



Health Committee

Oral evidence: [Public Health England](#), HC 840

Tuesday 19 November 2013

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Written evidence from witnesses:

- [Public Health England](#)

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Members present: Mr Stephen Dorrell (Chair); Rosie Cooper; Andrew George; Barbara Keeley; Charlotte Leslie; Grahame M. Morris; Andrew Percy; Mr Virendra Sharma; David Tredinnick; Valerie Vaz; Dr Sarah Wollaston

Questions 1-138

Witnesses: **Duncan Selbie**, Chief Executive, **Richard Gleave**, Chief Operating Officer, **Professor Kevin Fenton**, Director of Health and Wellbeing, and **Dr Paul Cosford**, Director for Health Protection and Medical Director, Public Health England gave evidence.

Q1 Chair: Gentlemen, you are extremely welcome. Thank you for coming. The Committee is not conducting a prolonged inquiry into the operations of Public Health England at this moment, but we were keen to meet you to hear how the establishment of the new agency and the development of public health in the new structures are working, and to seek to draw some immediate conclusions about what is working, what is not and how we can move things forward. That is the background to this session. I ask you to begin by introducing yourselves and your functions.

Professor Fenton: Good afternoon. I am Professor Kevin Fenton. I am the director of health and well-being at Public Health England.

Duncan Selbie: Good afternoon. I am Duncan Selbie. I am the chief executive.

Richard Gleave: I am Richard Gleave. I am the chief operating officer at Public Health England.

Dr Cosford: I am Dr Paul Cosford, the medical director and director for health protection.

Q2 Chair: We would like to start by reflecting on the development of the new agency since it was established and looking at the relationship between Public Health England and the Department of Health. One of the issues when the legislation was going through was the extent to which you have an independent voice—whether you are able to speak truth unto

power freely and in an untrammelled way. Could you begin by giving your reflections on those questions? We will start with the chief executive.

Duncan Selbie: Has the Committee seen the framework agreement with the Department of Health? It has only just been agreed; it was published on Friday, I am afraid. Has it been made available?

Chair: No.

Duncan Selbie: We need to get this to you. We made it available to the Committee Clerk but only on Friday. This agreement gives us all the necessary assurances. If you had it in front of you, I would direct you to paragraphs 7.4 to 7.6, which give an unfettered freedom to speak and to publish unto the evidence. In this agreement is a code of conduct that we have had extant since Christmas, which enshrines, as a contractual right, the right of our staff to speak truth unto power. That is enshrined in the framework agreement agreed with the Department of Health and approved by the Treasury.

Q3 Chair: If, for example, you have a view as a body on minimum pricing of alcohol, are you free to express that clearly and unambiguously in public?

Duncan Selbie: Yes—and, as you know, we have done so.

Q4 Chair: Indeed. I guess one of the bits of background to this session is to wonder where the voice of Public Health England has been in some of the public health discussions over the last seven months.

Duncan Selbie: Minimum unit pricing and, for that matter, standardised packaging came very early in our creation. We were certainly free to give our views, which we did. With some humility, we would accept that it was too early in our days for us to be of any real materiality in the policy decision, but our views have certainly been sought and, we believe, listened to. To go straight to your question—are we free to speak or to publish, or are we fettered in any way?—that is not how we are experiencing it.

Q5 Chair: Could you talk to us a bit about how you develop a point of view on those kinds of issues where there is a high level of political interest, sometimes with a capital P and sometimes with a small p?

Duncan Selbie: The most important thing to convey is that we would speak to the evidence rather than to opinion. Would this be an opportunity to involve Kevin Fenton in talking specifically about those two policies? It does go wider.

Chair: Yes.

Professor Fenton: A key part of what we do in the agency is really to look at the evidence regarding the burden of disease and what are some of the core priorities we should be focused on, whether in the health improvement domain, the health protection domain or the health inequalities domain. We know that there are substantial data showing us the burden of disease that is attributable to behaviours such as smoking, alcohol and drugs, high body weight or obesity, and other risk factors and behaviours. Those identify areas where we need to prioritise both investment in our research and investment in our programmes.

Based on those investments, we are able to generate new data, new policy positions or programmatic positions that we can then share with our partners working at local level or across the system. We certainly work with Government partners to say, “These are emerging priorities that need to be addressed,” and “How can Public Health England work with you to ensure that we are driving health impact in these areas?” Everything really starts at characterising the epidemiology of disease, characterising the burden, looking at where there are health inequalities, looking at where there is evidence for us to make real improvements and impact, and then using those data to drive and to prioritise action.

Specifically, on MUP and plain packaging for tobacco, it is very clear that these are two areas where we need to do a much better job as a country, to continue both to drive down smoking rates among adults and to limit the initiation of smoking among young adults. Data from a number of systematic evidence reviews from many western industrialised countries are now consistent in showing that standardised packaging would have tremendous benefits both in reducing the attractiveness of smoking to young people and decreasing the acceptability and attractiveness of smoking to current smokers. It would provide opportunities to have much clearer messages on the packages related to health and the harms of smoking. That is an area where the evidence on prevalence and incidence, prioritising where we should focus and then looking at the evidence on what works really drive our actions.

Duncan Selbie: We want to make an observation on a more recent issue—shale gas extraction.

Dr Cosford: If it is of interest to the Committee, as you will be aware, we have national scientific experts on the health impacts on people of chemical and radiation exposures. Over the past year or so, they have done some extensive work on the potential public health impact on communities in the areas where fracking or shale gas extraction would potentially take place. The process we have gone through there is a very extensive scientific exploration of the evidence on whether there are immediate health harms from that process. We have published openly—but for comment, in the first instance, from people who may think that we have missed some of the evidence—to get that evidence finalised and to give a clear view from Public Health England on the public health impact of shale gas extraction.

Q6 Barbara Keeley: The next shale gas exploration site is in my constituency, so this is a very lively issue for me. I have to say that I was profoundly disappointed in what you came up with, because my constituents are very concerned indeed about these health issues, particularly the possible introduction of new chemicals polluting an atmosphere where we already have some of the worst air quality in the country. My constituency has three motorways and some of the busiest trunk roads in the country; I definitely have the worst traffic junction anywhere in Greater Manchester. In fact, the Highways Agency has just shelved a plan to widen the motorway at that point because the air pollution is so bad on so many days of the year that it was thought that we cannot have the motorway any busier.

Into that soup of appalling air quality we now have very close to schools, farms and houses an organisation that wants to start introducing chemicals. The whole process—this is the point where I take issue with your initial conclusions—is that you seem to say, “This is a process that’s safe if it’s monitored properly and if the processes are followed.” My take on

that is that we have no idea. You have no idea and we have no idea. Nobody in this country has any experience of these processes. I think it is far too early.

I am sure the Government were delighted with what you said, given that they want to rush to shale gas and the Prime Minister wants to win a debate on it, but my constituents deserve a bit more calm and real consideration of evidence, which we do not have. I have read some very frightening things about pollution and emissions from the United States. I was very surprised at the extent to which you appeared to jump in and be prepared to say that.

Dr Cosford: I entirely understand the concerns around air pollution at a local level and at a national level. Our scientists are also doing work on combating air pollution, what is required to address that and the potential health harms from air pollution. We are very clear on those points.

Q7 Barbara Keeley: But this is additional pollution—additional emissions. There are some very dangerous chemicals indeed involved in this process.

Dr Cosford: What our evidence says at this stage is that it must be very clear all the way through the process what chemicals are being used and how they are being controlled.

Q8 Barbara Keeley: It is very clear that they are carcinogenic and mutagenic. Very toxic chemicals are used in this process.

Dr Cosford: The evidence that we have suggests that, like many difficult industrial processes, if it is done appropriately and regulated properly, it does not add extra potential harm to the local populations.

Q9 Barbara Keeley: But there is nothing to base that on. It has not happened in this country—you have nothing at all to base that on.

Dr Cosford: That is based on a thorough review of the international evidence.

Q10 Barbara Keeley: There is not much.

Dr Cosford: That is not to say that our message is that it is safe to take place in any local area. That is not what we are saying—what we are saying is that this is what the best international scientific evidence suggests. There are, of course, other issues around shale gas extraction, partly how it goes along with other circumstances that have to be taken into account locally. I am meeting colleagues in local authorities in the north-west of England next month to talk through how our work relates to the work that they are involved in.

Q11 Barbara Keeley: The danger of that is that you have come out with this draft report now. In my constituency there are two schools less than a mile from this site. This is an open-air site, not a factory where there can be much control or measurement. This is something that is happening in the open air. There are two schools. There is a young persons' secure unit 0.4 of a mile away from this. There are three farms, the closest of which is 1.1 mile from the site. You will understand what my concerns are.

Dr Cosford: Absolutely.

Q12 Barbara Keeley: Okay, but I am afraid that your conclusions were widely read as "This is a safe process if operated safely." There is no experience of whether it is safe—none.

Duncan Selbie: We were responding to the question about whether we are free to speak or to publish. There was no political interference in this. There was no direction. This was work that was under way because we possessed the scientists in chemicals and environmental hazards and because this is what we do. What you are describing is of immense importance to us, of course. Local concern and the weight of pollution are things we would be concerned about.

Q13 Barbara Keeley: But this is happening now—it is happening this week, in my constituency.

Duncan Selbie: What we are seeking to convey is that when we looked at the evidence as we understand it, which was not just a small matter—we really did look at it around the world—that is what we said, subject to these constraints or caveats. That was not to say that in every individual circumstance it would be the right thing to do. I think we need to—

Q14 Barbara Keeley: I did not read any caveats that said, “When there is a secure unit with young people in it 0.4 of a mile away from a site, it would be safe,” or “When there is a school 0.7 of a mile from it, it would be safe.” I read you as saying, and it was largely reported that you said, “This is a safe process if it is operated safely.” To be honest, that is so broad-brush that it is almost not worth saying. It is probably a good thing that I am here today raising these points with you, because this is happening now, at the moment, in my constituency, and I am very, very concerned about it. I think you have not followed through your health protection role in relation to the public. I will leave it there because it is of particular interest.

Duncan Selbie: We hear that.

Q15 Chair: I have a subsidiary question. It was you as our witness who raised the question of fracking. One of my questions, prompted by that, is what led Public Health England, seven months in, to express a view about fracking?

