



Health Committee

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

Tuesday 24 May

Ordered by the House of Commons to be published on Tuesday 24 May.

Written evidence from witnesses:

- Dr Ian Cameron, Director of Public Health, Leeds City Council
- Dawn Bailey, Health Improvement Principal - Health Protection, Leeds City Council
- Abdul Razzaq, Chair of Association of Directors of Public Health North West
- [Professor Kate Arden, Director of Public Health, Wigan Council](#)
- Paul Davison, Deputy Director Health Protection, North East Public Health England Centre
- Dr Dan Seddon, Public Health Consultant, Screening & Immunisation Lead for Cheshire and Merseyside, NHS England
- Dominic Hardy, Director of Commissioning for Wessex, NHS England South, NHS England

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Members present: Dr Sarah Wollaston (Chair); Dr James Davies; Andrea Jenkyns; Emma Reynolds; Paula Sherriff; Dr Philippa Whitford

Questions 165 - 277

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

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Q165 Chair: Good morning. Thank you very much for coming to this session on the landscape for public health following the Health and Social Care Act. To open the session, could you introduce yourselves to those who are following this debate from outside the room, starting with Abdul Razzaq?

Abdul Razzaq: Thank you very much, Chair, and for the invitation. My name is Abdul Razzaq. I represent the chair of the Association of Directors of Public Health in the north-west.

Dawn Bailey: My name is Dawn Bailey. I am health improvement principal for health protection in public health at Leeds City Council.

Dr Cameron: I am Ian Cameron, director of public health at Leeds City Council.

Q166 Chair: Thank you very much for coming. To kick off, starting with Mr Razzaq, in your experience what are the main issues and problems regarding the current arrangements for health protection at local level?

Abdul Razzaq: Post-2013 there has been a degree of challenge and issues to be addressed in health protection responsibilities. The prime ones are around creating a unified public health system; workforce development; data issues for directors of public health and their teams at local level—around screening and immunisation, for example—and testing the plans through exercises, through the existing governance arrangements such as LHRPs, that they have resilience partnerships, and the LRFs, as well as the health and wellbeing board. There are good opportunities for assurance, but the major problems have been in those primary domains.

Q167 Chair: Did you want to add to that, Ms Bailey, or Dr Cameron?

Dr Cameron: No. Our experience is that we are dependent on good relationships a lot in what is a fractured and very complex system; so we are dependent on goodwill. Our experience over the last three years is that there are capacity issues with all our partners in being able to respond to health protection issues. However, I would like to emphasise—certainly this is our experience at Leeds—that there is a huge amount of goodwill of partners wanting to work together and there is a clear recognition of the importance of health protection as an issue across the system.

Q168 Chair: It is reassuring to hear that there is goodwill in Leeds, but across the country people want to rely on more than goodwill.

Dr Cameron: They do.

Q169 Chair: They want to know that there are clear structures in place to allow a problem that arises at local level to be rapidly escalated. We have heard from some of our witnesses that there are areas where this just is not happening, where there is not effective communication. Could you perhaps set out for us, members of the panel, how you think we

can fix this to make sure that it happens well everywhere so that the public can be absolutely assured that this would be picked up, communicated and dealt with effectively? I do not know who wants to kick off on that.

Abdul Razzaq: Ian and Dawn may want to start with their case example in Leeds around their hepatitis outbreak.

Q170 Chair: It would be very helpful if you are able to elaborate on that.

Dr Cameron: We have experienced a community hepatitis outbreak, which involved two CCGs. It was a rolling outbreak that needed, initially, to be dealt with by community clinics but then continued and needed GPs to help. It is a very disadvantaged community. We found that there were literacy issues and people perhaps not coming forward. So we then involved a community bus to access those communities, which also went well, but it then continued and started going into a couple of the schools; we needed a vaccination programme in the schools. Our experience was that it involved a lot of different partners. While there was recognition of the importance of dealing with the outbreak, despite the fact that we do have good working relationships, we found there was an issue of who funds what. While across West Yorkshire we had a memorandum of understanding that said that agency x and y should be responsible for this, when it came down to the nitty-gritty of who funds the vaccines, who funds practice nurses to do x and y, who is going to pay for the security, the admin and the bus driver, that is where it undoubtedly got trickier for us.

Q171 Chair: Was there any delay in detecting the outbreak in the first place that might not have been there before the changes under the Act, or was that unaffected?

Dr Cameron: No. That was not an issue at all, and we have very good relationships with Public Health England, who identified this as an issue very quickly. We had extremely constructive discussions with Public Health England, both at our local level but also using their national expertise. I was very confident with the approach we were taking. At any one moment in time, this seemed the right approach to take, but the outbreak continued. I would like to give the Committee reassurance that we certainly had an extremely good and positive relationship with Public Health England.

Q172 Chair: It worked well in your experience. Mr Razzaq, did you want to comment on any experience or concerns about that?

Abdul Razzaq: Not specifically around the Leeds example, but our experience, from an Association of Directors of Public Health perspective, is that there have been some issues in the south-east in relation to outbreak management. That has been in relation to clarifying the roles and accountabilities of the respective organisations—Public Health England and NHS England versus the local authorities and the CCGs—in terms of large, prolonged incidents that require a sustained response for protection of the public's health.

Q173 Chair: In what particular area was it that you needed a sustained response, or is it a hypothetical clarification? Was there an actual example?

Abdul Razzaq: There was a specific example in the south-east of England.

