Public Accounts Committee

Oral evidence: Public Health England's grant to local authorities, HC 893

Monday 19 January 2015

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Members present: Margaret Hodge (Chair); Mr David Burrowes; Stephen Hammond; Meg Hillier; Mr Stewart Jackson; Dame Anne McGuire; Austin Mitchell; Stephen Phillips; John Pugh; Nick Smith

Sir Amyas Morse, Comptroller and Auditor General; Sue Higgins, Director, National Audit Office; Robert White, Director, National Audit Office; and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses: Dr Janet Atherton, President, Association of Directors of Public Health; Michael Brodie, Finance and Commercial Director, Public Health England; Dr Felicity Harvey CBE, Director-General, Public and International Health, Department of Health; and Duncan Selbie, Chief Executive, Public Health England, gave evidence.

Q1 Chair: Thank you very much. We are a bit late, so apologies for that. Let me start by saying that I think this is quite a positive Report. We are pleased with the progress that has been made, so the context of any questions we ask you is that it appears as if things are moving in a positive direction. I think David agrees with that. The tough questions are in that context—as long as you get that.

A BMA survey of local authorities found that half of them had used the new grant for services that would otherwise have been cut and that some even spent almost the totality of it on substituting for local authority expenditure on particular services. Clearly, that was not the purpose of the new regime. Do you, between you, have a figure for, or an understanding of, how much of the ring-fenced money has been diverted to support services previously funded by local authorities?

Duncan Selbie: I speak quite quietly—

Chair: And the acoustics here are awful, so you will have to speak up.

Duncan Selbie: I will speak up. If I start getting quiet, I'm sure you'll tell me.

Dame Anne McGuire: We'll shout at you.

Duncan Selbie: Thank you.

The first thing a local authority needs to do, before all else, is to meet the mandated services. About 29% of the grant goes on the mandated services. Beyond that, they have to have regard to the outcomes framework. We may get into the outcomes framework, but it is a good outcomes framework, and it covers everything that is evidenced about what makes a difference. The single biggest difference about the new arrangement is its concern not just for health care, but for good health, and not just for the consequences, but for the causes. It is good to be passionate about this, because it really matters, and we know that the gaps that exist today in terms of those that are living longer and those that are living in good health are as wide as they have ever been.

I do not have too much concern for what went on before; I am concerned for what local government will do with this money going forward. They have quite a lot of flexibility in how they spend their money. They have to have regard to the outcomes, and the director of public health has to say, "I agree," but, subject to those two things, they have this freedom. Some might call it substitution, but I would call it relevance. In Birmingham, they are concerned for homelessness; in Blackpool, it's alcohol. In another part of the country—Coventry or Leicester—it will be tuberculosis. It is not about telling authorities from Whitehall how they should spend their resource, but about them showing connection to the outcome and about their local professional adviser—the director of public health—saying, "Yes, I think that's a good use of the money."

Q2 Chair: I don't think any of us would quarrel with any of that, but it was new money going into local government, and one assumes it was supposed to strengthen those objectives, which you feel passionately about; indeed, so do we, and I was reminding members of the Committee earlier—those who were around then—that our very first inquiry was on health inequalities. So we take the issue really seriously. But it was not intended—maybe Dr Harvey is the right person to answer this—that some local authorities should, if the BMA survey is right, spend 100% of this new money simply on substituting for money they had had from elsewhere. That is one reason, I assume, why you ring-fenced it.

Felicity Harvey: It is indeed. It was particularly to make sure we had a safe transition. I have to say the evidence that we have, and the evidence that Public Health England has—that Duncan has—does not actually agree with that evidence.

Q3 Chair: What is the figure then? Have you got a figure?

Felicity Harvey: As you know, all the spend in local government has to be put into the 18 categories of spend—

Q4 Chair: Have you got a figure for how much was substituted—how much went to pay for services? Local authorities did a lot of public health.

Felicity Harvey: They did indeed.

Chair: And they do spend money on public health. So how much of this new money was used to keep services going which they might otherwise have cut? I am talking about services that were already funded by local government, and where authorities chose locally to use this money to keep funding those services, rather than to bring in new services.

Felicity Harvey: I don't have a figure for that.

Q5 Chair: Do any of you?

Duncan Selbie: We don't. The arrangement was that you meet the mandated services. We have regard to a few things, like drug and alcohol services and sexual health services—I can talk to that and to how much is being spent—but beyond that, it is for local government, with the local CCGs and the NHS, to come to a view about how to spend that money. They do have to report, but it was never reported in this way before.

Q6 Chair: I will tell you what I feel about that. It is an opportunity lost; because this was new money to local government, and ring-fenced, which again—we as a Committee would say we are trying to give a new duty to local authorities: it is much better to do that. We see too many instances where money goes and it does not get spent on the purpose that was intended. So all that is good, but you lost an opportunity if you did not monitor, actually, as to whether or not this actually went to build the public health infrastructure, rather than to substitute for existing local authority—quite well-intentioned—public health services.

Felicity Harvey: I wonder could I just add, though, that I think we did not know what the spend was on public health before the transition.

Q7 Chair: Well, you did, because you based your allocations on previous spend.

Felicity Harvey: We did a lot of work with PCTs around estimating what their spend was, but on a year-to-year basis, there was a single grant given, which was to the PCT, and actually the definition of spend that we now have in the new system, we did not have from PCTs.

Q8 Chair: Sorry to challenge you on that, Dr Harvey, but it says in the Report that your allocations were based on previous spend.

Felicity Harvey: They were, and that was from a piece of work that was done prior to the transition, where we did go to PCTs to try and estimate to a level of detail that we had not had before, on a one-off process, actually what the level of spend was; and absolutely, as you say, that was the basis, the first basis, of putting together the public health grant, along with the ACRA formula. But in terms of year by year: did we have accurate data year by year prior to the transition on the spending PCTs—on public health specifically? We did not. We do now.

Q9 Chair: No, it is also what local authorities previously spent. Do you want to come in Mr Brodie?

Michael Brodie: If I may, yes. So the NAO Report identifies where the spend in 2013-14 went, what the priorities were around that—

Q10 Chair: We're not talking about 2013-14. The point is that 2013-14, according to the BMA, was used—I mean we have been round it; I don't think you have got an answer to it—to substitute for previous local authority expenditure.

Duncan Selbie: I don't think that is fair. The NHS did not know what it was spending on public health. It did not have an outcomes framework. It could not actually answer the question: with what impact?

It did not know. The first time that it got to know about what it was spending on public health was in readiness for the transfer to local government. Now, the NAO looked at what the BMA had to say about this use of the money. We did, of course, and the NAO looked at what we had done. They said management was satisfied that no instances of irregular expenditure had been highlighted and they had reviewed that work and concurred with management's view.

There is a fundamental difference in the thinking about the use of this grant. When it was in the NHS—and I was in the NHS for 36 years—the money was through a biomedical lens. It was spent on things that, frankly, we had no idea about impact. We were not following evidence and we did not know what the impacts on outcomes were. It was not values-based—about people; it was thinking about diseases. We now have a system—I know you know this, but it is so important; this is not about a golden age from which public health has emerged in a difficult place. We had no idea.

Let us also remember: it was 3%. So my concern, as the leader of the public health system, is not 3% but 100%. And the outcomes framework is not about that use of that £10 million or £15 million, but about all of it. I am actually concerned for 200%, which is the money the NHS has got. So when I look at your constituencies, whether it is Hackney or Northamptonshire, or wherever you happen to be, I am concerned for the Hackney pound, not who is putting in for what, but what they are getting for it. It is, if you like, values-based; it is evidence-driven; and you can judge me on outcomes. You could not do that before.

Q11 Chair: Let me just push you a little bit, because that sounds theoretically very compelling, but to move you on, what the Report also says: there are two aspects to this. Of course we want an outcomes framework; that is much more sensible, but if you actually look at it the Report, on page 21, para 2.11, says that in those areas where less money was spent on smoking prevention, outcomes were worse. If you look, equally, at drugs, there is a similar sort of thing on page 24, para 2.12. So there are two—one on drugs—where it demonstrates that if you spend less you get less out. Your so-called new world is really outcomes-focused, but actually, what the evidence and the Report suggest is that because it is locally determined, authorities are free to choose where they spend it. Where they spend less on alcohol or drug abuse, their outcomes are worse.

Duncan Selbie: Well, actually, I could look at this data and cut it in any number of different ways. All we learn—

Q12 Chair: Don't you agree with what the Report said?

Duncan Selbie: No, I agree with the Report, and I wanted at the outset to say it is a great Report. I welcome it. It speaks to what we have got to do. It is wind behind my sails; it is a good Report. In a year's time, or whenever you call us back, I will be accountable for whether we have made the improvements in this. But it also speaks to the fact that we had one year's data, and all we were really doing was reporting what had gone on before. It will take at least another year to get a pattern.

As you can imagine, Michael could give you half a dozen different interpretations of this data. What it tells us is that we need to use the tools that Public Health England developed and that the NAO have used to point out that there should be a relationship between spend and outcome, and we should seek to close that gap, whether it is in obesity activity, alcohol and drugs or whatever. We have got the tool, but what the NAO are saying is, "We need you to be more relevant out in the field and more practical. We need you to support people in understanding how to use this tool, and we want to close that gap."

Q13 Chair: The other thing is that when we looked at a Report on health and inequalities, I think, three or four years ago, one of the things that came out of that is that it is not just what you spend; it is how you spend it.

