



Health Committee

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

Tuesday 1 March 2016

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Written evidence from witnesses:

- [Institute of Health Equity, University College London](#)
- [Royal Society for Public Health](#)
- [London Borough of Harrow](#)
- [Dr Virginia Pearson, Director of Public Health, Devon County Council](#)
- [Dr Eugene Milne, Director of Public Health, Newcastle City Council](#)
- [Ros Jervis, Director of Public Health, Wolverhampton City Council](#)

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Members present: Dr Sarah Wollaston (Chair); Ben Bradshaw; Julie Cooper; Dr James Davies; Emma Reynolds; Paula Sherrieff; Maggie Throup; Helen Whately; Dr Philippa Whitford

Question 76 – 164

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

Q76 Chair: Thank you very much for coming to our inquiry into public health and the changes post-2013. Could you start by introducing yourselves for those following the debate from outside, perhaps starting with yourself, Shirley Cramer?

Shirley Cramer: I am Shirley Cramer. I am the chief executive officer of the Royal Society for Public Health and Institute of Healthcare Management. We are a membership organisation of over 9,000 members. We are involved in education and training, policy and supporting our membership through our journals and other dissemination.

Professor Sir Michael Marmot: I am Michael Marmot. I am professor of epidemiology and public health, and director, of the Institute of Health Equity at UCL.

Q77 Helen Whately: Professor Marmot, your review in 2010 emphasised the health inequalities in our society and the consequences of that. Could you share some of the highlights of that and also talk about how health inequalities have developed since then?

Professor Sir Michael Marmot: For me, a highlight of it was pointing out that health inequalities are not confined to poor health for the poor and reasonable health for everybody else, but follow a social gradient. The importance of that is that if you think health inequalities are confined to poor public health for the poor, the problem is, “Let us address poverty”—and, indeed, I think we should address the poor health of the poor—but the social gradient means that everyone is involved, people in the middle. For example, I pointed out in my review in 2010 and in my recent book “The Health Gap” that people in the middle of the social gradient on average will have seven fewer years of healthy life than people at the top—fewer years of life and fewer years of healthy life. That means that the challenge is to improve things for everybody below the top, not only those at the very bottom. We coined the rather awkward term “proportionate universalism” to get at the idea that the evidence suggests that universalist policies are preferable in reducing health inequalities, but investment has to be proportionate to need.

My example is the national health service. It is a universalist service; it is available to all of us. Most of us would like the NHS to spend very little on us and die at 97 when the bungee-jumping rope snaps and say, “That was great. The NHS didn’t spend any money on me at all and I don’t regret all those taxes I paid. I feel really happy.” A universalist service with effort proportionate to need is what we are talking about, but given that need follows the social gradient—the lower you are, the greater the risk of ill health and shorter life—it means spending more as you go down. That was a very clear message from the review. I think—he says cautiously—that that is getting through. There are some signs that it is getting through. We are, I think, later this year going to do an event in Parliament where I want to spread that message.

The second thing is that there are positive signs that people are taking it up. I have not answered your question yet about what has happened to health inequalities. That is more difficult to answer because it is sluggish to move health inequalities. In our monitoring report at the end of last year, where we had been monitoring health inequalities, we showed the graph of disability-free life expectancy by degree of income deprivation of local authority—this remarkable gradient. The latest graph is exactly parallel, but it is at a higher level. In other words, health has continued to improve over time, but the gradient has not got shallower; the gap between the top and the bottom has not got smaller. I have always said we should have two aims. To improve health for everybody is the first aim—some sportsmen will say you want to reduce inequalities by making the best-off worse, but that is very clearly not the case as we want to improve health for everybody—but the

second is that we want to level up in terms of health, and we are not making progress on that. The evidence is that we have not moved on levelling up.

The excitement for me, with all the difficulties that have been going on with austerity, cuts and goodness knows what, is that local authorities have risen to the challenge. Last time we looked, approximately three quarters of local authorities claimed to have Marmot implementation plans. They are rising to the challenge and saying, “We think we can do something about this. You have given us an agenda. You have made it tangible and practical,” because we talk about the life course, as I hope you know, and we talk about early child development, education, employment and working conditions, a minimum income for healthy living, healthy and sustainable places to live and taking a social-determinants approach to prevention.

Q78 Helen Whately: You have covered many questions in that answer. One thing you said is that the country is taking note and there is a sense of optimism from that. Would you say that although you have not seen yet the levelling up that you are looking for—this time lag—things are moving in that direction?

Professor Sir Michael Marmot: There are two things going on. One is that we are not making much progress in some of the key indicators, looking at the social gradient in educational performance, for example, and looking at what has happened to income levels at the lower deciles—they have been getting worse. The top 10% has lost income and everybody else has then lost more income the lower they are. At the bottom end, income has been getting worse. If we look at housing—I hope we can talk a bit more about housing—there is a generational shift. In 1979, one third of the population lived in social housing; now it is 17%. Margaret Whitehead’s report “Due North” showed that for every region of the country the quality of housing was worse in the private sector than in social housing. The quality of housing is going to impact on people. There have been a lot of trends that have not been so positive.

Set against that, there is a level of optimism and commitment that I encounter in local government that is thrilling. They are saying, “We are not going to whine and say it is all too difficult. You have given us an agenda and we know what we need to try to do, and we will play with the hand that we have been dealt rather than whining about why we don’t have a different hand.” That is thrilling, and Shirley and I were talking outside about my friends the firefighters. They are terrific, they are inspiring and they are saying that they can make a difference. I went off to the West Midlands fire service—they invited me to spend a day with them on any day in 2015 I could make, and it seemed a bit churlish to say I had no days in 2015 to go to the West Midlands fire service—and they produced this wonderful report “Improving Lives to Save Lives” applying Marmot principles in the West Midlands fire service. These firefighters are absolutely terrific. They say they go to somebody’s home, and, for example, if they suspect domestic violence, they do not say, “That is somebody else’s job.” They are not trained, but they know whom to contact and who deals with that. If somebody is complaining they do not want to fit a smoke alarm because they have a leaky roof, they can advise them how they can get a grant from the local authority to fix the roof and so on. Maybe I just had a secure upbringing, which is why I am optimistic and that is why I do not get depressed about, “It’s all too difficult.” I think we can make a difference.

Q79 Helen Whately: One of your recommendations was about the importance of work and people being in well-paid work. Is that an area of optimism for you, given that people are more in work now and that wages are going up?

Professor Sir Michael Marmot: I am not a cock-eyed optimist. I am an optimist, but I am one who recognises challenges. My real concern about what is happening in the world of work is twofold. One is the persistent high levels of youth unemployment. While the proportion of young people that are NEET—not in employment, education or training—is tiny in Britain compared with Greece, Spain, Portugal or Italy, it is still far higher than we would like. Youth unemployment is of real concern. When employment levels in the country have been going up generally, they have not been going up at the same rate for young people, so that is a real concern.

My second concern, which is not unique to me, is that, increasingly, we are seeing a hollowing out of the middle in the workplace, and seeing high-paid, interesting, busy jobs at the top, and low-paid work fodder—insecure, part-time work—at the bottom. The evidence is very clear that if you want to improve public health, you have to improve the quality of working life. Related to that are the Joseph Rowntree figures on people below the minimum income threshold, which show that a majority of households below the minimum income threshold have at least one adult working. Of those who have one adult working, three quarters of the adults are working. Trying to make sure—we get into difficult linguistic territory now—that there is a healthy living wage as distinct from a national living wage, that there is a living wage, and that work is a way out of low income are also crucial, but that is part of this separation into interesting well-paid jobs with a future, and uninteresting drudgery, low-paid, part-time insecure jobs without a future.

Q80 Helen Whately: Better jobs are an important part of this.

Professor Sir Michael Marmot: Better jobs are absolutely vital. To take my first concern—the young people who are not in employment, education or training—I am not given to histrionics, but I did once describe having young people not getting into the workplace as a public health time bomb, because that is crucial to their futures. They need to have a stake in society. If they are not employed and they do not have a future, they are the young people who could cause mayhem on the streets. We know—I have referred to it—that in the Tottenham riots 91% of the people arrested for rioting were not in employment, education or training. The national figure was about 15% at the time, so it was 91% versus 15%. In Wales—I was in Cardiff recently—they are very proud of what they did in Swansea, where they identified young people in school who they thought were at risk of becoming NEET and took action. They reduced the NEET levels and violent crime went down.

Helen Whately: I am sure we can see it in our constituencies. I have a further question, but I know that Ben is waiting.

Q81 Mr Bradshaw: You said a moment ago that three quarters of local authorities have implementation plans, which still means that a quarter do not. Is there any pattern emerging as to the ones that are enthusiastically embracing this agenda and those who are not, and the reasons for it?

Professor Sir Michael Marmot: As an epidemiologist, I should be able to answer your question. I am not sure I know, so I can now speculate because I am not sure I can answer your question. Certainly, for example, in Coventry and Manchester, which have been very enthusiastic, there are very impressive chief executives. The directors of public health have played a very important strategic role, somewhat being in the background, because they see it is important that the chief executive and the political leader of the council take this on board and it not be seen to be driven by public health. For example, when I went to Coventry, when they had a big meeting to celebrate the first two years of being a Marmot city, only—it seemed to me—by chance I met the director of public health. I was entertained to breakfast by the chief executive—a very impressive person—and the leader of the council. They were clearly driving it because the director of public health cannot get early child development services and education, transport and all the other things that need to be lined up, but the chief executive of the council can.

Q82 Mr Bradshaw: You are making an argument for more and much further and deeper devolution. You seem to be implying that a lot of good things go on in local government but the policy of national Government is not necessarily moving in the same direction, in your view.

Professor Sir Michael Marmot: I think that is right. There are times where you say to people in local government, “You know, you should be doing this, that and the other,” and they say, “No, this is for national Government.” Then you say, “National Government should be doing this,” and they say, “No, that is for local government.” We need to get them lined up. Let me give you the example of Sweden. In Sweden, over several years, I talked to people in government—health Ministers, usually—about the importance of getting national action on social determinants of health, and it fell on deaf ears. They would not do it, but the cities of Malmö, Gothenburg, Linköping, Norrköping and Östersund took it up. Then I went back to the Parliament and met their social committee and said, “Every city in the country will be doing this and, if you are not careful, you will find you have been left behind.” I will not say it was because of that, but the health Minister contacted me and said he had plans now to set up a national commission, which they have done. They did not say, “Well, it is all happening at the city level, so we do not need the national level.” We need both and I am more encouraged, in terms of reduction of health inequalities, by what has been happening at local level than what has been happening at national level.

Q83 Chair: Are you seeing tangible changes already in local authorities that are implementing your demand agenda?

Professor Sir Michael Marmot: I have one that really excites me. I will not say it was because of the Marmot agenda, and I do not care really whether it is because I had said it or not. I said we had been monitoring and what we see is the predicted difference between two measures. We have been monitoring the percentage of children aged five who have a good level of psychological, linguistic, social, emotional and behavioural development, and you see it shows a straight-line relation with affluence of the local authority: the better-off, the less deprived, have a higher proportion of young people aged five with a good level of development. Or if you look at children on free school meals and children who are not, you see the expected difference. What is interesting in our monitoring is the difference in children in Tower Hamlets, for example, which is very deprived and did not

do well on early child development or on GCSE performance in the past. We see now the gap between children on free school meals and the average is smaller there than anywhere else in the country. In Bath there is a huge gap. So it looks like the more deprived the area, the better our children on free school meals are doing.

On the basis of Tower Hamlets, it almost looks like if we do not deal with this problem, we are not doing our job because so many of the kids in Tower Hamlets are on free school meals and are in poverty. If they do not focus on them, they are missing so many people, whereas in Bath they could be saying, “Oh, do we have poor people here? We hadn’t noticed.” I do not know if that is what is going on, but we see the slope in exactly the opposite direction. So, the more affluent the area, the better the kids do in general, except for the ones on free school meals, who seem to be doing better in the poorer areas, and we see it for GCSE performance. That is encouraging because that says to me that you can triumph over deprivation. I talk about two strategies. One is that we need to reduce deprivation, and I said that in my first answer. We need to do that, and we look at what has been happening to income by decile—it has been getting worse and worse the poorer the decile. Secondly, we can break the link, and that is what they have been doing in Tower Hamlets.

Q84 Helen Whately: You make a very important point that there has been success in areas where there is recognised high deprivation, but in an area that is on average more affluent, you are seeing the deprived children perhaps not doing so well. It is not picked up very—

Professor Sir Michael Marmot: That is right. I am not picking on Bath, but that seems to be a general pattern, if you look at our monitoring report. As I say, the slope of the relation between the deprivation of the area and early childhood development or GCSE performance goes in the other direction than for the general population, so the more affluent, the better you do, except that if you are poor, you seem to do slightly better in a poorer area.

Q85 Helen Whately: That is the importance of de-averaging the results. In your response you talked about Sweden and earlier about youth unemployment and how it is much worse in some other countries. Can you talk about how England is comparing with other countries on health inequalities and how the gap is widening or narrowing?

Professor Sir Michael Marmot: Yes. I used to say to the Labour Government, when they were wringing their hands because health inequalities had not narrowed under their watch—in fact they got bigger, and I produced a report pointing that out to the Government, which did not make me very popular, but my job is not to be popular but to tell the truth—that there is another measure that we need to look at as well, which is the health of the worst-off. There are two measures, which relate to what I said earlier: improving health for everybody and narrowing the gap. The Labour Government did not narrow the gap and over the last five years we do not seem to have narrowed the gap, but the health of the worst-off has improved, and it has improved throughout that whole period. That is one very important measure and that is not true everywhere.

