



Health Committee

Oral evidence: Public health post-2013 – structures, organisation, funding and delivery, HC 569

Tuesday 9 February 2016

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Written evidence from witnesses:

- [Local Government Association](#)
- [NHS Clinical Commissioners](#)
- [Association of Directors of Public Health](#)
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- [Society of Local Authority Chief Executives \(SOLACE\)](#)

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Dr James Davies; Andrea Jenkyns; Andrew Percy; Emma Reynolds; Paula Sherriff; Maggie Throup; Dr Philippa Whitford.

Questions 1-75

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

Q1 Chair: Good afternoon. Thank you very much for coming to the Health Committee today for the first session of our public health inquiry. Could I start by asking you to introduce yourselves to those following this debate, perhaps starting with Professor Ashton?

Professor Ashton: Good afternoon, everybody. I am John Ashton. I am president of the UK Faculty of Public Health.

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Martin Smith: Hello, Chair and members. I am Martin Smith. I am representing the Society of Local Authority Chief Executives.

Jonathan McShane: My name is Jonathan McShane. I am representing the Public Health System Group and also the Local Government Association. I am a cabinet member for health and social care in the London Borough of Hackney.

Julie Wood: My name is Julie Wood. I am the chief executive of NHS Clinical Commissioners. I apologise for coughing and spluttering, if I do.

Dr Furber: I am Andrew Furber. I am a director of public health in Wakefield but here today as president of the Association of Directors of Public Health, which is the representative body of directors of public health throughout the UK.

Chair: Thank you for coming. We will start with Philippa Whitford.

Q2 Dr Whitford: We have quite a lot of questions, so I am not going to ask everybody to answer everything or we will all be here burning the midnight oil. My first question to Professor Ashton and Dr Furber is: to what extent do you think the moves of public health into local authority are succeeding in allowing public health to influence housing, transport and education?

Professor Ashton: It is a mixed picture. It is difficult to generalise. There are examples of very good practice in some parts of the country, in some districts, and there are places where public health has not so far been thriving where there has been perhaps a subordination, in some cases, to other directorates.

Q3 Dr Whitford: What would you say is the proportion of succeeding areas to those that are not? Do you have any sense of it at all?

Professor Ashton: The Association of Directors of Public Health can probably give you more chapter and verse on this, but there should be 140-plus directors of public health in teams around the country. It feels to me as though we have perhaps 30 or 40 that are doing quite well, and there are still some that do not have a director of public health and do not have the leadership in place. Then you have ones in the middle that vary a lot. In this context as well it is pertinent to think about second-tier boroughs that have a contribution to make to public health. I was at a meeting recently of the district councils, at the Local Government Association, where quite a few of those feel they are not being included by the top tier and that the boards of health and wellbeing are not engaging with the second tier when the functions they have responsibility for, including housing, environmental health and some other important public health matters, need to be properly, strategically joined up.

Q4 Dr Whitford: How do you think the two-tier councils should be dealt with?

Professor Ashton: There would be different ways of going about it. It may be that boards of health and wellbeing should be required to be more inclusive about that. I am not sure. Your original question was about how they are doing. It was the right move, but in a sense

the problem that we have, to take a historical perspective, is that when the health service was established it was tripartite. We had the hospitals, the community services—general practice, pharmacy, dentistry, opticians and so on—and then local government was part of the NHS; the local government public health departments were described as part of the NHS. People have forgotten that in the intervening years. There was a lot of discussion when I was a medical student and a young doctor about the tensions of the tripartite system. We now have a different kind of tripartite system, but beneath all the complexity that we now have, since 2013, of all the different organisations there is a tripartite situation, which is local authorities, the NHS and Public Health England. How that is falling out and is joined up and made coherent is the big issue.

Q5 Dr Whitford: That is the big challenge. The prize is obvious in that I worked in a “national illness service” and we need to turn that around and stop people getting ill. Some people have raised concerns about the position of directors of public health, whether they have enough strategic influence or are ending up—I am not sure whether you or Dr Furber would want to comment on that—being made too subordinate or a little bit out to the side and, therefore, are not managing to influence these big policy decisions.

Professor Ashton: Before we address that, the other thing to remember about the move back into local government is that it has changed enormously since 1974. The police have become autonomous since 1974, so have fire and rescue and a lot of other functions that were part of local government before 1974. The task of corralling and networking all the different players that need to be involved in public health is not just a local authority thing any more; it is much more widespread. That is why I see the board of health and wellbeing being the keystone of that, potentially pulling all that together, and it needs to be charged with that. In some places, local authorities tend to see the board of health and wellbeing as another local authority committee, when it is something different; it is something 21st century, not a 19th century kind of initiative.

Q6 Dr Whitford: Is there a danger of some of them just being talking shops?

Professor Ashton: Some are struggling to realise their potential.

Q7 Dr Whitford: Could I come to you, Dr Furber, and ask what you think about the success it is having and the position of directors of public health and their teams within?

Dr Furber: The transition went remarkably well and a lot of those successes are being realised. You asked for a figure to be put on it. I would say it is maybe 80:20 or 90:10. There are a handful of local authorities where it is still not working quite as we would hope, as Professor Ashton said, but in the majority of places directors of public health are doing some incredible stuff. As to appointments, I think 86% of local authorities now have substantive DPHs in post—the highest it has been for some time—which is an indication that local authorities are making appointments and taking the function seriously. There are loads of good examples I could cite to you. Coventry produced their local development framework a couple of weeks ago; it now has health and wellbeing peppered throughout it. There is the Wandsworth healthy estate strategy that looks at how public health supports

people living on the estates, around healthy living, air quality and a whole host of issues. There are loads of tangible examples of where it is making a difference.

Chair: Before we move on, we also had a number of positive submissions from both SOLACE and the LGA. I wondered if either—

Q8 Dr Whitford: I was coming back to that. Do you feel that public health leaders and their teams need new skills to deal with chief executives and elected members—because it is a slightly different environment—and, on the other side of that, do chief executives and elected members need new skills to lead on public health?

Dr Furber: Directors of public health have had access to system leadership training. That has been very helpful because you are right that there have been new skills required in terms of operating in a local government environment and realising the potential of being the leaders for the local system. You also asked about the position of directors of public health. It is important to differentiate between structure and function, because a DPH may report to a chief executive but functionally not be able to discharge their duties. Equally, others, like myself, do not report to a chief executive but have access to the corporate management team and the cabinet and sit on the uppermost tier of all the management groups, so I can do everything I need to do for my job. It is less about structure and more about the discharge of the functions.

Q9 Dr Whitford: Do you think there is an impact in some local governments from it being combined with the post of director of adult services? Do you think being director of adult social services is an advantage or an extra burden that distracts them from looking at wider public health?

Dr Furber: There are pros and cons and it depends on the local arrangements. I know a number of areas—Hull, for example—that have a combined DPH and DASS role that seems to work extremely well and brings the mutual benefits that I am sure were envisaged. There are a number of very good examples of where the role has been combined, so it can work well. I go back to my point that it requires the post holder to be able to functionally discharge all the responsibilities of both the DASS and the DPH.

Q10 Dr Whitford: Could I come to Councillor McShane and Mr Smith? You are looking at it slightly from the other side. How do you feel it has gone and what particular aspects do you feel maybe need to be emphasised to make it the success everyone needs it to be?

Martin Smith: The starting point is that local government, as a whole, was really enthusiastic about assuming these responsibilities. That would not be true of all the functions that local authorities assumed over the years. Local government, as a whole, saw the potential that you have already alluded to in some of your questions. I am probably with Professor Ashton in saying how well it has gone. The transition went extremely well. As to whether we are making good on the promise and the potential, the answer is variable, and that is almost inevitable when you have 152 organisations taking on this new responsibility. I try to distinguish between anecdotes, example and some stronger

evidence. If you look at the public health outcomes for the nation, the trajectory is as good as, if not slightly better than, under the previous arrangements, but it is nowhere near good enough. Health and wellbeing boards have enormous potential because they are interesting creatures that bring about in one place political leadership, professional expertise and managerial effectiveness. We know that, if you get those things working well, you see rapid change, and I can point to other examples. Equally, as a sign of maturity, there have been three or four recent studies about health and wellbeing boards one or two years on. They have all said that they realise they are variable, but they have also all said that they do not think they have yet fulfilled their potential to fulfil the systems leadership role or indeed the preventive public health role, and they are working hard to do it. That is quite positive.

The other thing I want to pick up on is the position of the DPH, which tends to be a vexed question. It has gone away slightly since the transfer. A DPH will always be a senior person in the local government structure, whether it is second or third-tier or combined or separate. I would argue that it does not really matter; they will always be a senior figure. The bigger question is where the health of the people in the locality features in the corporate strategy of the organisation. In the best authorities, you will see it fairly prominently because local government has always had a role in that, even before it assumed the public health function. Delivering on that corporate priority then leads into how effective your public health director is and how effective your overall corporate management arrangements are. It is less about where the person sits and more about to what extent the health of your residents is embedded in your overall prioritisation and strategic processes.

Q11 Dr Whitford: Do we have any validated tools for a council, whether elected members or staff, to use when making decisions? I am conscious, having worked in the NHS, that a decision gets made, an impact assessment is done and everyone realises the weaknesses of the impact assessment but the decision is already made. If you are putting up health and wellbeing, like human rights or equality or something, as something you measure every decision against, do we have tools—and this is a little more from the academic side—that people who are out in the real world making the decisions in local government can use as they are making a decision? These are not easy things to match.

Professor Ashton: No, but there has been a lot of work done over the last 20 or 30 years on health impact assessments, the work that is going on that we and the parliamentarians are involved in on health in all policies—

Dr Whitford: It is exactly that idea.

Professor Ashton: —whether that is at a national level or at a local level. That emerging work is being used on return on investment as a way of looking at complex interventions and complex outcomes. That is also relevant now with the Five Year Forward View and the vanguards on the NHS side, the return on investment of looking at joined-up systems and how they work together to deliver outcomes in different areas. The academics, some of whom are in attendance today, have a lot of experience of developing those kinds of methods.

Q12 Dr Whitford: To finish off, do you think local authorities require any additional powers to allow them to follow this line to get the result they want for their local population, around planning and licensing—these kinds of things?

Jonathan McShane: There are a number of powers. Hackney has put in a successful bid as a pilot for devolution in London, and one of our neighbouring boroughs, Haringey, has done the same: our bid includes additional powers, but their entire focus is on what some additional powers in relation to public health could achieve. That will be a good test bed. One thing we have been calling for, for some time, is a public health objective in licensing. As someone who represents a part of London with a huge night-time economy in Shoreditch, I can see the impact, in terms of crime and antisocial behaviour, of a vibrant night-time economy and can make representations on that basis, and the police can make representations; but no one is allowed to make representations about the cumulative impact of, for example, lots of off-licences on liver disease and other things that would lead to someone ending up in hospital. We realise it is difficult and there are some difficulties about attributing liver disease at some point in time with a sale in a particular off-licence, but it is not that difficult to attribute, over time, an increase in certain health conditions and a proliferation of easy-access off-licences.

Q13 Dr Whitford: This is the kind of thing I mean. Councillors are deciding about the economy, jobs and money versus future liver disease and about car access or active transport. It is about trying to have the tools to make it easier to weigh.

Professor Ashton: This whole question of legal instruments and the use of them for public health is important. One thing I am hearing from some of the local directors is that they are having to become much more interested in the legal powers that might be available to them for pursuing public health objectives. It certainly was my experience when I was starting out that a lot of the medical officers of health before 1974 had law degrees as well as medical degrees because the environment of local government for the old public health, if you will, was so much hand in glove with bylaws and local regulations and so on. There is a need both to revisit and refresh the competencies and regulations for public health and, from our responsibility, from a curriculum point of view, to make sure that future employees in local government have the competencies in law to be able to play a full part. There is a lot of discussion going on at the moment here—a bit behind the discussion in Wales and in Northern Ireland—about whether we need a new Public Health Act as a framework for public health. We are working with a public health framework in this country that is nearly 100 years old. There is a question of whether we need new public health legislation nationally to frame the powers at different levels.