Duncan Selbie: Exactly.

Q14Chair: So, for example, on smoking cessation—I remember it, because I was quite surprised—if you do one-to-one counselling, it is ineffective, but if you have peer group sessions, it is much more effective. Nowhere in your outcomes framework do I read any use of that sort of intelligence, research or evidence in determining how you spend money.

Duncan Selbie: We've got seven priorities for the public health system, and they are straight from the evidence. There are two things that drive them. One is the global burden of disease—what is killing people early, and what is making them ill and miserable when they are alive. The other is, "Well, that is interesting, but why, and what can we do about it?" What it teaches you is that if you look at inequalities, and the average 10-year gap around the country, half of that is accounted for by tobacco. If we took tobacco out of England, half that gap would close. What we have got to do is bring the evidence to bear at a local level about what works. Tobacco is a fabulous example. The reason why we keep banging on about it is that it involves everything from counterfeiting to what we do with national campaigns like the one that we are running at the moment.

Judging Public Health England's impact is not theoretical or academic. You should expect to see those gaps closing because of the work going on in the north-east of the country, London, the south-west, Liverpool and all over the nation, based on three things. It is values-based: it is about people living their lives in places, not about conditions and diseases. It is about evidence on what works: getting it out there and into use. It is also about the outcomes you achieve. Frankly, I don't mind what a local authority spends of a 3% grant providing that it is closing those gaps. If we are concerned about how it used to be spent, we have missed the point. When it used to be spent in the way it was spent, those gaps never changed in 40 years.

Felicity Harvey: Can I also add that, in fact, what we are only just starting to see in local government is the impact of local government commissioning? When we went through the transition in 2013-14, the vast majority of contracts were just novated across, and we needed to make sure that they had a safe landing, so it's only really now that we are starting to see local government, with support from PHE and the various tools that they have, putting new contracts into place. We need to see the impact of those contracts on the outcomes of their local populations.

Duncan Selbie: We ought to see money saved.

Q15 Mr Burrowes: Dr Atherton wanted to come in.

Janet Atherton: The thing about the shift from 2013-14, which was essentially a kind of, "Let's get these services across safely into the council and make sure that we do not get dips in performance and the like," to 2014-15 is picked up in the survey that was done of directors of public health as part of this Report, which shows that from 2013-14 to 2014-15, there was a shift from historic priorities towards needs-based and council-based priorities. That does back that up. On the issue about the evidence and about what works and the like, we have got very good access to information through NICE and PHE.

Q16 Chair: You have; it's just whether they change what they do locally. Have they stopped on smoking, to take my little example?

Janet Atherton: I am here as president of the Association of Directors of Public Health.

Q17 Chair: You are. So you reckon your guys do listen to the evidence?

Janet Atherton: We use it day in, day out. There are areas that we would want to see strengthened—again, that comes out in the Report—around things like the economic modelling giving us better advice about return on investment across programmes. You did a report before Christmas around the financial position of local authorities. It is an incredibly challenging financial environment to be operating in, and we need really good evidence about what works, so that we can invest what we need to around prevention to stop those upstream costs.

Q18 Mr Burrowes: Can I just take the conversation back to a simple question, going from right to left? Who would you say is in charge of public health?

Janet Atherton: Leadership at the local level is through local government. In terms of national expertise, we have got the Department of Health and PHE.

Q19 Mr Burrowes: Would you respond differently to that?

Felicity Harvey: I think that that is absolutely right. In terms of public health, what we did in moving it from primary care and the NHS into local government was to give the responsibility to local government with the duty to improve the health of their population. The reason for that is that clearly a lot of the drivers of people's health are the wider determinants of health, which goes back

to Professor Marmot's work. That is something that you can do something about, and what all DsPH across the country can do something about in a much better manner in local government than they could if we were trying to do something nationally. However, at national level clearly we have PHE, which is there with the duties of the Secretary of State, to protect the health of the population and improve the health of the population through the support that it gives to local government.

Q20 Mr Burrowes: Mr Selbie, would you like to add to that?

Duncan Selbie: The duty to improve the health of the people rests with local government. It is not equivocal; it is in the legislation. That is what Parliament said, "to improve the health of the people". That was given back to local government in 2013. They last had it 40 years ago. It is not to provide a public health service, and it is not to spend a public health grant in a particular way; it is to improve the health of the people.

The most important contribution you can make to good health—I am talking about length of life and life in good health—is economic prosperity. It is having a job. That is the No. 1 thing. I have been to about 120 local authorities in the last 18 months. I have been to most of yours. I have been to Grimsby.

Austin Mitchell: Good.

Duncan Selbie: Every single local authority from Macclesfield to Liverpool to Southend to Southwark starts with a conversation about economic prosperity and getting a job. When we talk about well-being in that context, it is not some esoteric thing. Gateshead explain it by saying, "Are local people benefiting? How are local people benefiting?"

To answer your question, what is Public Health England? We are an expert body. We are not a commissioner; we are not a regulator; we are not an inspector; and we do not count things. We are an expert body. We are a fighting regiment. We are in support of local government working with the local NHS.

Q21 Mr Burrowes: You talk about the outcomes framework as being good, and that is a very important part of the outcomes. Let us turn to figure 7, where there is an interesting chart which looks at influence. This is a broad question: what influence has Public Health England had? I first want to go to Dr Atherton. Looking at the lower box—the fourth box—and areas highlighted by the public health outcomes framework, I read that to say that more directors of public health have said that it has stayed the same, rather than increasing its influence. That is making a judgment that the public health outcomes framework is not increasing its influence. It does not seem to have had a big impact in relation to changing influence on public health spending plans, as reported by your directors.

Janet Atherton: I would read that as saying that four out of 10 directors say that it had an increased influence in 2014-15, compared with 2013-14.

Q22 Mr Burrowes: And six out of 10 say—

Janet Atherton: Six out of 10 say it stayed the same as it was previously.

Q23 Mr Burrowes: In that sense—we are talking about what is supposedly a good outcomes framework—it hasn't had a majority influence.

Janet Atherton: If you look at those facts and read it like that, yes, that would be the reading of that. But I would say we are on a path from a steady state in 2013-14, and we are starting to move, improve and align things to health and well-being strategies and strategic needs assessments in 2014-15.

Q24 Mr Burrowes: I appreciate that it's early days, but why has it not had more of an influence? We are talking about a fundamental shift to something that is much more outcomes-focused. This question is not just for you. You are speaking on behalf of your directors, the majority of whom say it hasn't had such an influence. It would be interesting to know from Duncan Selbie and Dr Harvey why it hasn't had more of an influence.

Felicity Harvey: The NAO says that 83% of DsPH are actually using the public health outcomes framework, and it is still developing.

Q25 Mr Burrowes: You'd expect that, though. You'd be concerned if it wasn't that high.

Felicity Harvey: They are using it frequently. We need to remember that the outcomes framework is the first time we have brought together all these data in the four domains to give a view right the way through from social determinants to health protection, health improvements and healthcare public health. It enables DsPH to look at inequalities through all the sub-indicators.

Q26 Mr Burrowes: But why aren't they saying that it's of more influence?

Felicity Harvey: It is early days. The contracting has just—

Q27 Mr Burrowes: Is it just because it's early days?

Duncan Selbie: Well, we've never had an outcomes framework before, and we've never had anything quite like this. The NAO points out that we don't even have data for some of the measures, and others take a long time to collect. The first thing to convey is that I want the number of directors who use it and whose work it affects to be in the upper 90s.

There are two things that I would say to the Committee. The five health improvement priorities that Public Health England published in October—three months ago, on the same day as the NHS published its "Five Year Forward View"—are rooted in the evidence. Whether it is dementia, heart disease, cancers, strokes, the risk factors are exactly the same: tobacco, hypertension, diet, which we may get on to, activity or lack of it, and alcohol. You would expect to see those five risk factors. Public Health England is not introducing something novel; we are pointing out the obvious, which is that if you pay attention to those things—

Q28 Mr Burrowes: You are not mandating all those areas, are you?

Duncan Selbie: No, but I have six different ways in which I can have an influence.

Q29 Mr Burrowes: You mentioned drugs and alcohol, which take up a third of the public health budget but are subsumed as one of the outcomes that could be taken up, but may not be.

Duncan Selbie: No.

Felicity Harvey: With drugs and alcohol, there is now a grant condition, so we can ensure that local authorities are improving what they are doing year on year.

Q30 Chair: What is the grant condition?

Felicity Harvey: The grant condition sets out the detailed arrangements for administering the grant—this, again, is about outcomes not inputs—they have to demonstrate that they are getting year-on-year improvements.

Q31 Chair: But the prescribed functions don't mention smoking, alcohol or any of those things.

Felicity Harvey: It's a new grant condition that has been brought in.

Duncan Selbie: This is about speaking to all of the money. This is the NHS and councils coming together. I know that the "Five Year Forward View" was greatly welcomed—I want to say to the Committee that it was my "Five Year Forward View" as well. There is a section in it that says that prevention is the cure. We have got to get serious about it, and we can't just keep talking about the consequences—

Q32 Chair: But it's not in your prescribed functions, full stop.

Duncan Selbie: No, but it's going to be attended to because we are doing transparency: we are showing how people are doing; we are publishing information about how they are doing; and we are talking to the evidence about what works and getting it out there. I've got a network of public health professionals around the country. They are not bureaucrats but members—

Q33 Chair: But why isn't it in your prescribed functions?