If we look at the US, for example, it is shocking—really shocking. A recent publication said that men and women aged 45 to 54—non-Hispanic whites—had a rise in mortality,

and the lower the education, the steeper the rise. The gradient is getting steeper; the worst-off were getting worse and the best-off were not improving. It is shocking. Happily, we are not there. In terms of other European countries, we are middling. We do not have the biggest inequalities. The biggest inequalities are all to the east: the newer member states—the former communist countries of central and eastern Europe—have much bigger inequalities. The shallowest are Sweden, Norway, Italy and Malta, interestingly. The biggest are Estonia, Hungary, Romania, Bulgaria and Poland. We are between those two sets.

Q86 Emma Reynolds: Professor Marmot, how optimistic are you about embedding health across all public policy areas? You seem optimistic about the work of local authorities. Some of the evidence that we have had before the Committee is that, indeed, putting public health into local authorities has helped to embed health in that wider environment, but the progress in the importance that is given to public health in that environment varies quite widely among local authorities. Is that your experience?

Professor Sir Michael Marmot: I cannot pretend to have a great deal of experience on the ground of what has been happening all round the country in local authorities, so I am not the best person to ask. I can tell you the concern, but I cannot give you numbers. The concern is exactly the one that you said. Public health gets forgotten; the public health budget has been cut quite markedly—local authorities' budgets have been cut—so there is no room for give and take, and the concern is that public health will lose out. The more inspiring local authorities, such as the one I mentioned before, are seeing not just that health in all policies should be a reality, but health equity in all policies. My argument, both at local and central Government level, is that all policies should be looked at for their likely impact on health equity.

When I was giving evidence to the Scottish Parliament, I quoted the Joseph Rowntree figures. In 2010, 31% of households with children were below the minimum income threshold, and four years later that 31% had gone up to 39%. That is not something that local government can do; that has to be central Government. Other things being equal, that is going to make health inequalities worse, but there could be some countervailing trends. I was asked, "Are you anti-Government?", and I said, "Not at all." Whoever the democratically elected Government of the day are, I would like them to make sure that all their actions are in the direction of reducing health inequalities. My argument is not just because I am a doctor and care about health, but health inequalities tell us something important about how well we are doing as a society. Think of Britain in the earlier part of the 20th century. Things were going terribly wrong because we had such poor health and such dramatic inequalities, and they got so much better post-war, and they are so much better now than they were in earlier generations, because we are doing so much better.

To come back to your question, I would like to see two things. At national Government level, there should be a two-pronged strategy, one of which is a ministerial committee that has Ministers from every Department on it. Such a committee did get set up—it was one of the things that I recommended in my 2010 review, although whether it was because of my review or for some other reason, I do not know. The second thing is that at official level there was a cross-government meeting of officials. I met with them when I was doing my review and I reported back after I had done it at the level of officials. It is about how people who are dealing with early child development, education, transport, housing and all

the other key influences on public health can keep in mind the likely impact on health and health equity. They might say, “Sorry, mate, that is second to some other priority.” That is the way it is. When I first started sitting on expert committees and the like, I learned to swallow my disappointment and say, “I am an unelected expert. Nobody elected me to do anything.” The way the process works is that I can give my advice and be ignored. I have to say that I am happy with that—that is probably the wrong adjective—or satisfied that that is the system working as it should do.

Q87 Mr Bradshaw: Can I interrupt on that? Can you give us a little bit of the background of the genesis of this Cabinet sub-committee and what, in practice, it achieved, because there is a certain cynicism out there about what sub-committees can achieve? Speaking personally, they can achieve a lot, but it would be helpful if you could give us an example of what it achieved and what has suffered as a result of it going.

Professor Sir Michael Marmot: I do not know what it achieved. Andrew Lansley chaired it. He and I had, I think, a good channel of communication about public health—not very good on the Health and Social Care Act, but then we did not talk about that very much.

Q88 Mr Bradshaw: It existed before 2010, did it not? There was something under the Labour Government, some public health—

Professor Sir Michael Marmot: Perhaps, but I am not sure.

Q89 Mr Bradshaw: I thought it came out of your big report.

Professor Sir Michael Marmot: Do you mean the WHO report?

Mr Bradshaw: Yes.

Professor Sir Michael Marmot: I do not know. I was invited to talk to the one that Andrew Lansley chaired, but I was never invited to one under the Labour Government.

Q90 Mr Bradshaw: If you are calling for its reinstatement, it would be helpful to have some examples and reasons why you think it is a good thing.

Professor Sir Michael Marmot: The reason why I think it would be a good thing is this. As I say, I cannot tell you chapter and verse of what the Committee that Andrew Lansley chaired achieved because I do not know, and it is often difficult to attribute cause and effect, a bit like I said in response to Sarah’s questions about the examples. So, I do not know if it was anything to do with me, but here is a good example of how you can make a difference.

Take two of the Prime Minister’s priorities: dementia and obesity. From my point of view, both of those are characterised by inequality. We know from looking at cognitive function that people of higher income, higher education or higher status achieve the same level of cognitive function 15 years later than people of lower status. We are all declining, regrettably, but those of us of higher education on average get there 15 years later. If you want to deal with the dementia problem, you have to deal with the inequality problem, because we would like everybody declining at that low level—well, we would like people not to decline, but never mind that for we are mere mortals. We would like to delay the

onset of decline for people of lower education, income and the like. If the Prime Minister wants to tackle dementia, and I am delighted that he has declared it a priority, he cannot do it only by treating people and having more carers; he has to do it by investing in prevention. We know that it can work, but you have to tackle inequalities.

Take the second one, which is obesity. I know Shirley—I am going to let her talk soon—has a lot to say on obesity, so I will not say what she will say, but I will talk about inequality. We know there is a very clear social gradient, not just in this country but right across Europe and north America: the lower the status, the higher the prevalence of overweight and obesity. Alarming, when we look at children aged nine to 10, the good bit is that the rise in childhood obesity has now levelled off for children from higher-income families, but it is continuing to increase in children from lower-income families. The inequalities in obesity are going to get worse and, somewhat rhetorically, I have said you cannot tackle the obesity problem completely without tackling the inequality problem. So, as to the Prime Minister's two declared priorities on dementia and obesity, we would like to see a bit more tangible evidence of action on obesity, and, please note, we would like it a bit more quickly than it has been forthcoming. Quite apart from when that eventually comes, we need to be tackling inequality to tackle obesity.

Now, to come back to your question of cross-government action, if you have that in mind, if you had only the Department of Health looking at this question, you would not be looking at what we do about adult education and what we do about social isolation. Loneliness not only kills older people but it makes their cognitive function worse. Loneliness is a public health issue, but it cannot be solved by the Department of Health. It needs cross-government action, and I think it needs it at ministerial level and at the level of officials.

Q91 Chair: I am conscious, Shirley, about whether you might want to come in on any of these points.

Shirley Cramer: I absolutely agree—I think you will not be surprised to hear—on the health inequalities and how it is an underlying piece of the picture in improving and protecting the public's health. The question you asked about health in all policies I think we all agree is an essential approach. At the Royal Society for Public Health and across the piece now people are much more talking about the public's health rather than public health in a domain, so improving and protecting the public's health. The health impact assessments that we think we would like to see across all policies are that everything needs to be looked at in a different light—in the light of whether we are looking at this in a preventive way. Often, we find that things are not being looked at in that way, and if you take the lens of “health in all policies” you will begin to look at things differently.

I totally agree that it cannot just be looked at through health, because the social determinants of health are across housing, transport, education, early years and parenting—the whole group—and where you live and the kind of environment you live in. All those things need to be taken into account, which is why we would say—and the consensus is—that public health in local authorities is working well and getting better all the time. Obviously, a transition period is a difficult point for public health teams and overall, but in local authorities you have massive opportunities to work with colleagues, with public health teams working in an integrated way, to make sure that things improve.

Having health in all policies really works in local authorities and, to back up what Michael has just said about the national picture, to have health in all policies would mean that we would need a Cabinet committee, or certainly officials at all levels working together on this.

For example, one area would be mental health. A recent report, and its recommendations, that came out last week shows that this is not something that is just about health; this is about the house you live in and the school you go to. It is about a whole range of issues, and these can be tackled successfully, I believe, at a national and a local level. Just to give you one example—you will be getting many more, and, by the way, there are some really good examples in local authorities of innovation and progress being made— one local authority that took a very integrated approach right from the beginning, with the other characteristic of leadership across the public, professional and elected officials all committed to having a healthier place, was the borough of Wigan and Leigh. Through that real focus, both on health inequalities and improving the health of their population, they have seen an improvement in just two years in cardiovascular deaths: 25% in men and 27% in women. What we are seeing there is this. We say that public health is long term and there are long-term outcomes, and of course there are, but we can see some shorter-term improvements and we should be aiming for those in an ambitious way. Many local authorities are doing that, and we want to encourage that and make sure that they have the tools and the framework nationally in order to do that and to support people in local authorities.

Chair: To finish off the issue of health inequalities, I know Philippa wants to come in and then I will come back to Emma.

Q92 Dr Whitford: One thing was this problem, particularly in national Government, but also in local, which was the reason to move, that decisions were being made in silos, such that we would have a debate on something one day when we said you should do this and then the next day we were discussing that our policy is completely the opposite. Impact assessments tend to happen after the decision. Is there a way of developing a tool or a cross-check against both health and wellbeing that people can use in real time, literally, “Are you thinking of these five points, as you make the decision?” The decision never gets changed if the impact assessment is bad; it just gets a sticking plaster.

Professor Sir Michael Marmot: I think there is. It takes a little heroic modelling—not too heroic. You noticed the slightly cautious language I used before: “Other things being equal, this will have—” We have a pretty good evidence base now to be able to make statements like, “Other things being equal, this will have a positive impact on health inequalities. This will have a negative impact,” or, “This will be neutral.” We can say that.

Let me come back to housing, for example. My institute—although this was not a core part of the Marmot review; we did it afterwards—did a report on fuel poverty and showed that the evidence was pretty clear. Children develop less well if they grow up in cold homes, there is more mental illness, and, at the other end, there are the excess winter deaths, where somewhere between 20% and 25% of excess winter deaths can be attributed to being in the quarter of homes that are coldest. That is pretty simple. There are three issues here. One is the price of fuel; the second is poverty; the third is quality of housing. If you said, “We are developing a set of policies on housing. What is the likely impact on

health and health inequalities?”, we could say that before the policy was implemented; we would not have to wait. We could say, “We have a good enough evidence base to tell you that, if this happens, then that will happen in terms of health inequalities.”

Q93 Dr Whitford: In real time, obviously, both local and national Government are sitting there saying, “This is the pot of money. How do we spend it?” Are there ways of modelling tools that can be validated that allow people sitting around to say, “A pound there will do more good than a pound here to use in it”?

Professor Sir Michael Marmot: They are not perfect, but on the social determinants of health and health inequalities, we have enough knowledge now that we could say we could do it better than simply taking a step into the dark—that we could shed a bit of light on this. I was asked the other day if I would predict something, and I said that, if I have learned one thing, prediction is difficult, particularly about the future. So I would not say I could predict what would happen, but I could say, “If you did this, other things being equal,” that would have a positive impact or a negative impact.

Chair: I am very conscious that we have been going an hour and we have only got through a few questions. We have covered a lot, but could I come back to Emma?

Professor Sir Michael Marmot: “Tell Michael to be a bit briefer.”

Q94 Emma Reynolds: Related to what you have just said, Professor Marmot, but to both of you, what is your view of the current level of spending on public health, and the proposal that both local authorities and public health budgets will in the future be determined not by a Government grant but by business rates retention? In my view—I am an MP in Wolverhampton and business rates are not that great in providing revenue—I think there is a real concern that this could deepen health inequalities in those areas where deprivation is highest and therefore business rates retention is lowest.

Professor Sir Michael Marmot: I am very concerned about that. I reviewed Tony Atkinson’s book on inequality for *The Lancet* recently, and when he gets to the section on local government funding, somewhat disarmingly, he says this is not a subject designed to excite much interest. So local government funding is not a subject to excite much interest. I am very concerned at cuts to the public health budget and cuts to the budget for the areas that I think impact on the health of the public. I am very concerned. I do not know what the right mechanism is for funding it, but something that resulted in those sorts of cuts—and we know that, in general, areas with higher mortality rates, that is, more deprived areas, have had steeper cuts to local government funding—other things being equal, he said again, will have an adverse impact on health inequalities. Simon Stevens made very clear in his Five Year Forward View the importance of prevention. I looked at a King’s Fund report a couple of weeks ago looking at the question of waiting times in the NHS and they said it was pretty simple: demand had gone up, funding was relatively flat, and so waiting times went up. As I tweeted, it is almost Newtonian—you do this and that happens, like billiard balls. What are you going to do? You can put more money into it, reduce demand or put up with longer waiting times. That is what you have to do.

What we are talking about has the potential to reduce demand, so it is, again, joined-up thinking. If you say we do not want to keep putting more money into the NHS—you might want to or you might not want to, and I would not mind if you did do it, but that is a

political decision—okay, then you either have to accept longer waiting times or try to reduce demand. Joined-up thinking would say, “Let us reduce demand by taking action on the social determinants of health inequalities. Keep people healthier for longer.”

Shirley Cramer: It is certainly true that the whole public health community, and many other people who are not in the public health community, are very concerned about the disinvestment, in a sense, in prevention because it does not make sense to talk about wanting to prevent the tsunami on the NHS and then to disinvest in the one thing that might make a difference. The £200 million in-year cut, which was shocking because it came so quickly, and then 4% over the next few years, is very disheartening for local authorities. Our concern is that a lot of the innovation and progress that has been made, and the enthusiasm around some of the good projects and the good mainstreaming of this, may get cut because there is not enough money.

On your question on the business rates, this is of great concern to everybody. It is clear that there will need to be some kind of equalisation between local authorities, between those, as you say, such as your constituency and others—many others—that do not have a high business rate and those that have a lot. My plea would be that the equalisation process will need to be very transparent. There is a consultation starting, I think, this summer, 2016, and it needs to be very broad based. We need to have confidence that the process is going to come out with results that are fair and equal and will not harm or increase those health inequalities. In that process, it would be very good if a broad range of people was involved in that and that we had clarity of what the plan was so that we did not have health inequalities.