Dr Cosford: The genesis of this was from 2012 when, as part of the work that our scientists who specialise in the health impact of chemicals and radiation were doing with colleagues across a number of different organisations, it became apparent that there was a desire for a view from what was in those days the Health Protection Agency on what the potential health impacts of the shale gas extraction process would be. That was the genesis of it. It has been worked on over that period of time to make sure that all the different sources of evidence—

Q16 Chair: We have had the discussion about the merits—it is the process that interests me at this moment. Your answer to my question is that this was work in progress at the time that Public Health England was established. My question is whether the board of Public Health England took a view on its priorities and pressures as a new body and concluded in an orderly way that this was a priority that it wanted to address in its first six months of existence.

Duncan Selbie: I tried to say at the outset that there is some humility coursing through us about not making pronouncements and leading a debate until we are in a position to do so. Our first priority has been to secure safe health protection arrangements, to address the

concerns that this Committee raised and that others were concerned about at the point of transition and to get the new public health system under way.

Remember, it is early days. We want to get the new duty placed on local government. It is on life, but the conversation we would like to have is one about health, not just about hospital care. You know very well about Wanless and where Marmot has been. We have been established not to be the only voice but to be a voice—an important voice—in furthering a conversation and a narrative as a country that is about improving health. We have not been looking to find causes for publishing, but nor have we wished to slow down or just stop proper science. This was one issue where work that was already under way was helping us to understand.

Q17 Barbara Keeley: I will conclude on this point, but I think it was hopelessly naive of you to have done that at the point where controversial activities were starting to go ahead in a built-up urban area, as is happening in my constituency. There are real concerns that there is not enough monitoring, in any sense, to tie in with what you have said. The developers of these activities are the only people who really have the most say. Local authorities have hardly any role in this. I think it is far too controversial a subject for you to have just jumped into. I found your report naive in the extreme.

Duncan Selbie: We were responding to a question about the freedom of our scientists and clinicians to speak.

Q18 Chair: Freedom from Government, rather than freedom from the Public Health England board—that might be the point.

Duncan Selbie: There was thought given to this, and it was very carefully examined. I do not think we are going to—

Q19 Rosie Cooper: Thought given by whom? Forgive me, but I am going to jump in. For me, the answers I have heard in the few minutes I have been here address almost your credibility. You are saying that you dealt with fracking as opposed to smoking, alcohol or a million other really important public health issues. Out of the blue, without your board deciding it, but because somebody somewhere whom you have not named decided to do it, you picked that one issue. Either you are being helpful to the Government's agenda or Mystic Meg is alive and well and working for you. How did that decision get made?

Chair: Could we have one more go at this and then come back to the agenda? Otherwise, we will spend the whole afternoon talking about fracking if we are not careful.

Rosie Cooper: But we do need an answer.

Chair: I agree. One question, one answer, and then we move on.

Dr Cosford: It is important to know the genesis of this piece of work, which was, as I said before, a piece of ongoing work. It is not a reflection of our priorities to say that this was our highest priority, over and above smoking, alcohol, obesity and all the other public health harms. We are absolutely passionate about addressing those. I have personally been quoted in the *BMJ* giving my views on minimum unit pricing and so on.

Q20 Rosie Cooper: Fantastic. Have you done a report on that, besides being quoted?

Dr Cosford: Professor Fenton can outline our work on that area. It is important that this was a piece of work that our best scientists were already engaged in. For us to have declined to allow them to publish the work they were already engaged in would have given a message that would have been a very difficult one to our staff about the importance of publishing our best scientific evidence. We can argue about whether or not the scientific evidence is right. It is for consultation—

Q21 Rosie Cooper: My question is about governance. Why didn't the board look at it and decide? You have just said that the board did not do it. So every piece of work that was in train before you got to be—

Duncan Selbie: No, I did not say that. The chairman was very aware of what we were doing here. This was a scientific piece of work that was checked in the normal way, through consultation with other Government Departments, and was published in agreement with the Department of Health. We did not do any of this on our own. The suggestion that we invented this is just unfair.

Q22 Valerie Vaz: As someone who has done science, I think you have actually answered all our questions. You say it is a scientific piece of evidence, yet you checked it with the Department of Health, which sounds very peculiar to me. Isn't it peer-reviewed? You said that you looked at the evidence throughout the world. Could you state for the record what evidence you actually looked at?

Dr Cosford: The evidence that has been looked at is all in the report that is there for consultation.

Q23 Valerie Vaz: Could you state for the record here—

Dr Cosford: I do not have in front of me the list of all the different sources of evidence.

Q24 Valerie Vaz: Could you write to us and tell us what the evidence is?

Dr Cosford: Of course we can write to you and tell you what the evidence is.

Q25 Valerie Vaz: My understanding is that there is not much evidence on fracking around the world and it can only be one piece of evidence. I think reports of your report said that it is only in America—

Dr Cosford: There are a number of different sources of that evidence; we can give you the detail of it. I have to say that I would much rather that the evidence had said something different from that which it did, but our duty is to publish the best scientific evidence that we have. That is—

Q26 Valerie Vaz: But you have not, because you have not had it peer-reviewed. In your own words, you checked it with the Department of Health. Is that right?

Duncan Selbie: I do not think that is fair. We have a chief medical officer in the Department of Health. There are other experts around Government—

Q27 Valerie Vaz: That may be the case, but did you peer-review it?

Dr Cosford: We can confirm to you the extent of peer review. The sources of evidence, for all available sources of evidence, have been sought very carefully. We have put it on our website now as a means of identifying any further sources of evidence, if there are people across the UK or the world who think we are missing something. We would be very happy to take back your points and look again at the report we have looked at.

Q28 Valerie Vaz: Please do. I have two short questions. Seventy-five per cent of the chemicals used in fracking are toxic. As public health officials, do you think that is a good thing? Do you think that is acceptable?

Dr Cosford: The most important issue—

Q29 Valerie Vaz: No—I just want a yes or a no. Do you think that is acceptable?

Dr Cosford: The most important issue—

Q30 Valerie Vaz: No—I just want a yes or a no. Obviously we have to move on. As public health officials, do you think that is acceptable?

Duncan Selbie: It is not amenable to a yes or no question.

Q31 Valerie Vaz: It is.

Duncan Selbie: It would depend on the chemicals, wouldn't it?

Q32 Valerie Vaz: You obviously know what they are, because you have done a report on it.

Duncan Selbie: Dr Cosford is an expert. We have 2,000 scientists we rely on. We know what the impacts are, but I do not think this is a question we can answer with a yes or a no today.

Q33 Valerie Vaz: Not in this room, but perhaps you can tell me what your opinion is.

Dr Cosford: The issue for me—

Duncan Selbie: I am sure we could.

Dr Cosford: Absolutely—we will do that.

Valerie Vaz: Sorry?

Duncan Selbie: Yes, we could.

Q34 Valerie Vaz: Okay. Would you prefer to do that in writing?

Dr Cosford: Forgive me, but the issue for me is whether there is any risk of public exposure to any chemicals and whether those are handled appropriately. That is an issue with many industrial processes. That is absolutely our concern. If there is any evidence that it would worsen an issue of local air pollution, we will say so and will say so fearlessly.

Q35 Valerie Vaz: So we wait for a disaster to happen and then say that it was a bad thing.

Dr Cosford: No. Forgive me, but I think that is misrepresenting what I am trying to say. I may not be saying it very clearly.

Q36 Valerie Vaz: I am just asking whether you think it is acceptable that 75% of the chemicals that are used in fracking are toxic.

Dr Cosford: The consequence of that suggestion is that using harmful chemicals in any industrial, biomedical or other process would be unacceptable.

Valerie Vaz: No, not really.

Dr Cosford: Whenever we use harmful chemicals, in any kind of process, we have to make sure they are used safely. That is the key question here.

Q37 Valerie Vaz: Another statistic is that 25% are carcinogenic. As public health officials, do you think that is acceptable?

Dr Cosford: If there is any risk of exposure, that would be unacceptable. The report goes through the evidence as to whether there is any risk of exposure to the public from any of the chemicals that are used and makes some stipulations about how that should be considered if there is a desire to go forward with the process.

Valerie Vaz: Thank you.

Q38 Barbara Keeley: I have time to look only for certain evidence but it is quite important that I do. I found quite easily a published European Union report that mentioned a medically peer-reviewed report from the United States that talked about the incidences of cancer up to half a mile from a well site and the differences between those figures and figures from a mile or more away. I have talked about the distances in my constituency, so that is really of concern to me.

There are also many, many reports on United States public health websites on the impact of emissions of silica on people who work in this sphere of activity and the damage that there is—respiratory and other conditions, through to cancer—from silica, which is very dangerous if inhaled. I found those quite easily, and my constituents can find them quite easily. We are talking about a situation where that is happening—it is projected to happen now. We have moved to a situation where we have a planning system that is not capable of taking these things into account. Local authorities do not have experts. Their budgets have been cut and there are hardly any staff who work in planning. These dangerous things are happening in an urban area of Salford. We are not talking about desolate areas of the north—we are talking about somewhere in a built-up urban area, with appalling air quality now.

You have stumbled into this with this rather naive report that generated very naive headlines. I think it would have been better for the protection of my constituents and people like them in other parts of the north-west if we had had a proper consideration of what it is like if you drop this toxic soup that my colleague has just referred to into an area that already has appallingly poor quality.

Duncan Selbie: We have not stumbled into this at all, but we do share your concern. It is our first responsibility to make sure that people are not exposed to these chemicals. It is our first responsibility to make sure—

Q39 Barbara Keeley: So what will you do?

Duncan Selbie: We will have to—

Q40 Barbara Keeley: In the case of my constituency, what will you do?

Chair: Barbara, let Mr Selbie answer.

Duncan Selbie: That is our first responsibility. We take it very seriously. We will obviously have to continue this conversation with you. I am very happy to commit Public Health England to do that.

Chair: David Tredinnick wants to come in. Then we must go back to the agenda we started out with.

Q41 David Tredinnick: Speaking as a politician who has been here for quite a while, I absolutely understand what Barbara Keeley is doing for her constituents. When I was first elected in '87, there was a miners' rehabilitation unit in my Leicestershire constituency where the miners in the coalfield that was in my constituency went when they had emphysema and the other ghastly diseases associated with mining, but we had to get the coal out of the ground because we needed the energy. There are all sorts of subsidiary, secondary issues that we still have now of subsidence and goodness knows what else in my constituency, around Bagworth, Merrylees and all the places where we had mines.