Duncan Selbie: That's a matter for the Government. The two things that the Government were concerned about were that it needed to be consistent, so it had a measurement system for child weight—

Q34 Mr Burrowes: But there wasn't originally a grant condition.

Duncan Selbie: To speak to the concern, we are focused on outcome. The recovery rates for both alcohol and drugs, which has been fully not dependent for six months, have improved over the first year that local government has been responsible.

Q35 Mr Burrowes: But that is nationally. Have you been able to tell whether there is variation locally?

Duncan Selbie: Yes.

Q36 Mr Burrowes: Has that led to any action being taken?

Duncan Selbie: Yes.

Q37 Mr Burrowes: Has that led to the grant condition?

Duncan Selbie: Yes. Because it is so important, a council has to have regard to continuous improvement in recovery rates.

Q38 Mr Burrowes: It is more the principle of where things would change in terms of the devolved settlement. That's happened with the grant condition. Could a similar thing happen in another area of public health where there is a concern about variation across areas, so that you think, "Centrally, we need to have a grant condition."?

Felicity Harvey: Well, there's a grant condition for reducing inequality, which is very important. From our point of view that is extraordinarily wide-ranging.

Q39 Mr Burrowes: Let's say obesity. If there is a problem with variations—as there are—in outcomes and in spend, and a particular problem in a certain area, would you then consider having a grant condition?

Felicity Harvey: Those are the sorts of areas where, with the intelligence that Public Health England has through working through all of its teams—and indeed through local government—on improvement, were PHE to come to us to say, "Actually, we think we might need to do something," there are things that could be done, such as grant conditions. I will just highlight, however, that if you look across the priorities of the different directors of public health in local authorities across the country they will look different. In fact, you will have some that prioritise TB, or obesity, whereas others will be looking more to young families and so on. That is as it should be, because it is for local authorities to prioritise, through their joint strategic needs assessments and their strategy documents, those areas where they feel they need to be able to put the funding to meet the needs, through whatever commissioning they want to do.

Q40 Mr Burrowes: But I'm just trying to work out where your strength and your teeth come into being involved in some areas. If there are variations in outcomes, you may well get involved with grant conditions. Let's take somewhere like Enfield as an example. Simon Stevens recognises that there is a strong case for more funding—it doesn't get its fair share of funding and it needs to eventually. Would you then get involved in trying to make sure it gets its fair share of funding? Is that something that's your role?

Felicity Harvey: Funding across the piece is the public health grant. That is dealt with in terms of the funding across the system as a whole. Clearly, what happens to the public health grant as we move forward into 2016-17 will be an issue for the spending review, but it will be based on all the evidence we get in from Public Health England in terms of both quantitative and qualitative evidence from across the country.

Q41 Mr Burrowes: Do you advocate across Whitehall on issues of funding and wider issues that affect public health?

Felicity Harvey: Certainly, we work across Government in terms of public health. In fact, we have a cross-Government group that involves multiple Departments because of the impact of public health in general.

Q42 Mr Burrowes: Say Sefton was short of its fair share—I don't know whether it is—would you be particularly advocating on its behalf to try to make sure it got its fair share?

Duncan Selbie: That's not a good choice.

Mr Burrowes: Or Enfield, let us say.

Felicity Harvey: We get into discussions about the public health grant. We have had the settlement for the first two years and the settlement for 2015-16. That gets looked at in the round in terms of the target that we are aiming for, which is based on the total money available, the ACRA formula and where people are now, trying to move people through pace of change policy towards the target.

Q43 Mr Burrowes: You say you get involved in discussions. Do you get directly involved in trying to ensure that there is a fairer share of funding?

Felicity Harvey: Those are the discussions that we would have with Public Health England.

Q44 Chair: Let's ground this a little bit. This is too theoretical for me. A third of local authorities are over 20% away from their target. What are you doing about it? That's what David is really saying—it is what you are doing about it. It is all, "We worry. We care. We talk to each other." What are you actually doing?

Felicity Harvey: It is 13 at the moment that are more than 20% below—

Q45 Chair: A third of local authorities. Take that as read. Don't tell me—

Felicity Harvey: It's above and below.

Q46 Chair: Take it as read that a third are over 20% from their target. What are you doing to address that?

Felicity Harvey: That's where we come into the—

Q47 Chair: What are you doing, Dr Harvey?

Felicity Harvey: In the course of the public health grant that we have had over 2013-14 and 2014-15, we are seeking, though pace of change, to move local authorities towards target.

Q48 Stephen Phillips: I'm sorry, but all you've just said is, "We're trying to make it better." The question you're being asked is, how? That is the question you have to answer.

Felicity Harvey: And that's through the public health allocations that are made on the public health grant. We have moved—from 2013-14 through to what will be 2015-16—from a position with 20 who were below 20% to 50% in 2013-14, down to 13 this year. In this year, there are 13 local authorities more than 20% below target.

Q49 Mr Burrowes: That's the mechanism. I am trying to find out how much you get directly involved in trying to shift that sooner rather than later.

Felicity Harvey: That comes into the discussions on the public health grant, which will be part of the spending review.

Q50 Mr Burrowes: I appreciate that. I would be concerned if it did not come into the discussions, but I am just trying to see what difference you make. What difference do you make?

Duncan Selbie: There's not nearly enough going into prevention.

Q51 Chair: Can you just answer the question? At the moment, what is going in? I think more should go into prevention—I am a great advocate of that. The Report tells us a third of local authorities are over 20% from their target. Dr Harvey talked about five or 10 that were shifting. If I were to ask the NAO to come back on the 2015-16 allocations, which you must have done or almost have done—

Felicity Harvey: We have done.

Chair: I would hope you have. If I did that, how many would be over 20% from their target? A third of local authorities were over 20% from their target.

Felicity Harvey: For 2015-16, we will have 27 above the 20% target and 14 below the 20% target.

Q52 Chair: So that's 27 plus 14—

Felicity Harvey: It gives 41 in total.

Q53 Chair: 41 out of 150, so you are still almost at a third. You've not made much progress.

Duncan Selbie: But it's still only about 3%.

Q54 Mr Burrowes: You were about to tell us what difference you make.

Duncan Selbie: I know I am addressing Parliament, but I just think the argument is not about 3%; the argument is about the whole of the spend. All that we have in the public health grant is what the NHS used to spend. There is an argument that says—

Q55 Chair: Listen, Mr Selbie, we completely take the point that giving people a job is the best way to get them good health. Again, that is probably uncontentious around the table. So let's take that point. But the only bit of the world that you control between you, or that you are accounting to us for, is the public health bit. I completely take the point that good housing, good education and good jobs all matter. We know that; please take that as read. But in the bit of the world that you influence directly—you are in the third year of this grant now—about a third of authorities will be 20% above or below their target.

Felicity Harvey: Could I tell you what we have done? We have moved local authorities. Our aim in the public health grant was that all local authorities had growth. Those that were furthest above the target—those that had a lot of money—were actually upped by 2.8% (cash) in the first year and 5.7% overall for 2013/14 to 2014/15. Those that were furthest from target—that was about 20 local authorities—actually increased their budget by 21% in cash terms. So we have moved those furthest away from target, which is why we started in 2013-14 with 20 who were below the 20% to 50% below target and we have come to a position this year where there are only 13. In fact, next year, there will be 14, because of changes in population, and one of them will slip in one direction. But we have, through pace of change, decreased the number of local authorities who were over 20% below target. We are trying to make sure that all local authorities have growth, and the reason for that is that, in the first year or two, most of the contracts for the services that were provided were those contracts that were from the NHS and novated into local authorities. We needed to make sure that local authorities did, indeed, have the money to spend on those contracts that were novated across. Through pace of change, we are aiming over time to move those that are below target to target. We have only had two points at which the spend has been given out so far. The other thing I would say is that the rate of increase on public health spending across 2013/14 and 2014/15 and, if you take in next year as well, has been the same as the NHS.

Q56 Mr Burrowes: Dr Atherton, you are obviously recipients of this—or not. Speaking on behalf of other directors of public health, including in Enfield, what do you make of all that?

Janet Atherton: The progress that was made in the first two years meant that people moved closer towards target. The issue we have is that the 2015-16 allocation was a flat-cash allocation; we received the same in 2015-16 as we did in 2014-15.

Q57 Mr Burrowes: So somewhere like Enfield was due an increase and did not actually get it?

Janet Atherton: There was no increase in the public health budget from 2014-15 to 2015-16.

Q58 Chair: So there was no movement.

Janet Atherton: There was no movement towards target.

Q59 Mr Burrowes: That compounds it, because those that have not had the fair funding allocations then go back a step, don't they?

Janet Atherton: One of the issues is obviously wanting to move people who are below target upwards, given that the overall spend on prevention is not where it needs to be. As I say, some progress was made in the first two years—good progress with a 20%-plus shift overall for those furthest away from target. But that will need to continue to be done year on year to get people to target in a reasonable period of time.

Duncan Selbie: I am going to keep really focused on the £2.8 billion, but, if I may, I am only interested in the £200 billion. There is another way of doing it, which is to take away from those that have had more. There's Dr Pugh—we could take it from Sefton and hand it to you. What we were trying to do—within the normal constraints of how much money there is—if you just focused on the small amount, there are two ways of doing it. You either move people closer to target when you can, bearing in mind that we started by making sure—it was good—that nobody had less than they needed or had been spending. Nobody was penalised for having done the right thing. If you had spent well, you did better. If you hadn't, at least you did not get less. That was the first thing. You then move them towards target. Even I have to admit that it was not bad for the first two years. The other way of looking at it is to say, "Well, we could move a lot faster. We'll just take it from those that have had it." There are enough people that are above to even it out. We chose not to do that because the starting position was really low. Why would you do that when you are talking about 2% or 3%? Nobody credible would suggest that that approach to prevention would work; it is just not enough. You have to look at the whole.