Dr Whitford: Your comment about understanding the law comes back to the additional skills that directors of public health might need to move in that area. Thank you very much.

Q14 Chair: Before we move on to health and wellbeing boards, can I check whether it is the unanimous view of the panel that you would like to see public health as an objective for planning?

Jonathan McShane: If we are licensing.

Chair: Thank you.

Q15 Maggie Throup: We have already started talking about health and wellbeing boards, but I want to go into them in more depth. We have had a mixed message about how effective they are and how some are working better than others. Sorry to the people at this end of the table, but my questions are focused at Councillor McShane, Mr Smith and Professor Ashton. Do you think that they lack real power, and what would make them more effective? One of you mentioned about reaching their potential. How can they reach their potential?

Jonathan McShane: Shall I start? I am chair of a health and wellbeing board in Hackney. It is fair to say that some of the challenges that Professor Ashton outlined applied to us, certainly at the beginning. Legally, it is a committee of the council and, therefore, there are certain things we felt we had to do. We were dragging in people who represented CCGs—who were often working GPs who are used to working in a small organisation that is quite nimble and makes decisions quickly—and forcing them to sit through declarations of interests and minutes of the previous meeting and actions arising. You could see the GPs physically manifesting their frustration with this process. There was a criticism that it felt too much like a council committee. I said I did not think that was the case and thought we were trying hard, and someone pointed out that on the cover of the agenda were two photos, one of Hackney town hall and another of all the councillors on the steps of the town hall, which did not suggest that it was not a council committee. We have done some practical things like getting legal advice on what we need to do in order to discharge the various duties and not be challenged. It was then much slimmer and we developed a new visual identity for the health and wellbeing board: I thought the graphic was of DNA until one of the GPs told me it was actually brain synapses, which was an embarrassing moment in terms of my lack of scientific medical knowledge. We now meet in a neutral venue and rotate the venues. All of that has made a tiny difference.

The thing that has made the biggest difference to us is embracing the idea of becoming a devolution pilot. What that tells us about everywhere else is that, if you give health and wellbeing boards some practical projects to work on, they will really start to motor. If you say to them, “Your job is to oversee the development of the joint strategic needs assessment and a health and wellbeing strategy,” that is pretty dry stuff, particularly for people who are running hospitals, mental health services or—in the case of the CCG, the chairs certainly are—running busy general practices. It is all too high level and strategic and does not feel relevant to their day-to-day business, so it is important stuff that needs to be done. A health and wellbeing board is a good place to oversee that, but you get involved in practical work such that you start to have some of those difficult decisions about sharing risk and money and become more of a team. It becomes a much more real organisation. That would be a lesson to other places, to take on some projects. It does not need to be as full-scale as devolution but something practical that will give you the confidence that you can achieve more working together.

Martin Smith: My first point—it probably echoes what Councillor McShane said—is about tone. I cannot remember whether it was the Local Government Association or London Councils, but one of those bodies in their research into health and wellbeing boards said recently in one of their conclusions that, if you are running your health and wellbeing board like a council committee, you have got it wrong. There is a role for national representative bodies to keep sending those messages to health and wellbeing boards. It would be wrong—and I do not think you are suggesting this—to give up on them, because, in the same way as the transfer of public health to local government has huge potential, health and wellbeing boards have huge potential, but they are very young creations in the overall constitutional landscape. We need—and this is a job for people sitting at this table—to make sure that health and wellbeing boards regularly hold a mirror up to themselves, that there is a period of reflection and peer challenge against the best in class and a range of products available to do that so that health and wellbeing boards can engage in the programmes or will say, confidentially or otherwise, how you do it. As to more tangible stuff, and I do not have a concrete answer, you can see arrangements whereby perhaps—and this would raise the expectation placed on them—one might consider giving health and wellbeing boards permissive powers.

Chair, you asked a question around licensing. Perhaps you do not apply that uniformly. Perhaps you give the health and wellbeing board a permissive power to alter the licensing regime, or indeed the planning regime, as you mentioned, in a particular locality if all the players around the health and wellbeing board table agree to that. You could think of a range of things.

Q16 Maggie Throup: You mean tweak it for the locality.

Martin Smith: Yes. You would raise the ambition of health and wellbeing boards, raise a challenge and say you only get this through if you all agree. I am sure there are all sorts of obstacles to what I am saying, but you get the idea. Here is another practical example. Better Care Fund plans have to be signed off by health and wellbeing boards, for good reason, and I am not criticising it at all. One key parameter in a Better Care Fund plan is its ability to either lessen the trend or reverse non-emergency admissions into hospital. You all know better than I do the reasons for that. You could put alongside that and say, “One thing we would like to see in Better Care Fund plans is a clear explanation of how this plan also assists prevention and health outcomes rather than improvements in healthcare.” I think—it is partly Councillor McShane’s point—that if you give the health and wellbeing boards some meaningful task to do, and I do not mean that in a patronising way, that is a way of furthering the potential and establishing the relationships that are required across this sort of motley bunch of professions and different classes of people to get the whole-systems leadership that we are all entitled to.

Q17 Maggie Throup: There has been a lot of focus on the Better Care Fund within health and wellbeing boards. There is more to it than that. It is quite interesting to hear you say how you can incorporate public health into that.

Professor Ashton: The potential of boards of health and wellbeing is to provide system leadership and act as a catalyst for the transformational change that is needed. That is the

grand possibility. If you look at the interfaces, one of the weak areas at the moment is the interface with the hospital sector and the clinical end. I sit on the council of the Royal College of Physicians and on the council of the Academy of Medical Royal Colleges. I hear there is a frustration among hospital consultants that they do not really know what the boards of health and wellbeing are all about and that they would like to be engaged with them somehow, and even maybe have a consultant sit on a board of health and wellbeing. When you are looking at the kind of joined-up things that we are trying to achieve with the Five Year Forward View plan—and I am one of the clinical associates spending a day a week with the initiative with the new care model, so I was yesterday in Sunderland, for example, hearing what they are doing there—if you look at what they are trying to achieve, which really means that the housing issues sit alongside the clinical issues, care of the elderly, dementia, end of life and pathways that really cut across the sectors, the clinical sector has to be at the table as well as the housing sector. The NHS has historically been poor at talking to housing. We swap one set of difficulties for another. The whole issue of healthcare and public health comes up here as well, about having public health expertise in clinical settings, such as hospitals or mental health trusts and so on.

Chair: We are coming on to that later.

Professor Ashton: There is a connection, so I will leave that alone. I am saying here that the interfaces of the boards of health and wellbeing have to be unpacked, if we are going to get it right, to see what should be happening on each of those interfaces.

Q18 Maggie Throup: I have one last point, and can I have very short answers, otherwise the Chair is going to cut me short? Do you think that health and wellbeing boards lack power, do not use it fully or need more power?

Professor Ashton: Is that to me, or all of us?

Maggie Throup: Yes.

Professor Ashton: There needs to be an expectation. Whether that is a legal requirement or whether it is powers, there is something about an expectation.

Martin Smith: I think there is a journey. It would be very easy to say that, if health and wellbeing boards had more extensive powers, everything would be fine. I do not think it would. As they develop in their maturity, central Government have to be open to give health and wellbeing boards more powers, possibly on a differential basis to a permissive basis so that as they grow into the role we are expecting of them they have more tools available to them to make that happen. I do not think it should be an on/off switch, because that is too crude.

Julie Wood: The statutory organisations that make up health and wellbeing boards have a lot of power between them. It is how they then use that power as a collective that is important. As colleagues have said, health and wellbeing boards are on a journey. Last June ourselves, as NHS Clinical Commissioners, and the Local Government Association published “Making it better together”, which was a call to action on the future of health and wellbeing boards. That built upon workshops with LGA councillors, officers and CCG

leaders to look at how they were working. What was coming from there was some of the things that have been touched upon: the need to make the health and wellbeing boards an equal partnership across health and care to cover all services and that in a lot of places it feels, as you have heard, to be a sub-committee of the local council, and that is a bit of an anathema to some of the clinical colleagues around the table. It needs to feel as much like a sub-committee of the CCG as it does a committee of the local authority. That means doing things differently, just moving places and that sort of thing—simple, but really important symbolic gestures—as well as focusing on what they deal with. It is not just about looking at what the CCG is doing but, if we are to drive home and transform services, it is looking across the whole range of health and care, including public health, and each holding the other to account, holding a mirror up to each other for what they are doing for the health of their population that both have a collective responsibility to serve.

Dr Furber: One specific recommendation from that report is that at the moment we operate to a number of outcomes frameworks. If there was a single outcomes framework that the health and wellbeing boards were focused on, that would focus the mind.

Julie Wood: Yes, please.

Jonathan McShane: Can I add one tiny thing, which is that there is a danger—and we have done it here—that we talk about how it works for the members of the board rather than how it works for local people? We need to do much better in letting local people know there is this board that brings things together so that, if they have a problem that arises because health and social care are not joining up for them or their family, there is a place where they can get this sorted. In our board, we have allocated the first half hour in every agenda since we started to what we call a patient voice section, and our local Healthwatch supports people. The issue needs to be a general one that could be dealt with by the local hospital or a council; it needs to be an issue where the system is not working as well as it should and then the people secure commitments from very senior people in the system to come back to the next meeting with a plan of how they are going to address that. That is an effective way of making it real.

Q19 Chair: Before we move on, could you clarify this, Dr Furber? You say we need a single outcomes framework for health and wellbeing boards. Who do you feel should set that, and would there not be a danger that what might be a framework that works in a rural area might not be the same framework for a metropolitan area, do you think?

Dr Furber: Yes. There is a case for that single outcomes framework being determined locally. In Wakefield, for example, we have a Wakefield outcomes framework, which selects key outcomes that are relevant to our local population from the panoply of national outcomes frameworks that are available. That is probably a better way of doing it than some nationally imposed single outcomes framework, which, as you say, may not be applicable to every locality.

Q20 Chair: You would like to see a picking list that is evidence based. Who do you think should be responsible for setting that range of options? Who would you like to see holding the ring for setting out a range of outcomes frameworks?

Dr Furber: It is for Government to determine what their national overall strategy is but then for local areas to identify which bits are most relevant, of highest priority for them and their population.

Martin Smith: I am going to disagree with Andrew on one point. Obviously, coming from local government, we are locally orientated organisations and are relatively free to set the sort of framework that Andrew described. We have to recognise that our partners operate in a national context via the NHS, so local government would be very practical about this and say we probably recognise there are some standard outcomes that are of national significance that have to be delivered across the nation. They probably need to form part of our local outcomes framework whether we like it or not. On the second part of the question, as to who should develop it, DH should be leading that but it should be with the LGA, clinical commissioners and providers and so on. The ownership of the framework is important because if everybody has signed up to the outcomes that you are trying to achieve there is much more chance that they will work to deliver them effectively in their local places.

Professor Ashton: To follow on from Martin Smith, some things do have to be nationally determined. If you take this week's issue of the unacceptable levels of stillbirth, something like that needs to be a national requirement. Dealing with something like stillbirth is not just a question of maternity care; it is about nutrition, poverty and a lot of the things that local government has an influence over. There are things that need to be nationally given, but particularly coming into relief at the moment, with the devolution discussions, are the things that will vary from one part of the country to another. That is a debate that needs to be had, what the outcomes and indicators are that need to be given nationally and need to be determined locally.

Q21 Paula Sherriff: I would like to establish your views on some of the commissioning services. You will be aware that there has been a lot of criticism of the commissioning having failed to achieve its objectives, as being costly, not providing value for money and being little more than purchasing or contracting. What are your thoughts on that? That is for you and Dr Furber, please.

Professor Ashton: The Faculty of Public Health was very concerned about the reforms in 2013 from this point of view. The effort, time and resources dedicated to commissioning, contracting, having competition and all of that—the transactional costs—not being available for clinical activity was something we were very concerned about. The Faculty did a risk assessment at the time the Health and Social Care Bill was going through the Commons. That is an issue for us. The inequalities agenda, from our point of view, ought to be right at the top of the list. You have to remember that we were making progress on reducing inequalities with a lot of the spearhead local authorities. There is concern that the changes that have taken place over the last three or four years have been a diversion from what the primary focus should be on tackling inequalities on the whole.