Q174 Chair: Are you able to say more about what that was?

Abdul Razzaq: Not in detail in terms of that particular case. We know that, overall, it was very well managed, but those responsibilities and accountabilities were less systematic in their nature than they are in other parts of the English system as to public health. There is a degree of variation in relation to the level of integration between the public health system currently; and we find that as part of the regional prior history, the geography, as well as the actual relationships going forward. Clearly, retention of an adequately skilled workforce is vital to this work in terms of a career path.

Q175 Chair: We are going to come on to that in more detail later specifically. One other issue that has been raised with us is as to who holds the duty bleep. Under the old system, there would be a consultant at local level who would be on duty, whereas now that has passed to being a regional responsibility. Is that an issue you feel this Committee should be concerned about?

Abdul Razzaq: There are local authority responsibilities. There is a rota at local authority level. Chief executives and directors of public health are on rotas in the main, certainly within the Greater Manchester system, and we have a director of public health rota. Historically, we have also run a STAC rota—scientific and technical advice cell rota—as part of our health protection arrangements, but that is not a uniform system across the entirety of the English system.

Q176 Chair: Thank you. To go back to my original question perhaps in a slightly different way, we are looking for what recommendations you would make to this Committee in your experience at local level as to how the system could be improved to clarify those roles. Should it be arrangements that are the same in every area, or should it be left to local areas to clarify what those arrangements should be that suits them? Do you have any thoughts about that?

Dr Cameron: My personal view is that, while there clearly are, if you like, the macro-arrangements in place, LHRPs and I think the—

Q177 Chair: When you are using an acronym, can you—

Dr Cameron: Local health resilience partnerships. I am sorry about that. National arrangements are in place. When all the changes happened, I think the recommendation by the Department of Health that, in local areas, health protection boards should be established was an excellent recommendation. Locally, in Leeds, we have certainly endorsed that, and it has been under the health and wellbeing board. We have found that that has raised the profile of health protection.

Q178 Chair: You have a health protection board as part of the health and wellbeing board.

Dr Cameron: We do.

Q179 Chair: Who is on that in Leeds?

Dr Cameron: We have all the NHS organisations, the clinical commissioning groups and all the NHS trusts; we have environmental health and emergency planning from the council; we have Public Health England and NHS England on that.

Q180 Chair: Did you find that having that in place was what helped you to respond rapidly and smoothly to the incident that you described?

Dr Cameron: It has certainly strengthened relationships; it has strengthened the importance of health protection across the city. We have found that partners have welcomed the fact that there is a formal body that has all the key partners looking at health protection across all the priorities. So, yes, in the sense that it helps build relationships, it has been the board to which we have gone back, to talk about how the outbreak went and whether there are any lessons that we can learn—and there are, particularly around this issue of cost. We are using that board formally as the mechanism to progress the discussions for future outbreaks.

Q181 Chair: I do not want to put words in your mouth, but would you be saying you would recommend that is in place everywhere as a mechanism?

Dr Cameron: Yes; I would recommend that everywhere.

Q182 Chair: Do either of the other panel members want to comment?

Abdul Razzaq: We have a very similar arrangement in our local authority as directors of public health and in reporting directly to the health and wellbeing board in terms of the director of public health assurance role for health protection. I would concur with Ian's comments as to its usefulness. Having robust plans that are tested and exercised on a regular basis is vital to sustain a key asset to protect the public's health for any adverse incident, whether it be infectious disease or things like flooding or pandemic, as we saw in 2009, hepatitis or a fridge vaccine incident. There are multiple scenarios for health protection incidents, but the role at a local level of the director of public health is primarily one of assurance and, in terms of delivery at the frontline, a range of services, including infection control nurses and the community services within the NHS as well as the local government systems. As part of the multi-agency response, as we saw in the flooding in Cumbria and in Greater Manchester recently on Boxing day, our communities themselves have a vital role to play in assisting with the recovery elements.

Q183 Emma Reynolds: On the health protection boards, do you feel that you will come to a sufficient solution to the key question that you asked, Dr Cameron, which is: when these outbreaks occur, who funds what? Is that something that is going to—

Dr Cameron: Yes. As I said, although we do have a memorandum of understanding, when you get a real incident you find out what the specific knotty issues are. Some of it might seem very small, such as who pays for the admin, a bus driver, the vaccine or the interpreters. We are working through—this is an example—and saying what the issues

were that we did not feel we got solutions to, and trying to ask whether it is clear already who should have done it or which are the ones for which we have questions marked. All I can say is that partners round our health and protection board are absolutely up for having those debates and discussions. There is a real positive will to learn from this, to help to make sure that we do not have this again. In my area anyway, I underwrote the cost—or said I would—just to make sure that the funding issues did not delay all the action, and we want to get to a state where the number of grey areas is reduced in the future.

Q184 Emma Reynolds: Thank you. It is great to see that you are going to learn from that particular experience in your own local authority area. Are you going to share those lessons with other local authorities around the country?

Dr Cameron: The answer is yes.

Q185 Paula Sherriff: I want to address specifically the Ebola outbreak or the potential for the outbreak. How ready were you in Leeds for the potential of dealing with any number of Ebola cases should that have occurred?

Dr Cameron: I personally think we were very prepared, and that can be testified to by the fact that in Leeds we have a very big teaching hospital, which would take potential cases from neighbouring areas. In fact, there were a number of false alarms. I believe we responded extremely well in Leeds. It was, again, an opportunity. I chaired a meeting of all the key partners to make sure we had a co-ordinated approach. My experience was that our acute trust was absolutely geared up for this.