Isn't there a degree of proportionality here? If you are going to look at fracking, which is a political minefield, you also need to look at the potential for health improvements through reduced energy costs, which are very substantial indeed. We have to have a balance here. However difficult these issues are with the use of chemicals, we also have to look at the potential for a national increase in well-being through vastly reduced energy costs.

Chair: One question, one answer, and then we will go to NHS health checks, otherwise we will never get out of fracking.

Duncan Selbie: If you hear what we are saying about the health protection responsibilities, we will continue the conversation. We then want to move on to a conversation about improving health. Fuel poverty, decent housing, crime-free streets, enough money to live on and having a job are all the things that improve health, not health care, as important as that is. We really need to have this conversation as a nation.

Q42 Valerie Vaz: I am really sorry to have to move on to another controversial area—the health checks. I know there is some kind of dissent on that.

Duncan Selbie: I am only glad that you raised that, not us.

Q43 Valerie Vaz: Sometimes we talk to one another and we all know what we are talking about. Could I ask you first to establish for members of the public who look in exactly what health checks are? Then we can move on to the controversial aspects of that.

Professor Fenton: I will be delighted to do that. The health check programme is a population-based risk awareness, risk assessment and risk management programme that is offered to individuals in the population aged 40 to 74 years once every five years, with the

intention of identifying the early risk factors for cardiovascular disease, kidney disease and stroke. More recently, a component was added to increase awareness around dementia as well. We are looking at early intervention with individuals within the population, to educate them about their risks and to manage those risks.

Q44 Valerie Vaz: You know that the Royal College of General Practitioners does not like it very much. Clare Gerada has said that she does not think this is helpful. Could we hear your side? Why do you think this is useful?

Professor Fenton: Absolutely. In this country, we are dealing with a crisis of non-communicable diseases—high burdens of chronic diseases and lifestyle factors that are driving not only individual misery and premature mortality but also tremendous costs to the NHS. To be honest, we have been doing the same things over and over and having very little impact in terms of our relative performance in addressing these chronic diseases in this country. We really need, therefore, to think about innovative approaches that can help both to educate and to engage the population around their health earlier so that we can take control of health in a more strategic way.

The health check programme has come under some controversy, in part because of a systematic review that was done by the Cochrane Collaboration and published last year. It looked at about nine randomised control trials of general health checks that were offered between the late 1960s and the early 1990s—so the most recent study was nearly 20 years ago. That systematic review looked at the impact of those general health checks on population mortality. The Cochrane study was unable to demonstrate any impact on mortality. The systematic review also tried to look at the impact on morbidity—what happened with disease outcomes; did it make any difference? Unfortunately, the quality of the studies, because they were so old, did not allow it to look at those intermediate determinants.

I think that generated a certain amount of uncertainty and angst, certainly within some sectors of the provider community, about whether this is a worthwhile investment. We feel that the health check programme as it is currently designed is very different from the health checks that are in the systematic review. We are not doing a general health check—we are doing a health check that is really focused on cardiovascular risk. We are doing a health check whose individual components have been reviewed and approved by NICE. The pathways that are implemented are all based on NICE-recommended actions. What is different with the health check programme is that we are combining these individual interventions into one, for the first time. I think some colleagues are wondering whether or not that is an effective way of doing it.

Q45 Valerie Vaz: Do you think it is worth while?

Professor Fenton: We have certainly looked at the programme as part of the transition from management by the Department of Health to Public Health England. We took stock of the programme. We did a review, which was—

Q46 Valerie Vaz: My question was do you think it is worth while?

Professor Fenton: Yes, we do.

Q47 Valerie Vaz: What would be the outcome? You get someone in and do these checks. You say that it saves costs to the NHS, but aren't you going to be recommending medication, for example? You are going to say, "You've got a risk of dying from a heart attack when you are 45 or 50."

Professor Fenton: No—

Q48 Valerie Vaz: Are you not going to recommend medication?

Professor Fenton: No, it depends on what is found. I had my health check recently. I can tell you that it was a wonderful opportunity for me to speak about my level of exercise, alcohol intake and so on. It depends on what is actually found in the risk assessment. Most people who come through may have one or two issues that may require some advice, a brief intervention or referral to a risk management service—for example, a weight management service and so on. Very few, depending on their cardiovascular risk, may require further diagnosis for particular illness and, therefore, be placed on specific management. The good thing there is that the health checks offer us an opportunity for early identification of problems, engagement with individuals on their risk and having a conversation about health.

Q49 Valerie Vaz: Among the staff—the public health people who work in Public Health England—did you hear the voices against this, saying that this was not a good idea?

Professor Fenton: Yes. We also heard the voices of those who thought it was a good idea. We are committed to learning as we implement, knowing that we have very few effective tools to deal with some of these chronic conditions.

Q50 Valerie Vaz: You mentioned dementia, and there is a new screening for that. Do you think that is a good idea, given Dr Carol Brayne's report indicating that she did not think that this was helpful or even worth while—that there is no evidence to say that screening for dementia is a good thing?

Professor Fenton: Let me be clear—we do not screen for dementia in the NHS health check programme.

Q51 Valerie Vaz: What are you doing, then?

Professor Fenton: The opportunity is taken to speak to people who are aged 60 to 74 to raise awareness about dementia and simply to say that, as they are getting older—

Q52 Valerie Vaz: I think you used the word "screening" for dementia.

Professor Fenton: No; you may have misheard. It is about raising awareness about dementia and showing that colleagues are aware of the signs and symptoms and what should be done about accessing services for dementia. We do not screen for dementia in the health check programme.

Q53 Valerie Vaz: Okay. So you are just talking to people to see whether they—

Professor Fenton: It is about raising awareness.

Q54 Valerie Vaz: What do you say about Professor Brayne's report?

Professor Fenton: I saw that report. Again, I think—

Q55 Valerie Vaz: Do you challenge it?

Professor Fenton: No, I do not, because I think there is very little evidence regarding screening for dementia, although we know that the evidence is emerging quite rapidly, in part because of an understanding of the contribution of vascular elements to dementia. In other words, some of the predisposing risk factors—smoking, obesity and hypertension—that can predispose to heart disease and strokes may also increase the risk of dementia. In the near term, there may be not only opportunities for raising awareness about vascular dementia but opportunities for screening for vascular—

Q56 Valerie Vaz: Who is talking to the elderly people?

Professor Fenton: Who is talking to healthy people?

Q57 Valerie Vaz: Yes. You said that you were talking to them to ask them whether or not they have dementia. Is that what you are doing?

Professor Fenton: Let me clarify. We are not asking individuals whether they have dementia. We are simply saying, “Here are some of the signs and symptoms you need to be aware of. You should be aware of the prevalence of dementia and of some of the signs and symptoms. Here are some of the assets within your community that you can leverage or take advantage of to get more information on dementia.” Really it is about providing effective information to people who may be at risk.

Q58 Valerie Vaz: Does a larger part of the population need that compared with, say, obesity, which is quite an important issue? Do you think that it is important to put resources into that rather than into obesity?

Professor Fenton: The wonderful thing about the health check programme is that we are able to look at a variety of lifestyle factors that are really driving these chronic diseases. The individuals are screened for high blood pressure, cholesterol, weight, alcohol intake, physical exercise and so on. By doing that screening, not only are you able to look at a risk for dementia and cardiovascular disease but you have an opportunity to talk about healthy weight, obesity and other key risk factors for individuals.

Q59 Valerie Vaz: Can’t they do that anyway now when they see their GPs? You are making the GPs do something extra—another tick-box.

Duncan Selbie: Not just GPs.

Q60 Valerie Vaz: So it is not just GPs.

Duncan Selbie: It is GPs, chemists and various voluntary organisations. These are checks that are—

Q61 Valerie Vaz: They are just ordinary checks that you can do yourself, probably. Can’t you?

Professor Fenton: No, they are not.

Q62 Valerie Vaz: They are not?

Professor Fenton: They are not ordinary checks.

Q63 Valerie Vaz: You can't go into a pharmacy and get your cholesterol and blood pressure done?

Professor Fenton: If pharmacies are commissioned to provide the health check service, they will provide the combined package of interventions that I described earlier, so the individual or patient may be able to access all of these at one go.

Q64 Valerie Vaz: Is extra money going to all these different—

Duncan Selbie: I was referring to ordinary people, meaning you and me. No, I was not thinking of that.

Valerie Vaz: Me—not you.

Duncan Selbie: There is a dental practice in Manchester that is piloting the health check programme. We are keen to see pharmacies do it. Of course, there are many GPs doing it. The controversy about the health check programme has been not about the individual components but about the evidence for gathering them up and doing them all at once, if you like.

Q65 Valerie Vaz: Yes—and worrying people.

Duncan Selbie: What I have come to learn is that what is good for your heart is good for your brain. The vascular piece in this is all-important. It is the first time we have ever had such a programme that is preventive—

Q66 Valerie Vaz: I accept that it is the first time, it is wonderful, you are all advocates for it, you all want to do it and you have all had your health checks done.

Duncan Selbie: We need to evaluate it.

Valerie Vaz: I am just wondering why this is different from what GPs do anyway and why there needs to be an extra.

Q67 Chair: Can I supplement that with a question? What are you going to do to build the evidence base for the assertions that you are making?

Professor Fenton: As part of the programme transferring to Public Health England, we have made absolutely clear what our approach to the evidence is. In fact, we published a document outlining our approach to the evidence in which we committed to a few things. First, from 1 April moving forward, we would ensure that science—evaluation and research—underpinned the evaluation of the programme. That means learning as we are doing and looking at supporting evaluations that are being done both nationally and locally so we can generate the evidence that we need to look at the impact and effectiveness of the programme.

Secondly, we want to ensure that we have a good governance structure in place for any new additions or enhancements to the programme. We have created an expert clinical and

scientific advisory panel that now advises Public Health England on both the content of the programme and on the enhancement of the programme moving forward. Remember, the technology is evolving as we speak, so we need to ensure that the health check programme keeps up to speed with the emerging evidence. We are really committed to instilling evidence in the programme.

Q68 Valerie Vaz: Okay; I was just rolling my eyes about another panel being set up. Will all the people who do this, such as dentists—I am quite shocked that my dentist will be doing all of this for me—be paid separately for it? How much will they be paid for each health check that they do?