Q60 John Pugh: How does the target method of funding, which I understand is based on assessed need, deal with the other element that you alluded to earlier—conditionality? You insinuated that you could, in one form or another, penalise people who do not spend the money very well. If an authority was getting very near target and was extraordinarily successful, you could either reward it at that point or subtract from it. But they are two completely different agendas, aren't they?

Duncan Selbie: Yes. Hackney is doing a good job. Health is improving in Hackney. You have loads of great new housing coming along. It was so poor in some of the housing in Hackney that it was a film set for ghettoes.

Q61 John Pugh: Should you be penalising them for having reduced their problem or rewarding them for having done well?

Duncan Selbie: No—that was my argument to Mrs Hodge. Unless you can tell me a third way, it seems to me that you either put more money in, which allows you to move closer to target faster—something that I would seriously commend—or you move it from those that have had it. The conditionality is irrespective of how good you were. Just saying, "You've got more than you need," I don't buy that. I think that it is the wrong argument.

Q62 Chair: So are you going to get a bigger chunk of the NHS budget next year?

Duncan Selbie: Yes.

Q63 Chair: What is it next year? In the year we looked at, it was £5.8 billion. What will it be in 2014-15?

Robert White: It was 2013-14.

Duncan Selbie: It is the same.

Q64 Chair: So it is not more.

Duncan Selbie: Forgive me, I thought that you asked me whether I want more of it. Well, of course I do. But the good news here—I'm not away with the fairies; I am talking about real things—is that the "Five Year Forward View" is, for the first time, the NHS, not Government, saying, "We've got to get real about this." All we have been dealing with are the consequences, not the causes. I was an acute chief executive, until I took this role, for five straight years. We never asked why. We only dealt with what came through the door. It was too much for us to get involved.

Chair: I am going to stop you there, Mr Selbie, because you have told us that. I am just going to tell you that in Barking and Dagenham—my own patch—since 2010 to 2012, I saw massive cuts in the smoking prevention programme, which had been very effective. Surprise, surprise, smoking is up again. I saw cuts in the teenage pregnancy programme, and—surprise, surprise—that is up again. I am pretty fed up with that, locally, because I am in an area where the mortality rates are far too high. Now we have got no money, and you tell me that you have managed to get a bigger slice of the NHS cake. I do not feel that that is really good.

Q65 Mr Burrowes: The challenge is that historically—to get a little bit local—in Enfield, the legacy has been of high mortality rates. Going across the borough of Enfield, it is appalling the change in outcome level. Over two years, you have dramatically increased the funding from what it was before, but it is historically an unfair level, recognising the demographic change—the

deprivation change—with ourselves and other places like Hackney. It is the issue of fairness, which is not about more overall level of spend; it is, why are we not getting quicker to the level of fair funding for places like Enfield?

Duncan Selbie: For the avoidance of doubt to Mrs Hodge, I am not talking about wanting more from the local NHS. What I am looking to is how we are spending that money. You have said it is about how we spend it. We do not need more; it is about how we spend it.

Q66 Chair: Well, you do need more, but you are not going to get it.

Duncan Selbie: Sure, but in the conversations I have, and around the country, there is a bit of an argument about more, but the bigger argument is about how we are using what we have got. Of course we want fairness, and in the methodology for how the money is distributed, of course we want fairness. For the public health element of it, it is not a bad measure: mortality under 75. However, ACRA, the formula people, are having a look at this, because the two big drivers for the public health grant—sex, and alcohol and drugs—do not really work so well because they are around younger people. So we are looking at that, but the formula is not a bad one. If we could get people closer to it, it would be a good thing.

Q67 Meg Hillier: On the budget, first of all, while we are on that subject, clearly we are expecting changes on the ground. Hackney is working on the presumption that there will be a 29.3% reduction—certainly, there is a strong indication—of the cash envelope for public health in Hackney, and therefore is working on its commissioning. Is that a fair guesstimate by Hackney? Are we going to be struggling in this way as we try to do good things? I hear what you are saying, and I applaud it. Are we going to be trying to do the same with less money?

Duncan Selbie: I am terribly sorry, were you asking whether—you are 29.3% ahead of your—

Meg Hillier: Yes.

Duncan Selbie: Are you thinking that you might lose that?

Q68 Meg Hillier: Well, we have to work on the assumption that if we are that far ahead, it might go.

Felicity Harvey: In terms of the 2015-16 budgets, they have already been given out, and they are the same as the 2014-15. Where Hackney is this year, that is the funding that it will have next year, and that is indeed the £2.79 billion which will be given to local authorities across the piece in 2015-16.

Q69 Meg Hillier: I think that the key thing is managing the change. It is always bad to lose things, but to lose it without notice is a problem. Protections are fantastic, but if protection drops off a cliff edge in a couple of years' time, it will be disastrous.

Duncan Selbie: Public Health England's advice would be not to take away from those that have, but to level those that have not.

Meg Hillier: I see Dr Harvey nodding, for the record.

Felicity Harvey: Can I just say that that was the Government decision? In terms of the public health grant, we did not take away from those that were above target. We gave everybody a small amount of growth or a much bigger amount of growth, and if they were below target, it was those that we focused on.

Q70 Meg Hillier: I heard that point. It is worth really being clear, because in other parts of the health service, the indicators have changed to give a greater weighting to age and a lesser weighting on levels of deprivation. My borough—and, indeed, Enfield and Barking and Dagenham, to take the London ones that I know best—lose out, and I guess Sefton is similar. Are you telling me that that is not really reflected in the public health budget?

Felicity Harvey: That is why the ACRA formula, which Duncan talked about, is really important. The ACRA formula for public health is different from the one we use for the NHS, and it is about deprivation. It also looks at small areas, so you can pick up deprivation in small populations within and outwith local authorities. It uses the under-75s. As Duncan said, we have asked ACRA to look again. Dr Atherton is a member of the ACRA committee, which is very helpful, and they will be looking this year at the formula they had before, and looking again at those mandated services like drugs and alcohol and sexual health, because we now have experience of what sexual health costs actually mean to local authorities.

Also, of course, there is nought to five, because nought to five commissioning will also be transferred over. The £2.79 billion to local government in 2015-16 excludes nought to five. When nought to five transfers over, an additional £425 million will go with it. At the moment, we are consulting with local authorities on what that might look like for each individual local authority. We have also added £27 million to the baseline being utilised at the moment for NHS—

Q71 Chair: Is that the money that previously went to CCGs?

Felicity Harvey: No. At the moment, it is with NHS England, and NHS England commissions health visitors and family nurse partnerships. That money will transfer over.

Q72 Meg Hillier: Are you including all overheads and commissioning costs?

Felicity Harvey: That is why we have added—

Meg Hillier: Okay, so you've got a reference.

Felicity Harvey: The £425 million includes an additional couple of million for commissioning and a floor of £160 per nought-to-five individual. It is more than we have been utilising.

Duncan Selbie: What Felicity was referring to is the half-year cost. It is actually double that coming into local government next year. For 2015-16, it is October to March, so you double the £400

million and it becomes £800 million. To speak to Mr Burrowes's question about whether we are making a difference, we are emphatically clear that we wish to see the public health grant get to target as quickly as possible. We have no intention of taking away from those that have, because of what I have described, and the numbers are not sufficiently large.

Chair: Unless you get more money out of NHS England, it is for the birds.

Q73Meg Hillier: Chair, I would just fly the flag, as Mr Selbie has, for Hackney. As just one example, when the new substance misuse service launches in October this year, it will cost £1 million less per annum and deliver the same service with increased outcomes, and there are other examples. I think local government having an oversight of health budgets is incredible.

However, there is still an issue about the accountability of local functions managed by regional organisations. I am getting good feedback locally—you will be glad to know, Mr Selbie—that the strategic overview from NHS England has quite a positive view locally.

Duncan Selbie: From Public Health England?

Q74 Meg Hillier: From you lot, yes. You get a tick in Hackney so far.

Duncan Selbie: I am a great supporter of NHS England; it is just that it is not our organisation.

Meg Hillier: Sorry, NHS Public Health England. Forgive me; we deal with so many acronyms here. Anyway, you will be pleased to know you get a tick in Hackney.

Q75Mr Burrowes: You mentioned it as a mandated service.

Felicity Harvey: No, sorry. It is not a mandated service, but in terms of ACRA, you are absolutely correct. Apologies for that.

Q76 Chair: What is ACRA?

Felicity Harvey: ACRA is the Advisory Committee on Resource Allocation.

Q77Mr Burrowes: It is a conditional grant service, is it?

Felicity Harvey: It is a conditional grant service, but because it is quite a large amount of spend, sexual health services and nought to fives are areas that we have asked ACRA to look at specifically when it looks at the formula again, which will inform 2016-17.

Q78Mr Burrowes: Could it become a mandated service?

Felicity Harvey: No, it is a grant condition.