Q186 Paula Sherriff: You are absolutely satisfied that, had there been a significant outbreak in Leeds or, perhaps, given the fact that you are a big city, in some of the outlying areas, you could have coped.

Dr Cameron: I am confident that we were fully engaged in all the national discussions about the plans and arrangements that were taking place. It is fair to say that at the very beginning we experienced a huge amount of information coming down from the centre, coming down in different channels. So, when we had our first city-wide meeting about it, we spent quite a bit of time on how we were going to handle the communications that were coming down, because we had experience where some general practitioners were a bit confused with different bits of advice. We got all those arrangements in place. We have three clinical commissioning groups in Leeds, and we were clear that one clinical commissioning group was going to be the communication link to the GPs. I felt that everybody took part in all the planning events that were going on across the region and tried to respond accordingly.

Q187 Paula Sherriff: Am I right in saying that, thankfully, there were no Ebola cases, albeit that there were a number of scares?

Dr Cameron: Yes.

Q188 Paula Sherriff: Is there anything you would do differently that you would like to tell us about, given the time again, with the benefit of hindsight?

Dr Cameron: In this particular instance, off the top of my head, there is not anything that I can see. I got a sense that partners wanted to work together; they wanted to learn, in links with the ambulance service and the acute trusts, what to do, and there was a willingness to learn when we had false alarms.

Q189 Paula Sherriff: Did you examine those false alarms in terms of the ones where, potentially, you had to take the appropriate precautions in case the patient perhaps exhibited some of the symptoms of Ebola but it transpired that it was not?

Dr Cameron: When there were false alarms, the learning was more about how things went: whether transporting patient x from hospital a to hospital b went well; did it go well when they arrived in A&E; did everybody act accordingly; did they go into a side room, and so on. All I can say is that there was a willingness, which was led by the acute trust, in every one of those instances to have a debriefing: "What did we learn?" A lot of it is about staff attitudes and skills as well. You can have everything written down, but it is how you behave at the time. All I can say is: it was Ebola, but Leeds is a big city; it is a very big acute hospital; they have dealings with all sorts of emergencies, and this was yet another one, albeit with an infectious disease component. Hand on heart, there is not anything for me that comes out as a major screaming issue.

Q190 Chair: Do you want to add to that?

Abdul Razzaq: If I may. As our Public Health England colleagues will testify, there are a number of emerging threats that are regularly monitored by them on a global scale through the international global public health networks. We have had MERS-CoV, which is Saudi Arabia and middle east-based. Ebola was a good example where we put systems in place through the chief medical officer in screening within ports. We set up the appropriate mechanisms with algorithms for dealing with suspected and actual cases through our points of entry, whether that be A&E, GP practices, community settings or our ambulance services, and, clearly, through to the appropriate care for that individual as a suspected case through the regional infectious diseases unit. The system behaved very well and got better over time as those suspected cases emerged, especially around healthcare workers who were returning from Sierra Leone and other nations that were actually affected at the time. I also owe a great debt of gratitude to the NHS staff who went out there. I had a member of my infection control team who spent four months in Sierra Leone at the frontline dealing with and caring for patients with Ebola, so I would like to take this opportunity to thank all those staff as well.

Q191 Emma Reynolds: To follow up on that, to what extent do you think that the co-operation that we were able to carry out with our European partners helped in our preparedness for Ebola and managing that?

Abdul Razzaq: With Public Health England links not only across Europe but with the World Health Organisation, through Geneva and the west and east African regional office, those aspects were already available through those existing public health networks. There

is always an issue of making sure that we respond in the most appropriate manner to an emerging threat, and clearly it was an issue around understanding the full scale of that emergent threat. The response overall was very positive and is a clear lesson for future threats that may emerge during the 21st century.

Q192 Paula Sherriff: I want to look now at the local preparations in the event of a flu pandemic, or it could be any number of things, could it not, realistically? Are you confident that the structures that you currently have in place will enable an effective response, and could you draw comparisons with the 2009 flu pandemic to suggest how things would perhaps be different or lessons that could be taken from that time?

Abdul Razzaq: I am happy to take the question initially.

Dr Cameron: You go for it and I will answer later.

Abdul Razzaq: As to the 2009 pandemic—the H1N1 situation—directors of public health were situated within primary care trusts at the time embedded within the NHS. As to the system response, to some degree directors of public health were able to influence more and call upon NHS resources at a local system level slightly more easily as part of the flu planning. With the directors of public health moving into local government, we have those arrangements in place—we have plans in place—but the nature of the next pandemic is unknown. The 2009 pandemic came in at least a couple of phases, whereas we do not know what the next threat may be in terms of the type and the severity, as well as the actual response that we may need to adapt as part of that process. But, again, Public Health England is monitoring those genotypes to make sure that we are cognisant in terms of surveillance systems and that we know where the likely potential threat may come from. Clearly, there are some candidates that are monitored on a regular basis.

Q193 Paula Sherriff: Thank you. Dr Cameron?