Professor Fenton: It varies according to where you are in the country and the check itself. It depends on the contracting arrangements between local authorities that are responsible for commissioning the programme and the contracts that are created at the local level, so it varies across the country.

Chair: David Tredinnick wants to come in briefly.

Q69 David Tredinnick: Coming in on the back of what Valerie Vaz has just said, I said to my colleague on my left just before you came in, “I’m not sure I can see a justification for this organisation.” You have 5,000 employees, and I see massive duplication, I think. You have clinical commissioning groups that are making assessments, you have a massive commissioning board, you have the Secretary of State and his huge Department, you have health and well-being boards, Healthwatch and Hinckley and Bosworth borough council, which has a health strategy, and directors of public health.

I go through the brief and see that “Public Health England will support and advise Directors of Public Health and local authorities” and that you “will support the Secretary of State in considering how the Government can best achieve its...objectives”. I am not sure I can see why we need your body as well as all these other bodies. I would be grateful if you would answer that one question.

Duncan Selbie: It is a fabulous question. Our scientists at Colindale, at Porton Down and at Chilton are in great demand in the UK and around the world. A third of our income is derived from the work that we do in manufacturing and a number of areas that are of consequence to health in this country and around the world. We are in support of a new local leadership for the public health system, which is local government. We are organised around that to provide what support we can, particularly around making sure that we have a work force for the future. We have our health protection responsibilities, which are not replicated anywhere else in the system.

At Public Health England, as a body, we do not regard ourselves as important; what we hope is that what we offer will be important. There is the obvious work that we do around health protection, but there is the wider work that this nation has never prioritised, which is about the improvement of health. There is now a voice for health improvement that is national. We hope with and through others, particularly local government but across Government, to stimulate a debate so that we are not spending everything we have when it has all gone wrong.

Q70 Chair: Would Dr Cosford like to come in on the health protection function?

Dr Cosford: Perhaps I could give a brief story. Some time ago, on a Friday afternoon, we had identified to us a new virus from a patient from the middle east in one of our London hospitals. It was a very severe virus. Nobody could understand why he was as ill as he was. We did the work, identified the virus and identified what its characteristics were. It was the new MERS coronavirus.

At the time, we were not sure whether or not it was going to be a new SARS outbreak. Over a weekend we had teams working nationally in our laboratories sequencing it and with the hospital teams locally to know how to handle the patient, how best to protect staff, how best to prevent spread and what we could do internationally to find whether there were any other cases. On the Saturday afternoon we had our first advice out. We spent some time on it afterwards. It turns out not to be quite such a transmissible infection as we feared, but that is one example of an immediate response to a new, emerging, very severe potential harm that we would have sorted. I am sure the Committee would think that that was of value.

Likewise, we have some of the best vaccination programmes in the world. We are responsible for continuing the oversight of those programmes. Since 1 April, we have introduced four new vaccination programmes across the country that have protected people in a variety of different age groups from a variety of different infectious diseases. Those are just a couple of examples from a health protection point of view. I could quote many.

Q71 Mr Sharma: There are two points I am very concerned about. First, if somebody is told that they may be at risk in future of suffering from dementia, are you creating a fear in the mind of that individual, even if you are telling him or her, “These are the treatments. These are the best exercises,” and all that you have explained? That is the first point.

The other one relates to health checks. You are giving authority to the local dentist. The dentist might be treating your teeth and, right in the middle, might ask you whether you have had your health checks and advise you to get them done as well before you leave, because you are offering that individual extra payment and greed is part of human nature. They will say, “That is an extra few pounds that I or the dentistry will be making.” Don’t you fear that you are forcing people to have health checks or that others will force them to get health checks for different reasons?

Duncan Selbie: That is very interesting, because coercion is not part of this at all. What I was reflecting in response to Ms Vaz was that dentists are highly trained individuals who see 2 million people each week in this nation. We know that—

Q72 Mr Sharma: Don’t you think that this can happen and that you are giving an opportunity for it to happen?

Duncan Selbie: If you want to have a conversation about your health, catching people when they are coming to see you is a good moment. It is a good thing—it is an opportunity. People who go to see the dentist may not be going to see the GP. It is just about taking every opportunity to have a conversation about how you are doing and whether there is anything that you could be doing to improve your health and your life chances. What I was reflecting was that it is not just about GPs, as important as GPs are. There are many other professionals who can have these conversations. We know that

people still listen to their doctor, their pharmacist and their dentist. The connection with getting paid for it is interesting.

Chair: Rosie has a question specifically about that.

Q73 Rosie Cooper: I am obviously on another planet today. If you are going to engage all these professions allied to medicine—pharmacists, dentists, physios; whoever you are going to dig up—to ask them to encourage people to have these checks and to give them a token payment, can you explain to me how you will know that you will not get repeated tests on a number of individuals, individuals using a million names, someone who wants a health check a month, or whatever? We have severely restricted resources all piling down this avenue. How are you going to check? The databases will not be there to cross-check it. This is just another licence—it is G4 rampant, or Serco, or somebody else. They are going to take us to the cleaners. To have it described as an interesting point—I’m bewildered.

Duncan Selbie: The interesting point, to say it as we see it, was the connection that Mr Sharma was making about the payment—the connection to greed. That is what I was referring to. Professor Fenton said something about what actually happens. It might be an indulgence, but I led an acute teaching hospital for five years and can tell you what the consequence was of not having these conversations about health. Just listen to what Marmot has to say. We know that 50% of everything affecting length of life and life without misery in it is the personal choices that we make.

Q74 Chair: But what is the answer to Rosie’s question? What is the assurance that you are not paying for the same checks on the same patient?

Professor Fenton: Maybe I should explain the process for the health check. All individuals who participate in the health check are actually invited for their health check. This is done once every five years. It is done by a letter that is sent out from the GP practice. On receipt of the letter, they are invited to do the health check either in the general practice or at participating sites, which may include the local pharmacy or the local dental practice, depending on what sites are part of the programme.

When I did my health check, I chose to do it at my GP practice. I could easily have gone to one of the local pharmacies. Whichever sites are participating in a locality are able both to collect the data and to ensure that the data that are received from the health check are fed back to the GP practice, so the GP is aware of what has been offered, what the results are and whatever steps need to be taken. There is integration across the system. That is why I think that the health check programme is both responsible in managing resources and has built-in checks, so to speak, because we are able to look at the data flow—who has been offered the check and what its outcomes are. This is what we are doing as part of the implementation of the programme. I hope that reassures you that there is good governance and good oversight of the programme locally.

Duncan Selbie: The contracts are let by local government—

Q75 Chair: So these are not opportunistic health checks. That was the impression you were starting to leave.

Duncan Selbie: No. It is a five-year—

Q76 Chair: It is a planned, invited health check.

Professor Fenton: Exactly. Once every five years, an invitation is sent to individuals.

Chair: Virendra, you were in mid-stream.

Q77 Mr Sharma: I was saying to my colleague that you could go to the dentist and be told right in the middle, “If you don’t do it, you don’t get your tooth out or your treatment done.” That is the worrying part.

Duncan Selbie: Try not to worry about that.

Q78 Mr Sharma: I will talk to you afterwards. The Committee is currently undertaking an inquiry into the management of long-term conditions; I am sure you have touched on it before. Can you outline how obesity contributes to long-term conditions and morbidity in the population?

Professor Fenton: Thank you for that question. I am really glad you are focusing this on long-term conditions. As you know, obesity is one of the major public health crises that we have in this country. Currently, nearly two thirds of adults are either overweight or obese, and it has tremendous impacts on cost to the NHS and premature mortality in the country. We know that obesity is a challenge across the life course, with nearly one in five school-entry children being overweight or obese and one in three young adults as they leave school being obese. So we have a real problem.

I think the creation of Public Health England and the new system transformation we have just been through provide us with an amazing new opportunity to do something different to address this epidemic. First, we can use organisations and leaders such as ourselves to take the bully pulpit to talk about the burden of this epidemic and what needs to be done, thinking about the evidence and how we apply that to work. Secondly, the creation of local government as the seat of public health, looking at the health of its communities, leveraging assets from active travel to leisure centres, and beginning to think about the built environment and ways in which we can encourage both better eating through planning and changes to the obesogenic environment, provides an amazing opportunity for us to address the epidemic.

Finally, there are examples where we are now beginning to see real improvements in responding to the obesity epidemic. Recently, I visited Rotherham, which I am sure you have heard about, which is one jurisdiction that has done tremendous work in reversing the trend—the trajectory—of childhood obesity. There were three key elements of success there that I would like briefly to share with you today.

The first is leadership. The local council and local leaders agreed that this was going to be a priority and that they were going to put in resources—to put their money where their mouth is. The second is to look at what works and to do a much better job of implementing that, looking across the life course. The third is to ensure that there is robust infrastructure for evaluating their progress and to make mid-course corrections to enhance their efforts moving forward. I would like to see that rolled out across the country and to see more local authorities—more jurisdictions, supported by colleagues at Public Health England—doing exactly that.

Q79 David Tredinnick: My local council does this anyway. It has a programme of trying to get people into exercise and trying to address obesity, too. Does it really need a national push, with vast numbers of people, to tell people that they are too fat?

Duncan Selbie: The “vast numbers of people” are scientists. The great majority of our people are working in our laboratories and scientific centres. We are not talking about vast numbers of people employed by Public Health England who are telling everybody what they should eat and so on. This is not how we have been constructed. Half of everyone who had been working in the public health system and had been in the NHS was transferred on 1 April to local government.

Q80 David Tredinnick: I know. We have been looking at all of this. As a Committee, we have been over all the ground we can find on this terrain, and we are doing it assiduously. I am just saying to you that, for me, body mass index is a pretty straightforward measurement. You measure your waist. If you are 2 inches too big against the index, you weigh too much, you know you have the problem that Professor Fenton is describing. I just do not know to what extent we need a national body to tell us that we are doing this when all the local people—the doctors and everyone else—are saying, “You’ve got to lose weight,” and, “You must exercise more.” I am just questioning you—that is all.

Duncan Selbie: Before Professor Fenton gives the proper answer, whatever we have been doing for the last 20 or 30 years, it has not been working. We need to be standing in a different place, or the music has altered so we cannot continue to dance in the same way. The national organisation you are referring to—established by the Government, not by us—was set up to say, “This we cannot continue with.”

This is a big issue, because the conversation that is being had in this House today is all about what is going on in hospitals and A and E departments and not about where the main action is, which is what people are experiencing in their day-to-day lives, whether they have employment and whether they have decent places in which to live—the sorts of things that are absolutely core to what local government cares about.