Dr Furber: There are benefits and disbenefits with any way of transacting business. As to the commissioning of public health services, my perception is that, from our position in local government, it is probably now being done better than was the case previously,

where public health services were a small part of a much larger commissioning arrangement. Now public health services are relatively larger considerations within a local authority's thinking and therefore there is focus on them—sexual health might be a good example, whereby the commissioning arrangements previously were perhaps not as focused as they are now—but we operate within a legal framework that is set nationally and by Europe and that has some advantages and disadvantages.

Jonathan McShane: To build on what Andrew said, the decades of bearing the brunt of cuts is not great for local government, but the one positive to come out of that is that we have become very good at commissioning and redesigning services and trying to deliver the same or better with flat or reducing resources. We have brought some of those skills to bear in relation to the contract that we took on. We were surprised in a number of areas, and I would welcome the views of Andrew and others on this, by things like a lack of equity of access to some services across the geography of the predecessor PCT and definitely surprised at a lack of rigour, not only in initial contracting of services but the monitoring of those services going forward; it was at a completely different and poorer level than we would expect in local government. While in the first year we were very focused on a safe transition of services and valued staff into local authorities, in the last two years we have been looking at redesign. There are a number of examples I could give from Hackney, but if I look at one, which was smoking cessation services through general practice, through a redesign of that service we have moved from a 19% to a 51% quit rate in a year, and it costs the same amount of money. In that discussion, some people have said to me that that does not matter because people only get paid for providing smoking cessation services if the person has quit for a certain amount of time, so if we are bad at it, it does not matter, but, in my view, in relation to smoking cessation and a number of other health improvement activities, the scarce resource is not money or GPs; it is the willingness to quit. As a former smoker, I know that you do not want to stop every day: it might be because it is Stoptober, new year, Lent, a health problem or a health problem with a relative. On those relatively rare occasions where someone wants to make a positive health change, we need to make sure that they are able to access the service somewhere acceptable to them and that is easy to access, but also that the person delivering the service is best trained and best able to convert that desire to change into meaningful change. I am sure there will be other examples of areas where we have redesigned services and we think we are delivering the same or better outcomes but for less money.

Chair: I am keen to bring Julie in here, as a commissioner.

Julie Wood: Yes, thank you. One unintended consequence of the Act has been a more fragmented commissioning system. When thinking about public health services, we need to look for every opportunity to join that back up. Again, where you have a public health team working with the local authority and with the CCG to join back up commissioning of cross-care pathways—and that is great and what we want to see—it is important that we use every opportunity there is to make more of that so that it happens more and more. If you get alignment of that, the health and wellbeing strategy, around the health and wellbeing board and then each of the organisations that has the responsibility to commission commissions that in the right way, using the skills that colleagues have

described, hopefully you are going to have the right influence and the right impact on the health of the population.

The other point to make goes back to the previous question about accountability and the outcomes framework. We also need to make sure we line up the accountability and the responsibility for action. If we think about where CCGs are going in the year that is coming, there is going to be a new CCG improvement and assessment framework. Some of the metrics on there are around maternal smoking and childhood obesity, over which they do not directly commission now—they have no direct commissioning responsibilities—but they do have a responsibility increasingly to be in that place, so the relationship between the CCG and the local government, including public health, for how you commission to deliver on that metric is going to be important as we move forward. Getting that right is going to be critical.

Q22 Paula Sherriff: That takes me on nicely to my next question. There is fairly significant anecdotal evidence that some services, such as sexual health services, drug rehabilitation, alcohol and smoking cessation clinics, have suffered as a result of the transition of public health into the local authority. Do you agree with that conclusion? Also, there seems to be some disparity—I know Councillor McShane talked about how the services were done in Hackney—in relation to smoking cessation. Do you think there is either a north-south divide or potentially a divide in terms of rural and urban communities?

Julie Wood: It varies. I do not think it is as binary as north-south or urban-rural. It is much more variable. Again, it depends on what you were starting from, so what you inherited, and how the local authority took up, if you like, the mantle in terms of commissioning. I do not have the evidence to say, “It absolutely looks like this.” I think it is variable and the evidence from our members, when we surveyed them—it was a year ago now—was that again in some places it was working well and in other places it had some way to go. Coterminosity is an issue. If you have a single local authority and you have five or six CCGs who each will have responsibility for their section of the population, with a DPH having responsibility across the board, how you align all of that is an issue. That sometimes makes things a bit more difficult than perhaps it might be if you had a one-to-one relationship between the local authority and the CCG.

Professor Ashton: The problem with this topic is that there is a lot of opinion and not enough data. I know from my conversations with the Faculty of Sexual Health that there is huge concern among the clinicians working in sexual health about what has been going on with sexual health services all around the country: that is reports from clinicians on the ground providing the service, my data that I have second hand from them. We need proper robust data to know what is going on, particularly if you add into that chemistry the issue about funding as well. The local authorities do have a reputation as being good commissioners—that is the reputation they have—but we need to look at the data to be able to decide the case here.

Jonathan McShane: As to facts and figures on spend, the figures that the LGA have produced show that, since transition, local authorities have increased spend on sexual health—and this is across the country, so there will be differences in different places—by

1.7%, and they have increased spending on substance misuse. Again, something we hear is that there has been a lot of change in substance misuse, but there have also been significant increases in spend in some areas that did not get the focus they needed before: physical activity had a dramatic 38% increase and obesity in children 25%. To ground that practically, Hertfordshire county council report that prior to transition the PCT—and Hertfordshire is a very big county—was spending £30,000 on healthy child weight programmes and they are now spending £500,000. In the context of the cuts to public health funding and to broader local government funding that Professor Ashton has highlighted, if you are going to increase the spend to a reasonable level in something like childhood obesity, you need to re-profile your spend in other areas and it is just about how you can assure yourself that you are doing that in the right way. I am familiar with the feedback from the sexual health profession in particular, and it is always a difficult time when a new commissioner comes in and shines a light on the way that things are working and asks questions about the way things are done. That is uncomfortable and challenging for everyone and we have to make sure that we work together to ensure that the huge progress that has been made in sexual health in recent years is not lost.

Q23 Paula Sherriff: Yes. On a final note, I am aware of a clinic in Leeds, which offers support for men who are HIV positive and also offers testing and screening and such like, that may not be able to be supported going forward. Have sexual health services taken the brunt of the spending challenges?

Jonathan McShane: Andrew might have other detail. The data I have are that the spend has increased nationwide. The other thing is that, if you look at sexual health and drug and alcohol treatment, they are a significant part of a shrinking public health budget and they are also a growing part of those budgets, so we do have to do something different in both those areas in order to try to deliver the services that we have delivered to date, but recognise that there are new technologies and different ways of doing things in order to not necessarily reduce the spend but to control it in a way that does not crowd out investment in things like childhood obesity.

Martin Smith: Could I give one example that might allay Ms Sherriff's concerns? It is not in Leeds: it is in London. The issues around the importance of sexual health, some of the challenges around fragmentation of commissioning and the need to improve outcomes quite considerably, are well recognised by local authorities who have inherited this function. In London, we are about halfway through a major sexual health transformation project—it would have a title like that, wouldn't it—but, in essence, it is about more or less all of the boroughs coming together to combine their sexual health commissioning power to try to introduce things that, prior to the transfer, had been talked about for some time but had not reached the implementation stage, including an integrated tariff for sexual health, which I think clinicians had been asking for—I am not a clinician so I cannot comment particularly on that—and improving access to sexual health services with a view to improving the sexual health of Londoners more generally. So some of the challenges you have talked about are being recognised and worked on. My one moderate caveat to that is that it will involve change and a different mix of service provision to the one we have at the moment.

Paula Sherriff: I applaud that but wonder how that would work outside London, given the geography. Thank you.

Q24 Andrew Percy: My question is to Julie. I represent a constituency that is in two different counties, so I had two different PCTs before who did things wildly differently. I now have two different CCGs and a whole set of differences. On the issue of variability of services, do you think, under the new regime, variability is getting less or greater across the country?

Julie Wood: Are you talking specifically about public health?

Andrew Percy: I am talking about public health, yes.

Julie Wood: The honest answer is that I do not know. I do not think we have data from our members to show what is happening out there. Again, CCGs, working with their health and wellbeing boards, will have built up relationships with their public health colleagues. Where you have a one-to-one relationship, the same people and the same geography, the relationships have probably been there for quite some time and they are probably able to move faster than others where you have had a movement from a much smaller PCT and local authority to something that is much bigger. So we will see the variability. As to whether it has got worse in what they are able to achieve, I do not know; I do not have the answer to that. I do not know whether Andrew has anything from the data from the recent survey he was talking about.

Dr Furber: No. It is difficult to judge whether variability has got any better or worse. It is important to remember that all was not rosy back in PCT days. There were plenty of PCTs that would take funds from public health budgets or cut public health posts and so on, so it is not as if they were halcyon days back before 2013. As to whether it has got better or worse, I do not have data to answer your question.

Q25 Andrew Percy: When I used to go and see the PCTs, they never briefed me on public health; the local authority does. My second question was to Jonathan on the declining public health grant for local authorities. What is your perception of how local authorities have dealt with that? One of mine—they are both run by the same party, so it is not a political point—complains like heck about it; the other one is supremely relaxed about it because they have said it is all about doing things differently. They think they are getting outcomes with less money and are able to levy other funding from within the local authority. How important do you think this issue of the overall public health grant is, and is there a lot of evidence of councils starting to think, “We do that as a core function anyway, so that is a public health element of what we were doing already,” which is what one of my local authorities has said to me?

Jonathan McShane: There are lots of aspects to public health funding, but there are two important points that might relate to why there is a different reaction from the two counties, though I do not know which counties they are. On transition, the variance between spend per head in the highest and lowest councils in the country was 6.8 times. I appreciate there will be different need—a different need in Wokingham than there is in Hackney—but 6.8 times cannot be right, and that echoes Andrew’s point that there were

some PCTs that normally, not because they did not care about public health but because there were pressures in other parts of the health economy, were not investing in public health, and the funding has always been based on what the PCT spent in its last year, which, though it is an easy way of doing it, never struck me as particularly satisfactory. It may be that their baseline funding was better in one place than the other and therefore they were better able to cope.

Andrew Percy: Yes.

Jonathan McShane: As to the reductions, they are incredibly challenging because they come alongside difficult cuts in broader local government budgets. In particular, the £200 million cut in year is very challenging. In-year cuts are just bad behaviour; it is not the right way to do business and sends out all sorts of wrong signals. When you have an in-year cut that you have to deliver in year, you cut what you are legally able to cut and you cut what it is easy to cut in an administrative sense. You do not make a rational decision about, “With these different resources, what should we do?”

Having lots of prior knowledge of what your budget is going to be, having multi-year assessments, is really helpful, and in that context the fact that councils still do not have their public health budget allocations for 2016-17—we are now told they will be issued on Thursday—is not acceptable. We are not expecting any big surprises, but until we know for definite with central Government funding it is very difficult to make commitments. That is difficult and annoying for us, but for the voluntary sector organisations in particular that we fund, who maybe have to talk about redundancy with their staff, the later this gets, you are causing practical difficulties to organisations. I can understand why there is a difference in the reaction. Ultimately, we will all get on with this and deal with the hand we are dealt, but one challenge is that—at the very beginning Martin said local government was really enthusiastic about this, and I think we were, and when we take on new responsibilities we take them seriously and aim to do them really well—funding decisions have dampened our enthusiasm a little because we have so much on our plate that there is a limited amount of headspace to focus on everything. That is probably the real tragedy of the way that funding decisions have been made around public health.