Dr Cameron: I am going to base my response on some of the exercises that we have done, also having been through the 2009 outbreak. It is fair to say that we have done a number of exercises, both locally and across West Yorkshire. There are differences. Certainly our experience was that there was an issue about capacity of the various elements that were needed. Everything, in my experience, seemed to speed up in the sense of organisations suddenly struggling with being able to take various actions. The message with which I have come away from both our exercises is that the capacity that is available now has reduced and so is a concern for us. Also, quite clearly, people have come, people have gone and there are new people. It was clear that those who had experience of 2009 were far more knowledgeable about what happened there, and so, for some, that had gone.

On the positive side, with public health coming into the local authority, for me personally, one thing that came out in our exercise is the issue of how we handled excess deaths. It is fair to say that, probably, when I was in the NHS I did not really think about that too much, but as we were doing our exercise that is something about which I thought, “That is a problem.” Public health being within the council, we have found that we have been able to work within the council to try to take that forward. That is an aspect that possibly I

personally have learned from and we are trying to get the learning from being in the council.

Q194 Paula Sherriff: While I would not seek to put words into your mouth, you do not feel you are disadvantaged by being under the auspices of the local authority rather than the NHS in terms of emergency preparation and contingency for a potential pandemic or similar outbreak.

Dr Cameron: I do not—and here is the but. But all partners, and I think particularly the clinical commissioning groups, need to see that they have an important role in pandemic planning. My experience has been in the NHS, and in the past it was public health that was leading a lot of that work. Obviously, public health has now moved from the NHS, so the question is not the acute trusts or the providers but it is more the commissioners. It is fair to say, in my area, that the clinical commissioning groups have gone on a journey. At the beginning, in my experience, it was very much, “What do the rules say?”, and, “Do the rules say we have to do this or not?”, but, to be honest, in our patch, I have seen a transformation over the last three years. They have really understood it, to the extent that they have just held a planning exercise themselves.

Q195 Paula Sherriff: Finally from me, do you personally consider it to be a problem that directors of public health in their own right are not formally part of the response arrangements under the Civil Contingencies Act, although local authorities are a Category 1 responder?

Dr Cameron: Abdul, do you want to take that one?

Abdul Razzaq: I do not see that, because, as I outlined earlier, the very fact that directors of public health are embedded within local government, and are on the local authority rota systems for the local authority as Cat 1 responders, enables them to take that system leadership role as part of a system-wide response. It depends on the situation and the nature of the incident, but as to the element there, in my knowledge and experience over the last 13 years, and 20 years in public health, I do not see that as a major obstacle.

Paula Sherriff: Thank you.

Q196 Chair: Can I pick up on something you said earlier, Dr Cameron? You said that capacity is reduced. Where do you mean that the capacity is reduced?

Dr Cameron: When we were doing the exercises, it was particularly the providers; it was the NHS providers, where we might need nursing or other teams to do various actions in terms of the pandemic planning. Our experience, certainly in the last two exercises, was that as the scenarios built up around the pandemic the resources got stretched and there were not the nurses, particularly, to help out.

Q197 Chair: Do you mean in the community? So it was community nurses specifically.

Dr Cameron: In the community, yes.

Q198 Chair: Mr Razzaq, you referred earlier to the fact that when you were embedded in the NHS there were aspects of that that gave you better support. Which aspects of that were you referring to? Was that in terms of NHS advice or ability to link into providers? What did you mean by that?

Abdul Razzaq: Being part of the NHS family prior to 2013 enabled directors of public health to discharge some of their health protection functions in terms of intimate management in an easily recognisable way, such as being able to call upon NHS resources as part of the effort.

Q199 Chair: It is about providers again. It is the provider side of this that you are seeing. Ms Bailey, you are nodding there. Do you want to add to this?

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

Q200 Chair: Is there a recommendation you would like to see us make as a Committee as a result of what you have all said?

Dr Cameron: There are two levels. One is organisations, and then there is the resource on the ground. I am sure it would be helpful to reiterate to organisations their role and responsibility in responding to outbreaks and working in partnership with others, and from that leadership role trying to work through what that means in practice: do we have the skills, the capacity, either ourselves or with partners, to be able to respond in outbreak or emergency situations?

Chair: Thank you very much. We will come on to Andrea.

Q201 Andrea Jenkyns: First, especially, welcome to Dawn and Ian; it is great to have my local authority here waving a flag for Yorkshire and Leeds. I am very interested in the screening and immunisation side. I know that Dr Philippa Whitford and I have been very involved in this. I recently got back from India where I was looking at what WHO and partners have been doing on eradicating polio. I was impressed with the bottom-up approach, even at local community level, on promotion of immunisation to help eradicate polio in the country. I would like to touch on and examine how well you all believe screening and immunisation functions are working in the new system.

The first question is: what do you consider are the main problems in relation to screening and immunisation, as you see them, at the moment?

Abdul Razzaq: As to the major challenges for screening and immunisation services, the arrangements post-2013 meant that the public health-embedded screening and immunisation function was within NHS England and there was a bit of a disconnect between that particular function around health protection, local authority systems, in terms of the directors of public health and their health protection function, and the CCGs, because primary care commissioning became the responsibility of NHS England rather

than the local CCG, although that clearly has changed and full delegated responsibilities are merging back into clinical commissioning groups. That is a great opportunity to reunify the system in that regard.

Q202 Andrea Jenkyns: When all the changes came about, can you think of anything in particular that you feel worked for you—maybe best practice that you could share with other areas across the country?