Your county council, which I am going up to see in a couple of weeks’ time, will be as passionate about this as the other half that I have met in the last year. They talk with a passion about this. Their closest partners, as CCGs and GPs coming together, care more than we could ever care about this stuff. What is different is that there is now a national voice, with some freedoms but responsibilities to go with those, to say, “Do you know? Holding up the mirror, we are just doing this wrong.”

We can have a conversation about health checks and whether that is right, but at least it is a first endeavour to do something that is not about waiting until hundreds of young people pile into A and E departments, paralytic. All we are doing is rehydrating them, not having a conversation about why. Do you know that the test for an acute teaching hospital on vascular care is whether not to amputate, not, “Why are you a chaotic diabetic?” or even, “Why are you diabetic at all?” With the new legal duty placed on local government, this is a conversation we can now have. You decide whether or not we matter, not us, but it is a little early in the day to be saying that we have not made an impact, because we have barely got started.

David Tredinnick: I did not say that. I said that there are other impacts being made and that I think we might be duplicating.

Q81 Chair: What you have done is to articulate what we thought we were setting you up for. What we now want to see is—

Duncan Selbie: You did set us up, and that is what we are going to do.

Rosie Cooper: Notwithstanding fracking, of course.

Q82 Mr Sharma: I will give you a further opportunity to expand on that. What work are you undertaking to support local authorities in their programme to reduce the rate of obesity? In the last 20 or 30 years, we have failed, but what targets are connected to these interventions and over what time frame will their success or failure be measured? What is the time scale, and what support are you giving to local authorities?

Professor Fenton: Very briefly, we are aligning ourselves to the ambitions set by the Government, which are to see a flattening of the epidemic trajectory by 2020. Remember that no western industrialised country has turned the tide of obesity, so this is an ambitious target in itself.

In terms of how we support local government, we have now established a PHE healthy weight and obesity programme, which is focused on four key areas. The first is ensuring that we have and provide the evidence on what works and we work to translate that evidence to local government in ways that matter to it, so that it can do a much better job of implementing. Secondly, we are supporting local systems by really looking at what is working locally—looking at examples such as Rotherham to see what we can learn from those jurisdictions and how we can facilitate the diffusion of innovation and of that evidence, so that we can do a much better job of learning more quickly.

Thirdly, we are really looking at supporting the system through training and capacity building. We have not really had a national focus on obesity. For something that is so prevalent in this country, we have never had that at a programmatic level. Now is the time for us to do it and to look at ways in which we train, skill up and support our local systems.

Finally, the thing we are really passionate about is looking at health inequalities. We know that obesity is not randomly distributed in the population. If you are living in poor or deprived circumstances, you are far more likely to be obese or to have a higher BMI. We really want to work with those areas to understand what more we can do to target our efforts to address the obesity epidemic there. That gives you a flavour of what we are doing with our programme. We really just started in April this year.

Q83 Chair: So far, we have been discussing obesity for about 10 minutes without discussing food. Is there a status for Public Health England in engaging with the food industry and the things we eat?

Professor Fenton: Yes, absolutely. We do this through working with the Department of Health and the responsibility deal, which I am sure you will speak about this afternoon. I think that is an opportunity for us to—

Q84 Chair: “Working with” is a phrase that troubles me slightly, given the starting point of independence. Who is responsible for the responsibility deal? Is it Public Health England or the Department of Health? If it is the Department of Health, does Public Health England have a view on it?

Professor Fenton: On the responsibility deal?

Chair: Yes, and on the performance of the food industry.

Professor Fenton: Yes. We are supportive of responsibility deals, recognising that this is one of a series of interventions that we have really to change the environment to improve health. These include using legislation and policy, partnering with industry, thinking about individual interventions and thinking of community-level interventions. We should not view the responsibility deal as the only game in town—it is one of many.

We know that, through the responsibility deal, there have been some successes. It is currently being evaluated, and PHE looks forward to seeing the results of the evaluation, which will be available in the next 12 to 18 months. However, we have to look at some of the accomplishments: reductions in the population intake of salt; front-of-package labelling, which will come out shortly; and some of the interventions on workplace well-being, which have been done through collective leadership of business. Has it been enough? Has it been fast enough and impactful enough? That is what the evaluation will show, but I think we should not denigrate some of the real achievements of using this approach to help to change the environments in which we are currently living, working, playing and even praying.

Chair: Barbara wants to come to another cause of ill health—smoking.

Barbara Keeley: Before I leave our earlier point, just as a piece of information, there was a letter in *The Independent* yesterday from Professor Andrew Watterson, the director of the centre for public health at the university of Stirling, who pointed out—given the points we made earlier—that your report on shale gas specifically excludes occupational health and safety. I raised a point about occupational health, but clearly you have not covered that. I think that is a pity, because that is quite an important issue.

He said that your report “provides minimal information about its method, rigour and results,” which goes to the point my colleague made. He made quite a critical conclusion. He said that “Public health practitioners look for high-quality systematic reviews before accepting any conclusion about a lack of public health risk,” and that your report “raises as many questions as it” answers and “does not show that fracking is safe”. I am sure he is highly—

Chair: Do you mind if we do not have a further debate about that, otherwise we shall be back in another half-hour discussion?

Barbara Keeley: Our panel raised this issue.

Chair: Indeed. That is why I let it run.

Valerie Vaz: And they wrote the report.

Q85 Barbara Keeley: Indeed they did.

My question is about standardised packaging, which you have touched on already. We have had two recent debates in the Commons on standardised packaging, for which, I have to say, there is much cross-party support, but Ministers have said that the evidence for introducing standardised packaging is not conclusive. What is your view on Ministers' saying that the evidence is not conclusive?

Duncan Selbie: If Kevin begins, I will pick up on some of the colour around it and see whether there is anything I can usefully add.

Professor Fenton: In my earlier comment, I made it absolutely clear that in the review that we have done we have looked at both systematic and comprehensive reviews and at a variety of studies that have sought the consensus of global experts on this matter, and that the overwhelming body of evidence to date suggests that there would be tremendous benefits from introducing standardised packaging, in part to reduce the attractiveness to young people who are not smoking, in part to reduce the attractiveness to current smokers and, as I mentioned earlier, to provide an opportunity for better labelling about the harms of cigarettes. Those are some of the benefits that we are likely to see. It is our role as an agency to ensure that we are collating the evidence, presenting it to policy makers and presenting it to our local partners to ensure that they are able to make decisions based on the best available evidence.

One of the other things we are doing in the agency is looking at the impact of the introduction of standardised packaging in Australia, where, as you know, it was introduced last year. We are still in the first year post-introduction. One of the challenges is that at the time when Australia introduced standardised packaging, it introduced a range of other interventions as well, so it is going to be hard to tease out the unique contribution of standardised packaging.

That brings me to my last point—that none of these interventions should be viewed in isolation. They are a package of comprehensive, integrated prevention programmes that are really needed to drive down levels of smoking.

Duncan Selbie: If I think about hospital-acquired infections, a number of years ago we had very embarrassing levels of MRSA and clostridium difficile, which are dreadful things. Over a period of time, we tried a number of different interventions—washing hands, doctors not wearing ties and watches, looking at the antibiotic policy and looking at aseptic ways of doing things in hospitals. No one could ever say that a particular intervention was the main one that led to the improvements, but, if you had the package of them, you could expect to see improvements. As a nation, we have such a lot to be proud of on this.

Similarly with smoking, standardised packaging is believed to be the next step in the journey. It is not all that ever matters; we could spend much of our time this afternoon on everything else that matters. The supply chain for the tobacco industry is children—200,000 a year starting smoking. Normally, I would have the packaging in front. There is some emergent evidence about how attractive slimline cigarettes are. You would think that intuitively, but the evidence now supports it. There are cigarettes that change flavour when you flick a switch and ones that look like iPhones. It is just attractive. We do not know,

because the evidence does not yet exist and will take time to come out of Australia and other parts, but we believe—and it appears to be the view—that this is the next important step. It would be very odd to have a public health agency that was not in support of anything that would reduce the impact of tobacco. It remains the number one killer by a country mile.

Q86 Barbara Keeley: I understand that, because my local authority smoking rate is 25%, which is more than the national average, and 1,000 children a year are judged to start smoking in Salford. There is a concern that we included in our debate that fewer people are successfully quitting smoking now and fewer people are attempting to quit. Just a couple of weeks ago, we saw figures for between April 2012 and March 2013. There was a decline in the number of people setting a date to quit and a 7% fall in the number successfully quitting for four weeks. That has emerged in the debates we have had here. You have talked about a package of measures, but really we are seeing something that is going backwards. I do not know whether there has been anything in the last few months that indicates why that is.

Professor Fenton: There are various data that are coming out at the moment. I think we need to be careful in both taking a slightly longer-term view and triangulating all the various data sources. We know that patterns of use of smoking cessation services are changing as people's quit behaviours and quit attempts change as well. The ways in which people are quitting are also changing. They are using more nicotine replacement therapy. The emergence of e-cigarettes is also going to be a disruptive influence on the trends that we are seeing in terms of quitting from smoking and then, of course, from nicotine. I would say that, yes, there are some emerging data, but I think we need a little bit more time really to bottom out what is happening with the trends and to begin to triangulate those data sources.

Q87 Grahame M. Morris: I have a question in a similar vein, moving from cigarettes to alcohol. This has been a big issue for me in the north-east; my director of public health, Anna Lynch, bent my ear about it at a conference last week. On this idea of following the evidence, I am sure you are aware that this Committee held an inquiry and published a report last year about the Government's alcohol strategy; I hope you are familiar with that. One of the problems that we had—which you have just alluded to in relation to plain packaging—is that there seems to be little evidence on which to base policy, in terms of what the specific public health benefits would be.

I am talking about minimum unit pricing of alcohol here. Given that we have moved on a little further, what specific public health benefits would accrue as a result of applying pricing of 40p to 50p per unit? I want to put a figure on it, because this is the figure that the Government have chosen. What specific benefits would that bring?

Duncan Selbie: I suspect Professor Fenton might need to go and have a drink, but it is very much something for him to lead on.