Q79 Meg Hillier: Can I go back to the issue of local accountability for functions? Although centrally a lot of good strategic stuff is going on, a lot of functions are still managed by regional organisations. An example that I would pick out is TB vaccinations. There is no real strategy there; we are relying on local authorities to pay GPs, yet Hackney has traditionally had—although it is dropping—a high incidence of TB. That seems to be a lack of local accountability. How are you—both the Department and Public Health England—making sure that you tackle that and making those bits of the service more locally accountable? They might not be best organised at local authority level; you may need some regional input. Where do you have teeth there?

Duncan Selbie: Can I use TB as the example? This morning, here in the House, we launched the TB plan for England, in which Simon Stevens and myself committed to nine TB boards, locally set but with national oversight, looking at latent TB screening and find and treat. It will be like what we have had in London—you know the bus?—replicated in five other parts of the country where there is a really intense TB problem: Leicester, Coventry, Manchester, Birmingham and one other. This is national, regional and local coming together. Simon has put in £10 million, and I have put in £1.5 million. Together we are going to ensure that we wipe out TB in this country. If we don't do this—

Q80 Chair: What are you doing? In the context of today, you have this great big national strategy, which I am sure is really good, but in Barking and Dagenham, or the constituencies of any of us around the table, what is going to change?

Duncan Selbie: We are going to see people—it is not a strategy, it's a—

Q81 Chair: What's going to change? Are you telling Janet's equivalent in Barking and Dagenham that they have to spend their money on vaccination or whatever it is?

Duncan Selbie: We are introducing, for new entrants, screening for latent TB—you don't know that you have it, but you might be infectious. We are making sure that if you are infectious, we pick it up quickly and get you into treatment.

Q82 Chair: Who is "we"—public health locally? Who is going to do this?

Duncan Selbie: Yes, locally—local government, local NHS, public health teams.

Q83 Chair: And who is telling them? You do not tell local authorities what to do.

Duncan Selbie: No, we have agreed it.

Q84 Chair: Can you say that again?

Duncan Selbie: Sorry for my accent. We have agreed it.

Q85 Chair: Agreed it with whom? What happens if my public health chap or chapess decides not to do it?

Duncan Selbie: There is not a public health professional in the land who is going to disagree with focusing on TB.

Dame Anne McGuire: I don't think Mr Selbie has to apologise for his accent.

Chair: I can always understand you, Anne.

Q86 Dame Anne McGuire: I am being serious, actually, because I think that at one point, just because of your enthusiasm, we missed what it is that is going to happen on the ground. You mentioned that there would be centres in the cities that you highlighted, but perhaps we could just rewind a little and you could say what is going to happen on the ground. I certainly saw the bus or caravan outside Portcullis House just now. I think it was just a bit fast and we did not pick it up.

Meg Hillier: Also, who is paying? How is the payment going to happen?

Duncan Selbie: Okay. Essentially, it will be managed through primary care, through general practice, but there is a place for voluntary organisations that are often more likely to catch and keep people—for example, faith groups and the range of different organisations working with the homeless, out on the streets, if you like. We want to connect it back into a system in primary care, because that is how we do that. We will also have mobile facilities, such as the van out there, in five or six different parts of the country that will move around in places that people can be found.

Q87 Dame Anne McGuire: Effectively, it is almost a modern equivalent of the big campaigns in the 1950s that eradicated TB in some of our big industrial towns.

Duncan Selbie: Exactly. We have done this once before, but we forgot how to do it, and consequently TB rates in this country are a shocker. It is about reversing that again.

Q88 Meg Hillier: Finally, on that point, can I ask about budgets? You said earlier that you are here in support of local government, working with the NHS, and I think that you said you were the shock troops or something.

Duncan Selbie: We are a fighting regiment.

Q89 Meg Hillier: If you can put it in a nutshell, how does Public Health England influence DCLG, the NHS and others to align their aims? You can have massively different priorities in, say, Hackney from those in, say, Poole or Eastbourne. Population ages and mixes and so on are completely different, so there are very different local priorities. In those areas, you have to align all the different public authorities, including the acute health service, and yet you don't have teeth, really. You can persuade people and get them to agree, but what if they disagree? How do you make these things happen? How do you bring it together?

Duncan Selbie: Just remember that when we thought we had teeth, we did not, because we made no difference. When you look at the gaps, it hadn't altered in 40 years, so whatever we were doing was not working. I know you believe that what matters are the causes—do you have a job? Do you have somewhere to live? Do you have enough money to live on? Do you have friendship in your life? All the things that we know really make a difference are locally based. They are locally derived. Local government in this context are not perfect, but they are far and away the best people to co-ordinate. That is, if you like, the raison d'être behind the duty we have to help and support them.

Q90 Meg Hillier: What if the Department for Communities and Local Government comes up with a policy that cuts through in some areas that public health priority? It happens with every Government; it could happen any time. Do you have any influence there? Does Dr Harvey?

Duncan Selbie: Can I speak to that, and then the Department? So the NAO speak to this. It is one of the five recommendations. They say, "We recognise that you do work across Government, but we can't see it is co-ordinated. We can't see its connection with our priorities. We think you should be doing more of this and that there should be a public health voice in the major Government Departments." We completely agree with that, and if you go back in time to when Liam Donaldson was the chief medical officer, you used to have regional directors of public health attached to major Departments of state. We have forgotten that and we think we should reinvent that. There are other ways in which we can have an influence, as no doubt Dr Harvey will say.

Q91 Stephen Hammond: I apologise, because I have to go in two minutes' time to a legislative Committee. I am the new boy on this Committee. What strikes me about all the five hearings I have been at, and this follows on from your last point, is that somewhere in the Report there is always something about data—either too much data, too little, or it is not used in the right way, or we cannot really trace it. Again, in this Report, in terms of the recommendations, it is said that you have done some work on the poor quality of data initially and a lot of it coming late to you. It says you have done some work with DCLG and with local authorities to improve the quality of data. It also says, and this is even more important, that the local authorities still do not have—you are supposed to be working with them—a tool that enables them absolutely to analyse what we are spending and check that tool, therefore analysing lines of spending with outcomes. Could you give the Committee a flavour of that? If I walk out, it is because the Whips will shoot me if I am not down the road in about a minute and a half.

Duncan Selbie: So I've got 30 seconds. What directors of public health say—the NAO agree—is that we have developed some good tools. These are new tools. They have never existed before. The only reason that the NAO can write this Report is because we invented the tools. What the NAO are saying is, "We'd quite like you to use them." So local government are saying that they like the tools, but they do not think we give them enough help and support in making use of them at a local level. We have got to do more of that. The other thing, which is the most often-quoted thing from local government to me, is help on economic appraisal and how you do return on investment. I would love if the Committee wanted to get me started on that.

Q92 Stephen Hammond: And also, there is a commonality of that across all local government. We have found in local government that different local authorities fill in forms in different ways or use different criteria, which has been a major problem.

Duncan Selbie: But Mr Hammond, my concentration on return on investment is not on 3%; it is on 100%, because it is what the schools are doing, what the housing people are doing, what is happening in economic development and what is going on in planning that will make the difference.

Q93 Chair: Okay, so why are you not therefore critical—or are you?—of policies on public spaces? I am trying to think what I read in Ara Darzi's report on London, such as making public spaces smoke-free. Minimum pricing of alcohol was another of his ideas. There was traffic-light labelling on all foods and menus in restaurants. Have you been critical about any of that?

Duncan Selbie: Yes. This puzzles me. Public Health England is emphatic, has been on the public record, and has published that we believe in minimum pricing for alcohol. There is evidence that it makes a difference—

Q94 Chair: Have you published that?

Duncan Selbie: Yes, as we have on standardised packaging. The evidence is compelling. A minimum price for alcohol—I hope I am not being misunderstood—is a major deterrent for young people. It also has an impact on the hardest drinkers. This is evidenced around the world. We need to do this in this country. It is not sufficient—this is maybe where we part company—to have the evidence if you do not have the consent of the people, and that is the point to Parliament. However, I have been extraordinarily clear that the evidence is there. On standardised packaging, we have published. The difference between myself and Dr Harvey is that I am not making the policy. I am saying "Here is the evidence." And on open public spaces, the evidence is unbelievably clear that people who live close to open spaces, parks and the like live longer and live better, in better health. It's great for children.

Q95 Chair: Smoking in open spaces?

Duncan Selbie: Well, tobacco needs to come out of England. It is half of the cause of the inequalities in this country. Children start smoking. It is a safeguarding issue.

Felicity Harvey: May I just add that one of the things that was important in setting up Public Health England, and it came out through many of the debates during the passage of the Bill, was the importance of having an organisation such as Public Health England that could speak the truth to the data? And that is what it does.

Duncan Selbie: And I am getting fed up with it because, to be honest, what bit of it isn't understood? We want to see this happen.

Chair: Good. So do I.

Duncan Selbie: But you need to do it. There's no point in saying it to me; this is for Parliament.

Q96 Mr Jackson: Well, in answer to your challenge, we need to build a consensus that takes on some of the vested interests. I speak as a Conservative and I am in a minority on this issue. It will take time to build that consensus and win those key people round.

Duncan Selbie: But with all the big developments, this country has got a hugely great record. Smoking in public places, seat-belt legislation, not drink-driving, teenage conception rates—they always take you longer than you think. It just takes time. But the evidence is compelling and it is now time to act on it.

Felicity Harvey: In terms of the remit letter for Public Health England, as you will know the Government's position on minimum unit pricing is that it is keeping an open view on the evidence, and the remit letter has asked Public Health England to do an evidence-based review, which it will be doing. We expect to see it in the spring.