Professor Ashton: To follow on from Jonathan, the situation is, as he says, that before the changes there was huge variation in levels of funding and we were looking to have that equalised to some extent. It looks as though some of the parts of the country that have the biggest challenges are going to be the most affected by the funding changes. At one level, it is irrational to cut the prevention budget when we are expecting so much of the overall healthcare system to reduce demand on hospitals and to close beds and all the other things that need to be done. The written evidence that you have, not just from ourselves but from the Academy of Medical Royal Colleges, has really impressed on me—and attending those kinds of meetings—how strongly clinicians from all the colleges feel about this, including the surgeons and so on: they feel that cutting back on prevention in public health is crazy in this present context. On the other hand, there is a lot of opinion about this, and again there is not much data. Are we going to be asked about intelligence, because I think the intelligence side of this whole story is very important? Is this the time to say something about that or will it be later?

Chair: If you would like to say something, do.

Professor Ashton: From both sides, we are now hearing there is a problem about flow of information. We are hearing from directors of public health sitting in local authorities that they cannot get clinical data. We are hearing from clinicians in clinical commissioning groups that they cannot get access to local authority data, and that may be because they are not properly connected to the boards of health and wellbeing, or whatever. There are issues of information governance, of confidentiality, that are getting in the way. Again, I heard yesterday in Sunderland with the vanguard there about the problems of data and information flows across the system. Whether the Caldicott review will have any bearing on this—it is coming shortly—I do not know. Also, part of that story is what has happened to the observatories. We had a national system of regional observatories that was set up after 1999—they were developed on the model of the one I personally set up on Merseyside in the late 1980s—which were very locally facing. They provided local intelligence to local health authorities and primary care groups and trusts. Since 2013, they have essentially been nationalised. They have become part of a national intelligence organisation that is part of Public Health England. The ability to provide locally honed intelligence to the local system has changed. That whole question about what kind of intelligence we need and what is fit for purpose is at the heart of this. Without good local intelligence, you do not know what is going on. We need good local intelligence.

Q26 Andrew Percy: Can I ask a question on that? I understand what you are saying, but what is missing now that was there before? When I meet with my public health people, they have never raised with me the issue of access to data or other metrics in the area. What is missing that they would previously have had access to?

Professor Ashton: You need to ask Andrew Furber about this because he can speak for the directors of public health. When I was a director of public health, I used to be able to get all sorts of local special reports done. When I was working for Cumbria, I commissioned an audit of all the perinatal deaths over a two-year period and these kinds of things, and what was going on in A&E locally. I was able to commission all kinds of reports from the local observatory. My sense is that is not what is happening any more, but I may be wrong on that.

Q27 Andrew Percy: Surely all of that data are still collected and are all still available. If anything, they are collecting more data.

Professor Ashton: The observatories initially were developed with a very local focus. Even during the previous iteration before 2010, they were beginning to be centralised, but after 2010 they have become very centralised.

Chair: We are going to come on in more detail to the specific issue of data in a minute, but Ben wanted to come in after Paula.

Mr Bradshaw: I would like to hear what Dr Furber has to say about the data issue because it is pretty essential. It seems to me that there is an absence of consensus on anything. We have already seen disagreements among the panel about how this new landscape is delivering; it is partly because there does not seem to be any reliable data.

Q28 Chair: There is also the issue of data sharing, that you are now not allowed to access NHS data as well. It may be we should address that point to Andrew.

Dr Furber: It is an information governance issue. The data are collected, but now we are in local government we are not allowed access to the data in the way we were on 31 March 2013 when we were sitting in and badged as the NHS. It is a frustration for every local authority; it is a frustration for Public Health England that do not have the access that would be helpful for them to discharge some of the functions that John mentioned in terms of the old observatory role. It is a real impediment. These information governance arrangements need to catch up with the way that health and social care services work now because it is all about integrated working. For example, my team was asked to evaluate a care-home vanguard, which is the local authority and the NHS working together to deliver better outcomes for the residents of those care homes, but my team cannot access the data because they are deemed NHS data. We are probably going to have to find a workaround, which will take somewhere between four and six months, so it delays getting those data and knowing whether what we are doing is effective or not.

Q29 Chair: Specifically on the issue of data sharing and discussions you have had with Dame Fiona Caldicott on this—because I understand she has been very clear that, when it is in the patient’s best interest to share data, that should be the default position—who is telling you that you cannot share these data and what measures are being taken to try and overcome that?

Dr Furber: We have raised our concerns with Public Health England and they have taken these forward on our behalf, so I do not like to speak to them to know who they have spoken to, whether they have spoken to Dame Caldicott or not, but certainly I know they have been in discussion with the HSCIC and there are some issues there. There are some issues with local Caldicott Guardians and their understanding of their interpretation of the rules.

Q30 Chair: When you request the data, who is telling you that you cannot have them?

Dr Furber: It varies, depending on who you ask, but on the last request it was the local Caldicott Guardian that was advised that they were not able to share them with us.

Q31 Mr Bradshaw: These are the questions that we can and will pursue with Public Health England when we have them in for their evidence session. I completely appreciate there will be different views as to how the system is working depending on whether you are in local government or are an experienced professional public health expert, but on simple matters of fact, unless I misheard, we were given quite different figures from Dr Furber and Professor Ashton as to how many directors of public health there are or what proportion of local government have them in place. I do not know whether you want to repeat your respective figures, but yours was 80% or 90% and the other was a lot lower than that.

Professor Ashton: The figure that is being quoted at the moment is that 86% of directors of public health are in place compared with 84% before 2013. That is the figure that I have read this last few days.

Dr Furber: The current figure is certainly 86%.

Q32 Mr Bradshaw: Given the problem with data, Martin Smith, I was very struck by something you said earlier, where you thought that the local or the new landscape was already delivering slightly better outcomes. How on earth can you already quantify that or tell that so early in?

Martin Smith: This is Public Health England data. Public Health England do track health outcomes at a high level for the aspects of population health.

Q33 Mr Bradshaw: It is already possible to detect the impact of this landscape change. We can ask Public Health England that, but do you want to elaborate on the statement you made?

Martin Smith: I suppose the challenge with all these things is attributing changes in data to particular aspects of how the system is working. I think I am right in saying—but you probably should check with Public Health England—that, if you look at a national level at what has happened to public health outcomes, they have continued to improve where they were improving before, so the trajectory is on the same line. Those that have deteriorated have tended to continue to deteriorate—there is some slight change in the trajectory—but, broadly speaking, there is a positive direction of travel in public health outcomes at a national level.

Q34 Mr Bradshaw: But that was going on anyway.

Martin Smith: It was going on anyway, yes. I am not claiming that, as a consequence of transfer, we have seen massive improvement; it is far too early to say because of data lag.

Professor Ashton: Again, at the national level, we should have the data on life expectancy very soon. I do not know when you are seeing Public Health England, but presumably that is a conversation for them.

Q35 Mr Bradshaw: Yes. We are storing up lots of questions for Public Health England and for the Minister; do not worry.

Martin Smith: What one can point to at local authority level—and Councillor McShane made a reference to health checks—is where you have seen a particular intervention or a change in commissioning lead to some improvement locally, and there will be a plethora of examples, but I do not know what the aggregated total of those might be.

Q36 Mr Bradshaw: I want to return briefly to the area we covered a little earlier about how good the new system is in interacting with clinical services, particularly around sexual health, because we have had an absolute plethora of evidence from professionals and

users of sexual health services and alcohol and drug services that have not been positive and yet we hear a very positive story from, admittedly, a very good forward vanguard-type local authority as to how it is going there. Can you help the Committee find its way through this? How are we going to make a judgment at the end of this inquiry as to how things are going? All we seem to have at the moment is anecdotal evidence, which is completely contradictory to it.

Professor Ashton: I think you are right. My previous boss in Cumbria used to say, “In God we trust. Everybody else must bring data.” The problem with this whole area is that there is so much opinion around. The very basis of public health is data and we need the data, reliable data, transformed into intelligence, to be able to draw any conclusions. That is my primary concern.

Mr Bradshaw: I think I feel a title for our report coming on, Chair.

Chair: I think you are right. Did that complete all of your questions for this section?

Mr Bradshaw: Yes—on to the next lot; let us keep going.

Q37 Chair: Can I come on to the area of health protection? One area that the public would want to be reassured about is that in the event of a public health emergency, or in a new emerging threat, the system would be able to respond to that. We have been hearing in some of our evidence that that has become more fragmented. I wonder, perhaps starting with Professor Ashton, if you could set out what the concerns are in this area.

Professor Ashton: How long do you have? This is the problem. I was regional director of public health in the north-west for 13 years, and on my watch we had several IRA bombs, the big Legionella outbreak at Barrow, the mass shootings and floods. We had everything. In that time, it came to be necessary to build on our capacity for public health protection within the local level because the HPA, as was, was not able to respond quickly enough to these sort of things when they happened. When you have a major incident, a major emergency, for the first few, 24 or 48 hours, it is the local people who have to deal with things. That is the way it is. If you are going to have resilience, then you need to have the generic capacity on the ground in your local system locally. In the north-west we used to insist that everybody was on the duty rota and that they were up to date with their “safe on call” and so on. Since 2013, a lot of that has changed. The duty rotas are now run out of Public Health England through the centres, and the centres have been halved in number so that there is quite a big gap between the centre in London—soon to be Harlow—and the local people in the local authority areas. This is a bigger issue about the regional level of everything, of the health service and so on as well.

From a public health and health protection issue and resilience in the case of an emergency, whether it is pandemic flu needing all hands to the pump, or a bioterrorist incident—and we had a lot of those in my region after 11 September, a lot of white-powder incidents and things that we had to respond to locally—there are big questions now about the resilience of the system. These are questions about the maintenance of skills, the parcelling out of skills, with more medical skills being concentrated in Public Health England, the more social health promotion skills, policy intersectoral skills in the local authorities, and what are the public health skills to be found in the health service

itself, which is seen to be a gap, particularly considering Mid Staffordshire and Morecambe Bay and the recognised need to have people within those organisations who can understand the data, again, and see when things are going amiss, or awry, and when there is an issue that needs to be investigated.

Q38 Chair: On that point around data sharing, would it be much more difficult for a local area to know even if there was an emerging threat in their area if there is an issue with data sharing? Who is holding the ring for recognising that, say, there is a new emerging threat? We know, for example, there was a bit of a delay before people realised that the flu vaccine was not effective last winter. Is that something you think was partly because of a lack of data sharing, an awareness of local trends?

Professor Ashton: I find that difficult to answer. You probably need to ask people who are currently active at that local director level. I would mention one example of something I was involved with. Every winter in the meningitis season in Cumbria, we had an increase in the number of meningitis cases in a particular set of neighbourhoods, which I became aware of because of our very local close-to-the-ground capacity and monitoring and having somebody in my team up there who was a health protection person. In the end, with quite a bit of difficulty, we persuaded the Health Protection Agency, as was, to put a bit of manpower into investigating this in quite a sophisticated way about the contacts between the families in the neighbourhoods and the intimacy of the thing. That very fine-grain epidemiology is something you need to have a capacity locally to be aware of. If you are distant from the situation with your capacity, if it is all concentrated in Manchester, Liverpool, Leeds or wherever, you do not have that degree of awareness of what is going on in your communities.

Q39 Chair: Dr Furber, do you want to come in on that?

Dr Furber: In establishing any large organisation like PHE, there is always going to be an inevitable impact on its functions. As some of these areas were affected, so there were a number of vacancies within the system and the systems took a little time to become established. Last year, for example, the flu vaccination coverage was very slow coming out, which meant it was difficult to chase up practices that were perhaps underperforming. We encouraged them to put on extra sessions, or whatever. This year, however, it has been a bit better. They are improving and systems are getting better, but there are still some areas where there is a lack of clarity. For example, there was an outbreak of hepatitis A in Leeds last year where there was some confusion as to where roles and responsibilities lay. At the end of the day, these things need to be responded to and the director of public health agreed to underwrite it and sort it all out afterwards, but it was only because of that that the response was able to move ahead. So there are still areas that need further clarity as to who is responsible for what, but Public Health England are improving their capacity and capability around some of these health protection issues.