Professor Fenton: Alcohol misuse is the third greatest contributor to ill health. Tackling it is a top priority for Public Health England. As you rightly mention, anything that can limit the widespread availability of cheap, strong alcohol within our communities is a good thing. We need to think about not only minimum unit pricing but other effective interventions we have in the toolkit, which include zoning laws, restricting the sale of alcohol and a range of things that can be done.

Specifically to your question, which is about what could be gained from 45p minimum unit pricing, I do not have the specific return on investments here with me, but I would be very happy to provide that to you. What we do know is that this is one area where there have been trials. Modelling studies have also been done to illustrate the impact of setting a minimum unit price on both the prevalence of drinking and associated adverse health outcomes. This is an area where we have robust information. Unfortunately, I do not have it at my fingertips today, but I would be very happy to submit it subsequently.

Q88 Grahame M. Morris: It is quite complicated, isn't it, because it is not restricted particularly to one type of outlet? I am thinking of pubs and clubs, but there are off-licence sales and other sources. Is there any information that we could legitimately use that is available from abroad—for example, the study that was carried out in Canada?

Duncan Selbie: I was thinking of the Canadian study, but there are others. I think half a dozen countries are generating evidence on this.

Q89 Grahame M. Morris: I suppose there is Scotland as well.

Duncan Selbie: There is Scotland as well.

Professor Fenton: Yes. We would be very happy to pull that information together.

Q90 Grahame M. Morris: In your opening remarks, you answered the question about the agreement that you have struck with the Department in relation to where there are conflicts of interest over your ability to speak out on a particular issue. I have a couple of examples and want to clarify that. I am very passionate about the public health observatories. A number of us have been really concerned about how their funding has been cut over recent years and their capacity to provide the evidence base on which policy decisions are made.

Quite recently, there was a report about a dramatic increase in the admission to hospital of people suffering from malnutrition. When I tried to find out whether there is something about the age profile—whether these are old people who are choosing between eating and heating, young people whose parents may be suffering as a consequence of welfare benefit changes and benefit cuts, or people who are relying on food banks—there wasn't any information. Has there been a reduction in the capacity or the tasking of the public health observatories as a consequence of the Health and Social Care Act?

Duncan Selbie: This is hugely important to us. The knowledge systems that we have—the observatories and the registries—are a national asset.

Q91 Grahame M. Morris: They are an international asset, really.

Duncan Selbie: We have the world's leading cancer registry, which was written about just recently. It is unbelievably good. Sitting behind me is the chief knowledge officer for England, who leads the observatories. We had nine, if you remember; it is now eight, but that is because we merged the two that were in the north. That was a sensible thing to do. We are investing more. We will provide the Committee with the actual number, but I need Professor Newton for that. I know about this, because we have had other conversations about making sure that the observatories are properly resourced.

We have talked about the surveillance systems, which are world class, and the immunisation and screening programmes, which are second only to clean water in the difference they make to health in this country. This is all now within Public Health England. That is all very well, but you had a question and could not get an answer. We need to address that.

Q92 Grahame M. Morris: Isn't that an interesting example? When a journalist asked me, "Why the hell has this happened? You are on the Health Select Committee—you should know," I said, "What are the public health observatories saying?" but we do not know. Isn't it important for us in terms of energy policy, food banks and all manner of things to know how the numbers break down and whether there are regional variations?

Duncan Selbie: It is entirely legitimate. We need to be a "knowledge" service.

Q93 Chair: So what are you doing about it?

Duncan Selbie: Am I able to bring in the chief knowledge officer, or is that inappropriate?

Chair: I suspect that is a bit difficult. Could the chief knowledge officer provide you with a knowledge that you can transmit to us?

Grahame M. Morris: That is a marvellous title. I think we should have one of those on the Committee.

Q94 Valerie Vaz: Where are they actually based?

Duncan Selbie: They are regionally based. They are distributed—

Q95 Valerie Vaz: Where is that information going? Where is it? Do they have websites?

Duncan Selbie: Yes, we publish a huge amount. There are a series of things that we have published—three things, while I am creating time.

Q96 Valerie Vaz: Do all of the regions have websites? Do they now pool all their knowledge and intelligence—

Duncan Selbie: No. We are creating a website. We have three immediate projects, but this is something we need to return to. We have the longer lives work, which you will remember. That is nothing original, but it is original in the way it is being presented—interactively, showing how we are doing on the four biggest killers by ward and local authority. We have the health profiles, which are fabulous, on every local authority in the land. In four pages, they tell you everything you could ever want to know about what is happening.

Q97 Valerie Vaz: What is your time line for creating it? When are you going to do it?

Duncan Selbie: This is happening now.

Q98 Valerie Vaz: But you said you were creating something.

Duncan Selbie: What we are creating is a website that is capable of being interrogated and supporting people—frankly, a website that works. The chief knowledge officer says that it

is the same people, in the same place—I cannot read this. What I can add is that, in addition to the products that we have been getting out there, we have a number of intelligence networks. We think this is hugely important; I should really have made the point about knowledge to Mr Tredinnick earlier. We want to expand those networks to include themes and age groups, so the data are relevant to doing something about improving life chances in this country. Children and mental health care come to mind, but there are a number of them.

If I may, I will supply the Committee with an erudite note—I will try to make it so—about how we are approaching this, to address your point about what we can offer that is complementary to what NICE is able to offer now and that you can rely on when you are having conversations locally and nationally to inform policy.

Chair: Virendra is going to talk about emergency planning.

Q99 Mr Sharma: In 2012, the Communities and Local Government Committee expressed concern that there are not clear lines of responsibility for managing health emergencies. What steps have been taken to establish where responsibility lies?

Duncan Selbie: I want to introduce Mr Gleave. He and Dr Cosford work together on this. Standards are with Dr Cosford and implementation is with Mr Gleave. Is it an opportunity to give you a chance?

Richard Gleave: If we set the principles and the framework, I can talk about the application on the ground. That is the crucial bit.

Dr Cosford: The absolutely important thing is that we checked our emergency response arrangements very rigorously before we moved into Public Health England and have checked them continuously afterwards. We are confident that the ongoing response to incidents and emergencies is there. Since 1 April, we have responded as before to 4,500 incidents of various kinds across the country. They have varied up our emergency response scale. We have had three we have taken national control of. So the systems have been up and running and working.

There have been some concerns about precisely who is responsible for what at a local level. Richard can come on to some of the issues we have been talking through there. The principles are clear in my head—and, I think, in others' heads as well. The principles are that Public Health England leads on the specialist health protection response. It will chair an outbreak control committee, for instance, if there is an outbreak, make sure that the right specialist advice is provided on how to control an outbreak of infectious disease or mobilise our air quality monitoring cells when there is a fire that is spewing noxious chemicals across a community. The NHS is responsible for responding and providing the clinical response. The local authority is responsible for making sure that those plans work properly and are working in effect for the local population.

Richard Gleave: This has to be a local first service that is focused around what happens in the individual patches, but it is a service that needs to be escalated quickly should something grow and spread. Those two principles, about handling both of those aspects, are absolutely at the heart of the Public Health England contribution.

We have put together a group that has the Faculty of Public Health, the Local Government Association, the Association of Directors of Public Health, NHS England and us. We have come together to address the specific issue of what happens with the individual responsibilities in different sorts of incidents, because the range of incidents is enormous. The risks here are not just biological threats but also the chemical and radiation incidents we have talked about before. The breadth of knowledge that we need to provide as Public Health England to support the local teams is crucial.

We have agreement that we are going to ask each of the local health resilience partnerships across the country to look at their own local arrangements, to ensure that the partners together have looked one another in the eye and agreed how they will address the different sorts of incidents that might occur. There is not one national, one-size-fits-all model that will work for this. There is a national resource that can be pulled upon to provide consistent support. That is what we provide—often with support from NHS England, but that is our unique contribution to it.

Q100 David Tredinnick: On the point that you made about nuclear issues, as someone who served in the forces a while back, can I ask what liaison you have with the Ministry of Defence? Would it not be the lead authority on problems nuclear?

Dr Cosford: It depends on exactly what the issue is. If it is an issue in relation to an existing nuclear site—a power plant or something—we are not the lead but we provide much radiation expertise. We have the national expertise on radiation exposures and also contribute to the monitoring around a site. We liaise very closely with the Ministry of Defence, not only on nuclear issues but on bioterrorist issues and a range of others—with the DSTL laboratories at Porton, for example, but also through the nuclear authorities within the Ministry of Defence. We also have a very clear chemical, biological, radiation and nuclear response plan. It is a cross-Government plan that we are party to, and we have a full contribution to that.

Q101 Mr Sharma: Does the PHE have the power to direct local authorities in their response to a local health emergency? You mentioned that you had a working relationship with the Local Government Association, but do you have the power to direct or instruct local authorities?

Richard Gleave: What we provide is clear and unequivocal advice about how an incident should best be managed. We also feel that, because of the Secretary of State's powers that oversee the whole of the system, if we had a substantial concern that an incident was being mismanaged locally we would take a more active role in it. The best solution is that people locally—the key agencies locally—draw upon our expertise and support and manage it properly. That is the purpose of the whole planning and resilience system—to set up those systems and processes so that people know how to respond in those situations. Then we provide the expert support.

Q102 Chair: But time is not on your side in those circumstances, is it? If you become dissatisfied, is it the Secretary of State's power or do you have the power to act, as an agency?

Richard Gleave: The legal source of the power is the Secretary of State, but we do not need to go to the Secretary of State in order to engage. If that led to a judicial review with

the advantage of hindsight, so be it, but we would say that protecting the public's health is of absolutely paramount importance in these situations.

Duncan Selbie: That is to say, that is what we do.

Chair: Quite. Thank you. I wanted to get that clear. Barbara wants to talk about health inequalities.

Q103 Barbara Keeley: Across Government, are there any specific policies that you believe are widening or will widen health inequalities? I have to say that I think that is an incredibly leading question because, from my own experience as a Member of Parliament, unemployment, worry, stress, the bedroom tax, benefit sanctions, cuts to social care, malnutrition and cold seem to be issues that I run into and that are affecting my constituents. I invite you to answer.

Duncan Selbie: Professor Fenton is advising me to begin. I do not think that there will be any disagreement between us. It has been very clearly set out. I referred earlier to Wanless's point about the fully engaged scenario, but more recently there has been Marmot's work on the leading causes and, importantly, what you could do about them.