Q97 Austin Mitchell: Right. I'll come in now. One of the best ways of getting people to improve is to incentivise them, and you could do that by paying more to those local authorities that have successful campaigns, or that achieve objectives such as reducing smoking, etc. So why is the public health bonus so mean, as to be only £5 million? That is peanuts; it will not incentivise anybody.

Felicity Harvey: I think the reality is that we have been very clear that there needs to be an incentive programme. This is the first year and, if you like, what we are doing is piloting the "how we do it". It is only £5 million. We would expect to see that as an element that goes into the spending review for what happens in future.

What we have had back from local government, when we consulted, is that in doing that they would like one national indicator, and for us that is drugs—again—but also one local indicator. Where we are in what is being taken forward at the moment—the health premium for 2014-15—is that most local authorities wanted us to have, as a fallback, health checks, if they didn't decide to design their own. Many local authorities will be able to design their own, but within a limitation of indicators that can be clearly measured. Again, that was on the evidence that we had from the Advisory Council of Resource Allocation, which set up a sub-committee for us to give us robust indicators that come from the public health outcomes framework, which could be utilised so that we can really ensure that a difference has been made at local level.

Q98 Austin Mitchell: But when, and by how much is it—the premium—going to be increased? This is all hypothetical, and in the future.

Felicity Harvey: How much it will be increased will be an issue for the spending review. How we do it we will learn from this year, and that learning will then be taken into what happens with it next year.

Q99 Austin Mitchell: I gather that the spending, or the initial allocations, is based on what was being spent by the health service beforehand. This is all being transferred to local government, but when will it be based on local problems and local need? I see from figure 3 of the NAO Report that the "non-prescribed functions" are "Sexual health services…Obesity…Physical activity…Drug misuse". I would imagine that we have a higher level of all those problems in north-east Lincolnshire

and other urban areas where local industry has been killed, so while Hackney is getting better treatment—it has more money than it can spend, as I understand it—why is money not pouring into north-east Lincolnshire?

Felicity Harvey: That is for the Advisory Committee on Resource Allocation, which will relook at the formula this year.

Q100 Austin Mitchell: So why is it not directly related to need?

Felicity Harvey: In terms of the ACRA formula, we will be looking at under-75 mortality and the smaller area deprivation, but also at how much need there is on drugs and alcohol, even though it is not a mandated function, and how much need there is on sexual health, as well as what we have learned from the last 18 months and the nought to five. The allocation formula for 2016-17 will take all those issues into account more—Dr Atherton is a member of the ACRA committee—which will feed into the allocations for next time, which will be 2016-17.

Q101 Austin Mitchell: Mr Selbie, you have been to Grimsby, you tell me. I am plagued by the fact that Sacha Baron Cohen is now making a film about Grimsby called "Grimsby", which indicates that Grimsby is full of fat ladies who wreck football matches and populate the football ground and that obesity is a major local problem. The film has been made in Tilbury and South Africa and not Grimsby, but did you think, when you went to Grimsby, that we have a major problem with obesity?

Duncan Selbie: No, not at all—

Q102 Austin Mitchell: Apart from me.

Duncan Selbie: No, you are doing all right. I have spoken to the chief executive. I have met the councillors. I have been shown around. The passion that they have for the place and for their people is second to none. I say that in the full and certain knowledge that—I have not been to Barking or Norfolk yet, but I am going—I see this all over the country.

Speaking to your point about the north, once you hit Manchester and you go further north, everything turns red relative to the south. There are problems in the south, in London and in Cornwall, but nothing to the scale and extent. The two measures I am using here are public health measures: "How long do you live?" and "How long do you live in good health?" You asked me not to talk to what you know, but those are the two measures. Have we talked about them as a health service for 20 years? No, we have not. That is what needs to be different.

I am more concerned that the narrative is about good health being about more than health care. When we reach the point where the Department of Health is as concerned for the numbers of people in work as the DWP, we will know that we are winning. The concern I have is about length of life and length of life in good health. I have no difficulty with the passion, the concern for the people and the leadership in Grimsby.

Q103 Chair: I tell you what is interesting from that: we should cut the NHS budget and increase the DWP budget. I do not know how my friends around the table—

Duncan Selbie: Billions and billions and billions of pounds are spent on benefits for people, but half of the medical scripts in this country are written for depression and pain. That speaks to the question of what we are spending our money on.

Chair: I agree.

Q104 Nick Smith: I want to rewind a little, Dr Harvey, to some points that Mr Selbie was making on plain packaging for cigarettes and minimum pricing for alcohol. Mr Selbie said that the evidence was compelling and that the two issues needed driving forward, although he said that there was a lack of consent at the moment, by which I presume he meant political consent—

Duncan Selbie: No, consent of the people expressed through Parliament.

Q105 Nick Smith: Okay. Dr Harvey, you said, I thought—it is what I wrote down—that the Government were open-minded. What will it take to get legislation on those two issues?

Felicity Harvey: In terms of minimum unit pricing, the Government have been clear that they are keeping their mind open on the evidence for it.

Q106 Nick Smith: You have said that already. I am asking what it will take for there to be legislation.

Felicity Harvey: I think we have asked Public Health England to provide an evidence review. That is what it is doing, and it will be publishing that—

Q107 Nick Smith: He has already told us that it is compelling.

Felicity Harvey: We haven't actually seen it yet.

Q108 Nick Smith: You are sat next to him. He just told you.

Felicity Harvey: We will wait until we receive the report from Public Health England, but it is an area that we are keeping under review. In terms of tobacco—

Q109 Nick Smith: So, you will put it in the long grass.

Felicity Harvey: I haven't said that we are putting it in the long grass. It is an area that Ministers will wish to look at when we have the review, but clearly there are issues that are cross-Government, and not just for the Department of Health, in the decisions that the Government will take.

Q110 Nick Smith: So, is some other Department stalling it? What is going on?

Felicity Harvey: We will look at the evidence base, but there are cross-Government interests and issues around both alcohol and tobacco.

Q111 Nick Smith: So who is trying to stymie it? Which other Departments?

Felicity Harvey: It is an issue for Government to address once we have an evidence-based review. On tobacco, as you will know, there has been quite a lot of legislation in the Children and Families Act on smoking in cars with children and proxy purchasing of both cigarettes and e-cigarettes. As you will know, we have been out to consult on the enabling legislation on plain packaging. Ministers said that they were minded to move in that direction, subject to consultation. Ministers have not yet taken a view following the consultation on standardised packaging.

Q112 Nick Smith: Do you think that the enabling legislation means that that could be brought forward before the general election, or do you think it has been put back until after the general election?

Felicity Harvey: I think the Government will need to come to a conclusion about it. However, we have the enabling legislation and we have consulted on regulations. There is also a European dimension to this, because clearly there is also the European tobacco products directive. This will be for the Government to decide, and the Government have not yet decided.

Chair: May I just ask some quick ones? And then I have Anne, Meg and Stephen at the end.

Mr Jackson: What about me?

Chair: Sorry. You are right. I forgot you. Come in first, before me.

Mr Jackson: Naturally, I defer to a Dame.

Chair: There's nothing like a Dame.

Q113 Mr Jackson: Please don't break into song, Margaret.

May I ask two quick things? You were talking about the methodology for assessing need in terms of public health spending. How detailed will that be across a local authority? Will it go down to super output areas? You will have seen the Centre for Cities report that has been published today. It talks about income and disparities between jobseeker's allowance claimants even within city areas, which is obviously the same for health. Will you say a bit about that?

Michael Brodie: It does do that. It looks at disparities between authorities and within authorities, so it does go down to the super output areas.

Q114 Mr Jackson: Excellent. That was a slightly technical question. You were talking about the money allocated for nought to five, which is a very important area. Politically, there has been some controversy about that over the years, but I think there is agreement across the political divide—there has been work by the Centre for Social Justice, Graham Allen and others—on the need for that. How will you encourage local authorities at local level to co-ordinate the work between the zero going up—from five to adult? Obviously, we are talking about endemic social problems of third-generation welfare dependency, poor health, depression, mental health, smoking and drugs misuse. How will you encourage local authorities to look at the children and move up through the teens and older people, in practical terms? Are you going to co-ordinate?

Duncan Selbie: Well, nought to five finishes it, if you like, because having local government leading on the outside of hospital care for five to 19 needed to be joined up with nought to five. What you are reflecting is what I hear around the country. It is greatly welcomed. It is about how local government, in the lead but working with the NHS and others, co-ordinates around individuals and families.

We are supportive of the Family Nurse Partnership and the Troubled Families Programme. We think that the uncoordinated effort—having lots of different people going in—is simply not working. So we look to local government to lead this, working with, as you are describing, the most troubled, chaotic individuals and families. The nought to five finishes that, because you had—

Q115 Mr Jackson: I don't like the term "chaotic", because I think it's a bit politically correct. It does not seek to ascribe any responsibility. It is sort of a generic word.

Duncan Selbie: Okay, but families that are in difficulty.

Mr Jackson: Okay. I mean, as troubled families—

Duncan Selbie: And you know that every local authority chooses how they describe the programme. Very few of them use the term "troubled family". It is about the people who are finding it most difficult who are absorbing a lot of resource, involving a lot of public services.

Q116 Mr Jackson: Do you see the nought to five as taking a major, or the major, role on early intervention, co-ordinating with adoption and fostering, mainstream health, local education authorities, academies, all together? Is that going to be important, given that it is a relatively minor amount of money?