Abdul Razzaq: As to screening and immunisation, what worked well was relationships, primarily; a lot of this hinges on their strength. As we were beginning to orientate through the new system, it was the strength of those relationships that endured for the first emergent year, and, as systems got embedded and became more pronounced, that helped with the director of public health role in the health protection boards that we set up to be able to link in with our Public Health England colleagues embedded with NHS England around some of the data systems, looking at performance issues with trusts and those programmes, as well as linking in around remedial actions for our populations.

Q203 Andrea Jenkyns: Do you think that not having a direct relationship with general practice or community pharmacists has caused problems, and are any of these problems related to practice-level data?

Abdul Razzaq: Public health commissions a whole range of services from local government, and one of our prime responsibilities as directors of public health is to ensure there is a pharmaceutical needs assessment produced on behalf of our population, reported into the health and wellbeing board and ratified through that process. We also commission a whole range of pharmaceutical services, or pharmacy services, such as NHS health checks, sexual health services and a whole range of other things. Data flow around screening and immunisation has got better, in my experience, from our Public Health England team, but it has taken a bit of time to get that level of information out. Within Greater Manchester, NHS England has been very robust and rigorous in setting up a Greater Manchester screening and immunisation board where directors of public health are represented, and, as part of that process, a health inequality strategy was initiated to look at how we can address some of the performance issues, as well as making sure that uptake, both for screening and immunisation, is increased in the areas where it is lagging.

Q204 Andrea Jenkyns: Can I ask Dawn and Ian how you are finding it in your area? Are you finding something similar?

Dawn Bailey: In the first question in relation to screening and immunisation and as to how it is working in Leeds, NHS England's screening and imms team are on the health protection board. We have very strong relationships. There is some really good proactive work happening between NHS England, the clinical commissioning groups and local authorities, addressing some of the local issues that we have identified. There are some positive examples of how things are working in Leeds. As well, Ian and I are part of the governance structures of NHS England's screening and imms, so there is a good two-way process there and strong relationships that have enabled that to continue and strengthen.

The area that I personally think would help us in Leeds is greater clarity on what is called the section 7A, which is an agreement in place nationally, outlining some of the roles and responsibilities for NHS England around screening and immunisation. Locally, in Leeds—I will talk from a Leeds perspective—particularly in the outbreak management of the case that we submitted, there was a real lack of clarity, which led to us having to make some interpretation of that agreement. When speaking across to regional partners, they had similar issues. For screening and immunisation, the issue that we would have is around greater clarity of some aspects of section 7A.

Q205 Andrea Jenkyns: Thank you. These are my last couple of questions. Have you experienced any problems with incident reporting, ensuring that directors of public health and PHE are informed of any clinical incidents that are important for protecting the public's health?

Abdul Razzaq: As a director of public health, I certainly am notified on a regular basis of all incidents that are relevant to my local patch through Public Health England, and I have not experienced any communication gaps in that regard. At the outset I have made it very clear that I want to know of every incident that takes place within my area, so I have taken that proactive step. Clearly, I will recommend that all directors of public health are cognisant of all those incidents and fully aware, even if they are not required to respond directly, and if Public Health England are the lead response agency, or otherwise, that they at least have knowledge and are able to log that for information purposes.

Q206 Andrea Jenkyns: You cannot recall any issues previously.

Abdul Razzaq: Certainly not in my local area.

Q207 Andrea Jenkyns: My final question is this. It has been suggested that, because Public Health England screening and immunisation teams and NHS England regional teams cover a large geographical area, they may be too removed from local services to work effectively. Would you agree with that statement?

Abdul Razzaq: There are clearly models around. Historically, we had a separation of role, of screening versus immunisation. Pre-2013 a lot of directors of public health worked with a dedicated immunisation programme manager or similar role. The amalgamation of screening and immunisation post-2013 has resulted in an environment where those members of staff have had to learn other aspects of a discipline that they were not directly familiar with. There has been a workforce development challenge.

Q208 Andrea Jenkyns: Are you suggesting it is more of a training need than the geographical size?

Abdul Razzaq: Geography is well handled, certainly within the north-west. A lot of the issues have been in relation to workforce development: career pathways for those roles in screening and immunisation; having a career pathway from low bandings up to the highest bandings at consultant level; making sure that we do not have a totally flat structure; that

there is an ability to be promoted; and clearly to make those roles attractive to go into in terms of recruitment and retention.

Q209 Andrea Jenkyns: What about from Leeds?

Dr Cameron: Our experience is slightly different in that, inevitably, if you are in NHS England or Public Health England, covering a much larger geography, there is a distance from the local patch. Looking back, getting parochial for a minute, in Leeds quite a few years ago we had some issues about MMR vaccination in that rates were not very good. We put a lot of effort in at local level—in the local communities—to try to increase that. As Dawn has been saying, we started off with some very good West Yorkshire arrangements, but we are now setting up Leeds arrangements to get that Leeds focus. The bottom line—as you know Leeds—if the uptake rate of certain things in screening is not doing well in Harehills or Gipton, is: who are the people who are going to work in those areas to up the rates? You began by talking about your experience in India, that bottom-up experience; we all know that for certain communities that is the way to do it. Who is going to do it?

Q210 Andrea Jenkyns: What sort of solutions have you found for this, if any?

Dr Cameron: As I said, we are now more and more going back to, “Let’s have a lead focus.” With respect, when we are at West Yorkshire level, of course there are issues across West Yorkshire, but it is getting down beneath just a Leeds figure to, actually, there is variation in our area. What are we doing in the particular local communities? It is then having the resources and action to make concentrated efforts there.