Q95 Chair: There is already a huge discrepancy; I see £132 in Westminster to £20 in Surrey. Does that translate into measurable differences in outcomes? As far as you can see, is there a correlation between what you spend and what you achieve, obviously depending on the background level of deprivation?

Shirley Cramer: My colleagues in their roles of public health directors would probably say yes, indeed there is; if you are in an area of higher inequality, you are going to have to do a lot more and you may have to invest a lot more in certain areas—in early childhood, in school meals. There is a huge variety of more expensive things you might have to do. In fact, the argument would go that areas that have more inequalities and more deprivation ought to have more funding rather than even just equalised. I would say to whoever is looking at the economics around that work that I think that consultation, to be honest, should not be just the normal consultation that we do, but it should have some people round the table looking at that, who are thinking about what it is going to be like to improve and protect the public’s health in the next five years. Any decision that is made around that is going to affect from 2019-20 and on. It will have big implications for the system.

Professor Sir Michael Marmot: Could I come back on that, having said I do not want to get into local government financing? Think about the US, where local services are funded from property tax, and that means poor areas spend less on schools. It is almost building the inequalities into the system because the poorer the area, the less they have to spend and it remains a poor area; and the less they have to spend, they have more crime and more other bad things. I have drawn the parallel between the poor parts of Baltimore and the

rich parts of Baltimore, with a 20-year gap in life expectancy, like the London borough of Westminster. When Baltimore erupted, with civil unrest, after a black man was killed in police custody, it was the poor area, with a male life expectancy of 63, that erupted, and that area spends very little because the property tax is so low—the tax base. If we move to something like that, which enshrines these economic inequalities in the poor areas that have greater need, it is my proportionate universalism upside down. It is not spending proportionate to need; it is getting it the wrong way.

If I could come back to you, I liked your question earlier about whether we could do it in real time. I think we could, but you need to think about a mechanism to get it done. The Department of Health would, I think, say they do not have the resources in-house any more.

Q96 Dr Whitford: I just thought maybe academically there could be four things that people round a table should ask themselves. I am sure the academics could do that modelling.

Professor Sir Michael Marmot: I am sure they could, so I did not need to add that.

Q97 Paula Sherriff: I would like to look briefly at the Making Every Contact Count initiative. I am very conscious of time, so could you briefly explain your rationale behind why you subscribe to this initiative?

Professor Sir Michael Marmot: I will talk quickly about the west midlands and then pass over to Shirley. What was so encouraging about the firefighters was this. To take their figures, they spend half their time preparing, training, shift work and fighting fire. I said 6% of their time fighting fires, but they said, “No; let’s make it half because of shift work, preparing and the like.” In the other half they are not fighting fires, but they go out into the community to look at prevention and they also get called to fires. The example one firefighter gave me was that she was called to a flat of an elderly man living by himself because there had been a fire. At first he would not let her in. It took her three weeks to convince this elderly man to let her in, and it turned out he was socially isolated; he had had a fire because he was cold, because they had turned the gas off. She said, “What do you do here? Do you watch television?” He said, “I used to, but they turned the electricity off,” so she got involved. She got social services and the medical people to come. One thing led to another and she finally got him rehoused. This was Make Every Contact Count.

I used the example of domestic violence before and this came from the firefighters. They do not go away and say, “That’s not my job.” They say, “If I can’t do it, who can?” Then I go back to the general practitioners—I should have said in the introduction that I am currently president of the World Medical Association for a year, so I talk to the doctors—and say, “This is what the firefighters are doing. What are you doing? When you see a patient who is ill, do you ask if they are homeless? Do you ask if they are in poverty? Do you ask if they are lonely? You may not be able to deal with the fact of their homelessness, poverty or loneliness, but you may know who does and who can and who you should work in partnership with.” That is part of Making Every Contact Count.

Shirley Cramer: We have been working over the last year with Health Education England, Public Health England and others on what we have called redefining the public health workforce. That is looking at the wider workforce in the public’s health. That would be the

group that can usefully and intelligently use Making Every Contact Count. For example, we have looked at the scaling and scoping of the wider workforce to say what they can do in a local context. With the Centre for Workforce Intelligence, we have highlighted 15 million people in employment today who have the opportunity or ability to improve somebody's health. These are people in all sorts of different jobs. The fire service is a particularly good example, but there is housing, allied health professionals, leisure services and pharmacy—a really wide range of professionals. If they have prevention hardwired into the work they are doing so that they are making every contact count, having that healthy conversation, signposting people, noticing and helping to enforce prevention, we would have an army of people who would be supporting public health teams in the prevention agenda and helping people stay at home rather than being in NHS services or in residential care homes.

Part of the role I have been taking in chairing People in UK Public Health, which is a group looking across the UK at how we do this at industrial scale, is what we can do with this workforce that can really make them active in the community. We have been doing some research into what, with the engaged populations, makes them active and makes every contact count and works with their local population. We have discovered that for allied health professionals and others it is about giving them permission to be involved in prevention. I know that might sound a very obvious thing to say, and wouldn't everybody think that would be obvious? But it is not obvious, because people need to know it is okay to have a healthy conversation and to be involved in prevention and signposting. The role would be to have permission to do it, to have a little bit of training in understanding health improvement; it might be in mental wellbeing or whatever issue particularly interests the group or the profession we are talking about, them having that healthy conversation and signposting people to support and help or into community action. There are all sorts of things that can happen. Then we need to acknowledge that they are in there doing the job, helping and supporting prevention, and celebrating that. At the moment, we are looking at how we get this into job descriptions.

The way you would mainstream this kind of workforce in local communities into supporting this prevention would be to have it aligned with the job description. At the moment, the National Joint Council for Local Authority Fire and Rescue Services and the Fire Brigades Union are working together and looking at how they can map health improvement into the role. In that way, you would have up to 15 million engaged professionals. At the moment, it is about 750,000. Even then, if you think about the number of people who would be involved in prevention, as opposed to the small numbers—40,000—we have in the core public workforce, they need support from the wider community; but the wider community needs some tools, support, permission and confidence in order to do that. In many local authorities where they are making some real headway in this area they have been doing this with lots of different groups— police services, ambulance services, leisure services, occupational therapists, a whole group of people. In order to do that, we need a number of things that need to happen nationally. It is going to happen locally in that that is where we will get the benefit, but there needs to be a national canvas, a national leadership and a national framework so that if people in the wider workforce want to have a role in public health in the future, or see their future in a career in public health, there are some progression pathways and flexibility for them to be supported to do that.

Q98 Paula Sherriff: Finally from me, in terms of some of the challenges facing the public health workforce at the moment, not least the current financial context, could you talk to us about some of the challenges that that workforce face at the moment that you are aware of?

Shirley Cramer: Again, colleagues who are coming later will be able to talk more about that, but some of the challenges in the research that we have been doing around the bigger picture are that people feel that the progression routes within the core public health workforce are quite opaque and sometimes it is not very clear where you might go next or what your career might look like. In order to encourage people—younger people and people coming out of university and others into these professions—we need to have a very clear pathway and career route. At the moment, that is not the case and one thing we are trying to do through People in UK Public Health is to look across the UK and say how we get those flexible paths. Another frustration is around the funding and things—that if you are having to cut back on services you have set up or been involved with, it can feel that it is an undervalued role.

Q99 Paula Sherriff: It must naturally lead to a cohort of staff feeling unsettled given the downward trajectory of looking at funding.

Shirley Cramer: Interestingly, although there may be one or two—I am sure the leadership must feel like that because they are involved in the strategy and how the money is spent—most people I have talked to on the ground are very buoyant about the work they are involved in and enthusiastic about being part of the bigger whole, working with colleagues across housing, education and others, so there is a bit of excitement and enthusiasm to do these things. There is a lot of enthusiasm and motivation in the system. At national level, we have to make that system better, clearer and argue for investment in it because it is clear that you do not want to be in a profession that you feel is undervalued, where people do not recognise the good work that you are doing.

Q100 Julie Cooper: Shirley, you have already helpfully given us a lot of information about the wider public health workforce, which is really interesting, to inform our thinking going forward on it. It almost seems like we have come full cycle, and hopefully we are going in the right direction now. People have gone down specialist routes and everything has been self-contained: “This is not my business; it is that professional.” Now we are opening this up and saying that lots of us have a lot to offer in this, and if we are the first point of contact maybe there is something we can offer on that. What would you say are the wider implications of increasing the number of non-specialists? How would the public respond to this, for example?

Shirley Cramer: That is a good question and we asked ourselves that when we were looking at the work we were doing with the Centre for Workforce Intelligence. We did a bit of deeper diving in a number of areas and asked the allied health professionals, first of all, if they thought they had a role in prevention and would they like to have a role in prevention; 87% of them said yes, indeed, they would, and they thought they ought to, and in fact they could see that a lot of their patients and the people they were visiting had issues such as diabetes and weight problems, and were not eating the right food or they were smoking, and they felt that they could make a difference. Then we asked the public if they would be happy to take health advice and guidance from their occupational therapist,

physiotherapist, radiographer and paramedic, obviously. The answer was that 90% would. Of course, it is partly about the relationship of the person that you are working with, and if you trust them then you are much more likely to take advice from them and move on. As to pharmacy, it was the same; 93% of the public are very happy to take health advice and guidance from their pharmacist.

Then, working with Sitra and the housing associations, we asked people in social housing if they would be happy to have health advice from their housing officer, and again 85% said yes, they would be very happy; again, it is a relationship they already have with their housing officer and they would be very happy to talk to them about their personal problems and to be guided and signposted on. So there is an enormous amount of public appetite on this, certainly that we have researched, and it is about the relationship you have with the frontline. In so far as the fire service go, they have a 98% public approval rating, so it is about what the person in the wider workforce—let us say somebody in the fire service—is happy to do, but as they get trained and they build confidence they are able to talk about lots of different health advice as long as they know where to signpost.

Q101 Julie Cooper: This is already happening, which is good.

Shirley Cramer: It is; it is really exciting.

Q102 Julie Cooper: Do you think the Government should take steps to formalise this?

Shirley Cramer: We have to be careful not to say, “You are members of the public health workforce and you will be regulated, et cetera.” That would not work at all. We need to make it very clear that the leadership at national level thinks that it is a good idea that all these people are involved in prevention. I was very surprised that one of the biggest barriers even to people with health training doing this was that they did not feel they were allowed to. It is a matter of saying, “Yes, you have permission and we want to give you the confidence to do this.” All these people, or most of them, are already in employment, so the cost is very little. It is about giving them the confidence to do some of these things, funding some of the training and supporting some of the leadership to make this happen. Then the cost for change in this case is much less than we might see in terms of investment in other things. We have not done the financial modelling, but we are talking about training, acknowledgment and perhaps celebrating. We have certainly had, for many years, awards. We look at good practice and provide lots of awards in various areas. There is a real appetite among the wider workforce, the blue-light services and others, to be acknowledged for the work that they are doing in prevention. That would go down very well and help to encourage.

The other thing we have been told by the ambulance service and others is that it was very motivating for their staff to be involved in prevention, because they were too often going back to the same home for the falls prevention with the same person who had fallen going back into hospital, and they felt they could do something more about that. Staff morale was raised by doing some of this work.

Q103 Julie Cooper: It is a very common-sense solution. Returning to the specialist public health workforce, what are your concerns around them? Do you have any concerns and, if you do, what can be done to address those?

Shirley Cramer: It is about valuing their contributions. That is a very important thing. Paula mentioned how people were feeling in a time of austerity and the money going down—that it makes you feel that you need more support. The role of specialists is valuable. There are lots of different areas of technical expertise that need to be shored up, if you like, on that. What we are looking at over the next five to 10 years—and we are looking at the future of the public health workforce—is that it will perhaps be shaped very differently. We will still have our specialists and all the people we need at the top, but we will also have other roles that may come in between this. We are looking at apprenticeships, for example, in health improvement and in other areas, where the shape of the workforce may look slightly different, so some of these roles may look very different. They need to be flexible and to be able to move across different employers. Something that we have been told by the specialists and the other workforce is that they want to have that flexibility. They want to have their professionalism, their competencies and expertise valued across the piece by the different employers and for the different employers to understand what those are.

Q104 Dr Whitford: My question has largely been covered. One thing we have not particularly covered that I would be interested to ask Professor Marmot is this. Obviously books like “The Spirit Level”, and so on, also talk about the economic gain of balancing out this gradient. Do you have any comments on weighing that economic gain against the investment to even out the gradient?

Professor Sir Michael Marmot: Yes, I have two comments. One is that I have always resisted—I am a bit squeamish—putting a monetary value on a human life. I know economists love to do this. They can tell you how many pounds an extra year of human life is worth, and you can weigh it up and decide whether to build a football ground or—

Q105 Dr Whitford: I was not meaning that so much, but in “The Spirit Level” they talk about getting greater economic involvements—you have a successful economy—if it is more equal.

Professor Sir Michael Marmot: Thank you. Then there is the second thing, which is the actual cost, so we can calculate costs of obesity, alcoholism and so on, which cost a huge amount. The third point, and the one that you are talking about, is a bit harder to quantitate. To say, “If we have the kind of society that has less inequality”—which is the “The Spirit Level” argument—“it will grow faster,” it is harder to quantitate. I can quote the kinds of studies the OECD have done, which suggest that with too much inequality, or, to put it their way, if the bottom 40% has too little, the economy grows more slowly. To a non-economist like me, that makes such sense. If people cannot afford to consume anything, the economy is not going to grow, and if the bottom 40% have too little purchasing power the economy will not grow. The OECD put it in more sophisticated language than that but did say that too much inequality damages economic growth. We can see the mechanism.