Felicity Harvey: I think maybe it is worth saying that when we went through the transition, we only gave local authorities at that point five to 19, and that is because we were building the work force. In fact, we built the training of health visitors by 500% since 2010. We are now going to be transferring in October, having built the work force in health visiting—it's the commissioning we are transferring, not the people—building on what they have been doing with five to 19.

Local authorities have been very keen to get nought to five. So, exactly as you say, they then have the entirety of children from their earliest years right the way through. That is also particularly important, because I know a lot of the discussions that you have had, Duncan, with chief execs and directors of public health around the country have been around those early years and getting ready

for school, and achievement through school. So this is something that they have very much been wanting to have, so that they have this full view.

What we will have, when we transfer it over—which is why we have been quite careful about making sure it was when the health visitor numbers were up to the right number—we are transferring it over with some mandated functions initially, with a sunset clause, to make sure that those sorts of interventions that are able to support families best are actually taken forward.

Local government have wanted this since 2013. Everything we have heard is extremely positive.

Q117 Mr Jackson: Well, I think it's very important. Anecdotally, I know my local authorities are under a lot of pressure with safeguarding children, because of the historical legacy of taking over from a bigger county authority, and it is a relatively small unitary authority. I have situations where children are arriving at school not socialised, not being able to hold a pencil, not being able to hold a conversation, not being able to eat properly, no table manners—that sort of thing. It is that kind of education, both for the parents and the wider extended family, and others, that would be very useful.

Felicity Harvey: That is where the Family Nurse Partnership in those families that are particularly challenged—very, very young women having families—as well as the health visitor programme are really important, in terms of giving those professional skills and help.

Janet Atherton: I agree entirely with what you are saying there. Local government has been keen to take on this function right from the point at which the whole of the public health function transferred over. So it is kind of bringing it to a natural conclusion, really, transferring those services, and it brings with it lots of opportunities about joining up with children's centres, early years provision—you name it. There is lots more potential through doing it joined up in a council way, rather than having it in different parts of the health system.

Q118 Mr Jackson: I've got a quick question and then an ad break. First, there seems to be an issue in terms of capacity and the people in the system: directors of public health at a local authority. In terms of remuneration, the relative attractiveness of going over to do that vis-à-vis continuing to work in the NHS, where there has been hitherto a culture of bonuses, clinical awards, excellence awards, etc., means there is a disparity. I wonder what your view is on the general idea that potentially you have not got enough people in the talent pool to fulfil these challenging roles.

Janet Atherton: That situation is improving, so at the time of the transition, there were about 35 vacant DsPH posts, but I think, as of yesterday, it is now 26. That, in large part, is due to some of the work that has gone in about putting into place—

Q119 Chair: That's one in six vacancies.

Duncan Selbie: It shifts around—it is about 20%.

Q120 Chair: That's a lot.

Janet Atherton: Yes. So while it is improving, it is not where it needs to be. In all those places where there are vacancies, interim arrangements are in place, but in some of those, they are long-term interim arrangements, which is less than ideal. You need to be in a substantive post, really influencing as part of the management team in a council to be fully effective, so we would want to be seeing that moving on. But the aspiring DsPH programme, which is being funded through PHE, has been quite successful in building that pipeline of people coming through into DsPH posts.

I would say that we will continue to see quite a lot of turnover over the next few years in DsPH posts simply because of the age profile of directors of public health, with retirements and that kind of thing. So that work needs to continue and some of the issues around terms and conditions need further work as well to ensure that there is easy movement of people throughout their careers from local government into PHE and the NHS and back again. Issues like continuity of service are probably more of an issue than salary.

Duncan Selbie: If you asked directors of public of health if they think that they should be in local government, they will universally say yes. However difficult, they would rather be in the room having the argument than on the outside commenting. We have got nine people competing for every training place. We have had 65 people go through the aspirant director programme and 20 of those, in the last two years, are in substantive posts. We do not think that one in five or one in six is sufficient. We need to get to about 90%. As Dr Atherton says, there is turnover, and we will always have that, but these are the most interesting and pointful jobs that you can have.

We have some fabulous people. I am just going through the list of who you have got. Penny Bevan—that is your director of public health, Ms Hillier—is one of the most experienced that we have got. Mr Jackson, you have got an interim at the moment, but, if I look around the country, Dr Pugh has got the most experienced director of public health of all: Dr Atherton. We have got a cohort—*[Interruption.]* We have some fabulous people, so I do not want you to be—

Q121 Mr Jackson: We are delighted to go through public health's greatest hits, but can I finish? I am not even going to ask you, because I know that you will agree with this: I am, I think, the only Member of Parliament who for 10 years has tried to get Government to fortify folic acid in foodstuffs to prevent neural tube defects. My plea to you is to keep up your good work with the Food Standards Agency in government. No one else seems to be interested, but I am and I think it is really important.

Duncan Selbie: We will shortly get the next evidence review and I would love to talk with you more once we have got that. It is imminent and we could talk further about it.

Q122 Dame Anne McGuire: When we did inequalities in health, there was a sense that we had all been there before, because some of the indicators of inequalities had been pretty well known for years. Mr Selbie, I wonder whether you were displaying the historic frustration of public health officials when you said that the evidence is there and overwhelming, yet from Dr Harvey we got, "Nicely put, but we need to wait until we see the evidence." How do you encourage us to take risks? When we have taken risks, such as on advertising on tobacco, which has developed over the past number of years—everyone said you could not stop smoking in public places, in Ireland, Scotland and the north of England, in all those areas where traditionally you said you could not do it—we did so and it has made a significant difference. How do you use the levers that you have, not

only to present the evidence, but to say to the NHS, "Sometimes it's about changes in behaviour and not how many prescriptions that you write"?

Duncan Selbie: We have never had such a focus on public health. I have not had the opportunity to say it: we have never had such a focus. You have a national agency in England, which has never happened before; you have got a Department focused on it; and you have got an NHS chief executive who says that cure is prevention. This has never been the case before. We know that it works, but public health professionals are in the space where no one else is, and they can often be quite irritating, with Government saying, "Why won't you just shut up?" because you are talking about things that are difficult. We have got to be in that space.

I have got a framework agreement with the Department of Health, agreed with the Secretary of State, that says we have the freedom to speak and to publish the evidence. We can bring professional judgment to bear. That does not mean that we comment on everything, but we can speak to the evidence. I am very confident—I am not angry, but I am passionate—that I am reflecting only what I see out there. This can be done. Do you remember when people said, "You can't do anything about hospital-acquired infection"? Watch what happened. People said, notwithstanding wiggles, "Teenage conception, we can't do anything about that." What I can tell you is that Whitehall cannot direct what a teenager in Newcastle decides to do on a Friday night. There is not a single public health agency in the western hemisphere that believes that. We have to get local and we have got to give them the chance. I believe that with passion.

Q123 Dame Anne McGuire: You believe that you have that authority to be able to do that. Can you give us an example of something in the past year that you have done that has been really controversial? Or are you not yet pushing the envelope that far?

Duncan Selbie: We have published the global burden of disease, which is the best public health science in the world. It shows the UK and how it sits relative to the rest of the world, which spends the same or more than we do, and it shows that although length of life has improved in this country, life in good health has not. We are always talking about how great the NHS is, and I love it—I do—but we have not improved life in good health, and the reason why is that we conflate the NHS with good health. We think that if we invest in the NHS we will get better health, but the truth is that that is much more likely if we invest in the environment, behaviour and people having a job.

I do not think that that is controversial; it is speaking to the evidence. On sugar, we have been quite open on every single age, irrespective of what the scientists say about whether it should be 10%, 5% or 7%. Teenagers and children in this country are consuming 50% more than that, and we have got to be concerned. So we have been saying things about sugary drinks. We have concerns about a whole range of issues. I do not know that that is controversial.

I could go on for a while. For the avoidance of doubt—I think Mr Burrowes started with this—let me say that I do not feel constrained, and do not feel that I do not have levers. I agree with the NAO that it is about outcomes, transparency and so on, but actually I have a whole set of other things. It is called human relations. It is about knowing the people on the ground and being relevant to them—

Q124 Chair: May I ask something? We have to get on, because we have a private meeting after this meeting, so may I ask for some quick answers on this one? Are you intending to keep the ring-fence, Dr Harvey?

Felicity Harvey: The ring fence is one of the issues that we will be taking forward into the—

Chair: I don't understand what that means. Are you intending to keep it or not?

Felicity Harvey: No decision has been made at the moment. It will be for the next Government, subject to both quantitative and qualitative evidence—

Q125 Chair: Would your recommendation be to keep it or not?

Felicity Harvey: At the moment the jury is out. We need to have evidence. May I say that directors of public health and chief executives are in slightly different places on this as well?

Chair: Chief execs won't want it, directors of public health will. It's obvious.

Felicity Harvey: We need to have the evidence from what has happened over the first two years from the outcome indicators, and lots of qualitative evidence from Public Health England.

Q126 Chair: What is your view? Has it worked? Let me tell you, we look at a lot of Government initiatives. You are one of the few that has done it through a ring fence. A lot of initiatives ask or encourage local authorities to do something, then do not ring-fence the money and are surprised when it is not delivered. I am interested in whether it is working.

Felicity Harvey: In terms of giving us a safe transition and transparency of spend, it has been successful. We will see what happens when we transfer the nought to five across, which will happen in October.

Q127 Chair: Will it also be ring-fenced?