The Committee has commented on this previously. We are new to this, of course, but we see our contribution as being not only to the NHS—we have not talked today about the contribution we make to that—but more dominantly, to those wider determinants. Of course, whole-Government action is an important element. The Committee made a recommendation at an earlier point about a health impact assessment on Government policy. That would strike us as a perfectly sensible measure. We have had some initial conversations with the head of the home civil service about what we could be doing across Government in wider policy terms.

Q104 Barbara Keeley: Before you move off that point, quite a lot of people outside and inside this place have called for a cumulative impact assessment, for instance, of the set of changes that are currently going on—things like the bedroom tax, benefit sanctions and so on. Is that something that would help? A lot of people have thought that the contribution of one particular aspect might not really impact on the health of people, but, if you were subject to two, three or four of them, that might have a very serious impact on your health.

Duncan Selbie: We know that the context in which people are living defines the choices that they might have. It is about widening the opportunities or choices that people have—the opposite of direction and coercion, which we know does not work—and the impact of having a good job and somewhere to live. We have been through all of this.

Q105 Barbara Keeley: I was focusing on the negative aspects because those are more of a worry for health. If you have to pay the bedroom tax and council tax, and you are having to cut back on your food, and you do not have a job, and you get benefit sanctions—

Duncan Selbie: Where I was getting was that having enough money to live on directly influences your health.

Barbara Keeley: Of course.

Duncan Selbie: That is what I was trying to say.

Professor Fenton: The key issue here is being mindful of the intended and unintended consequences of policies and programmes—thinking about not only what we are trying to achieve with those policies but some of the allied impacts that may occur. An agency such as Public Health England is well placed to work with academic partners and partners in the voluntary and community sector to do work that can help to shine a light on some of those unintended consequences, which may be beneficial in some circumstances but detrimental in others. We need to take that broader view in thinking about health in all policies.

Q106 Barbara Keeley: My question was, are there any specific policies that you believe are widening health inequalities? That is the question for now—do you think now that there are those policies? Can you point to one and say, “That is widening health inequalities”?

Duncan Selbie: I would prefer we did not. In a sense, it goes back to the humility point about where we are in our stage of development. Of course, if you asked us about how we would—

Q107 Barbara Keeley: So it is too controversial.

Duncan Selbie: Just for the moment.

Q108 Barbara Keeley: Yes, it is.

Duncan Selbie: For the moment.

Q109 Barbara Keeley: So it is too controversial for you to do that. You advise the Government, but it is too controversial for you to say what the impact of their policies is.

Duncan Selbie: No. I do not believe that is what I said. I was commenting—

Q110 Barbara Keeley: No, I am saying it.

Duncan Selbie: Okay.

Q111 Barbara Keeley: It is a specific question that this Committee had. It is not my question—it is a Committee question. In my view, you are not able to answer it because you think it is too controversial.

Duncan Selbie: Put it to me again.

Q112 Barbara Keeley: Across Government, are there any specific policies that you believe are widening or will widen health inequalities?

Professor Fenton: We have to think about the realities we are currently in at the moment, with the economic downturn and the challenges from that.

Q113 Barbara Keeley: We spend a lot of time on that. You do not have to remind us of it.

Professor Fenton: Policies that will accentuate some of the challenges that we are having in terms of the real-world experiences of people who are living, as you mention, with challenges in meeting their food needs or their fuel needs will have a detrimental impact on health. Again, we have to be mindful about policies and their intended and unintended consequences. That is what we are committed to doing.

Duncan Selbie: You would expect us to be as authentic as we can be. As an agency, we are not in a position, from the evidence, to say about specific policies. If you ask a general question about whether Government action is helping or not, there are aspects of what the Government will be doing that are not helpful. We just have to look at the position across this nation and at how your life chances deteriorate the further north you go. This is about Government action. Marmot made the point that the auditor of the health of the nation is Government action or inaction.

Q114 Chair: Would it be fair to say that health inequalities have widened over the last 30 years under Governments of all political complexions?

Duncan Selbie: Yes. There is a discussion to be had about why that might be, but a big driver of that is that the folk that have heard the messages about what they can do to improve health, and have had the choices, have been exercising them—you meet very few doctors who smoke, for example—and those who have not been hearing them, or have not been able to act on them, have not. We have seen the gaps widening.

Q115 Barbara Keeley: There are still some very specific things. If you do not want to answer, I can understand that, but I raised examples that I get every week of things such as the bedroom tax and benefit sanctions, which I think are having an appalling effect on people's health. We have seen £2 billion go out of adult social care budgets. Surely, in those places where that is happening the worst there is going to be an impact on health inequality, because people are not getting care and support this year that they may have had last year or the year before.

Duncan Selbie: What I would add—perhaps this is something we have not talked about—is that, with the local public health system, the legal duty to improve health now rests with local government. It has that democratic voice, of course—the ability to talk and to say what is happening to it. It will be less constrained than we are. We do have to talk to the evidence. We have not yet gathered the evidence; we have not been part of a conversation across Government about individual policies. I thank the Chairman for the point about whether we accept that inequalities have been widening. Yes, definitely; I tried to address that a little bit in my response earlier. We have no systematic programme yet agreed about looking at what the rest of Government are doing.

Q116 Barbara Keeley: That in itself is not helpful. I can understand where the Chairman is coming from because he is the Chairman—that is the Chairman's position.

Chair: Trying to take a cross-party view.

Duncan Selbie: I am grateful for the assistance.

Q117 Barbara Keeley: Indeed, but surely it would really be helpful to the Government in weighing things on, for instance, a very controversial matter such as the bedroom tax, if it were clear that it was affecting the health of a very large proportion of the 600,000 people affected by it. That is something that has been running since April. It would be useful to collect data on that so that after a year or 18 months of a policy you were able to turn around to the Government and say, "You are spending this much money on the NHS, but what you are doing with this other policy is costing you money over there." I think this Committee

would be of the view that it is not very smart to cut social care, because it will land you in A and E issues and other issues in the acute sector. That is our view, and we keep pushing it.

Duncan Selbie: The Committee might invite us to look into it.

Q118 Chair: We are always happy to issue invitations to everybody, but wasn't Public Health England set up as an independent voice of public health to call the Government to account—to go back to the phrase I started with, to speak truth unto power? I am not sure that you need to wait for an invitation from us, from the Cabinet Secretary, to whom you referred earlier, or from the Department of Health, because Public Health England is intended to be—as directors of public health are locally—the authentic, independent voice of public health.

Duncan Selbie: I do not think we lack ambition. We are at a stage of our development where we are learning. It is a perfectly reasonable—

Q119 Chair: We also do not believe in cruel and unusual punishment.

Duncan Selbie: It has its place.

Q120 Grahame M. Morris: I was quite interested when you mentioned the importance of addressing health inequalities and when Professor Fenton mentioned that, on obesity, there is quite a wide variation in intensity in the lower social classes, where the majority of cases are. There are lots of other examples. I raised with the Health Minister the incidence of hepatitis C. Half of all cases are in the bottom 20%; 75% of all the cases are in the bottom 40%. So there are both regional variations and variations in social class.

I want to know what your role is in identifying this. Does Public Health England have a role in advising the Government about funding allocations for different parts of the country? I do not want to lead you up the garden path—I would not do that. I am asking because NHS England is currently consulting on funding allocations; in fact, it is next month, or within the next couple of weeks. Do you have a view on that in relation to CCG allocations, because there is a move to transfer resources from poorer areas that have the worst health outcomes to areas where people live longer—which necessarily means, I presume, that you have better health outcomes?

Richard Gleave: We have set up a conversation with NHS England about this in 10 days' time, because it is an area we feel we want to express a view on, with the perspective about health inequalities we have talked about before. We recognise that the starting point that NHS England, as a new body as well, has inherited is not the best place to be, so there is a case for a review and for looking at the way in which the allocation should change. I am not going to comment today on our view on the options that it is pursuing, before we have had that conversation with it. If, when we have had the conversation, the Committee would like us to come back and give you a view on where we have got to with NHS England, that would be a very reasonable thing to do. We feel we have a voice to speak on this.

Q121 Grahame M. Morris: I think it is very important to get that.

Duncan Selbie: The answer is yes.

Q122 Chair: I think that the Committee would be interested to hear your view on this subject after you have met NHS England. You should expect that the Committee will not keep your view to itself.

Duncan Selbie: Well—

Q123 Rosie Cooper: Otherwise there would be no point in your being here. I have felt very frustrated all afternoon. I want you, as an independent body, to be out there doing it. What I hear is that you seem to be settling for all these agendas. I do not know whether you work in concert with the Government, but what is coming over today to me—and maybe to other people—is that you are working hand in hand with the Government, which is not what Public Health England is about, in my view.

Duncan Selbie: It allows me to address a little bit better Ms Keeley's point about controversial issues. Absolutely, we have a view to express about allocation processes and how they are going to impact—what effect they will have if you make this choice over that choice. Professor Heymann, the chairman of Public Health England, and I have met Sir Malcolm Grant and his team on this, and what Richard is referring to is a follow-up action to that. We do not expect any of it to be kept secret and I do not think that you would expect our views to be particularly surprising, but we will share with you what happens.

In our first few weeks, we published a brief description of how we saw our first steps. We said that health protection was the first of those, but we were going to begin this conversation, this wider narrative, on what is meant by health and what drives good health—not synonymous with the NHS, and not just about the absence of injury or disease. We said that within six months—we are in this period now—we would begin a conversation about three and five years, with a view to the next 10 and 20 years, because some of these things take longer, but other things can happen a lot faster.

The conversation with the head of the home civil service, was around what we wanted to do: to introduce the idea of a framework for health and well-being as a nation, one that set out the evidence of what was driving poor health, inequalities—all the things that Ms Keeley referred to about when you are with your constituents, and you are out there and seeing the lives that people are having to live. Within that, then, is what works, what the health service can contribute, and what it means for welfare, housing and all the various things that we know have an impact.

Where we have the evidence, we say, “This is what the evidence has to say, and this is our advice to the Government.” Where the evidence does not exist, we will be equally clear about it and put in train a programme of work to gather that evidence. That is where we will be when we are having this next conversation, should you invite us back.

Chair: I think you can count on that.

Q124 Barbara Keeley: We have never found an organisation willing to look into what is the impact of changing eligibility, but there is a lot of interest in that issue at the moment. My local authority, Salford, is just changing from moderate to substantial, and it would be very beneficial if you would work, say, with Salford and other places that are doing that, and give

advice, saying “Okay, that is what happened, but what happened in other parts of the NHS? What happened to the hospitals? Were they overrun and did the numbers really increase?”