Abdul Razzaq: I am spending a lot of time speaking about my local area rather than from a national ADPH perspective, but for my population within Trafford we have been successful in improving our cervical screening rates to above 80%, which was a local CQUIN target with the CCG. We have managed to do that by working with the local authority, our consultant of public health and myself, with the CCG, the CQUIN and the practices, but most importantly with the communities themselves and a community voluntary organisation called Voice of BME, which has managed to get the women in from those vulnerable populations, such as south Asian populations and BME communities—women who, despite all the efforts of general practice, were being invited and were not forthcoming in screening.

We have just celebrated that as part of our ongoing work. It is a collaborative movement and it has taken a lot of work on the issues around information governance, making sure that data is protected and working through some of those protocols. The very fact that community members themselves, with other third sector organisations, are able to get to 150 women that practices were not has increased our rates, and we are the highest in the north of England for cervical screening. That is the outcome we have achieved. We worked nationally with Jo’s Trust as part of that campaign.

Q211 Chair: It has been a success story in your area.

Abdul Razzaq: It has indeed.

Andrea Jenkyns: I would like to finish off by saying thank you, and, particularly to my Leeds colleagues, if I can help at all to raise the profile on this, let us work together because it is something I am passionate about as well. Thank you.

Q212 Dr Whitford: You touched on looking at the data and improvement in your screening uptake. When we had some of the witness sessions with public health practitioners and directors of public health, they reported having difficulty in bringing the data together now that they were, if you like, sitting outside the NHS. On our visit to Coventry yesterday we heard different workarounds that people have, but how are you getting the data? Have you come up with a system that gives you clean, direct access to that, or are you having to go round corners to pool your screening and immunisation data together?

Abdul Razzaq: Certainly, within Trafford and GM, we are getting the data from our Public Health England and NHS colleagues, so our cover data comes in through those routes. CCGs can provide InForm data, which is the system that GPs input to get their payment for immunisation. That data is also available to us via the clinical commissioning group. But screening data in the main has been quite challenging—it is the screening programme's data—and primarily comes from Public Health England colleagues embedded within the NHS England teams. That is a report that I have requested as a dashboard, which comes to my bi-monthly health protection board as a standard item.

Q213 Dr Whitford: What is the issue with it? Is it that you cannot drill down into it to see the variation you talked about?

Abdul Razzaq: At the moment it is borough level. It is available. It is an issue around trying to get the analytical capacity at scale for the entire north-west to be able to provide that information.

Q214 Dr Whitford: But you did not have issues with it being shared with you because you are no longer an NHS—

Abdul Razzaq: It took some time. Getting that level of information is a recent development. There was a period post-2013 where we were seeking information regarding screening programmes in particular for our populations for the entirety of screening programmes, both cancer and non-cancer; the information from providers, and the coalescence of that information, was proving to be difficult for Public Health England colleagues, but this has got far better over time.

Q215 Dr Whitford: That may be a local solution that you have developed in Manchester. Obviously, talking about the outbreak in Leeds, you have worked your way to having structures now. What strikes me, listening to all three of you, is that the system seems to be much more complex and fragmented, and, while big cities like Manchester and Leeds might sit round a table and hammer it out, the worry is a major health protection issue in somewhere that is more scattered. Do you not think that roles and responsibilities, and particularly funding in the current climate, need to be worked out and you should share your experience with other places quickly?

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

Q216 Dr Whitford: Is there any movement to bring together all that experience and come up with roles and responsibilities in the short term? For three years you have been feeling your way by experience. We are lucky that Ebola did not go crazy, that we did not have a pandemic, but you absolutely have no idea when something like that would happen. Do you not think there is a bit of urgency to bring the experience together nationally and come up with that, because, in the current climate, whether it is your purse or my purse is quite a big issue for the different parts of that fragmented structure?

Dr Cameron: I would agree with you.

Q217 Dr Whitford: Part of that, once you get the agreement of going forward, is the skills on the ground. Do you feel—I am not sure who wants to answer first—that you have in the new structure the health protection skills on the ground going forward?

Abdul Razzaq: Workforce retention and skill development is a key component part. There are different models. Some directors of public health have embedded their health protection, nursing and staff complement within other health protection arrangements within local government around environmental health to create a health protection service or a unit, which is to be seen in a very positive light, because it enables skill sharing and an ability to see health protection in the round in terms of the likelihood of being able to respond to complex system incidents. Some of us, certainly within my area, have retained our infection-control nurses outwith local government. They are within a community provider. That arrangement has worked very well. We have not seen a huge turnover. We have seen sustainability of relationships over those three years, and those individuals work very closely with me and the health protection board that I mentioned on the system response. They are primarily looking at things like healthcare-associated infections and doing a lot of that preventive and early detection work to keep the system safe and links with patient safety and clinical quality.

Q218 Dr Whitford: Where the health protection specialists have stayed within more of an NHS structure, do you feel that provides the public health system within the local authority with the expertise that they need? The problem is that you have this disconnect.

Abdul Razzaq: Yes. In my instance there is not a disconnect. If anything, it is a very strong working relationship and it is a commissioned service. The current arrangement that I have in place is that the infection control service is commissioned from the public health grant through a community contract with the CCG. That is the arrangement that we have in place, and it has worked very well and endured. It has stood the test of time because we have had hep A outbreaks, fridge vaccine issues of large scale, and we have had other incidents that have been well managed. We are among the lowest in terms of C. diff and MRSA rates within my area.