Q40 Chair: Having identified the problem in Leeds, is that now something, nationwide, where areas are looking at their response planning and those lines of accountability?

Dr Furber: Yes. There is learning from all these incidents that is fed up centrally. I have met with Paul Cosford, the medical director of Public Health England, on a couple of occasions, and he has agreed to set up some table-top exercises to test some of these issues out in a role-play type of way to see what learning there might be.

Chair: Thank you.

Professor Ashton: On that, something that is very odd, I think, is that there is not a routine system in this country for capturing the learning from major incidents. I mentioned some of the things I have been involved with over the years, and it always struck me that there was no format that captured that information and logged it as a library. When we had the mass shootings in Cumbria, I was fortunate enough to be at a meeting sitting next to the American expert on mass shootings and was able to play in about it, but in trying to find out what to expect in the aftermath, when we defined it as a mental health emergency after the immediate thing that went on for over a year, dealing with the first responders and the bystanders who were susceptible to post-traumatic stress and so on, the only reference point we had was the major reports into Hungerford and Dunblane. There was no proper logging and recording place that you could go to online and find out what to do if you ever got one of these situations. That is the same for major incidents. It seems to me to be a huge gap that we do not automatically have a team, or whatever, that goes in and captures the learning, formats it, and puts it online and so on. I just mention that; it is a very specific thing.

Q41 Chair: Thank you. Coming on to the issue of immunisation, we have already touched on the issue around data sharing, but I understand there is a particular problem with data sharing around immunisation. Is that something that concerns any members of the panel?

Dr Furber: Everybody is looking at me. It is just part, I think, of that wider issue of access to clinical data that I described earlier. Fundamentally, it is an information governance issue. We work very closely with the screening immunisation leads, who are Public Health England people but are embedded within NHS England, and local areas are increasingly developing improvement plans. We have one within Wakefield, for example, which identifies key improvement priorities. It is a bit of a workaround, if you like, so that we no longer have direct access to the data. One could argue that it is not our function any more, that it is a function of NHS England, but inevitably we are on the ground, we understand the local context and want to see these things improved. That is how it is working out in local areas.

Q42 Chair: Thank you. Finally, we move on to screening. Are there any comments about screening since the changes under the Act that anyone wants to comment on?

Professor Ashton: I have a very specific thing on immunisation. For my sins, I have been involved in the last two or three years in working with the Boarding Schools' Association on issues to do with child health in boarding schools and colleges. There are weaknesses

there that you might wish to address in the relationship between the NHS and boarding school establishments. There are 500,000 children in the UK in boarding school settings. As to the protocols for admission, a lot of these children come from overseas and there are real weaknesses about knowing what immunisations they have had before they come and then about knowing what happens if there is an outbreak in those settings. It has been an issue particularly with regard to mumps in some places, and so on, but the boarding schools are not on the radar. The relationships with the local NHS teams are not necessarily very good, so there is an issue.

Q43 Chair: Thank you. On the wider issue, going on to screening, we have heard some evidence around concerns about fragmentation in screening programmes. Is that anything that any of the panel wants to comment on?

Dr Furber: It goes back to looking at outcomes or, in this case, coverage or uptake of both screening and immunisations. The trajectory of the coverage before 2013 is largely unchanged. That would indicate that, if there is any fragmentation in the system, it is not particularly affecting uptake. There is maybe more potential from the system that could be realised. Local government has elected members who are figures within their local areas and could be champions for screening and immunisation, and encouraging local populations. This may be a case where local government is not involved enough and there might be an argument for local authorities being champions for improving uptake on screening immunisation.

Q44 Chair: We did have some evidence that looked at a fall in the uptake of cervical screening in some areas following the changes. Is that something that concerns you?

Dr Furber: That has been my understanding, but please confirm with Public Health England and those who collate the data that it is part of a longer-term trend that the uptake of cervical screening has been going down for some years now.

Professor Ashton: I could have answered that question before 2013 or 2010 from a regional point of view, probably, but now it is the responsibility of Public Health England.

Chair: We will raise that with them. Thank you for clarifying that.

Q45 Emma Reynolds: Councillor McShane has already talked about the in-year cuts to public health budgets for local authorities. Could you or the others say something more about the cuts to the ring-fenced public health budget that are coming up but also the impact on services at the removal of the ring fence in 2018 and what the impact on services and outcomes might be in your area and in others?

Jonathan McShane: There is a linked issue with all of those. The big mistake would be if you moved the approach to public health that was taken in the PCT into local government and it just sat somewhere else. There needs to be a benefit and the benefit has to be recognising the role that local authorities have in relation to the wider determinants of health, probably a better understanding of, and links to, local communities than the NHS was able to develop. How do you make the most of that? The danger of focusing either on the ring fence or the amount of what is a relatively small public health budget within a

council is that you lose focus on the wider benefits. That is probably all you can say on that. Other than that, it is incredibly difficult. It is the point I made to Mr Percy earlier that a lot depends on where you started from. If you started from a relatively low base, in terms of your public health grant, then things like drug and alcohol treatment, sexual health and mandated services that you have to provide are going to take up a big chunk already, which means that the scope for upstream interventions is already limited, and then when you are 3.9% every year for four years the danger is you end up with a budget that simply is not able to allow you to fulfil the ambitions you have for your local area.

Chair: Before we go any further, unfortunately, there is a Division in the House, so we are going to take a short break and be back.

Sitting suspended for a Division in the House.

On resuming—

Chair: I am sorry for the break. We are going to return to Emma's questioning.

Q46 Emma Reynolds: I do not know whether you had finished, Councillor McShane, and whether we want to pick it up.

Jonathan McShane: I was answering the question about funding. The point I wanted to make was that if you started from quite a low base, as a number of places did because of this 6.8-fold difference in funding per head, then the wriggle room when you have an in-year cut and then these other cuts means that some of the stuff we all want to be doing, which is the upstream prevention stuff, gets squeezed out by things like treatment of drug and alcohol problems or sexual health services. That does not feel sustainable in the long run. That leads into the proposal around business rates retention and what that might mean going forward. That is a slightly different issue. The other thing I would add is that the frustration for local government is knowing—particularly in relation to sexual health, but in other areas too—that some of our biggest contracts are with the NHS. So when we hear that NHS funding is being protected and this is something slightly different that the public do not need to worry about, this is absolutely in year, and then there are subsequent cuts to our local hospitals and our local community providers, with all the tension and issues that creates going forward, so—

Q47 Emma Reynolds: Notwithstanding the different starting points for you in Hackney and in terms of colleagues in other parts of local government as well, what is your prediction as to what these cuts will be, because the prevention agenda is very much part of the Five Year Forward View? They talk about a radical upgrade of prevention and public health, which is to be welcomed, but it seems to me that the decisions regarding funding in this area are going in a different direction.

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

Q48 Emma Reynolds: I would welcome other views as well, but, before I do that, maybe I can also press you on this. I am an MP in Wolverhampton and am concerned about the proposed move from the public health programmes to be funded by our business rates because, frankly, our business rate return is not great—it is all right, but it is not very good compared with other local authorities—and we have significant levels of deprivation. What is your view on this proposed move? I would welcome Mr Smith's and other responses to just the general funding questions as well.

Jonathan McShane: On business rates, the LGA wants to work with the Government to make sure this works effectively so that you are incentivising boroughs to attract inward investment. The LGA recognises that that is a good thing but that, if you were to take a public health approach to this, you are not doing anything that means the areas that most need investment in prevention lose their funding. There needs to be an effective system of equalisation and we want to work with Government at pace to try and get to a situation that addresses the sorts of issues that would arise in Wolverhampton and in lots of other parts of the country.

Q49 Chair: Can I ask one quick supplementary on that? Do you think there is a danger that, because of that, in some areas there will be more of a pressure to encourage businesses that might be profitable but will not necessarily be for the good of the public health?

Jonathan McShane: I know that at the moment, as a ward councillor in an area with a lot of night-time economy, frequently the challenge we get is, "You are only allowing this licence so you get the business rates," and we have to explain to them that is not how business rates work. It would be a very difficult conversation where we have these competing pressures, so that is another important consideration. It feels like this is a direction of travel we are definitely going in, so the LGA's focus in the first instance is on trying to ensure that we have a mechanism in place to ensure that areas, whether it is Wolverhampton, Hull or others, are not disadvantaged.

Professor Ashton: Of course, we saw a version of that in the 1990s, probably, with the alcohol-based regeneration of northern cities where we got a high density of drinking outlets in city centres because they were desperate to have any kind of economy. That is a hint of the kind of thing that can happen if you are so desperate to have economic activity

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

The other thing worth thinking about is that when some services are provided by local authorities, as opposed to the health service, the question of people's values comes in. I am thinking particularly about sexual health services. Again, in the old days, before 1974, it was often contested at local government level about providing family planning services. You had whole local authorities that were set against providing family planning services. It took some very articulate and persuasive medical officers of health to settle it—sometimes quite devious, actually. Andrew Semple in Liverpool dressed them up as mother-and-baby clinics and provided contraceptive services to the working-class women of Liverpool because he said he did not see why they should not have the same services that the middle-class women in Liverpool had, which they got elsewhere—that whole issue about the value side. You see it in America a lot with abortion services.

If there are not national requirements and standards and so on, that is one issue, but it also raises the issue of having local directors of public health who are able to comment on things and who have the freedom of expression, the independent voice and who are not subordinated to the corporate will. This is difficult territory. We had this in the health service for many years after public health came across to the health service: the directors of public health were told and expected to be corporate players, to not rock the boat and not raise difficult questions. Over the years, those of us who belonged to that generation managed to negotiate space to say and do things that we felt were imperative. We are in that situation now with local authorities, as to whether all local directors of public health will have that freedom to say unpopular things or to push for things that are in the public health interest but may not necessarily be in the local electorate agenda.

Chair: Julie Wood wants to come in and Martin Smith.

Julie Wood: On the funding issue, CCGs were concerned, for the reasons we have talked about earlier, about the in-year reduction in budgets and the differential impact that that would have. I certainly applaud the Five Year Forward View's emphasis on prevention but again reinforce the point that the requirements for the £22 billion and £8 billion were on the back of no cuts to social care and no further cuts to public health, so there is a real concern. For that reason, from a CCG perspective, they are keen that the ring fence should continue longer and would support the NAO view, which is, in order to minimise the risk of public health funding moving away, we need to protect the ring fence for longer, not least because of the very broad definition of prescribed and non-prescribed public health services that is laid out. Some of your comments about sexual health services may arise because some services are in the prescribed list and some are in the non-prescribed list. There is a lot you can do that sits within that non-prescribed list and you can move funding

around without changing the ring fence. For those reasons, we would want to keep the ring fence going.

Martin Smith: I have a slight variation from Julie's line on one point, which will become apparent. My starting point is the SOLACE view, which I think is shared by everybody. If you look at the whole picture, the current model of public service provision is unsustainable, with a decade of austerity, which is why we spent lots of time talking about integration and whole-systems leadership. We need somehow to secure a shift to outcomes in favour of services, to people-centred services rather than institutions and particular functions of organisations, and we need to build independence and resilience rather than simply meet need; otherwise we will simply run out of money. I am a practitioner so I have to deal with that equation on a day-to-day basis. The cuts to the public health grant—it was touched on before—were particularly galling for two reasons. One is the symbolism of it. If we are serious about what is being said in the Five Year Forward View, why would you do that? It does not seem to tally, so there is an incoherence to it. Secondly, of course, it betrayed in a way an approach that is basing funding decisions, which the Government have every right to make, on institutions, not on outcomes, because if public health had been in the NHS, it would have been protected. That seems just wrong, I suppose.