The other thing that we can see is this. Take Japan, for example, or Sweden—it looks similar—or Finland, and look at the social gradient in educational performance. As we

know, Finland always does best in Europe on PISA—Programme for International Student Assessment—at age 15 in maths, literacy and science, and it has the shallowest social gradient. We look now at Macao and Shanghai, which now do better than Finland, and they have a shallow social gradient. We know that that social gradient in educational performance links to wider social and economic inequalities. If you ask me, “Okay, you have just mentioned Japan. Is that looking so good in terms of economic growth?”, the answer is, no, it is not looking so good, so I am not going to pull out particular examples. But, in general, investing in—I do not like the expression human capital—human development and good education is going to be good for the economy, good for health and for reduced civil unrest and crime, which is part of the argument of “The Spirit Level” and it is part of my argument too.

If I may, I will come back on that last question about the expert workforce. I am an academic, so I am not in the frontline of being a director of public health; my colleagues behind will talk about that experience. But the parity within the NHS of public health specialists and cardiac surgeons was hard won. It is probably true that the consultants in public health got invited in to dinner after the psychiatrists, who were after the obstetricians, who were after the cardiac surgeons, who were after the neurosurgeons. It is probably true that there was still a pecking order over the dinner invitation, or whatever, but the apparent parity between consultants in public health and consultants in other fields of medicine was hard won. I am very happy that public health should be in local government. I do not think it should be in the NHS just because they have parity of esteem, but let us not lose that professionalism, that sense of pride and knowing something, which I think is part of what Shirley is saying.

In Liverpool in 1847, William Henry Duncan was the director of health; he was the local medical officer of health. He had great pride, great power and achieved great things. Look at what happened in Birmingham in the latter part of the 19th century. The medical officer of health had enormous influence and did a lot of things for good, and so with the move to local government let us not lose that job pride and professional expertise that can make a real difference.

Q106 Chair: That is an excellent note on which to end. Thank you both very much for coming this afternoon. I am sure we could have gone on a lot longer. It was fascinating, thank you.

Professor Sir Michael Marmot: But I have not said half of it yet.

Chair: No; we could have heard more, I know. Thank you both very much for coming.

Examination of Witnesses

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

Q107 Chair: Thank you for coming this afternoon and for your patience. Can you introduce yourselves to those following from outside this room, starting with you, Dr Milne?

Dr Milne: Good afternoon. My name is Eugene Milne. I am director of public health for Newcastle-upon-Tyne.

Ros Jervis: I am Ros Jervis. I am the director of public health for the city of Wolverhampton.

Dr Pearson: I am Dr Virginia Pearson. I am director of public health for Devon.

Andrew Howe: I am Andrew Howe, director of public health for the London boroughs of Barnet and Harrow.

Q108 Chair: Having a panel of four, if there are comments that you agree with, please do not feel the need to repeat them, but chip in and add. Can I kick off by asking each of you how you feel about the transfer of public health into local authorities and whether you think that has been a good or a bad thing or a mixed picture, perhaps starting with Dr Milne?

Dr Milne: Thank you. Unequivocally, I would say that the transfer of public health to local authorities was a good idea. It was probably one of the least contested ideas in the Health and Social Care Act. It is something that we had anticipated prior to the transfer in the kinds of work that we were trying to do in the way that we were trying to move the public health agenda to a much broader base than simply those things we were able to do in the NHS. I do not think the transition is complete. There is a tendency to think it happened and it is sorted, but it is a continuing process because we are still, I think, building confidence across different parts of the local system to be able to operate properly within that new context, and there is quite a lot of getting to understand the way that the different parts of the system work. We have also lost quite a lot of protections that we had previously, most obviously in relation to the funding. There are difficulties that I am sure we will want to go on and talk about with the Committee this afternoon, but, as a starting point, I would say it was a very good idea and there is a lot of opportunity, despite the difficulties that currently exist.

Ros Jervis: I do not want to repeat everything Eugene has said, but I would echo every single point he made. It was the right thing to do for us to get some traction in terms of those efforts we wanted to put into facts across the social determinants of health, trying to get into the mix around educational attainment and housing standards, and trying to get into the conversation around skills and employability to try to improve getting people into work. It was the right place to be to start having those conversations compared with where we were previously in the NHS, so I would echo everything that Eugene said. Again, it is not without its issues, and I think for some of the staff who transferred over it was a culture shock to many and took a little bit of settling down. As to some of the transactional issues that had to take place, such as making sure that all our commissioned services and the contracts that we had in place with our providers were fit for purpose, those things took time and we are just about getting started now and getting involved in some of that work that we aspired so much to do during that transition period. It was a good move.

Dr Pearson: It is the same for me, Sarah. As my colleagues have said, a lot of us have been trained in that way to think about all those wider determinants of health, so there is a

natural relationship between public health and local authorities. Unlike colleagues, I have more local authority relationships because I am in a two-tier area. There is the relationship with my county council, by which I am employed, but I also have eight districts, including Exeter city council where Ben is from, so that gives an added dimension to it. It means you are quite busy in the job because you are making lots of relationships, but I do not think we have lost the relationship with the NHS. It is a different relationship, and you could say in some ways it is slightly weaker than it was than when we were embedded within the primary care trust. Nevertheless, it is a much more robust relationship, one of being able to provide advice and constructive criticism, and that is counterbalanced by the advantages that we get through working in that local authority setting. But I do want to say—I put it in my written submission, and Ros mentioned culture—there is something for me about the empowerment that you have as a director of public health working in a body that contains democratically elected members. It is an incredible experience. I have been born and bred in the NHS, but the work that we do, working with those elected members and bringing democracy into what we do in public health, is very powerful. I had underestimated just what that would feel like, and that is why I think my team are so enthusiastic because we can influence, shape and control, and we are masters of our own destiny, which is very different from working in the NHS. It is very important for the ethos of public health to be able to do that.

Q109 Chair: Thank you. Can I come back to that in a second? I am keen to bring in Andrew Howe's opening remarks.

Andrew Howe: I have little to add. I think it was a good thing as well. We have made improvements to tackling some of the broader determinants of health that you have heard about that we simply have not been able to do while in the NHS previously and I am sure that we could not do from the NHS now, particularly working across multiple boroughs. I work across two London boroughs, but we work very collaboratively with other local authorities as well. That seems to have been a real added value for me. I had worked in the primary care trust for some years before and I have noticed a step change in us being able to tackle some of those broader determinants of health.

Q110 Chair: Thank you. Could you perhaps go further, Dr Pearson, in telling us how it has made a practical difference? You talked about how empowering it was to work with elected members, but how has that, in practice, enabled you to make a difference to determinants of health within Devon and across?

Dr Pearson: For me, it is the community leadership role of the elected members and it has been a gradual process. When we arrived, they probably did not quite know what to make of us because we came over from the NHS, but in talking about some of the things you were just talking about, specifically health inequality, fairness and equity—all those things—our elected members really get that. They understand that because they are serving communities, as you do as MPs, but if you can hook them in and talk about that and explain what the data show, it is very powerful. For me, it is about developing that conversation and getting into the heart of communities. It is talking and listening to them and understanding what their constituents say, feel, experience and need that brings the qualitative aspect to the work we do. We do a lot of data analysis—that is part of our skillset—but it is very empowering to hear what real human beings think about the stuff that is going on. That is the thing that is so powerful. That is when you can get the

traction. If you get that buy-in and traction, have control over your budget and influence the other budgets in the local authority, whether you are talking about social care or education, it is massive because that is what local authorities do: they touch every single aspect of our lives—a very powerful position.

Q111 Chair: When that works well and you have good communication and relationships, and you can see the benefits, is there a danger that where those relationships do not work, for whatever reason, the local population suffer as a result?

Dr Pearson: I do not think everybody has moved into these jobs and has necessarily enjoyed them. You may have here four very enthusiastic, well-embedded directors of public health with good relationships with the NHS. I think there are some colleagues who have not found the move easy, and particularly if you end up with friction between elected members and the director of public health, you have issues there. Then we have Public Health England, and Public Health England are there as our professional colleagues, but they can also be there to support us as directors of public health; so we are not on our own. We have Public Health England and we have each other as well. Many of us have probably formed stronger relationships with each other as directors of public health since the transition than we did when we were working in the NHS.

Q112 Chair: That is encouraging. Do you feel at all under pressure—any of you—to adopt a corporate approach, or do you feel constrained in your ability to speak out and be independently critical where you are not supportive of perhaps what the local policy is?

Andrew Howe: The answer is no. I do not feel constrained. I work in exactly the same way as the director of children's services and the director of adult services in that I attend both senior management teams at both councils, I meet with portfolio holders and shadow portfolio holders, and members more generally. We have presented independent public health annual reports. We have had a very robust degree of debate in both councils. Certainly, as Virginia has just described so well, I feel we are able to have that influence with members right across the piece.

Dr Milne: There is a balance to be struck. There is an important element of corporate responsibility that anybody needs to have who works with a local authority because you cannot simply be on the outside shouting at them. That balance needs to be made. I do not feel constrained in talking to members. I am possibly in the privileged position that we have a very high degree of agreement. The comment about members being very ready for the kind of discussion we wanted to have about public health is correct and we already had a lot of that embedded in the council prior to that change. There were people there who really were starting to think in that paradigm already. There are inevitably going to be decisions that councils have to make where you want to be part of the debate about how that policy is formed. It is not a thing that you would necessarily want to be outside of, but the freedom is still there to step away if necessary. The positioning of annual reports is helpful. I took my annual report direct to the council last year. It is one of those things that is talked about a lot, and I think, in practice, it turns out to be not as big an issue as I thought it might be before working in a local authority.

Dr Pearson: I would agree with that. You have that dual role. You are there as part of the team because that is how you get influence, but, professionally, we do need that

independence. I would say, as Eugene said, about the public health report that every single report that gets published by local authorities is in a lead member's name, including scrutiny reports. The public health report is the only report that goes to Devon county council where it is my report. It is not a lead member's report; it is not a political report; it is my report and they know that. They are a bit wobbly about it because it is very different, but they have embraced that, and, particularly if using information that is relevant to them and their ward and their constituency, they really understand that. That independence is very important because things may come up that we are not happy about and we have to have the freedom to speak.

Q113 Mr Bradshaw: I want to pick you up on that because one thing that was made clear to us in earlier evidence was the importance of this independent role. Historically, if you think about the great public health experts over time, they have spoken out and challenged. I can think of examples in London, for example, with air quality now being such a massive public health issue, where you need a public health champion who is going to speak out and say, "You cannot adopt this transport system." Can any of you give examples of things you have stopped happening that you think would be negative in this role that you are using so well and so independently?

Ros Jervis: I have an example where there were concerns about the terminology I wanted to use. In Wolverhampton we have—there is no other way to put it—an obesity crisis. We have huge issues with overweight and obese children and adults, and of course you do not want to promote your city as being one of the worst in the country for people being overweight or obese. It is about the toning down and whether we should be talking about obesity in that way. It is about making a statement and saying it as it is, the scale of the problem, but then being solution-focused in what you are going to do about it. We had to talk through that. You do not want to put your city in a bad light, but we do have an issue. We have some plans to try to address that issue, and everybody, from the senior leadership team to the elected members, has been absolutely behind me in trying to address that problem. Using the terminology and spelling it out in the hard-hitting way that we did was accepted and we did it.

Q114 Mr Bradshaw: Are there any other examples from the rest of you?

Andrew Howe: The issue of sexual health services crops up. That was a new thing to be talking about with elected members. Many struggled to understand the scale of that service development. I do not think it is about saying that I stopped anything. I think I took people on a journey, to influence, lead and develop a way forward within the boroughs where I work and more broadly. It is more of a strategic leadership position than saying "Stop."

Q115 Mr Bradshaw: Dr Pearson, I am not picking on you, but you are the representative from my local area, so I have some local expertise here and I can think of two examples of policies, which, on the face of it, given what Professor Marmot has just been talking about, are probably quite damaging to the public health of my constituents. One was the significant cut in supported living that was implemented by Devon county council following the Government's change of policy; they de-ring-fenced the money. This has led to a huge increase in homelessness and rough sleeping in Exeter, with drug taking, alcohol abuse and so forth. The other example is the decimation of our youth service. Were these

policy areas that you were involved with and, if so, did you try to influence them; did you speak out against them?

Dr Pearson: The first one, around supported living, happened before we made the move over. At that point, we had done a homeless and a housing needs assessment, and we were in quite a lot of debate with both the city council in Exeter but also with the county council, the lead member, about whether this was the right thing to do. We were very clear at that time that we had concerns about the impact. It is difficult when you are looking at the impact of a policy change, and this is a social care policy change, to disentangle it from other things that are happening in policy terms elsewhere. For example, when I was last in London about three weeks ago, I was shocked at the number of people who were on the streets and when I saw some statistics, I think last week, which showed how it had increased. There is a global issue for us, but there is also a local issue as well. It is our role to challenge and unpick that. That is, for example, something that I have been talking to our scrutiny chair about because, as well as dealing with my lead members, the cabinet, I also have a role in respect of scrutiny chairs and talking to them about what the data show. There is something there for us. How far we go along that journey of unpicking it and looking at cause and effect I have yet to determine, but it is something that is of concern.

In terms of youth service provision, Devon, like a lot of places in the country, has been looking at how it can get more for its money. Youth service provision was part of a cost-improvement programme. There is a different model in place now, but it retains something that Professor Sir Michael Marmot was talking about where you have a universal service, and there are different ways of delivering that. The route that Devon has gone down is to engage the communities in delivering that service, which is going very well in some areas, but retaining that employed staff to offer that targeted service. They are not the same staff, so it has separated the staff working together, a bit like the way that we as directors of public health work with Public Health England—we work in partnership—but it is able to do that and to get, hopefully, the same outcomes for less funding.

Q116 Mr Bradshaw: You would have no qualms—I may have missed it—about speaking out publicly and critically of a decision to do something like cut the supported living.