Q219 Dr Whitford: Some of the things—I will come back to you in a second, Ian—
Dr Cameron: There are quite a few different aspects to the question you are posing to us there. If I talk first about Public Health England, we really value the work of Public Health England and their contribution around health protection. They are a crucial bit of the jigsaw for us. Public Health England has funding challenges; certainly in Yorkshire and Humber they are going through all sorts of reorganisations. Speaking on behalf of the Yorkshire and Humber directors of public health, we are always keeping an eye on what is happening in Public Health England around health protection, and we regularly discuss this at our network meetings. They are an incredibly valuable help for us and we would not want to see that being diminished in any way.

Just as Abdul has said, in terms of our funding for or provision of infection control services, we commission the service, and I am comfortable, just like Abdul, using the contract mechanisms defined. That works well. In my own neighbouring areas some of those teams are embedded; they have come over into the local authority. As far as I am aware, those arrangements work well. So, as long as you have confidence about the arrangements, whether it is commissioned or in-house, they can work. Of course, as your Committee will be aware, the public health budget has been cut, so we all have to respond to that. That is a concern.

Q220 Dr Whitford: In your paper about the hepatitis outbreak, there was talk about the difficulty of communication and so on around this fracturing. It is a totally different structure in every place, and there is a kind of centre of gravity in a big city that makes it able to pool resources into the middle and make a decision that may not be there in semi-rural, suburban or other situations. That means there may be other parts of the country in much worse situations than you.

Dr Cameron: I suspect you are right. If you think about the move from NHS into local authorities around health protection, we know Public Health England's role, for example, is a very important role, and I would put a question. As public health has moved into local authority, have different local authorities had a different emphasis on health protection, and is this now the opportunity to work on health improvement—those wider determinants? In Leeds, we have taken a very deliberate view that health protection is important, so we have staff led by Dawn here; we have taken it seriously. There is a resource, and Dawn's role was absolutely crucial in co-ordinating the hepatitis outbreak.

Q221 Dr Whitford: One issue is having the skills and staff there for a surge, in that obviously some of these things are huge and fast. Do you feel that you have that surge capacity there?

Dr Cameron: I feel—in Dawn and her team—that I have capacity that is working on a day-by-day basis with health protection. Then, when the surge comes, other people have to drop things as well, but we have a bedrock of a health protection resource in public health in the council that the whole council can depend upon, tied to emergency planning as well.

Dr Whitford: Thank you very much.

Chair: Thank you very much for coming this afternoon. It has been very helpful to hear your evidence.

Examination of Witnesses

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

Q222 Chair: Thank you for coming this afternoon. Could you start by introducing yourselves to those who are following this discussion from outside the room, starting with Professor Ardern?

Professor Ardern: Thank you, Chair. I am Kate Ardern. I am director of public health in Wigan Council. I am also chief officer for emergency planning and civil contingencies and lead DPH on behalf of the Association of Greater Manchester Authorities for health protection and civil contingencies.

Dr Seddon: My name is Dan Seddon. I am screening and immunisation lead for Cheshire and Merseyside, serving 2.5 million people, and managing a team of around 15 people to do that. I work for Public Health England and am embedded in NHS England.

Paul Davison: Good afternoon. My name is Paul Davison. I am deputy director for health protection for the north-east health protection team, Public Health England.

Dominic Hardy: Good afternoon. My name is Dominic Hardy. I am the director of commissioning operations for NHS England's Wessex team, covering Hampshire, the Isle of Wight and Dorset. Part of my remit is to include a screening and imms team, of which Dan is a part in a different team in the country.

Q223 Chair: Thank you. Welcome this afternoon. Following on from the previous panel, perhaps starting with Professor Ardern, how clear do you feel the roles and responsibilities now are within health protection post-2013?

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

Professor Ardern: In Greater Manchester, we started work on setting out roles and responsibilities as part of the transition process from the NHS into local government. We were able to build on some very excellent assets that local authorities had already put together around joining together their emergency planning function. So we thought through what health protection would look like in a local government public health function and had very clear dialogue with both Public Health England and the civil contingencies and resilience unit in Greater Manchester, which had been set up to offer emergency planning support and 24/7 response, which was a very attractive offer to support DPHs going into local government.

In Greater Manchester, we were building on existing good practice and existing structures that were firmly embedded within the Association of Greater Manchester Authorities. Clearly, that is much easier in a conurbation like Greater Manchester where you have those existing relationships, but we should recognise that there are some very good systems around the local resilience forums, the local health resilience partnerships, which have themselves statutory functions, and, of course, the health and wellbeing boards at upper-tier local authority level. It is sometimes about using effectively the systems that we have in place. For example, within my own health and wellbeing board, health protection is a standing agenda item. We bring regular reports on screening and imms, and indeed the local emergency planning and health protection group, as Dr Cameron was saying, reports directly into the health and wellbeing board. Perhaps it is about using existing systems properly and looking at the assets that have been developed within local government.

Q224 Chair: Thank you. Having listened to Dr Cameron, one thing he highlighted was the issue of who pays for what. Is that also an issue for your area?