On the question of the ring fence, there can be good reasons for having ring-fenced funding. Some of those are to do with transition and some might be tactical. This may be where I am slightly at odds with Julie, but, in the long term, ring-fenced funds are always a bad thing because they tend to encourage the silos that we are trying to break down. You can see why in the short term you might want them, that you might want to do particular things with a bit of protection, and, as regards the local government perspective, it says if the public health ring fence gets preferential treatment in overall funding settlements we need to keep it. I could point to various sorts of ring-fence funding whereby you will find that over a period of time the ring fence leads to a lot of wasted activity because people build a performance-monitoring regime around the ring fence and people game the ring fence, and all that sort of thing that John has described, to try and do things within or without it. Therefore, you waste a lot of management effort and capacity doing it. In the longer term, it is a much better system to have the aggregation and agglomeration of funds to a local place and ask the local players to make the difficult judgments about how those funds are distributed between the various bits of public service to achieve the best outcomes.

Q50 Mr Bradshaw: Could the other witnesses respond to Professor Ashton's concern that, under the new landscape, public health directors who are subjugated to council chief officers and others, potentially, will not have the confidence, licence or authority to speak uncomfortable truths unto power? What is the evidence so far?

Jonathan McShane: As a chief executive, you are probably very familiar with this, but certainly from my perspective I know that there are a number of senior officers who, as well as their day-to-day role, have specific powers and abilities to raise concerns, the finance director being the most decisive one. Finance directors very rarely would go public about the behaviour or the proposals of members, but I imagine on a daily basis

they give some quiet advice such as, “This is probably not a terribly good proposal.” It is about that balance between the quiet advice and the incredibly rare occasions where you would have to speak in public. I would certainly want a director of public health to feel they could do that, but it would be—I do not know what John would think—a very rare occurrence, and a director of public health who has built up the confidence of the other senior people within that organisation would be able to have those quiet conversations on a regular basis about sharing his or her views on the wisdom of certain courses of action. That strikes me as the way a functioning organisation should operate.

Martin Smith: To amplify that a bit, there is a range of senior officers in a local authority with statutory responsibilities who are almost outwith their employment relationship with the council. I am one of those as head of the council; the finance officer would be another one, the director of children’s services, the director of adult social services, and so on. We are pretty used to giving clear advice to politicians about what the impact of their potential direction might be and our view of how that should happen. That is part of the day-to-day job, and in the best places that works well and in the worst places it works badly. Where it normally works badly, you see it because it will be in the papers or the trade press.

The other aspect, I would say, is this, and it comes down to innovation. I was interested in the example that John gave about the director of public health providing contraception in a roundabout way. One of the reasons that local government has sustained the level of funding cuts so far is because of its ability to innovate and do things in a different way, which requires professionals to help politicians make the different decisions they need to make and run services in a different way. That requires professionals to not be shy about saying what they think about the way services are run and the way to achieve better outcomes with less money.

Professor Ashton: This is a very important issue as far as I am concerned. Looking at the history of public health in this country, the independent voice of medical officers of health was fought for over many decades in the 19th century, as was the independence of the annual report that the medical officers of health produced to the annual meeting of the full council with the press present. It was the opportunity for them to hold up a mirror to the local authority in the same way as a district auditor would over the finances. The report could not be interfered with by anybody else. At this present time, I have no idea how many of our local directors of public health are in that position, but one hears that in many cases they do not have access to the media except through the communications office and so on. I am concerned about that. It needs clarifying and needs a focus on it.

A litmus test, I suppose, for innovation might be the sort of thing that we did in Liverpool in 1986, which was to establish the first large-scale syringe exchange programme in the world, which was very controversial. If you read the recent book by the Secretary of State for Health at the time in a Conservative Government about the battles that were fought to put those advertisements on television, you will realise how politically difficult it was to do the sort of thing we did in Liverpool with the regional health authority, with the support of the chairman, Sir Donald Wilson. If we were back in the 1980s, with AIDS just on the horizon, an epidemic of heroin injection and high youth unemployment, which is what we faced in Liverpool at that time, would a local authority public health director today be able

to do that when it was so controversial and when you would see the battle lines drawn up? Somehow there needs to be the space for directors of public health acting professionally on evidence, as far as possible, to do that kind of thing.

Q51 Mr Bradshaw: An equivalent today would be a public health director being very outspoken about the folly of car culture and the car's dominance of our urban areas in terms of public health impacts, but I do not seem to hear directors of public health in my area or anywhere else banging on about walking and cycling, countering the inexorable economic development idea that this all has to be about the car. I do not know whether any of you want to comment on that.

Professor Ashton: I do not know whether that is a good example, but what might be is if London decides to have Formula 1 racing in central London, which is what they are talking about at the moment, and whether the local directors would speak against it.

Dr Furber: The director of public health role has always required the balance of corporate accountability with that independent voice. It was the same in PCT days; it is the same in local authority days. Our members have not particularly raised with us a concern that they are not able to give that independent voice to any public health issues that might be relevant to their local population, and indeed all of them now are producing independent annual public health reports, which local authorities are required to publish. A number of them do relate to climate change and physical activity—walking, not reliance on the car—and we collate those; we are very happy to forward examples of those to the Committee.

Mr Bradshaw: That would be helpful, because at the national level you have Dame Sally Davies coming out with stuff that is completely against what the Health Secretary is saying on things like the sugar tax and it would be quite reassuring to have examples of that at a local level, where you have directors of public health standing up to their local politicians on an issue.

Q52 Emma Reynolds: Following on from that, we are not entirely sure what the Government are going to say on a sugary drinks tax, which is something that our Committee put forward in a recent report. Related to that, has anybody any strong views on whether fiscal measures in helping to fund more prevention, whether it is on tobacco, alcohol, sugary drinks or anything else, could be used?

Professor Ashton: The Faculty position is that a sugar tax would be used for preventive work.

Emma Reynolds: That is the Committee's view as well.

Dr Furber: Similarly, the Association of Directors of Public Health believes that some of those fiscal measures are important and would contribute to funding some of the preventive measures that we have spoken about this afternoon. They are not silver bullets: they need to be part of a comprehensive approach, so sugar tax is a good example. On its own, it will not cure childhood obesity; it needs to be part of a range of measures, but it is totemic and is of itself of value.

Q53 Chair: Do other members of the panel support these kind of fiscal measures?

Jonathan McShane: Certainly the Public Health System Group—I am wearing two hats—in our evidence talked about a sugar tax and about the proposed levy on tobacco manufacturers. I know the LGA has previously talked about the VAT element on sugar-sweetened drinks, for example. In all those cases—I do not know what the other panellists think—what is done with the money is important. Certainly there is a strong view that that money should be spent on other preventive measures against the harms that are caused by those products, whether it is alcohol, tobacco or sugar.

Julie Wood: We would support, obviously, an obesity strategy and I think, like Councillor McShane is saying, it is about what you do with any income that comes from that, to then reinvest it in preventive measures. It is critically important.

Chair: Thank you. That is helpful. We come on next to Ben.

Q54 Mr Bradshaw: How concerned are you about the impact of the Government's abolition of the cross-departmental Cabinet Sub-Committee on Public Health on the overall national strategic drive on public health—Professor Ashton perhaps?

Professor Ashton: We are concerned. Of the Lansley reforms, two of the strong positive things were that and the boards of health and wellbeing, because the joining up at a national and local level is so essential to public health. It really is a pity that that has gone.

Q55 Mr Bradshaw: Who is doing the joining up at national level now? Who is providing the systemic—

Professor Ashton: I do not know. All I can tell you is that when Liam Donaldson was chief medical officer—as chief medical officer to Government and within that to each Government Department, it is an almost impossible job for a chief medical officer to do that—for a period, the regional directors of public health, of which I was one, and there were nine of us, persuaded Liam that it would be a good idea if each of us took on a different Government Department to link to. I linked to the Department for Work and Pensions, for instance. As a line managed by Liam, we were able to link into those other Government Departments as a regional director but with national responsibility. That was another way of coming at it. It did not survive many years because of change of Government and so on, but that was one way. There do need to be mechanisms to join up policy.

Q56 Mr Bradshaw: Martin and Jonathan, you have talked about the value of being able to join up policy at local government level with your new responsibilities for public health, but your jobs are also impacted by the lack or absence of cross-departmental thinking at Whitehall level. I do not know whether that is something you would like to say something about.

Jonathan McShane: One of the examples we always think of that relates to public health is around physical activity, where there are—I cannot remember how many it is—numerous Government Departments with separate funding streams that councils can bid

for around physical activity. It would make sense, for a whole host of reasons, for that to be streamlined. You are right that it does seem odd that the Government would say that a health-and-wellbeing-board-type structure makes sense at local level, with all the key players coming together to discuss knotty issues and a way forward, and then remove one of the ways in which that was done at a national level. I have no idea how effective Cabinet Sub-Committees are as a way of driving change, but public health is much higher up on the agenda than at any time I can remember. That is partly because of the creation of Public Health England, so this is a single focus, and locally people are talking about public health because the responsibility has transferred to local government. It is also the scale and urgency of the public health emergency we face, and people realise. It is the work of Committees like this, the Chair and people like Jamie Oliver. All sorts of people can claim responsibility, but, ultimately, it does feel slightly frustrating that it is high up on the agenda but that the mechanisms for making some joined-up policies proposals to deal with it may be—

Q57 Mr Bradshaw: I cannot remember the motivation for the abolition, but is this something you would all agree on—that you would all think it would be beneficial?

Jonathan McShane: I see it crop up an awful lot in lists of recommendations and I think, “Would it?” I do not have enough knowledge of the effectiveness of that sort of body, but in my own borough I would always be wary of a solution to a problem that sets up a committee.

Martin Smith: The substance of your question is whether joining up at a national level is essential and if we feel the effects of not joining up. Absolutely, we do, simply by virtue of the sort of creatures we are. We are general-purpose bodies serving a locality; we are not looking after any particular element of state; we are trying to join the whole thing up. Looking at my personal time, I spend a lot of time joining bits up. Anything that can be done to ensure they are joined up before they get to me would be better. It is partly why we are pursuing devolution so hotly, because it is all wiring, joining up locally, rather than joining up just to come down again. Rather like Jonathan, I do not know whether a cross-departmental Cabinet Sub-Committee is a way of doing that.

Julie Wood: There is a joining up of the national arm’s length bodies around the Five Year Forward View: NHS England, Monitor, the TDA, NHS Improvement, the CQC, Health Education England and Public Health England. That is good, and every few months those national arm’s length bodies also join up with the LGA, the NHS Confederation and NHS Clinical Commissioners. That is good because it brings the service into that. Sometimes it does not then feel joined up as you go further down into some of the regional-type levels, which can be a problem, but I echo the point that it would make sense for there to be more joining up across Departments. Whether a cross-departmental Cabinet Sub-Committee is the right way to do it I do not know, because I have no evidence on whether that is the most effective way to do it.

Professor Ashton: The simplest solution would be to have a Minister in the Cabinet Office for public health.

Q58 Mr Bradshaw: Are there any data—to come back to your favourite subject—that anyone has on the impact of the Cabinet Sub-Committee, when we had it? Speaking personally, when you have an issue like public health, which crosses almost every Government Department—transport, culture, housing, the Treasury, everything you can think of—the only way that you get Government working together in a worked-out way is to have a Government sub-committee. You might not want to set up more committees, but that was the only way you got the Minister of Transport to focus on public health and the Ministers who would not normally have thought they had a remit in public health. It would be very interesting if any of your esteemed academic colleagues has any evidence or data, even anecdotal, to show what a difference this made, because if we are going to make a recommendation on it, it would be helpful to make it based on some evidence rather than just instinct.

Professor Ashton: That is the Healthy Cities approach; the WHO has promoted that for the last 30 years. It has been about getting the people from the different parts at a city level round the table. That is what needs to happen at a national level as well.

Q59 Dr Davies: I have some questions about workforce. What are the main challenges facing the public health workforce at present? Professor Ashton, could you start?