Dr Pearson: No, I would not. With the youth service, I was involved in that because I had done a big review of early help services, so I could see—in fact, it was something the Committee was just hearing about—that all sorts of public sector professionals have a role in providing advice and support, not necessarily health improvement, but thinking about children and our responsibilities for children and young people and making sure that they are getting the support they need at a very early stage. I was doing that work, and some of the things that we got out of the consultation with young people were that they really did want to see different models of delivery of health and care services. We have a danger, if we carry on doing the same thing all the time, when we say, “No, actually, it was always like that, and we need to do it like that.” We need to be part of assessing need, advising and making changes to get best value for money.

Dr Milne: The problem I would have in answering your question is that what I have mainly seen at a local level is heroic efforts to ameliorate the difficulties that local government finds itself under. I certainly think that we are being listened to in trying to do

that, but it is a very difficult task. There are far more opportunities to speak out frankly against national policy that is being imposed on local areas and creating those difficulties, and that—

Q117 Mr Bradshaw: What is the political control of your local authority?

Dr Milne: It is Labour.

Q118 Mr Bradshaw: So you are in a slightly different position from Dr Pearson, who works for a Conservative shire county, who may feel more inhibited to speak out. You are free to say what you like about the Government, are you not, and you are probably encouraged to do so by your political masters?

Dr Milne: It is not quite the way that I have seen it.

Q119 Mr Bradshaw: Do you accept it is much more difficult for Dr Pearson?

Dr Milne: I do accept that, but I have not been in that position so I cannot really comment.

Q120 Mr Bradshaw: Can I pick you up on the thing you said, while I was out of the room, on the challenges of working in a two-tier area, and this may apply to more than one of you? I will give you another example. We often feel in Exeter that our public health needs are very different from neighbouring east Devon, and they are. When there was a cut to our school nurse provision, which did heroic work in reducing teenage pregnancy rates in my constituency, it was felt that that was a decision that was being made by the county council, which had very little knowledge and even less concern about what was happening in the small urban part of that shire area. How much of a challenge is that for you and how much do you think it is generally in two-tier areas?

Dr Pearson: The facts of that are that we are just coming to year four of a five-year contract for integrated children's services, and the funding for school nursing over that period— and certainly next year—will not change because we have protected that. There is a difference between what you put in financially as a commissioner and the difficulties or challenges that a service may find because of, for example, recruitment. Recruitment to school nursing posts is difficult. In a way, the drive to get additional health visitors put the focus on health visitors for nought to five but took away from school nursing, and with commitments such as training, education and maternity leave, it can be very difficult to find that level of support for those things. The role of the school nurse in early help is crucial. One constraint on our school nursing service is the inordinate amount of time that is spent either doing administration or in safeguarding meetings. There is a public health issue for us there because that comes down to prevention. The opportunity we have—and I would say particularly with health visiting as well—is that we are now the commissioners. We have large budgets, all of us, for commissioning that service, and we need to apply some of those things that I was just talking about that we have been doing in Devon around the youth service, engaging with young people and finding different ways of delivering the service in a more integrated way so that we get better outcomes.

One thing that is really important to us is the public health outcomes framework. That is one of the best things that happened because it focuses us on outcomes, less on the processes or being too directive with providers, but we must keep focus on outcomes. On

teenage pregnancy, every single director of public health is delighted to see that rate coming down. We must make sure that we keep those rates low. It is the outcomes that really matter to us.

Q121 Chair: Thank you. Can I ask you what other powers would help you to achieve your ambitions? Would you like to see local authorities be given a say in things like planning or licensing? Would you have recommendations for this Committee that would help you to do a better job?

Dr Milne: We are starting to explore what some of those options might be through the discussions that are going on around devolution. I think there may be regulatory powers that might usefully be applied in improving public health. Particularly when we are looking at licensing, we have a constant headache over the spread of availability of alcohol outlets in the city. We devote a lot of time to trying to support regulation in those areas. I would very much like us to have more formal public health input to some of the broader determinant decisions that at the moment we really do not get in early enough for. I am thinking about transport and planning in a way that we currently do not manage. Some years ago I was—

Q122 Chair: Are you consulted at all at the planning stage on things like clean air?

Dr Milne: Yes, but I think some of the rules tend to militate against the way that we might operate into this. If you look at the way, for example, road planning decisions are taken, the way in which benefits are monetised tends to neglect the utility of some groups. For example, a cycle journey tends to be considered of less economic value than a car journey and there is no utility attached to a journey by somebody who is retired. That seems to me to be very foolish. There is a substantial social value in that kind of mobility that we should be building into our decision making. A few years ago, I was involved in the health impact assessment for the second Tyne tunnel, and the problem we had at that time was that we were presented with an option that was exclusively about a road tunnel. We had never had the opportunity upstream to say, “Is this kind of infrastructure the way that we really want to go? Would it be better, in the long run, to be thinking about alternatives?” It is about that kind of upstream engagement, and some of that requires the changing of rules that are so obscure that it is quite difficult to find out how you set about doing so, but I do think those things are there. There are opportunities that we could be taking to try to influence health further upstream in that way that maybe we have a chance to do now that we were not able to before.

Ros Jervis: It would be beneficial if health and wellbeing was seen as a material consideration in planning applications that the planning process is considered in its own right—the benefits to health and wellbeing for that particular process or trying to minimise some of the harmful impacts that might have.

Q123 Chair: So a health objective.

Ros Jervis: Yes, and I totally concur in terms of introducing a public health licensing objective, and that is not just around the sale of alcohol. As to the other licensing powers that the licensing authority has, it could make a real impact rather than us trying to fudge it with some of the other four licensing objectives that we have. We were talking in the last

session about tools and toolkits around health impact assessments. They do not have to be onerous—there are some quick, mini-health impact assessments—but they need to be seen to be systematic, so not ad hoc just when you can persuade them to be undertaken. There needs to be a requirement, when you look at every single major planning development, to look at the benefits for these new communities that you are trying to build in health and wellbeing and trying to minimise some of the detrimental impacts that might not have been thought about in some of these developments.

Dr Pearson: It is the day that Simon Stevens has announced the healthy towns, and we have in Exeter and East Devon Growth Point Cranbrook, which I am delighted has been selected as one of the 10. One discussion we had with NHS England was the difficulty for us of giving health and wellbeing sufficient weight as part of the planning process, and particularly when dealing with private sector developers rather than local authority developments, it is much more difficult. There is something for me about how we get whoever is developing the land to put that level of priority into the planning. There is a lot of evidence around the built environment, going right back to what you can do about structuring the world in a way that makes it easy for people to make healthy choices so that you do not have to rely on health professionals giving advice. You do not want middle-class finger-wagging. You want people to be empowered to live their lives in the best way they possibly can, and they can do that within a nice environment where relationships are good, where social capital is high. It is those sorts of things we want to see, so planning is very important. I do not think we would have said that three years ago when we were working in the NHS. Because we see it now from a different perspective—what it is like being in the local authority, because NHS England is a statutory consultee and public health is not—we can see the disadvantages of it, but there is huge opportunity there for us.

Q124 Chair: You would like to be a statutory consultee.

Dr Pearson: Yes.

Andrew Howe: I would echo my colleague's comments. I would add that, of course, we are waiting for the childhood obesity strategy. The issue of licensing and regulation of fast-food joints, particularly around schools, would be really important. Anything that can make it easier for us to do that would be very helpful. I suppose in London we have a devolution offer, which is slightly different and I know it differs around the country. One thing that is common across London is devolution of estates and working with the NHS and new powers, which I think is helpful. From a public health perspective, anything that can help us locally with minimum-unit pricing or, as I have said, a sugar tax and fast-food outlets is going to be very helpful. So, yes, I would agree with colleagues.

Q125 Chair: You are saying you would still like to have a local ability to implement that. Do you not think there is an argument for saying it is better for it to be national?

Andrew Howe: Yes. Some of my colleagues have struggled locally in implementing things like all of the examples we have just quoted because there is not a national structure.

Dr Milne: It is interesting that some years ago, when we were looking in the run-up to what eventually became the tobacco legislation that was put into place in 2007, and looking at American models that we were trying to build on, with the experience in

California and so on, a lot of that had been built on very local actions, so action that was taken in towns and particular areas. There is a great strength to that because you have to build that local ownership of issues, which I think is helpful. One thing that we could do and do a lot better, I think, at a local authority level is to start to get information about specific local populations down to a level that allows us to be able to have the dialogue with councillors far more specifically about their electorates than we can at the moment. That has been improving and some of the stuff that we now have in Public Health England supports that, but I do not think we have gone far enough yet. We want to be in that position of having local dialogues about what works for local communities. It ties into that thing about design and what communities want. Engaging those communities in thinking about what their space—their environment—should be like is part of what we are trying to achieve.

Ros Jervis: Can I add another one through a slightly different lens? I have had a very positive experience as we have moved across into local government, but there has been a slight trade-off in our relationship with the NHS. I can only speak as I find in my own personal experience, but perhaps not being in the NHS means that the status of the director of public health and the work that the public health team can do to support commissioners within the NHS in their remit has eroded slightly. I do not have a clever idea in my back pocket, unfortunately. I wanted to come here today very solution-focused and I do not think I have an answer to this one, but a recommendation that would encourage direct relationships between the local NHS and their local directors of public health would be helpful in trying to maintain what we have. As we, hopefully, influence and become integrated in the world of the local authority, we can put a stop clock on anything going any further in terms of distancing ourselves from the NHS. That, hopefully, would support not just clinical commissioning groups, with which I have a very good relationship—we are coterminous with our CCG and it is really strong—but, as to the wider NHS, in terms of acute providers, community services and mental health trusts, some form of support of the relationship between a local authority director of public health and the NHS would be helpful.

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

Q126 Julie Cooper: What do you think of the value of health and wellbeing boards and what do they contribute to the processes? Are they a useful tool or a hindrance?

Ros Jervis: It is early days. They have huge potential in trying to lead a local system. There is a level of maturity that probably varies across the country as to how developed health and wellbeing boards are in making progress and outcomes against their agendas and their priorities. Again, personally speaking, there is a strong sense of wanting to do the right thing across our local partnership, and that is what it is. It is not a local authority

committee; it is a local partnership for the health and social care system in trying to do the right thing. The latest NHS planning guidance on sustainability of transformation plans might aid that local system and hopefully give health and wellbeing boards something tangible that could show their mettle a little more in driving through change at a local level. There are still quite a lot of things that health and wellbeing boards could do. There is a lot more potential out there.

Q127 Julie Cooper: It is about finding the role, you think, and defining it more clearly; is that right?

Ros Jervis: Yes, possibly. Sometimes not trying to change everything and trying to absolutely choose just a few priorities that you are going to do well for a local system might be a better way forward. Yes, some clear priorities and understanding across the entire partnership is what it clearly needs to be. There are a lot of players around that table who need to contribute to meeting those outcomes.

Andrew Howe: Certainly, my local experience echoes some of the national and regional reports. There was a good report in London done by London Councils that suggested that, yes, we are at an early stage of health and wellbeing boards, but particularly I think CCGs saw them as a threat initially because they were very much a council-focused committee. While I was on a learning curve in terms of a new culture, so was the CCG. I think we have moved on from that considerably. The ability for us to be able to engage with Healthwatch and residents is much better than any mechanism that I ever witnessed locally before three years ago. Being able to discuss the Healthwatch “enter and view reports” and “take actions”—you were hearing all about health inequalities and the Marmot report earlier—to translate that into a health and wellbeing strategy that we can get local ownership on and track outcomes has been helpful at a local level. We need to take it to the next level. We sometimes struggle with engagement with providers. People are not necessarily comfortable with that commissioner-provider split, with having chief executives or chairs of acute or mental health trusts on the same board. We are certainly, locally, on that trajectory. I would echo the point about the sustainability and transformation plan because that takes us to a new level. It takes us to a new level on a more patch-based geographical footprint, particularly with our ability to engage with senior officers or chairs of the provider trusts. That is going to be a bit of a challenge for the health and wellbeing board—all of them in the region that I work in.

Dr Pearson: Since their creation, it has been good to know that there is one place where the main players come round the table and all agree, as Ros said, a limited amount of priorities based on a joint strategic needs assessment. Before 2013, directors of public health were very engaged in undertaking and talking about joint strategic needs assessments, but they never had any traction, so it has, as Andrew says, made the link between the needs assessment, the strategy and the outcomes, which is really important. From our local example, we have spent a lot of the time talking about mental health because that is such an important issue for us. We feel that, just by talking about it, with our CCGs, clinical chairs and our chief probation lead and the police and crime commissioner around the table—we have the key players around the table—it is a very significant place to have that debate and discussion.

The disadvantage comes in that health and wellbeing boards have no teeth. They have no statutory powers, so they have to do a joint needs assessment, they have to produce a joint health and wellbeing strategy, and there are a few other things they have to do, but they do not have a specific joint commissioning role. Those things were talked about at one stage but did not materialise. The question for us is where they fit alongside devolution and where health and wellbeing sit in that. They are strange because they are committees of the local authority, but officers sit on them and have a vote to the same degree that the elected members do, so they are very odd committees. It is like us sitting round here and having a vote, and we have the same vote as you and we are not democratically elected, so they are very strange bodies, but if you just take them at face value they are a place where you can come and agree those priorities together and can make sure that everybody's plans align. That is their value.

Q128 Julie Cooper: That is pleasing to hear. I used to sit on a health and wellbeing board as a former council leader when they were new, and on the one I was on I always got the feeling people were not quite sure where it was going. We all had views about it and we would identify priorities, and then it would be, "Where are we going with them?" The CCG, I do think, felt the pressure as to whether they were under criticism, et cetera. It is good to hear that they have moved on; I have been away for a couple of years. Did you want to add to that?

Dr Milne: Yes, briefly. If we did not have one, I would want one because it provides a place where you can establish consensus around issues. The dialogue is very good. They have suffered from the burden of expectation—that people have thought they are going to do all these things and they do not have an infrastructure to do that or, as my colleagues have pointed out, the statutory powers to allow them to do some of the things that people expected of them. But, at the same time, the accountable officers group that works to our health and wellbeing board is being effective. We are starting to make real progress there in developing working relationships that are quite strong. These things are all work in progress, but, as I say, I would not want to be without it.

