHS England South, NHS England

[Q222-277](#)

Tuesday 7 June 2016

Professor John Newton, Chief Knowledge Officer, Public Health England, **Professor Paul Cosford CB**, Director of Health Protection and Medical Officer, Public Health England, **Richard Gleave**, Deputy Chief Executive and Chief Operating Officer, Public Health England, and **Professor Lisa Bayliss-Pratt**, Director of Nursing, Health Education England

[Q278-342](#)

Jane Ellison MP, Parliamentary Under-Secretary of State for Public Health, Department of Health, **Simon Stevens**, Chief Executive of NHS England, and **Duncan Selbie**, Chief Executive, Public Health England

[Q343-404](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee’s website.

PHP numbers are generated by the evidence processing system and so may not be complete.

- 1 A Local Authority ([PHP0102](#))
- 2 ABPI Vaccine Group ([PHP0025](#))
- 3 Action Cerebral Palsy ([PHP0015](#))
- 4 Action on Hearing Loss ([PHP0080](#))
- 5 Action on Smoking and Health & Cancer Research UK ([PHP0077](#))
- 6 Adam Chaffer ([PHP0133](#))
- 7 ADASS ([PHP0091](#))
- 8 Advisory Group on Contraception ([PHP0063](#))
- 9 Alzheimer’s Society ([PHP0095](#))
- 10 APPG on Sexual and Reproductive Health ([PHP0005](#))
- 11 APPG on Smoking and Health ([PHP0108](#))
- 12 Arthritis Research UK ([PHP0086](#))
- 13 Bath & North East Somerset Council ([PHP0128](#))
- 14 Bayer ([PHP0094](#))
- 15 Breastfeeding Network (BfN) and the Association of Breastfeeding Mothers (ABM) ([PHP0109](#))
- 16 British Acupuncture Council ([PHP0002](#))
- 17 British Association for Sexual Health and HIV ([PHP0082](#))
- 18 British Association for Sexual Health and HIV ([PHP0119](#))
- 19 British Dietetic Association ([PHP0030](#))
- 20 British HIV Association (BHIVA) ([PHP0081](#))
- 21 British Medical Association ([PHP0023](#))
- 22 British Pregnancy Advisory Service ([PHP0026](#))
- 23 British Society for Immunology ([PHP0010](#))
- 24 Collective Voice ([PHP0046](#))
- 25 Collective Voice ([PHP0113](#))
- 26 County Councils Network ([PHP0090](#))
- 27 Coventry City Council ([PHP0136](#))
- 28 Coventry City Council ([PHP0137](#))
- 29 Debbie Holroyd ([PHP0122](#))
- 30 Department of Health ([PHP0068](#))
- 31 Devon County Council ([PHP0107](#))
- 32 Dr Alison Forrester ([PHP0071](#))
- 33 Dr Alison Furey ([PHP0096](#))

- 34 Dr Alison Furey ([PHP0120](#))
- 35 Dr Andrew Howe ([PHP0103](#))
- 36 Dr Hilary Pickles ([PHP0110](#))
- 37 Dr Jeremy Wight ([PHP0039](#))
- 38 Dr Jonathan Howell ([PHP0070](#))
- 39 Dr Mark Lim ([PHP0092](#))
- 40 Dr Phil Ayres ([PHP0117](#))
- 41 Dr Rachel Joyce ([PHP0006](#))
- 42 Dr Ruth Speare ([PHP0036](#))
- 43 Dr Ruth Speare ([PHP0116](#))
- 44 Dr Wikum Jayatunga ([PHP0004](#))
- 45 Dr Bruce Laurence ([PHP0009](#))
- 46 Faculty of Sexual and Reproductive Healthcare ([PHP0032](#))
- 47 Fit for Work UK Coalition ([PHP0101](#))
- 48 FPA ([PHP0011](#))
- 49 Greater London Authority ([PHP0037](#))
- 50 Greater Manchester Fire and Rescue Service ([PHP0130](#))
- 51 Hampshire Breastfeeding Counselling ([PHP0112](#))
- 52 Health Education England ([PHP0018](#))
- 53 Health Foundation ([PHP0100](#))
- 54 Health Statistics User Group ([PHP0040](#))
- 55 Institute for Government ([PHP0013](#))
- 56 Institute of Alcohol Studies ([PHP0048](#))
- 57 Kate Eveleigh ([PHP0123](#))
- 58 Local Government Association ([PHP0054](#))
- 59 London Councils ([PHP0052](#))
- 60 London School of Economics and Political Science ([PHP0003](#))
- 61 Medconfidential ([PHP0008](#))
- 62 Mental Health Foundation ([PHP0087](#))
- 63 Mind ([PHP0020](#))
- 64 Mr Greg Fell ([PHP0053](#))
- 65 Mr Phillip Woodward ([PHP0038](#))
- 66 Mrs Glenda Augustine ([PHP0075](#))
- 67 Ms Julie Hotchkiss ([PHP0012](#))
- 68 Ms Kate Eveleigh ([PHP0028](#))
- 69 NAT (National Aids Trust) ([PHP0083](#))
- 70 National Childbirth Trust ([PHP0115](#))
- 71 National Children's Bureau ([PHP0050](#))