To be honest, that is a key question as the Care Bill comes forward. What is the eligibility set-up? It seems to me that it is the one area where we can look at discrete parts of the country and say, “They did this. What impact did it have over there?” The Committee argues all the time for integration, but it would help.

Duncan Selbie: For the avoidance of doubt—this is the first time we have had this conversation—that is what we think we are for. In addition to the health protection responsibilities and the knowledge service, that is what we are for. That is what you have set us up to do. Our reticence is because we have not done it yet. This is early days. Hopefully, what I have just described—whether we call it a health and well-being framework, a health plan for England or whatever it happens to be—will not be dominated by health care. It will be about these wider issues.

Q125 Rosie Cooper: Can I ask—

Chair: Rosie, we have only 15 minutes until the vote.

Rosie Cooper: Can I test what you just said? I go back to your willingness to talk, to speak out. The Government changed the formula, and Sir David Nicholson is now talking about almost refining it. What did you have to say about the Government’s initial change of the formula, and its impact on inequalities in health?

Duncan Selbie: We have had this conversation with NHS England, because it now holds this responsibility. We have been anxious that, whatever it chooses to do, it does not cause difficulty about the inequalities.

Q126 Rosie Cooper: They have already made one—

Chair: Rosie—

Rosie Cooper: Have you spoken out publicly? We have the impact of—

Chair: Can we have an answer to that? I then want to call David Tredinnick—and Andrew George has not got in yet. We have only 10 minutes left.

Duncan Selbie: If we felt that inequalities were being harmed—if we felt that the decision of NHS England was against the interests of the health and well-being of this—then we would speak out.

Q127 David Tredinnick: Just before Rosie came in, I was commenting on the feel that I am getting from the Committee. I think that you are being asked not to be paper tigers or pussycats. We are asking you not to be that. This is not a policy, but I think that the mood here is that you should be exercising your powers in much the same way as we do. We do not have to call before us all these regulatory bodies, but the Chair took the decision that we had the powers and would jolly well use them, and we sit a few extra hours to do it.

Running on from that, do you think that Public Health England should comment on and influence the local government health reconfigurations that are taking place at the moment, in particular to guard against the widening of health inequalities? Should you intervene?

Duncan Selbie: We would expect to be involved and to provide advice at a local level about the impact of any decision. Remember that the way that this system has been established means that the primary public health advice to the health service—to CCGs—comes through local government. We support them in this. We are the primary adviser to NHS England, so we have more than a single way in to conversations about reconfiguration and its impact.

Q128 David Tredinnick: You use the words “expect to”. That means that you have not yet, so perhaps it is time to get on with it. There is a mass of things going on on the ground. It is the biggest change in health care in Britain since Bevan set up the health service.

Chair: That was more a comment on the reconfiguration of services than changing the commissioning structure. That is the question.

Duncan Selbie: It is a good—

Richard Gleave: That is an important contribution. It goes back to the earlier point about the distillation of the evidence and applying that evidence to the local situation. It is not about commentary or opinion, but about focusing on the evidence. The lessons learned in the reorganisation about stroke care are now evidence-based; they are published, and there is clear literature about it, but in the grey literature there are other things that are important that we will use in making that commentary.

Q129 Chair: Just picking up on the point about reorganised stroke care services—I shall then call Andrew—there is a clear evidence base for that in London. Is it part of your function to co-ordinate the activities of DPHs around the country to insist that those lessons are applied in health economies outside London? Is that part of the function of Public Health England?

Richard Gleave: In terms of creating a knowledge-based network that shares the best available evidence, it depends on the ability of individual DPHs and their teams to access the information. Yes, it is our job to create that knowledge network and to share it around, and to say, “This is the strong evidence, this is the intermediary evidence, and this is where there is not sufficient evidence.” That is undoubtedly so, but the decision making sits with a different part of the new system.

Q130 Chair: It goes to the heart, does it not, of what has been underlying our discussion this afternoon? Is it your job to co-ordinate the evidence, or is it your job to use the evidence—not merely to fashion the bullets but to use them?

Richard Gleave: Yes, it is about the application of the evidence and how it will work best in local situations. Our job is to help people in terms of the application in their local situation.

Duncan Selbie: I want to answer more directly to your question. I would say that it is both. We co-ordinate the evidence. We do not want to get in the way of NICE; we work with it. It has given evidence to the Committee about the early conversations. Our

particular contribution, if you are familiar with the NHS atlases, is in looking at variations in outcome around the country, and we definitely have a role in co-ordinating and extending that evidence base. We also have a local implementation duty. We will go with the priorities that are set locally through the CCGs, the local authorities and the health and well-being boards.

Q131 Chair: I am sorry to interrupt you, but if stroke victims are dying unnecessarily in a city in England, it is surely your job to express anger on behalf of those patients.

Duncan Selbie: And to be alongside them in helping them to understand what they can do.

Chair: Thank you. I now fulfil my promise to Andrew, but the Minister is now on his feet so we are in the last few minutes.

Q132 Andrew George: Thank you for that; there is no pressure, then. I have been uncharacteristically quiet because I am making a major contribution to the public health of this country by keeping a quarantine space around me. I am attempting very heroically, although I say so myself, to manage what is without question the worst common cold in the history of mankind—or, indeed, of womankind.

My question is the antithesis of David Tredinnick's earlier question. Is there any point in local directors of public health, or, rather, local authority involvement in public health at the local level, given that a lot of the programmes are mandated? Mr Gleave, you indicated earlier that Public Health England can use the Secretary of State's power to step in if they are failing, particularly in the case of emergencies. Is there any role for local authorities, who have a democratic mandate?

Duncan Selbie: It is difficult to know where to start about where we have been on this. This is not meant to sound terribly unkind, but the public health responsibilities that have rested with the NHS for a number of years have not had the attention or thrived in the way that we would have hoped. Mostly, I am talking of upper tier local government, but districts have a place as well. They are receiving new clarified duties to improve health, but they have never not been responsible. All the determinants that we have been talking about are hugely important.

A small amount of money—not insignificant, but not huge compared to the health care spend—is transferred into local government. It is roughly £3 billion a year, so that gives you a sense of the percentage. Local government's interest, like ours, is not in that £3 billion but in the £100 billion that they spend, and the £100 billion that the health service has, and the £100-plus billion that the voluntary and third sector has. If this conversation had taken a different course, we would have spent most of our time talking about the impact of local government on improving health. It is massive, and what is driving it is a passion and a knowledge of place and people. They do not present as conditions; they present as people—real people living in real places, in context. Coming along and saying, “We don't think you should be smoking,” is probably not a smart intervention when dealing with all the issues that have been raised this afternoon. The democratic connection is hugely important as well.

We see the health protection responsibilities that Richard was referring to and the Secretary of State's power, but we are not going to hang around and wait for permission; if

it needs to be done, it will get done. The majority of our added value from where previous organisations have been is in this wider context, and local government is mission-critical to this.

Q133 Andrew George: Why do you need to mandate funding? Is it to ensure that they undertake certain programmes of work?

Duncan Selbie: Richard is looking meaningfully at me, so he can probably give you the percentages. As you know, it is a ring-fenced budget. With consent, this has been extended to a third year, so that takes us into 2015-16. The Secretary of State has mandated that it must do certain things. The biggest contributors are the sexual health services. What is not mandated is drug and alcohol services, but that is another huge contribution. Then there are a small number of things, like child measurement systems and so on.

The most fundamental mandation is the public health advice that they must give to CCGs about how they prioritise, what they choose, straight from the evidence. We are not having a conversation as Public Health England about the balance between mandated and non-mandated, although the Secretary of State was positive. He said, "I want you to." It really is not what is done first thing on a Monday morning that drives the rest of the week.

Q134 Andrew George: Do you think, though, that local authorities are taking on this role in the co-ordinated way that you suggested in the early part of your answer?

Duncan Selbie: Yes.

Q135 Andrew George: So their overall budget is being driven by public health rather than public health being an afterthought.

Duncan Selbie: I am in mortal danger, but I have been to more than half of the local authorities. I meet the leaders, I meet the cabinet members and I meet the chief executives and always the directors of public health. I was in Brighton last week, and I met the leaders of all the political parties as well. I was in Bristol and Bath, and I was in Tower Hamlets on Thursday, and in every single instance the political leadership is leading that conversation.

Q136 Andrew George: Why are the directors of public health on many local authorities not on the chief officer's board, for example, but actually working under another local government department? It has been denigrated.

Chair: How widespread is that?

Richard Gleave: In terms of the numbers, we do not have the data about precisely who reports to whom within the structure, but we are absolutely clear, in terms of the statutory guidance that we put out recently, about them having a direct relationship with the chief executive and access to councillors. We are seeking an assurance from everyone about that.

It is interesting to ask what are the views of the directors of public health themselves. If we look over the last three surveys that the Association of Directors of Public Health has done of its membership, the question was about the degree of confidence that they had in local government across the totality of its remit in order to take on these responsibilities.

The numbers are 47%, moving to 57%, and moving on to the provisional survey where the indicative analysis of the survey yesterday was 68%. We have a rising tide of confidence among DPHs that local government is embracing this agenda and is taking it on.

Q137 Andrew George: Are those answers known to each local authority? Speaking to a number of directors of public health, I have to say that they may say something polite to the local authority, which will be in the public domain, but it will not necessarily be the same message that they give privately.

Richard Gleave: This is an anonymous survey that the association, not us, has run. The Association of Directors of Public Health had a meeting yesterday, and the most recent numbers were shared with them at the end of that presentation.

Duncan Selbie: The hesitation was because the duty is on the council. The responsible person, the senior head of paid services, is the chief executive. We are, of course, passionately interested in the director of public health, but we are even more interested in what the leader and the chief executive are saying about this.

Q138 Valerie Vaz: Are all of them in the survey?

Duncan Selbie: Four out of five are. That is 79% for spurious accuracy. We are in a good position. The sky has not fallen in, and the world has not ended.

You have not asked us about access to training. We have a fabulous pipeline. We have people queuing up—how many people for every place?

Richard Gleave: Seven.

Dr Cosford: There are 7.7 people.

Duncan Selbie: We have seven and a bit people for every place.

Chair: I am afraid that we have run out of time. It has been an interesting session. Thank you very much for coming here today. I suspect that it will not be the last time.