Julie Cooper: That is pleasing to hear; thank you.

Q129 Emma Reynolds: I would like to ask about commissioning. Perhaps unsurprisingly, the Local Government Association say that, now that public health has been transferred to local authorities, there has been a huge improvement in the commissioning. That is evidence to the Committee, but we have also had evidence to the Committee to the contrary, particularly from sexual health campaign groups, I must say. Can you tell us a bit about your experience of commissioning from within the council rather than commissioning from within the NHS, and do you feel that your team has the skills and support that they need from the council to do that commissioning effectively and the monitoring, crucially, I guess, of what is being commissioned as well?

Dr Milne: To kick off, the commissioning process we have on the council is substantially better than I have seen in the NHS. The NHS deals with enormous contracts and ends up, to a large extent, rolling them over from one year to the next with small adjustments for inflation. It does not get into the sort of detail that council commissioning gets into. We have reviewed services more thoroughly and effectively as part of the commissioning process since I have been in the council. It is doing it very well. The support is excellent. I

am very happy with the way that has operated. A testament to that is in the public health budget that came over to Newcastle, where I think we have made some significant efficiencies without losing any significant amount of service, which has allowed us then to invest in some areas that we would not have been able to, even given my comments earlier about the financial situation. I think it is better.

Ros Jervis: I would agree. It is better. I came in with a very small team, so we had to build up some resources to do that and get a plan. We developed a commissioning strategy and a procurement plan within that over a five-year period where we wanted to review our services. We were able to draw out quite substantial efficiency savings that we wanted to reinvest in services that were going to meet the needs of our population. If we had not developed those strong systems in the local authority, particularly around contract monitoring, I do not think we would have been in a position to do that. The services we have been recommissioning and retendering I think are much more tailored to meet the needs of our local population. We have been able to consult to a wide degree. We now have services embedded and established, particularly around drugs and alcohol, so we are in our third year of our drugs and alcohol service. A new service started right at the time that we transferred over. We have also been spending a significant part of our time in the local authority looking at retendering our sexual health services. I can say it is much more community-focused; it is going to meet the needs of our population. They had a good chance to feed their thoughts in, particularly our vulnerable groups. I think, especially from a sexual health service perspective, we will have a much better service for Wolverhampton residents than we have currently.

Dr Pearson: I am in the same position. I do not think you can make a comparison. As Eugene says, one reason why costs probably continue to rise within the NHS is that they do not do what we have had to do over the last three years, which is to take a critical look at what we are commissioning, listen to what our residents say, look at their needs and then retender. The downside is that tendering is time-consuming. To do it well, you have to have good support from procurement colleagues. We are in a similar position. We have had to make investment in procurement capacity because the NHS did not have anything like it. Where we have gone through that process and will go through that process over the next two to three years, we will be using it to seek efficiencies and, not only that, to readjust what we commission so that we are getting better outcomes for our money and better value for money. Again, it is difficult to know where the comments have come from.

For example, I chair a sexual health alliance, which involves providers—it is for Plymouth and Torbay as well as Devon—and we have voluntary sector representatives there and have topic-focused meetings. It is not about the contract, but we debate and discuss where the gaps are and how we can best meet those needs. It is a very mature relationship. They understand the procurement process. It is difficult for providers and it is competitive, but they understand that process and see that where we think something is important we will invest in it, and we have invested. We did not invest prior to 2013 in sexual health services. We have invested hugely since 2013 because it is an important thing for us to do and we have seen the benefits of that. We have that discretion.

Again, that is the difference with the NHS. Within the NHS, you do not have that discretion. You do not have that control over what you do because you are part of a huge

contract. We still operate payment-by-results contracts; we still have a relationship with the voluntary sector where we do a different type of contract; and we have hundreds of contracts with GPs and pharmacies. It works well, and the other feedback we get from our providers is that we know what we want now, whereas in the NHS the contracts went on but they did not really know what we wanted. We have that debate with them. It is fantastic. It is just how commissioning should be. The LGA—I will put in a plug for the Local Government Association—support us with that and use sector-led improvement, which does not exist in the NHS. That is about us helping ourselves do the best thing. It is about peer review, support and benchmarking, but it is all internally driven. It is a very powerful way of getting people involved in things. There is a huge amount that we have learned from the local authority and I do not think we have lost that much in leaving the NHS.

Andrew Howe: I would echo some of that. I do not think sexual health services were actively commissioned in the NHS because they were part of larger contracts. I am intimately involved with a London sexual health service transformation project. It became apparent that London spends about £100 million on genitourinary medicine services and another £60 million on other sexual health services. Then there is money spent on HIV prevention. Because people flow around London, and of course people come from all over England for the scene, as it were, in London, the clinics are used by everybody. The complexity of cross-charging and who pays the bills meant that we had to work together. Currently, we have 30 councils working together on a collaborative agreement. We have been able to put in common performance indicators and measure outcomes, probably for the first time, within these contracts, and now we are looking at reprocurring or recommissioning a new service model because we were not meeting the needs.

Sexually transmitted infection rates have been rocketing in some areas in London. We have not had good control of the clinical governance and serious incident reporting, so we need to work together. The new model we have been looking at has a much more electronic-service-faced front end, so people can order self-test kits for gonorrhoea and syphilis from the web to be delivered at home or the pharmacy, and people can book their appointments online if they need to. This is causing quite a lot of concern in the clinical community. I regularly meet with the presidents of the appropriate royal colleges. We have large events with clinicians from all around London. There is great support, I think. People know that the model has to change, and of course we have to make efficiency savings. Attendances have been rocketing at some of the clinics in London and they come from all over England. I do not think we are not making best use of public money there. We can do it much more effectively in a new way.

These are challenging times. Reprourement will be a complex undertaking, particularly when we have over 30 sovereign local authorities, ensuring that they will collaborate. We cannot have a bit of the system in London doing one thing and another bit doing another. It will cause problems with patient flow. Patients will not know what we are doing or where to go, so we will have to have a big behaviour-change programme so that people have access to the ways to address their needs. This has not been done previously. The NHS did think, in London, about implementing an integrated tariff, which is a new way of paying for all sexual health services and getting properly integrated services. We are just at the cusp of introducing that now, pending some work we are doing over the next few weeks. We have taken huge steps ahead.

Ros Jervis: Can I add one thing to that? The picture looks rosy from what we have been talking about, but one thing that is creating quite a problem for us is around clinical governance arrangements. That might be some of the feedback that the Committee has heard, particularly from clinicians. Since we have come over into local government from the NHS reporting systems, such as a system called STEIS, which is used to log and report a clinical incident that can be investigated, we have lost the ability to access that system. If we had a clinical incident within a drugs and alcohol service or an incident within a sexual health service, it is not seamless any more in terms of the commissioner receiving the report on that clinical incident. We feel as if we are walking in a bit of treacle in establishing systems to try to overcome that. We have gained enormously with our commissioning and procurement ability, but we have lost this ability to hear in a very timely fashion about clinical incidents and being able to investigate in the way that we would have done in the NHS. That needs to be looked at.

Q130 Chair: Is that part of a wider issue around data sharing that we have been hearing about in many areas? Would this be a good point for the panel to share their thoughts about issues around data? That is a data-sharing issue, is it?

Ros Jervis: Yes, absolutely. It is linked to that, because often there will be confidential and identifiable information that is part of that incident—

Q131 Chair: It is the flow-back from the NHS into public health that is now—

Ros Jervis: —or the provider of those clinical services. The mechanism has been lost—the simple process where a report or an incident would be put on this STEIS system. The commissioner would immediately be able to see that this incident had taken place and then contact the provider as to what happened and what control measures have been put in place. We do not have that immediate response any more.

Q132 Chair: What is to stop you saying you would like to have those data? Is it that you are being told you cannot have the data because of data protection or just that it is a system issue?

Ros Jervis: I will give a “for instance”. We had an incident in our drugs and alcohol services. Our services are provided by three different organisations that have come into one consortium. One of those providers is an acute mental health trust. There was an incident and we got to hear of the incident—it is out of the Wolverhampton area, a mental health provider out of the city—from our CCG, which had heard from the CCG of which that mental health provider was a part.

Q133 Chair: What I mean is, having identified that there is a problem there, when you say, “We would like to receive those incidents,” what is stopping that happening now?

Ros Jervis: We do not know they have happened.

Q134 Chair: What is to stop you saying, “We would like to hear about all these incidents? Can we set up a mechanism?”

Ros Jervis: We do, but it is about knowing that they have happened in the first place. We have immediately reacted to these sorts of issues and tried to address this by putting in

processes. It is written in the contract that if any untoward issue happens they need to feed that back to us. I do not think it is happening in a systematic way. We do not have that failsafe process any more to know when there has been an incident or not.

Dr Milne: I understand your point, but I would have said it is part of a broader range of issues relating to data and there are all kinds of reasons why these things do not happen. Some are to do with the systems themselves and some are to do with either data confidentiality or perceptions of data confidentiality and the reasons for which data might be shared. It is generally perceived as a key issue as we try to move towards more integrated services, but at the moment data do not flow and are not linked in ways that would be useful and to substantial patient benefit. Frankly, although a lot of the time it is motivated by trying to protect the public, the public shares so much of their data now in any case that they probably expect us to have shared it in order to benefit them individually in regard to their care and support. We are failing to do that, but that is a very broad system issue rather than a specific one, I think, about the public health transfer. This applies every bit as much to links between social care and the health service as it does to public health.

Dr Pearson: There are some strange anomalies, and this is one, Sarah, that you will be aware of. A few years ago, I published my annual public health report, and one thing I did was to publish immunisation rates for all practices. You picked up that immunisation rates for MMR in Totnes were significantly lower. We put in place a huge programme on the back of that—not just your personal interest in it—because we could see there was an inequality. I have not had access to those data for three years. I know, for example, that my scrutiny chair has also tried to get hold of information and has not been able to get it. There is a difference between having to go down on bended knee and plead for it and getting it shared and, as Ros was describing, it being our right as directors of public health to have access to that because we are interested in inequality in health, we are interested in clinical safety and we are interested in a whole range of things. If we cannot get access to that information in a timely way, we cannot exercise our statutory duty around inequalities in health because we cannot see it, so we are blind to it. Not only that, we cannot hold NHS England to account for its actions in respect of any inequalities that arise.

Some of these are significant, because when we are talking about screening and immunisation programmes those are some of the things that can mitigate what Professor Sir Michael Marmot was talking about on health inequality. We know that cervical cancer is more common in women from lower socio-economic groups and we need to know that information so we can work with colleagues to act on it. So there are issues that are getting in the way. Having said that, there is progress, after three years, just being made to allow local authorities to be safe havens for some of these data, but it has taken three years and we are not there yet. That has been very slow progress by the Health and Social Care Information Centre. That has been for a number of reasons, but it has been a shame that it has taken three years. We have lost ground on that.

Q135 Chair: You are expecting a change imminently, are you?

Dr Pearson: Yes. It will not do everything that we want, though. We are still concerned about access to things like pseudonymised NHS numbers, which we need for analysing the relationships between interventions and outcomes. There is a lot of epidemiological

expertise that we have so that we can do these analyses and answer the questions that members perhaps have about things. We can help support our NHS colleagues with some of this analysis, but if we cannot see the data and we are blind to them, we cannot do that. That has definitely deteriorated.

Q136 Chair: I should rephrase my question. When have you been told that you will start to have proper access to the data you need to do your job properly?

Dr Pearson: It will improve when we are designated as a safe haven. I do not have a timescale for that yet.

Q137 Chair: You do not know what the timescale is.

Dr Pearson: It varies across the country, so you have to comply with the information governance requirements before you can be accredited to be a safe haven. I think that work is progressing. I do not know what the situation is across the country, but certainly it has been a gap in information that has been a shame.

Andrew Howe: Yes; we are just about to receive what is called a pseudonymised dataset, which will help to some degree because then we can understand who is being admitted to hospital for what conditions and do some of that analysis that we used to do. We will not have the ability to link it to other datasets. I think in my written submission I quoted the example of the troubled families programme. My team are frustrated because, if we had the individual patient data, they could look at the information for a child going into hospital with asthma, for example, and link that to what sort of housing they are in and develop better preventive inventions quite locally. Another example locally is that we have done some work on burns and scalds in children, and we can get access, if we have an honorary contract or other mechanisms for the NHS data, but again we cannot look at how the rate of scalds and burns relates to other housing interventions and the type of housing they are in.

Q138 Chair: That has a direct input, would you say, on the Marmot agenda that was being discussed earlier?

Andrew Howe: Yes.

Chair: That is helpful. I am sorry, Emma; I am conscious I asked a supplementary and you had not finished your questions.

Emma Reynolds: I think the supplementary was about sexual health services and that has been answered.

Q139 Maggie Throup: Are the respective roles played by different organisations for health protection—that is including screening and immunisation—sufficiently clear?

Andrew Howe: In London, we have a memorandum of understanding between all of the councils, NHSE and Public Health England. The roles are reasonably well described there. It has run smoothly in terms of health protection issues—the incidence and the outbreaks of notifiable diseases. That bit has been relatively straightforward. As Virginia was describing earlier, the difficulty on immunisations and screening is much more

problematic because of the data. First, we cannot get data. The system was fragmented in 2013 at transfer. We are still struggling to get the reports that we need to understand the immunisation rates locally and how we can help improve those. I imagine this is a national problem, not just our regional problem. Members in our health and wellbeing boards, not just of our scrutiny committee, are very keen on this. To one degree, we have had a good response from NHS England. They have written reports and presented quite regularly to scrutiny committees, because it is not just the data getting to us; it is the data transfer between the general practices that are doing some of the immunisations to NHS England themselves. We are not sure, as we sit here today, whether our coverage rates, which allegedly have been falling in some areas, are due to fewer vaccinations or some dataflow issues. There is some real work still to do there.