- 72 National Deaf Children’s Society ([PHP0129](#))
- 73 National Institute for Health and Care Excellence (NICE) ([PHP0076](#))
- 74 Newcastle City Council ([PHP0105](#))
- 75 NHS Clinical Commissioners ([PHP0084](#))
- 76 NHS Confederation ([PHP0059](#))
- 77 NHS England Specialised Commissioning ([PHP0126](#))
- 78 NHS Providers ([PHP0073](#))
- 79 Oxfordshire Baby Friendly Alliance ([PHP0111](#))
- 80 Paediatric Continence Forum ([PHP0016](#))
- 81 Pharmacy Voice ([PHP0060](#))
- 82 Primary Care Women’s Health Forum ([PHP0019](#))
- 83 Professor Jonathan Nicholl ([PHP0047](#))
- 84 Professor Kate Ardern ([PHP0124](#))
- 85 Professor Kate Ardern ([PHP0131](#))
- 86 Professor Kate Ardern ([PHP0134](#))
- 87 Professor Kate Ardern ([PHP0135](#))
- 88 Provider Public Health Network ([PHP0118](#))
- 89 Provider Public Health Network ([PHP0056](#))
- 90 Public Health Action Support Team ([PHP0055](#))
- 91 Public Health England ([PHP0132](#))
- 92 Public Health England ([PHP0099](#))
- 93 Public Health Provider Network ([PHP0125](#))
- 94 Public Health Specialty Registrars ([PHP0057](#))
- 95 Public Health System Group ([PHP0065](#))
- 96 Public Health Wolverhampton ([PHP0098](#))
- 97 Richmond Group of Charities ([PHP0021](#))
- 98 Royal College of Midwives (RCM) ([PHP0029](#))
- 99 Royal College of Nursing ([PHP0017](#))
- 100 Royal College of Paediatrics and Child Health & the British Association of Child and Adolescent Public Health ([PHP0079](#))
- 101 Royal College of Physicians ([PHP0064](#))
- 102 Royal College of Physicians of Edinburgh ([PHP0045](#))
- 103 Royal College of Psychiatrists ([PHP0093](#))
- 104 Royal Society for Public Health ([PHP0024](#))
- 105 Samaritans ([PHP0088](#))
- 106 School And Nursery Milk Alliance ([PHP0014](#))
- 107 Shropshire Council ([PHP0049](#))
- 108 SOLACE ([PHP0041](#))

- 109 SOLACE ([PHP0104](#))
- 110 Somerset Council ([PHP0127](#))
- 111 Stockport MBC ([PHP0058](#))
- 112 TCPA ([PHP0031](#))
- 113 Terrence Higgins Trust ([PHP0035](#))
- 114 Terrence Higgins Trust ([PHP0121](#))
- 115 The Association of Directors of Public Health ([PHP0043](#))
- 116 The Hepatitis C Coalition ([PHP0042](#))
- 117 The Hepatitis C Trust ([PHP0062](#))
- 118 The King's Fund ([PHP0061](#))
- 119 The Royal Society for the Prevention of Accidents (ROSPA) ([PHP0074](#))
- 120 UCL Institute of Health Equity ([PHP0106](#))
- 121 UK Faculty of Public Health ([PHP0066](#))
- 122 UK Faculty of Public Health ([PHP0067](#))
- 123 UK Health Forum ([PHP0051](#))
- 124 UK Public Health Register ([PHP0007](#))
- 125 Unite The Union ([PHP0097](#))
- 126 University of Kent ([PHP0022](#))
- 127 Weight Watchers UK Ltd ([PHP0027](#))
- 128 Wolverhampton Council ([PHP0114](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2016–17

First Report	Impact of the Spending Review on health and social care	HC 139
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Session 2015–16

First Report	Childhood obesity—brave and bold action	HC 465
Second Report	Appointment of the Chair of the Care Quality Commission	HC 195
Third Report	Appointment of the Chair of the Food Standards Agency	HC 663
Fourth Report	Primary care	HC 408