Professor Ashton: There are a number of issues at the moment. There is a lot of uncertainty and concern among the young ones coming through about whether there are going to be jobs for them. We have a very bright crowd of people now training for public health careers who come from a wide range of disciplinary backgrounds. Public health in this country is now multidisciplinary, so you do not have to be a doctor. About half of our local directors of public health have a medical background, but the rest have a wide variety of other backgrounds, including humanities, not just science—environment, education and so on. It is a very rich mix. The concern of the ones coming towards the end of their training is about whether there are going to be jobs for them, because there are cuts going on in the size of public health teams in local authorities; that is one of the things that is happening. Secondly, because of the changing terms and conditions in local authorities, it seems as though there is a kind of steady move of the medical ones into Public Health England when jobs come up in Public Health England. Quite a large number have moved out of local government into Public Health England jobs over the last couple of years. That is not desirable because the whole point of multidisciplinary is that you have medicine and biology round the table as well as the other disciplines to do with more lifestyle, behaviour and environment and so on. That is an issue about transferability of skills, different terms and conditions between the different agencies, and so there is not the mobility around. Public Health England say they have been trying to sort that out, but it has not got anywhere.

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

should be treated the same and they should be required to do CPD and re-accreditation and all of that. Those are the main issues.

Q60 Dr Davies: Other than strategy regulation, what levers do you think are available that could be deployed to deal with some of the issues you have identified?

Professor Ashton: Andrew, do you want to have a go at that one?

Dr Furber: No, but I will add to your comments, if I may, John. We do have some brilliant people in public health training. They are the future of the profession and we need to make sure we do the right thing by them. It remains one of the most competitive of the postgraduate specialist training programmes to get into.

Professor Ashton: We have 800 applicants for 80 places. If you look at the other medical Royal Colleges and so on, that is so much more competitive than most of them.

Dr Furber: As we sit here today, most of them coming off the training programme are getting into jobs. Again, going back to the theme of data, Health Education England will hold those numbers and I am sure will be able to supply them to you, but there is concern and the trainees did a submission to this Committee, which expressed some of those concerns, about the future that John has talked about. The other aspect to workforce is that wider public health workforce. That is where there is huge potential for doing more, whether that is NHS colleagues and Making Every Contact Count, or whether it is about people working in schools or as refuse collectors. There is a whole range of people who have a contribution to make in delivering on some of the public health functions.

Professor Ashton: The Faculty is establishing a new category of membership for practitioners to speak to a lot of these other folk, many of whom are in local authorities in different departments at the moment and in a sense doing public health without knowing that is what they are doing but could do with some kind of extension training, registration and accreditation and so on. There was a survey done in London some years ago of people who are involved in public health and it came out at something like 80,000 in London. It gives you a sense of the number of people who are, one way and another—they may not be full time, in their job description, public health people—making significant contributions but may not have had the extension training and the validation to make sure they are playing a full part.

Q61 Dr Davies: As to ensuring a continued supply of skilled specialist public health staff, what would you personally do as to terms and conditions and other factors you have raised, other key points that you would like us to highlight as a Committee?

Professor Ashton: The others may have things to say. It is really important to solve this issue once and for all of the parity between those who have a medical degree and those who do not have a medical degree but have done the same training and the same exams that we set for the jobs that they are appointed to, with the same appointments procedures, and yet they are on quite big variations in salary. That is one thing. That is the top of the professional group. We need Health Education England to take on the need for this

capacity, building much wider among local authority staff and other staff in how they are funding programmes at the moment.

Martin Smith: In response to your first point—you asked about what extra skills might be needed to perform these roles effectively in the future—my answer would be something that I would apply to any of the major professions probably working in public service. The theme of some of your questioning—well, it certainly started with it—is how we can harness the various functions of local government to achieve a public health dividend. That was the whole idea of the transfer. I could say this if I was talking about other professions as well. Being a great director of public health, in the terms we are talking about, is no longer good enough because, quite clearly, you are only going to achieve the improvements we want in the population health through working across this wider range of services. You have to learn how to influence, to collaborate and to effect change through others and organisations. That is a skill in itself that would apply to a range of public service leaders. I would want public health people to aspire to the most senior ranks of local government, and, as well as their professional skills, they are going to have to learn to do that very effectively because that is what it is going to take for all of us to survive the decade of austerity.

Jonathan McShane: There is a particularly pressing issue coming up. My understanding is that there is a number of directors of public health approaching retirement and I know there is some really good work going on involving aspirant directors of public health. I have done some sessions with some of those people around how you work with members and some of the peculiarities of working in a local government context. To give the Committee some reassurance, it is an incredibly impressive bunch of people who are coming through at that level, just below director of public health, and it is encouraging that the various organisations involved have had the foresight to try to plan that next generation knowing that there were a number approaching retirement.

Professor Ashton: One thing we have not mentioned is that, as a consequence of the 2013 reforms, a significant number of senior public health people took retirement. When we look at this figure of 86% of the posts of directors being filled, you have to remember that that is missing quite a chunk of people who were very senior, very experienced, who went, and consists of some quite young, inexperienced ones who were promoted possibly prematurely into director posts because of the gaps that were created. That is what has happened. The issue about supporting those young ones who have been promoted early is an issue. It is a similar issue to what is emerging in the clinical specialties as well where a lot of consultants in hospital medicine are talking of going or are in the process of going, and where the national health service, or the Government, should be thinking about how, somehow, to keep them on board as mentors, educators and supporters for the young ones coming through for another few years perhaps rather than losing them to the health service. It is a broader issue.

Q62 Dr Davies: Budget cuts have been touched upon a few times. Do we have an accurate idea of how those have impacted on staff levels? Is it very variable across the country?

Dr Furber: We surveyed our members and published the results last week. I think it was 58% who felt there would be a reduction in capacity of local teams as a result of these cuts. Certainly, I know in my own patch, I have had to take a number of posts out as a result of having to deal with the in-year nature of the cuts.

Professor Ashton: I have been aware of teams that have gone down from 70 or 80 to 20 or 30.

Q63 Dr Davies: But it is very variable.

Professor Ashton: It is very variable, yes.

Martin Smith: It is pretty significant, I think. If you took it across the piece, it would be significant.

Q64 Dr Davies: We have also talked about reliance on a wider workforce in the future—teachers, carers, child care workers, health professionals, those working in emergency services and in housing and welfare sectors. What are the implications of that and if local authorities are employing fewer medical public health practitioners?

Professor Ashton: I did not quite catch that.

Q65 Dr Davies: It was the implications of extending the public health role to all of these additional people working in the public sector in particular.

Professor Ashton: You do need people who are full-time public health people. In this broader workforce there are a lot of people for whom public health may be part of what they do or it has a public health perspective. If you are managing a sports centre, you need to be able to think about that population who are coming through and the fitness tests that are going on, all those sorts of things, and some public health skills would be useful for that. That is an example. As to the full-time people who are providing public health leadership at a local government level, Public Health England or in the national health service—and we have not talked about that yet—there need to be maybe 200 or 300 public health consultants probably with some kind of clinical background, though not necessarily, in hospitals and other clinical settings. There is plenty of scope for people to be working. One of the concerns we have at the moment is that the concerns about careers in public health may be putting off some of those medical people who would normally have come into public health, and we need the mixture to be right.

Jonathan McShane: On that point about the wider workforce—and Andrew touched upon it too—the Royal Society for Public Health has submitted evidence. It estimated there are approximately 15 million people who, in the course of their job, with some modest training, could give public health advice. That is something that needs to be pursued with greater rigour. Also, there are people who are already operating in a health role but not necessarily in a public health role. Healthy Living Pharmacies are a good example of pharmacists whose entire pharmacy team, instead of only dispensing medicine, is focused on proactive public health messages, and one of their staff is trained by the Royal Society for Public Health to be a health champion. There is lots of evidence that that improves quit

rates and has other benefits. A great focus is needed on the widest possible range of people, such as firemen, hairdressers, and so on, but we also need, as John said, the public health impact that people working in the NHS can have.

Julie Wood: It is worth saying that there are some examples where that is happening. In eastern Cheshire, south Cheshire and Vale Royal CCGs, they have wellbeing co-ordinators. There are lots of examples where CCGs and local authorities working together are going to identify people who can reach a much broader range of the population to fulfil a public health function.

Q66 Dr Davies: That has been successful, but is there anything the Government could do, do you think, to promote the wider workforce and the opportunities it brings?

Jonathan McShane: As a very small-scale practical suggestion, I know that in my own local authority it feels wrong for us to talk about wider workforce and not walk the walk with our own workforce. Perhaps central Government could encourage their own employees to think about how they can adopt a public health approach to their work.

Professor Ashton: This is a challenge for various people, Health Education England perhaps particularly. To give you an example, I spoke last month, by invitation, at a sixth form college in Wigan as part of the Speakers for Schools programme. It is the first one of these I have done. I was talking it through with the headteacher beforehand, the principal, and she thought it would be for the ones doing medicine, dentistry, veterinary training or something. I said, no, that this is something of interest to a lot of different backgrounds. People might go and do a geography degree or may do some other medical-type thing, or they may do housing or whatever. I had 100 students come in for an hour and a half, who were lower sixth. We had a fantastic session. They were all totally surprised that there may be careers for them in public health and that they could go down different paths and then do public health stuff later on perhaps. There is a very low level of awareness at the moment of careers in public health. If you talk to people who are in public health, unless they went to medical school and got some modules in public health, they will have found out about the opportunity by chance from somebody they know or something will have happened. There is no systematic communication about it as a career option. There is something to be done about careers people and Health Education England's activities in generally raising awareness. Working in public health is one of the best jobs there is; it is a great job and is open to a much wider group than people tend to think.

Q67 Dr Davies: Now, Health Education England and Public Health England are working together on Making Every Contact Count to normalise conversations about public health for staff not working in the healthcare sector. How effective does the panel think that is likely to be?

Jonathan McShane: Making Every Contact Count is a buzz phrase at the moment. Designed in the right way, it can be effective, but I have seen it work well where it really does not add to any transaction costs or significant training costs. It is simply staff, who are already interacting with people, thinking slightly differently with a bit of additional knowledge about how they carry out their role. It seems to be win-win from that

perspective and certainly, at a local level, often staff feel that having some additional training supports them to do their job better, which is good in terms of morale and staff retention. Others on the panel might have better evidence about how effective it is, but the investments are quite low.

Professor Ashton: It is part of a much bigger agenda. It is over 30 years ago that they did research at the Maudsley on smoking cessation where they were looking at GPs giving smoking cessation advice to each patient who came in with a smoking-related illness. They found that if every GP did that, at the end of a year, something like five patients per GP would have given up smoking and stayed stopped at the end of the year, which, if you multiply it by the number of GPs in the country, is 300,000 or something like that. It is the mass impact of multiple Making Every Contact Count. I was at a meeting of senior medics very recently and it was asked of them by somebody—not me—whether they gave smoking cessation advice to each patient that they saw. Only a small proportion of them did that. We have a long way to go in embedding preventive content in the clinical consultation. That is important.

If you look at another perspective on the behaviour change, I took a group of managers to Finland a few years ago and we visited a county where they had the data that they had reduced GP consultation rates from the public by 20% by systematically educating the public about how to manage common conditions for themselves. We just do not do it. We do not do it in schools with children. Children do not leave school knowing how to manage sore throats, earaches and cystitis and things. When we talk about pressures on the health service, there are some big things we should be doing that we are not doing.

Martin Smith: As well as that general level of intervention that John and others have described, looking across the breadth of public services, we need to come up with things that have a benefit for multiple parts of the public sector. I will give one general example and a specific one I came across recently. The general one, I think, is that the links between health and employment and the mutual benefits that come from both sectors are underdeveloped, and I do not think we have cracked that. We could do a lot relatively quickly on that and there is some work going on in a number of places to do that. The very specific example I got was a wonder to behold. This is in the East Riding of Yorkshire. Everyone talks about making the right connection between public health and leisure and activity. Most have not got very far with doing it, but they have cracked it. They are sort of referring obese people to their leisure centre, but it is much more sophisticated than that sounds. The consequences are they are saving the CCG £1 million, and I cannot remember whether it is a year, a month or a week, but it is a big number. They are absolutely transforming the lives of the individuals concerned, and there is evidence from those individuals' personal accounts, but, alongside that, their leisure centres are No 1 in the UK in any sector for customer satisfaction. Usage of the leisure centre and the income generated from that has gone up as well so that everybody is happy in that situation. We need more of those sorts of examples where you are killing—not a great metaphor—or achieving a number of objectives all at the same time.