Dr Pearson: It is quite interesting. One thing I have noticed is that my direct relationship with GP practices is not the same as it was before when I was in the NHS. You always were in the position, as director of public health, where you could just phone up the practice, speak to the senior partner or practice manager, have a conversation about it and it was instant. Because I have been in Devon since 2007 I know the practices still know who I am, but I would not have the same relationship with them because NHS England is the body that has the relationship with them, and that is a shame because that relationship that we have with our GP practices, in terms of what is going on locally, is very important to us.

Ros Jervis: Health protection relies very much on local relationships and networks. In Wolverhampton, we have a very strong relationship with Public Health England and the team that deals with outbreaks of communicable disease. As a result of that, over a number of years, and since our transition to local government, our relationship has maintained a strong link. We are very clear in terms of reports to one another and there is dialogue immediately on any threats that are on the horizon or concerns that might get into the public eye and cause some real anxieties. I do not think that side of the coin is of particular concern to us locally. However, if we had not had those local relationships and networks, that would be an area of real concern. A system should not rely on personalities and individuals to make it work. It should work whoever is in post and whoever has been, historically, working in that field.

My second point—and it is a tale of two halves—is on the screening and immunisation side of our health protection work, which I have some real concerns over. I cannot fulfil my scrutiny and challenge role as a director of public health in Wolverhampton in relation to screening and immunisation programmes. I feel that information is being deliberately withheld from us, from local authority officers who are part of my team who are trying to get involved in this world, and—

Q140 Maggie Throup: Who do you think is withholding it?

Ros Jervis: I have a particular instance where we are invited to sit on screening programme boards at a local level and the member of my team who went along to that particular board did not have the same paperwork for that meeting as others around the table did, and the missing papers were the performance data in relation to that particular screening programme. There are some real anxieties in the NHS in sharing that particular data. Finally, through a very protracted process, we managed to get information at a

GP-practice level in relation to seasonal flu vaccine uptake, but we do not get any information at a practice level in relation to childhood immunisations. For an area like Wolverhampton that notoriously has had some real issues in the uptake of absolutely crucial immunisations for children—I was a part of the system before we transferred over and we were constantly on top of that, having that very direct relationship with GP practices in terms of cues and of children who missed their appointments—I feel that the new system has lost that local feel. You have NHS England, which is on a much wider footprint, that does not, and cannot on that footprint, have that relationship with GPs. It is not going to work. They cannot have that same relationship. Therefore, I do have worries that something big might happen and we are going to be finding out after the fact when we could have got involved at a much earlier stage of the process and prevented something like that from happening. It is a tale of two halves.

Q141 Maggie Throup: Do you think that improving data sharing would solve the problem? That is the answer, is it?

Ros Jervis: I think so, yes.

Q142 Maggie Throup: Relationships built up over years do not go on for ever more because GPs retire and people move on to different jobs, so it is purely down to that data sharing.

Ros Jervis: It is. Those local practices still contact us, so on the recent issue with the meningitis B vaccine, it was the public health team within the local authority that received the calls from worried parents, that received the calls from practice managers and GP practices in terms of the programme. We are not the commissioner of these programmes but we still have this voice; we still have a role to play in putting out information to our local population and calming down anxieties and painting a picture that is fair. The fact that we are often playing catch-up and potentially even finding out about issues in the local press is not helpful.

Q143 Maggie Throup: Apart from data sharing and the relationships, is there anything else that can be done to solve the problem?

Ros Jervis: If we had access to data at a level that would enable us to carry out our scrutiny and challenge function—our statutory role in that—that would resolve a lot of the issues.

Andrew Howe: I am not sure it is just about data. Prior to 2013, we had primary care performance teams in primary care trusts and there was quite a lot of capacity staff who had close relationships with general practitioners who were able to support, develop and monitor. I do not think NHS England have that capacity and they have lost a lot of staff. I feel great sympathy with everybody in the system trying to control this at the moment. It is not just data.

Dr Milne: On the data issue, likewise I have had trouble in getting data at a level we would like, although the performance has tended to be very good in our area so it is not a thing that has been so high on my agenda. As to broader health protection, the service we have continued to enjoy from Public Health England in support of that has been very good. Despite the fact they have also suffered from being outside the NHS ring-fence now

and so have suffered significant cuts to the services they are offering—and that is problematic and short-sighted, frankly—they have continued to provide a very good service that we have been extremely happy with. This question of data is something that gives us a real headache. We cannot get that practice-level data in the way we want. Part of that locally for us has been because of the commissioning service that supports commissioning on the NHS side, which, although we have tried to buy data from them, have not been forthcoming. There are some problems there that need to be resolved.

Ros Jervis: Can I add one point on proactive health protection work? We put health protection as a reactive service, so we are trying to respond to an incident of some kind, but there is a role in a proactive way to try to do some preventive work. An example we can give on that is potentially some of the blood-borne virus issues within our vulnerable population groups. We have been doing a piece of work with our local refugee and migrant centre where we have been looking for latent TB, but we have also been looking for blood-borne viruses at the same time. We have had some real successes in supporting those individuals through and navigating the healthcare system. That might be an area that is not a clear remit in terms of responsibilities, by organisation. I am sure Public Health England are very much focused on trying to do their work with regard to responding to incidents, and, as a discretionary service within a local authority setting, it might come under financial pressures moving forward.

Q144 Maggie Throup: My last question is: do you think the NHS is able to meet the public health challenges set out in the NHS Five Year Forward View?

Dr Milne: That is a big question. Are they able to? Will they do it? Are they trying to do it at the moment? I will start with the things that have got the big headlines. On the NHS Diabetes Prevention Programme, I am disappointed in the way they have gone about it. We commission local services from a variety of different providers who are already working in the kinds of areas that are talked about. We would very much have preferred to have been in a position of being able to develop a diabetes prevention service with them rather than having a national procurement that was visited upon us from above. My criticism of that would be that there is a sense that NHS England is looking to try to reinvent public health when we already have public health structures. That bothers me quite a lot.

To some extent, the healthy new towns initiative is part of the same thing in that the reason we are where we are and the reason why we welcomed the move is so that we can do the sorts of things that they are now trying to do through that initiative. I have to say I am not sure whether there is any money attached to that initiative at the moment. It seems to be advice, but I do not know where the advice is going to come from in order to do the things that they say they are going to do. At the moment, my feeling is that there is talk—the commitment to secondary prevention in the Five Year Forward View is very welcome—and it is quite appropriate that we should be trying to get into that area, and the NHS needs to get into that area. It has to do that, and if it is going to get anywhere near to dealing with the financial challenge it has in the next few years, there is no question that they have to do it to a much greater extent than they are at the moment. There is a blurring there and a lack of understanding about the way that these things ought to operate and how they will operate best. I fear for a lot of the third-sector providers who are caught between a rock and a hard place in all of this. They are suffering from austerity at the moment as

well and they could be very potent in this area. We have heard a lot about how non-traditional agencies can play into the public health agenda. A lot of what we should be trying to do over the next few years is to build on those community assets to deliver that agenda. That does not feel like what we are being offered at the moment. It is a small rant.

Maggie Throup: It is fine. It has got you going, yes.

Andrew Howe: Building on that—and I support that— what concerns me is the timeframe. We are one year into the five-year plan, and you will have heard this plea many times. The idea that return on investment can always be within five years is very challenging to some of the fundamental things that we have to change; prevention takes a lot more time to deliver. Until we get out of that short-term cycle, we will all have challenges. That is my fear for the NHS. I welcome the high-level commitment from Simon Stevens and the Five Year Forward View, but being able to deliver it, because of resource challenges, is my anxiety.

Q145 Helen Whately: Can I pick up on that comment about the delivery of public health under the Five Year Forward View? How integral do you feel, as directors of public health, in that delivery? Do you feel part of that or does it sometimes feel separate from the objectives you are trying to achieve?

Andrew Howe: I feel very much part of it because of the sustainability and transformation plan. For me, that is how it has been enacted locally in both sectors that I work in. We are certainly being asked to help them to describe, using JSNA, the health of the local population, but also to put into place and advise them on broader preventive strategies. Although we are doing lots of preventive work, as you have heard today, I am being asked to say what the NHS can do now and how we can help them to implement Making Every Contact Count. Bringing in Health Education England, being able to argue for resources from HEE to deliver Making Every Contact Count, to support the delivery of the SDP is fundamental. There is lots of work to go, but we are at the table.

Q146 Helen Whately: That is very helpful. You feel integral, yet it is interesting, in hearing your language, that it feels slightly “us and them”; it feels like there is a distinction between what you are delivering and what they—

Dr Pearson: It is the difference between national and local. At a local level, we are actively engaged on that agenda because we have been saying for a long time that we believe in public health; we believe in prevention; we need to do more of this. One big advantage of moving over to the local authority is that we have been heard by our local members, and Simon Stevens’s Five Year Forward View was brilliant in saying that the NHS needs to take prevention seriously, so that is great. We get a bit of disparity between our local NHS partners and what happens nationally. There is a bit of top-down, “We are going to do it this way,” as Eugene has described, which is not sensitive to the local needs and does not necessarily take sufficient account of the outcomes locally. You want a bit of a graduated response because you cannot say we are going to have this across all of the population if you do not know where your differences are, because you need a bit of targeting. You will have populations that are more obese and will need more support, so you need a bit of variation. That is the thing that seems to be lacking: it is the

disaggregation between what the CCGs are doing locally and the way that NHS England is approaching some of these things. They are too big and too distant to be able to engage with local communities and local directors of public health because they are very few and far between. They have gone through huge reductions in staff, and I think, as Andrew was saying, that we are very mindful of the fact that both in Public Health England and in NHS England there are many fewer staff than there were in 2013. It does make relationships difficult.

Chair: I am conscious of time because we are coming to an end. Did you have any further points?

Helen Whately: I have a couple of questions on funding and now might be a good point to ask.

Chair: Yes, it is a good point to bring them in, because then we have James and Philippa. James has to leave at 5.30, so shall we quickly take his first?

Helen Whately: As do I, in fact.

Chair: You carry on then. Can we have short, snappy answers if possible?

Q147 Helen Whately: My question is this. Given that we were talking about the importance of public health and prevention—they are very high on the radar—and many of your responses or concerns have been on funding reductions, can you give me your view on the impact of the funding reductions to public health, not just the impact in terms of services that will need to be reduced, potentially, but the impact in outcomes terms as much as possible?

Dr Milne: So far, for the reasons we have already discussed earlier, in terms of the efficiencies in the way we have recommissioned, we have managed to cushion a lot of things. I do not think we can carry on doing that. As we go on from here and get into the reductions over the next few years, that is going to start cutting into some of the core services and I fear what that is going to do to outcomes. There has been a lot of discussion about sexual health services. It is quite clear we are going to have to start making reductions in that area. Some of the areas we would want to protect, such as early years, in line with Professor Marmot's recommendations, are also going to start to feel the squeeze over the next few years as a consequence of those things, so I do not think we are seeing it yet. Public health is a long game. These things register over a long period of time. When I say "a long period of time", it places start to lose, for example, action on smoking in pregnancy, that is going to impact on health not only now and within the next few months but in 70 years' time, when people who were born with lower birth weight because we did not manage to do anything about the smoking then have heart disease. The outcomes are spread over a long period, and in a way that is what makes public health vulnerable; it is that you do not necessarily see those immediate changes. You cannot put an easy number on to that impact, but it will be there.

Q148 Helen Whately: Although the fact that emphasis on prevention in the Five Year Forward View and the timeframe of that suggested quite a quick impact from—

Dr Milne: That is a slightly different thing. It is the distinction I was drawing before between primary and secondary prevention. The NHS needs to do secondary prevention. It is for those individuals who already have established disease or risk factors where you can intervene with them and you are going to change the course of their illness in a short space of time. The sorts of things we are talking about are primary prevention for people who are currently well, where we are preventing them from getting to the point where they need the secondary prevention. That is generally by far the more cost-effective and impactful area to operate in, but you do not get the results quickly.

Q149 Helen Whately: You are looking further out in fact—essentially, the sustainability of the health service, as well as the impacts beyond that, but beyond the five-year period.

Dr Milne: Yes.

Q150 Dr Davies: The reason I have to depart shortly is to meet the chief executive of Public Health England, but my question to you is: what could he or his body do to help you in your roles? What more could he or they do?

Dr Pearson: He did a fantastic thing getting the additional funding into public health for local authority directors of public health and their councils in the beginning. There is no doubt about that. His personal work behind the scenes to achieve that was magnificent. It was almost too good to be true, in a way, because it started us all thinking with local authorities as to how we could really do that primary prevention work that Eugene has described. No one was expecting the £200 million in-year cut. That has had a varying effect across the country, depending on a whole range of things. As I often say to my elected members, one of the greatest inequalities is the inequality in funding. The per capita funding per head of population varies sixfold. We are fifth from the bottom—we have moved down—but it is huge. It is right that some of that should relate to outcomes, but there is something there that Public Health England never got to grips with because the ACRA formula, which was going to sort some of this out, for some reason was not applied, and I suspect that is why we only found out two and a half weeks ago what we were going to get in terms of that budget for 2016-17.

I would say to Duncan thank you for what you have done, but please help us over the next three to four years as we are making those cuts and understand what it feels like. He is great at going round to places and listening, but across the country there will be a huge variation in the impact of those things and he needs to understand what that is because he did make a point—I think in one of his weekly briefings—or some comment about it not being maybe as important as some of the things that the NHS does. Locally, there was quite a lot of concern, because we have to keep investing in primary prevention and we have to help people to help themselves to do it and need to make sure that we are working with our NHS colleagues to guide and support them in their secondary prevention agenda. If we do not do primary and secondary prevention, healthcare and social care are unaffordable in this country. So we need Duncan behind us, working with us—Public Health England working with us—to make sure that we are supported to use the diminishing resources that we have in the best way possible.