Felicity Harvey: It will be within the ring fence. The ring fence is maintained until the end of 2015-16. Therefore, we will have had a three-year ring fence. We will have quite a lot of evidence from that and, indeed, qualitative feedback from Public Health England. That will all go into ministerial decisions.

Q128 Chair: I hope this second question is a short one. We have Public Health England. How many of you are in the Department of Health?

Felicity Harvey: Around the similar functions, about 140 in my directorate. However, there are areas that you touch on such as mental health and children's policy that impact other colleagues of mine.

Q129 Chair: Do you report to the chief medical officer?

Felicity Harvey: No, I don't. The chief medical officer is the Government's independent health adviser. That post has been on the statute book for about 180 years.

Q130 Chair: So, do they have support here as well? I am really getting at duplication; we have you, PHE and NICE.

Felicity Harvey: And they are very different, although they have public health functions. On Public Health England's advice to us, we advise Ministers as to which products would be most beneficial to support, for example, return on an investment or whatever from NICE, and they would then be commissioned by Ministers to produce them.

Q131 Chair: Why do you need 140 people?

Felicity Harvey: The functions in the Department of Health are different from the functions of Public Health England. Ours are around setting the strategic framework, doing the legislation and policy development. The evidence base that informs that, which used to sit in the Department of Health, now no longer does, so all the expert committees and so on—all of that function—was transferred to Public Health England. Between the Department and Public Health England, we need to work relatively seamlessly in policy development using general evidence about what the science tells us, and evidence about what works. All of that feeds into policy.

Q132 Chair: That is what Mr Selbie does as well.

Felicity Harvey: It is indeed, and that needs to sit in Public Health England. His staff will then work with ours to finalise policies for Ministers to make decisions on.

Q133 Chair: I will give you one more go at it, but you haven't convinced me that there isn't duplication.

Felicity Harvey: One of the things that you will be aware that Public Health England is doing at the moment, through the strategic review, is addressing whether there is any duplication between, for example, the health improvement functions nationally that Public Health England has and what we are doing in the Department. We are pretty sure that there isn't duplication but that is always an area that we are looking at further.

Q134 Chair: I will ask my final question. We have talked a lot about obesity, drugs and alcohol. If you look at the prescribed functions, the only one that is clear is sexually transmitted infections, which was always done at that level. That is where all the spending goes, if you look at figure 6. Why on earth haven't you changed the prescribed functions? Two of them—public health advice and local authority role in health protection—seem wallydom to me. I am sure that they are very important. Why do you not put in absolutely clear prescribed functions around the issues that really matter?

Duncan Selbie: Because the mandation has been widely misunderstood. It was never about prioritisation, but about ensuring that if it needed to be done consistently, it was done

everywhere. You couldn't measure a child in Liverpool in a different way from a child in Southwark. Also, for sexual health, you could not have one part of the country saying, "You could get that" and another part saying, "You couldn't get that". It was never about prioritisation. This goes straight back to what I was trying to say at the outset: prioritisation has to be a local matter.

Q135 Chair: Sorry; if you look at figure 6 and you look at spending on sexually transmitted diseases and spending on "obesity: adults" or "alcohol: adults", you can see—you may not have mandated it—that the spending goes on sexually transmitted diseases.

Felicity Harvey: And that is why that is one of the areas that ACRA is specifically going to look at when it comes to the funding formula for '16-17.

Q136 Chair: Why didn't they change it? You may not have meant it as priorities. If you put it as a mandated function that is where the money goes.

Felicity Harvey: The reason it is mandated, as Duncan said, is to make sure that we have equity of service across the system.

Q137 Chair: I know, I can understand that. But it does not reflect—it would be nice to have a bit of equity of service around preventing smoking, actually.

Duncan Selbie: Mrs Hodge, you looked at me, I think, quizzically, when I said, "Well, actually, it is about how we use the money, rather than more of it." Simon Stevens and I have committed in the five-year forward view to a pre-diabetes prevention programme at scale everywhere in the country. That is essentially, once you meet the markers—you know, blood pressure, this sort of stuff—access everywhere in the country to help and support around diet and activity. Now nowhere in the world has done this. We think it will cost between £50 million and £70 million. That money is committed by Simon, by me, in the spending plans for the NHS into future years. We are going to pilot it, next year, and we are going to run it everywhere in the country. That is not because Government are saying we need to do this. This is because the public health service and the NHS are saying unless we get serious about prevention, the NHS will be overwhelmed.

Felicity Harvey: Could I just add two of the areas that we have got in there? Within the mandated functions are actually public health advice to CCGs, which is of critical importance, but is not an area that necessarily would have been prioritised by a local authority; but if we did not have DsPH and their teams advising CCGs as the experts as to how CCGs spend their money—

Q138 Chair: So the interesting thing in that answer is you have said you are using mandation to prioritise; you have just said you are not using mandation. Mandation does not prioritise. You have got to come to an agreement, you guys.

Felicity Harvey: It is for those areas where we were concerned that a function that was essential may not otherwise happen. The other one would be the health check.

Duncan Selbie: I would only add that if you take the total spend in the NHS and you look at what went into the public health grant, there is no way we can solve childhood obesity by just looking at that small amount of money. We have got to be concerned for the whole spend.

Q139 Chair: If we had Simon Stevens here we would have a go at him about the Better Care Fund, because that actually has gone back from where it was intended.

Q140 Stephen Phillips: Dr Harvey, this completely off topic and has nothing to do with the Report from the NAO, but I am told it is legitimate none the less, since you are here. The Committee is currently writing a report about the outbreak of EVD in west Africa. Your formal title, as I understand, is director general, public and international health. Is that right?

Felicity Harvey: It is indeed.

Q141 Stephen Phillips: And you are a standing member of the regional office for Europe of the World Health Organisation. Correct?

Felicity Harvey: I am. Actually, it is the chief medical officer that is, but we deal with WHO in support of her within my directorate.

Q142 Stephen Phillips: Right. In order to assist us with our report I have a couple of quick questions. Why did the WHO drop the ball so badly on this outbreak of EVD in west Africa?

Felicity Harvey: I think there is actually a session just before the executive board, which I think is next Sunday, where there will actually be a discussion of all the executive board members with WHO in terms of what, indeed, did happen, and how we can ensure, moving forward, that WHO is in a position to respond as it needs to for future outbreaks.

Q143 Stephen Phillips: What will your position be in that discussion? What will you be saying about what the WHO did wrong?

Felicity Harvey: I think we need to understand more what did happen. I know that you did have a hearing on this, and we work very closely with our DFID colleagues around this. We are very clear that we need to have a position where the WHO is able to respond, to identify an area in one of its regions—any of its regions—in a way that is transparent, but also then to be able to respond to it in a timely manner; and those are the areas that we will be particularly interested in.

Q144 Stephen Phillips: Is it your view that WHO is a corrupt organisation in Africa in the sense that there are political appointments to it of unqualified persons?

Felicity Harvey: No, it is not. I think we would need evidence, and I am fairly sure that the WHO themselves will be doing a review of this. We want to the support WHO so that it is enabled to respond, whether it is in the Africa region, the Euro region, or any of the regions that it has.

Q145 Stephen Phillips: I have one other question. Since there is no medical reason, in terms of infection, as to why there should be no direct flights between west Africa and anywhere else, since the mechanism of transmission is very difficult simply by means of travel, why were direct flights between the United Kingdom and Sierra Leone stopped, in the sense that the licence of Gambia Bird was revoked on the instructions of the Government?

Felicity Harvey: That is a wider Government discussion. What I am particularly interested in is what the issues are in terms of transmission, and the risk to people within this country and to our health workers who are out in Sierra Leone at the moment.

Q146 Stephen Phillips: As far as you and the CMO were concerned, there was absolutely no reason why there should not be direct flights between the United Kingdom and Freetown.

Felicity Harvey: We did not have any particular concerns. If you did have direct flights, we would be working with Public Health England to ensure that the screening arrangements were robust. Over the course of the last two or three weeks, we have proven them to be very robust. As we have moved through the Christmas period, we have now started to have the first and second tranche of our health care workers coming back into this country, screened and given the right advice by PHE, which has done a superb job, so that they know what to do if they develop a fever within 21 days after their return.

Q147 Stephen Phillips: Mr Selbie, do you want to say anything about screening very briefly? I have been subject to it, I might add.

Duncan Selbie: How did you do?

Stephen Phillips: I passed. It was my intention to come back and infect the entire Committee.

Duncan Selbie: In all seriousness, I am very proud of my people. We have screened seven days a week for three months. We have seen over 3,000 people. We have kept the country safe. This is public health at its best. To speak about my fighting regiment, I have got 70 people in west Africa providing all the laboratory services for the UK Government. I have got hundreds of people committed to keeping this country safe. We have been talking about the duty to improve health, but I also have a duty to protect health, and I think we are doing it.

Felicity Harvey: I very much support that. We have talked this afternoon very much about health improvement. PHE is the fighting force for health protection. Since they were established, not only have we had Ebola. We work very closely with PHE and they have been superb on this. You may remember that two weeks after the transition, we had an outbreak of measles, because we had had a low uptake among 10 to 14-year-olds of the MMR vaccine. Two weeks after the transition, the health protection system around this country was severely tested, and it actually delivered.

We have also introduced four new vaccination programmes since the new system came in, and they have been done very successfully. So we have focused on health improvement. The health protection side is the bread and butter that we both deal with on a day-to-day basis.

Chair: I did say that, on the whole, we think this is a good Report going in the right direction, but our job is to challenge on those areas where we think there is room for improvement. Well done.