Q68 Maggie Throup: We will finish with the small subject of devolution. We could be here for some time, but hopefully not. In the city where we are sitting, the mayor is not obliged to take any public health action. It does not need a director of public health. Moving that forward to devolution across England—Mr Smith, you have touched on the fact that one opportunity for devolution is joined-up functions—what do you think the opportunities for devolution are and what do you think the risks may be?

Martin Smith: I will give it a go, as you mentioned me. One can have an intellectual argument about whether devolution is good because it brings decision making closer to the people affected by decisions, but I will leave that to one side. There are distinct advantages. Let us go back a stage. We talked about the desire to join things up. With the best will in the world, we are not going to join everything up at national level. There is not going to be a Government Department for everything. We can establish cross-Cabinet committees and other mechanisms, but it is going to be really difficult on that scale to join things up. There is much more chance of joining up at a local level. You can define local in different ways, but there is much more to it than that. Some of that needs to be at a hyper-local level, of course; it is not the local authority level but the level below that. Devolution brings a real opportunity to integrate services in a single place, to establish mechanisms for place-based commissioning, which is regaining popularity as a term—it went out of fashion a little while ago—and to have an impact in a locality where the benefits of that impact are felt by the organisations working in the locality as well as better outcomes for the public. I think that it has huge potential.

You asked about what the risks are. The two that spring to mind are as follows. Probably the more important one is the second one, but the first one is, to do that, you have to overcome a number of barriers; certainly in the work we are doing in London, we claim we are equipped to overcome those barriers—whether they be around performance systems, regulation, payment mechanisms, different financial management arrangements and so on and so forth to break down the institutional system barriers—but it is a tall order because we have not done it before. There is a risk that it will not work and deliver the outcome. The other one is that we probably have not worked out properly what the accountability mechanisms should be in this sort of arrangement and where ultimate accountability rests for some of the things that we are doing. So that I do not finish on a negative point, I am not sure we know that at the moment and it was not great before we started tinkering around with things. Although we know we have good accountability mechanisms for spending public money—I think I will argue that on the whole—we do not really have good accountability mechanisms for outcomes for residents. I think we need a bit of licence to experiment, but there is an issue about how you have clear accountability for population outcomes working across organisational systems boundaries in an environment where decisions are being taken at a devolved level.

Professor Ashton: I agree with that. Clearly, the concerns relate to things about future funding and those kinds of issues and so on. If you look at what has gone on in Greater Manchester Public Health Network for the last 10 or 15 years and look at the same Merseyside and Cheshire public health network where you have had them all working together very well on key strategic big issues, part of Mersey coronary prevention, tackling all the risk factors, on a media footprint, as well as on the bigger footprint, you can begin to see the potential of working together across that bigger footprint. At the

health service side, there was the story this morning about access to mental health services—we have not talked about public mental health at all, which is an omission, I think—with people travelling big distances. When I was working in Cumbria we had no eating disorder service and people were travelling over the Pennines, and after head injury they were travelling over the Pennines. If you have a big footprint for a devolved strategic service, some of these gaps become apparent. People will be asking why they cannot be self-sufficient at that devolved level for most of the things—not heart transplants and that kind of thing, but for what it is reasonable to expect self-sufficiency at a strategic level like that. It becomes clearer, and we empower the public more in their own services. At the moment, it has become very fragmented and you have dog eat dog over hospital closures and all the rest of it because people do not see how the whole system works together.

Jonathan McShane: We are a London borough pursuing a devolution pilot around health and social care on a small scale—so a small London borough. We recognise that devolution will be on a different scale in different places, but there is a danger that we will say we have arrived at a right scale so that everything gets devolved at that level. Some things would make sense to be devolved to a small borough, some to London, some to England, perhaps, and some to a sub-region. If it is going to work well, we need to recognise that that is not a problem. You need accountability arrangements; you need to make sure that does not cause too many issues in terms of the relationships between the different levels; but forcing everything into one level does not make sense and there is a lot that makes real sense at a very local level.

The other thing is the old postcode-lottery issue. In relation to public health, we all know the biggest postcode lottery is where you are born. If you are born in Glasgow, where I am from, or in Hackney, where I now live, your chances in terms of your future health have very little to do with healthcare. That postcode lottery already exists. People are very sensitive about it, so you need to be clear from the beginning what the core entitlements are that everyone will still get regardless of whether you have devolution or not. The NHS Constitution is a good start and there are issues around housing and benefits. We need to be very clear at the beginning that this stuff is non-negotiable—it has to be delivered everywhere; and we need to be very clear about where the scope for doing things differently is. The scope for doing things differently we have already seen in public health terms: by not having everything driven from the centre, people are trying out different things and some of them will work and some will not, but we already see some good projects that deserve to be taken up in other areas.

If I can abuse my position, I will talk about one particular project we are very proud of in Hackney, which is called the Pause project. This project works with a small cohort of women, which we will have all across the country, who have had multiple children taken into care immediately, so the children are taken into care in the hospital because of the circumstances they live in. We looked across the NHS and children's social care, and people were seeing the same women again and again. The costs to those individuals, both the children and the parents, are unthinkable, and the costs to the system are enormous. An incredibly intensive support package has been put in place that involves people who have been hired for their attitude and the way they can work with these women, rather than a specific professional background; some are social workers, some are nurses and some are

prison officers. They have very small caseloads, working with those women to try and overcome some of the barriers in their life on condition that they are on long-acting reversible contraception. That creates the “Pause” in their life, where the name comes from, so that is one thing they do not need to think about. In two years, of 29 women in Hackney, there has not been a single pregnancy. That costs £430,000; it is incredibly expensive. We talked about Making Every Contact Count costing pennies per intervention but potentially having an impact on a lot of people. This project is for very small numbers of people and is incredibly expensive at £430,000, but they have worked out that that would save £900,000 purely in the social care costs of the children who would have been born and would have been taken into care, and that is before you talk about criminal justice and drug and alcohol treatment and all sorts of other budgets are affected. It is about being able to try out things like that at a reasonable scale, see if they work and then trying them everywhere else. I know that the Department for Education is now funding Pause in a number of other cities. It is one thing that makes me really hopeful about devolution. We are already learning from Scotland, Wales and Northern Ireland; let us learn even more from different parts of the country.

Q69 Maggie Throup: We were talking earlier about the health and wellbeing boards. Do you feel they should still be at the level they are at?

Jonathan McShane: Again, it will vary from place to place, and in Manchester I do not know how that is going to work; there will be Greater Manchester health and wellbeing board, but I do not know whether there are also health and wellbeing boards in the constituent boroughs. It feels like the right level of geography for us.

Julie Wood: The key is that there is not just one place. CCGs support localism and definitely support the development of place-based commissioning, but you need to work together sometimes at a much more local level than a CCG or a health and wellbeing board and sometimes even higher; it is not one model. So, yes to devolution, yes to subsidiarity, but let us get the decision making and the joining up at the right level to make the difference. It has to be a real partnership between the agencies involved without one taking over the other. The other bit for me is the point about being clear on what the flexibilities and freedoms are that you can make a difference to—constitutional standards—so that we are clear that they cannot be varied or, if they can, where and how they can; and how you transfer and translate that into meeting the needs of the local population is really critical.

Professor Ashton: It is about right-sizing, to use a bit of jargon, to have it big enough for the big issues but not too big for the small issues.

Julie Wood: Absolutely.

Professor Ashton: It is that kind of concept.

Dr Furber: When it is done well, the opportunity to deliver the right actions at the right level—the right footprint—is the exciting thing about devolution as well as joining things up. For me, talking to the chief executives in Manchester, the most exciting thing is hearing them say that they have realised the thing holding back their economy is the health

of their workforce, in a sense, and so improving the health of the workforce is going to improve their economy as well as being good for the local population.

Q70 Dr Whitford: Councillor McShane talked about this innovative process of Pause and the whole idea of localism is these different experiments. Exactly what forum do you have to share them so that we do not have 100,000 reinventions of the wheel?

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

Dr Whitford: So the mechanism is there.

Q71 Chair: Thank you. I have one final question before we close. Could the panel comment on what you feel about both the quality and usefulness of the evidence that Public Health England produced, perhaps starting with Dr Furber?

Dr Furber: I think it is good and it is improving, or should I say the process by which they produce the information is improving. It is a matter of public record that when the report on electronic cigarettes came out, it was quite controversial and people were maybe a little taken by surprise by some of the findings. As to the sugar report, I know this Committee has looked at that in some detail, but if you look at the recommendations within the report they are very helpful. They have a third one coming through the pipeline on alcohol, where I think the level of engagement has been even better. The quality of the reports is improving—certainly the sugar one was very helpful in terms of the recommendations—and the process by which they produce them is improving in how they are engaging directors of public health in their development.

Q72 Chair: Thank you. Does anyone want to add to that?

Jonathan McShane: One thing that has impressed me about PHE is that they are constantly reflecting on how they can improve their offer to local government. They constantly describe themselves as an organisation with some important national roles, but a key function is supporting local areas to deliver on their ambitions for public health. That is refreshing for us to hear. They have worked very hard on asking us what would help us deliver best on those ambitions. One thing that has come back very clearly is some effective tools on return on investments so that we can make the argument locally about something like the Pause project where it involves quite a lot of up-front money. They are working on that and it is very encouraging. The other thing they are working on is ensuring that the work that NICE does—there is some overlap with NICE's public health guidance—works seamlessly with PHE's work and is not duplicating any effort. We are very encouraged by what they have done.

Martin Smith: I have a very practical point. In my day job as chief executive of the London borough of Ealing, I regularly use the Public Health England public health profile for Ealing. It is easy to interpret, accessible and concise, and I use that with my teams to say how we are doing or, more accurately, in saying, “Why are we not good enough?”, basically.

Chair: That is good.

Professor Ashton: All I would say is that a national agency for public health is an important thing to have. It was faced with a lot of challenges when it was set up. Bringing together, whatever it was, 80-something bodies was a major challenge. There has been unease in some quarters of our membership about whether they have the culture quite right yet, particularly with regard to some of the ways the reports were commissioned and peer reviewed, and the handling of them once they had been produced. There were concerns in some quarters about that. Also, there was a feeling expressed by at least one of our senior colleagues about the difficulty they seem to have in accepting criticism. There is something about what the culture needs to be. If we draw the comparison with what we now begin to expect of our hospitals as to continuous learning and reflection and being willing to accept criticism, there is something about that that perhaps is worth thinking about.

Martin Smith: Something John said triggered not a related point but a different point. From a local government perspective, it would have been very easy for Public Health England to have adopted a prescriptive command-and-control approach over the public health function in local authorities. There was plenty of opportunity for them to do that by policing the ring-fenced grant, holding us to account and all sorts of things. In my view, they were right to resist doing that but maintain their position as a body that provides evidence, advice and objective reports on what works, recognising explicitly that, at a local level, which is where the “joined-upness” needs to occur to get better health for our population, it has been quite brave of them because there have been a lot of people wanting them to act in a much more top-down hierarchical manner.

Chair: Thank you. That is helpful. If there are no other questions—

Q73 Dr Whitford: I have a short one. Does Public Health England have a role in assessing whether local government has achieved the health objectives that they are aiming for, or who does that—or does anybody do that?

Jonathan McShane: There is the public health outcomes framework, which is constantly monitoring performance against—I do not know what the exact number is, but Andrew may know—a huge number of outcomes. In terms of useful tools, the other thing they have done is made it very easy for you to compare yourself not just with your geographic neighbours but with boroughs with very similar need.

Q74 Dr Whitford: Is that within PHE?

Jonathan McShane: Yes, that is a PHE tool. It is a good example of them responding to our request for support that would help us because, in the sort of conversation with the

senior team that Martin is talking about, it is, “You people will always say, ‘Well, it is harder for us in Ealing because we are different,’” but you are able to say this is—

Q75 Dr Whitford: You have benchmarking.

Jonathan McShane: Yes.

Chair: Thank you all very much for coming this afternoon. We appreciate it.