Ros Jervis: Can I add to the last point that Virginia made as to the work that Public Health England can do at that national level? It can help us with the narrative around primary prevention and those long-term outcomes, value for money and return on investment indicators that actually land. They are tangible and realistic. It can help us with that narrative so that we can continue with investment on a needs basis at a local level and stand shoulder to shoulder. Others are all competing for that same diminishing investment. He could really help with us that narrative through some clear indicators. The other thing is around some modelling work around business rates retention and how that is going to be established. I have major concerns. If the ACRA funding formula had been applied—and I perhaps come at it from a very different perspective to Virginia—it would have been devastating for the city of Wolverhampton. We stood to lose a significant amount of money if that had been applied. Looking at those deprived areas, when aligned to indices of multiple deprivation, it shows that ACRA was going to have a significant effect on areas that are more deprived than others. It would have been really bad for us if it had been applied. My concerns, therefore, relate to getting ready for 2020 and public health being funded through business rates retention. As to the modelling that is going to be used in Wolverhampton—Emma Reynolds already stated that business rates would not be great in areas like ours—this equalising out across the country of spend through business rates needs to be looked at carefully. I would want Duncan and his team at a very high level to be part of that process around a fair share for areas around the country.

Andrew Howe: We have had great support from PHE regionally and from Duncan as well. I would want him to do more of that, but particularly work across other Departments. He came to look, locally, at an example where we have employment advice, training and mental health services together and benefits advice very much joined up. We need to do more of that, so the ability for him to work across is critical locally.

Dr Milne: Can I say briefly that to preserve the health protection function we need that very much? The information function that they provide is developing and I think could go further. It could still provide some practical support to us at a local level that it does not yet. I am thinking, for example, about journal and data access to a level that we do not currently have; that would be very helpful. On the health improvement side, it is more problematic for Public Health England because of where it is placed and because it does not have that many levers it can pull. On that, they could be more responsive to local leadership rather than trying to lead from a national level for the local areas, if you see what I mean.

Duncan has been a great champion for public health. He has been very strong on articulating the position of local authorities in relation to public health. Particularly, he has made the point repeatedly about what the public health budget is for and how it should be used at the discretion of local authorities, which I think is terribly important.

Q151 Dr Whitford: We have heard your view on basing it on business rates, which is what I am going to come on to now, but I want to hear from other members of the panel their concerns, whether they think it is going to widen inequalities, which is the concern of some of the Members here, in that clearly a deprived area will have poorer business rates to start with, but also what the solution is. Do any of the panel members have an answer to how

a fairer funding formula or an equalisation formula could be generated? I do not mind who kicks off. Eugene, that is fine.

Dr Milne: The problem is we do not know how it is going to operate. There is no detail to it and, until we know that, it is very difficult to comment. If it were simply a question of saying, “Just cope on your own. Whatever you get from business rates, just find something for public health out of that,” that would be regressive. It would be incredibly problematic and in the north-east I know that local areas would suffer very badly as a consequence of that. Until we know what the proposals are, it is a bit dangerous to comment. I differ slightly from Virginia over the ACRA formula. I would not have welcomed a rapid move to it, not from Newcastle’s viewpoint because we are close to our target anyway, but because I know a number of poorer areas in the north would have suffered hugely as a consequence of moving rapidly to the ACRA formula. None the less, there was a logic to trying to develop a needs-based approach that could then properly be applied. It is very difficult to see how that can operate under the terms of the spending review, so at the moment it is really up in the air. We would like some more detail about how this is supposed to progress.

Dr Pearson: From Devon county council’s perspective, we see ourselves on a journey moving to the point where public health just becomes part of the routine funding in the same way that we fund children’s services, adult services, or the—

Q152 Dr Whitford: You are not concerned about the removal of ring-fencing in—

Dr Pearson: No, partly because, unlike Eugene and Ros, we would have gained under the formula. The impact of that will become clear as we go over the next two to three years because already there is probably quite a great disparity across the country in what services can be funded. We have to accept that the mature position is to move to a place where local authorities take responsibility, they feel confident in their public health responsibilities and public health does not need the protection of a ring-fence round it. If we do that, I would say “Do not tell us what to do with the money.” We do not want mandated services; we want discretion; we want to know what we need to do for our population and then we need to do it. It is all right as a starting position. It is a bit like a playpen, is it not, in that you put your baby director of public health in your local authority playpen and you say, “Here you are”? This is what it is like, but, as you grow older and you mature, you do not need that and you can have those debates around getting the right outcomes.

Q153 Dr Whitford: You would like standards and outcomes set but that each DPH could say, “In our community, this is how we will achieve it.”

Dr Pearson: Yes. Some of it will be standard because we would not want to lose the national childhood measurement programme; it has been the key to understanding what is happening in childhood obesity. We have mechanisms for agreeing things collectively, for example, through the Association of Directors of Public Health—we can do that—but we do need that mature conversation. If business rates play into that in a way that does not increase inequality, that is fine, but I do not understand how it will do that because of the issues about the disparity between what can come in; so there needs to be some mechanism for protecting those areas.

Q154 Dr Whitford: The chances are that, unless there is a very clever mechanism, it will, and we already have an inverse curve law anyway, in the poorest areas at least.

Dr Pearson: Yes.

Q155 Dr Whitford: Is there anything you want to add, Andrew, or I will just go to my final question?

Andrew Howe: My locality would have gained under the ACRA formula. The ring-fence has been incredibly helpful to embed public health thinking and working locally, allowing development of innovation, but in the medium to long term the ring-fence is not useful, and I am worried also about the implementation of business rates and waiting to hear more.

Q156 Dr Whitford: Thank you. My last question is: just what are the opportunities and risks posed by devolution as in the Greater Manchester devolution where the NHS budget in its entirety will go in and then eventually be not ring-fenced?

Dr Milne: It is fascinating. By the way, it is interesting that one of the first things they did in Greater Manchester was to say they will abandon the ring-fence, so they immediately moved to that position in their thinking. It does offer opportunities, but a lot of the opportunities that are offered are about health and social care integration and structure of the NHS and the possibility of grasping some nettles that have not previously been grasped. It is quite interesting if you look at the maternity review that was just published—Baroness Cumberlege’s review. In that, it talks about an optimal size for maternity systems covering populations of 500,000 to 1.5 million, which spells out some of the challenge of thinking at that kind of level and that we will need to be rational about the configuration of services within devolved areas. That is tough and really hard to get to grips with. From a public health perspective, the real opportunities of devolution sit with other bits of the agenda. If you have transport-planning devolution, it is really interesting that you can start to think at that kind of level and about the advantages that might be drawn from that because it is hugely significant for public health. You have seen over recent months that the air quality issue has been growing and I do not think it is going to go away, because it clearly is a contributory cause to such a large proportion of deaths and we must start thinking about it as a key public health issue.

Q157 Dr Whitford: Do you see any risks within Greater Manchester taking over of the NHS as well, because obviously it is not just public health? It is health, healthcare and social care. In among that is that budgets are also being squeezed.

Dr Milne: There are significant risks. The risk that has been most frequently cited outside is the idea that you get the responsibility but not the money and it then becomes very difficult to try to cope. The pressures that are going to be faced by the system are going to be there anyway. At least with devolution you get the opportunity to try to do something about it at a local level for the sorts of reasons that we have been discussing—that you can build on community assets and so on. The thing that worries me about the approach they are taking in Manchester is that an awful lot of faith is placed in culture change to try to deliver their expectations, and I am not convinced that that is necessarily going to deliver in the way that they would hope. It seems that that kind of approach depends on a lot of

individual choices and individual behaviour change choices. It is just not the most effective way to try to practise prevention. We know that broader environmental change and regulatory change is more potent in doing those things than simply exhorting a lot of individuals to try to behave differently.

Ros Jervis: It is exciting not just because of what we are seeing around the country, and particularly in Greater Manchester, but in that one size does not fit all. The opportunities are there for lots of different models. It does not have to be an integration of health and social care at that sort of scale. As to embedding health in all policies, the opportunities provided by devolution are far-ranging, so if you are talking about transport policy, again across a much broader footprint, we are talking about, locally, around the West Midlands combined authority and the opportunities that that can provide. If you are looking at economic growth, getting more people back into work, and good-quality work and education, and good-quality housing as well as transport, and potentially some of the air quality improvements that can be made with real strategic transportation plans, some of the impact that can make on health inequalities across those social determinants is huge. There is a real opportunity there for local public health teams to work within their local authorities across much broader footprints and to take health improvement being part of these sorts of policies on to a much more strategic level. It is quite exciting.

Dr Pearson: It is the same for me really. The relationship between our local devolution organisational footprint, the local economic partnership, is really important. It starts to bring partners to the table. We have included our two national parks as well, so it brings other partners to the table that you might have a relationship with, but it means you can all have a relationship with each other at the same time, which, if you think about what we were talking about with health and wellbeing boards—that thing about getting people together with the same vision—is very important. There is a huge amount of enthusiasm and energy around what might be achieved and freeing up thinking outside the normal organisational boundaries to think about how things could be organised on a much bigger footprint, as Eugene describes.

Q158 Dr Whitford: Do you not think that there is quite a lot of risk—and, clearly, Manchester is a huge devolution—in not piloting or developing it on a smaller scale before that? It is quite big if it does not work out in the first couple of years. You do not seem to have many concerns about it; you just feel it is more opportunity than concern. Being from an NHS background, I would say a lot of my colleagues speak about it much more from a point of view of concern.

Dr Milne: I can understand that, but given the financial challenge to the NHS in the next five years, the solutions, whatever those may be, are going to have to be fairly radical, and if they are going to be that radical and operate within the timescale that is available, we have to have some of those sorts of initiatives. I do not think they can simply be pilots. We do not have time to pilot them and then do them. You are caught between a rock and a hard place on this. I agree there are huge risks involved with it, but there are clearly opportunities that are worth exploring.

Q159 Dr Whitford: What would you see is the risk, other than the responsibility without the cash, or do you think that is the main one?

Dr Milne: I am well aware that the trusts are very uncomfortable about this. They have been supported by the payment-by-results system over a long time and they are very worried about what the funding system is going to do because they fear that the streams of revenue that they have been able to use over recent years will be restricted much more tightly. That seems to me to be the biggest source of worry in all of this: that they will find themselves—

Q160 Dr Whitford: Do you think that the direction might go away from the private provider? We have talked about tariffs in previous sessions and about how that is countermanding the direction we want to go in. Do you think that they may go away from outsourcing and tendering and having lots of different providers to being more Manchester NHS?

Dr Milne: Collaboration is essential to whatever we do in the next few years. I do not think we can do it by defending our own corner. We have to get involved and help each other to do it. The tendering and so on is a slightly different question from the tariff question. Tariffs are really interesting, because if you look internationally there are examples like Maryland now where the providers are effectively operating under block contracts rather than payment by item of service, which is what they have done in the past, and it has increased the level of community and preventive provision within the state. They start from a very different position to us and it may be that those things are not directly translatable. We always need to be a bit careful about those examples, but I do not think the thinking that is going on at the moment is particularly out of kilter with what is happening in other health systems.

Q161 Dr Whitford: Is that not where we originally came from in that we had more geographical systems rather than competitors within an area? We used to have, whatever it was, strategic health boards.

Dr Milne: Yes, that is true.

Q162 Dr Whitford: I am an outsider looking at your NHS, not our NHS in Scotland. Is it going back round to slightly where you started?

Dr Milne: Some aspects would be. You could argue that public health has gone full circle by ending up back in local authorities, but there are elements of those things that we are doing at the moment and we talked before about the frank superiority of commissioning processes that we have experienced in local authorities that we would not want to lose. I do not think we would be doing the same thing now. We would be looking to bring the better aspects of our working in recent years into the system.

Andrew Howe: I was going to add that one of the most interesting developments for me is the development of the accountable care organisations—ACOs. Some of that requires devolution, but some of it does not, I think. I need to understand what it is we can do anyway with good relationships. ACOs are developing—one in London is within the devolution bid—where the providers, the council and the CCGs have very much come together, as you have just described, without, or trying to avoid, some of the provider-commissioner split. Other ACOs are starting to develop not within the context of

devolution. That, for me, is one of the most interesting models emerging because that will address what you have just described.

Q163 Dr Whitford: We got rid of the purchaser-provider split over 12 years ago in Scotland, so in my health board, where I worked in secondary care as a surgeon, they got rid of the primary care trust and the secondary care trust, and it was just under the board; and now we have integration boards between health and social care that have been live since last April.

Dr Milne: There was a Nuffield Foundation report a few years ago that looked at the devolved healthcare systems and used the north-east of England as a comparator, and mortality had reduced better in the north-east than in the devolved systems. It is not a question of one system being inherently superior to the others, although there are aspects of each that we would want to try to capture.

Dr Whitford: It is just for me, looking in, that the bidding, tendering and competing seem to all go against co-operating, sharing and integrating, which is what we talk about.

Q164 Chair: You said at the beginning that it has been your experience that commissioning has become more powerful since you moved into local authorities.

Dr Pearson: It is not that. It is very co-operative because you are co-operating with your colleagues, your public and your providers in getting them to come up with some of the ideas, but it is all about how you do it. Where it does not work, it can be awful. There are probably places across the country where it has not worked and there is acrimony that has developed, but for us, if it is done in the right way, it works well. You are empowering your providers to show you how it needs to be done, in a way that you cannot do when you are line managing, because you are looking at the creativity within the marketplace. As Eugene was saying, the voluntary and community sector will come up with the ideas, particularly for very vulnerable groups, because they deal with them and they know, as they are the experts and we are not. It works, I think, particularly for some of the public health areas of commissioning, because we are dealing with people who do not usually engage with standard services.

Chair: We have kept you a very long time, so thank you very much for bearing with the Committee and for your evidence today. It has been terrific. Thank you.