Professor Ardern: No, it is not. In fact, we have been very clear to embed civil contingency and outbreak management support into our commissioned services. For example, working with our community trust, we have embedded it within the school nursing contract and within the health visitor contract. We have surge capacity arrangements set up with our local acute trust where their infection control team will support mine, and, indeed, I think in my written evidence we have also given the example of our health protection confederation across Greater Manchester, which links all the infection-control nurses in local government and the commissioned services that Mr Razzaq was referring to into a confederation that enables them to give mutual aid across Greater Manchester. If you have an outbreak in Bury, you need to be able to flex a resource from the rest of Greater Manchester to go and give them support.

Q225 Chair: Indeed. One issue raised by the previous panel was that the weakness in the system seemed to be in the provider arm. Do you feel that you have now resolved that to your satisfaction?

Professor Ardern: Yes, because we have the ability to call on resources from across the conurbation.

Q226 Chair: Having thought about a number of the problems that could have arisen, are there still some outstanding areas that concern you that you feel this Committee should address?

Professor Ardern: Yes. They are twofold. Resourcing issues, in terms of the public health grant reductions, remain a concern. Another example I would give with respect to the screening and imms part of the system is the training of people to undertake screening and imms. That was quite an intensive resource that we had within the NHS, but who pays for and delivers that training is an issue.

Q227 Chair: That is an area we are going to return to specifically, so I am not going to press you further on that now. Could I perhaps return to the point about the public health grant and the in-year cut in the budget as well? Can you give us some examples of how that has practically hit your ability to respond on the health protection side of your responsibilities?

Professor Ardern: It has not directly affected me so far because health protection is what you prioritise; it is the business critical function of public health. You look at other areas where you can more safely make reductions and you protect your health protection resource to be your business critical function; plus, it has been helpful in embedding it within my wider role within Wigan Council, which incorporates the rest of civil contingencies and emergency planning, also to have that resource, so I have a much wider asset to support me. So, no, it has not directly affected me yet.

Q228 Chair: What are you doing as a local area to try to spread your experience to other areas that are struggling? We have heard in this Committee that there is still some variation in how confident people feel to respond to public health emergencies.

Professor Ardern: One thing we decided to undertake was a sector-led improvement review. I am a peer review challenger for the Local Government Association and I find that undertaking peer challenge, going and learning from other areas, but also being able to hold a mirror up and reflect on your own practice, is a really good route to try to look at how you might improve services. We undertook a sector-led improvement review across the whole of Greater Manchester. We involved all 10 local authorities, all 12 clinical commissioning groups, Public Health England and NHS England, and that was specifically looking at outbreak management and response. We have come up with a set of recommendations for Greater Manchester itself, which we are taking through the local health resilience partnership, which I co-chair, and reporting into the local resilience forum—Greater Manchester resilience forum—and we have come up with recommendations and advice for each borough and each CCG to work on locally. The assurance framework for that is through the health economy resilience groups, which report back into the local health resilience partnership.

Q229 Chair: Thank you very much, Professor Ardern. Do other members of the panel want to add to what Professor Ardern has said or identify particular problems in your own areas?

Paul Davison: Yes, please, Chair, if I could, and it is going back to your first question about public health protection assurance. There are a couple of points I would like to make. One would be that public health and health protection are very broad terms. It is quite a specific set of discussions that we are having this afternoon. We need to recognise that national organisations like the Environment Agency, the Food Standards Agency, local authority EHOs and national colleagues in PHE have a role to play in health protection.

You asked about assurance—about roles and responsibilities. From a Public Health England perspective, we are very clear about our health protection roles and responsibilities and very clear about the partnerships that we need to discharge those roles and responsibilities. I manage a team similar to many teams around the country, comprising nurses, practitioners and consultants in health protection, that day to day are dealing with thousands of inquiries, cases, incidences of infectious disease and environmental hazards, and dealing with outbreaks on a day-to-day basis. That is our root and branch—our core business.

Linking back to the discussions that you had in the previous session, however, the context and complexity play a part in how we discharge those responsibilities. In terms of being clear about roles and responsibilities, we are absolutely clear about those.

Dr Seddon: I would like to complement what my colleagues have said in this respect. Thinking about the screening and immunisation function and the whole section 7A remit of NHS England that I am involved with, broadly, yes, it is very clear. Section 7A is clear around the NHS screening programmes, the NHS immunisation programmes, in which we are responsible for ensuring quality and effectiveness, and the public health services into prisons and sexual assault referral centres. The section 7A remit is clear.

There is a difficulty, however, when one gets to the edges of that. For example, as was touched on in the previous session—I think Kate has touched on this as well, and, by implication, Paul has—where there is an outbreak of vaccine-preventable disease, whose responsibility is it to lead and to write the cheque for a group of immunisers to be provided to immunise rapidly a population of university students, as we had when we had two linked cases of meningitis W? In university students, you can imagine the noise and anxiety that created, and we wanted to take advantage of that in order to accelerate the immunisation programme.

The system is not clear about that, but, again, as was touched on with the last panel, the relationships that we have and the commitment to serve the populations that we are there to serve meant that we mobilised and did that. In that circumstance, it was NHS England that underwrote it. In the example that was given earlier this afternoon, it was a local authority DPH that underwrote it. We are having different people underwriting; so there are gaps in there. There are some other gaps where things are less clear. For instance, standards and training for travel vaccinations are not within section 7A. In the advice and support that I and my team provide to front-line immunisers, when they ring up about travel vaccinations, do I say it is not our remit and tell them to go to someone else, and I cannot tell them who, or do I support them? Of course we support them, but it is not clear. So there are gaps. The fragmentation—a word that has been used—around the system is

there, but I would not want you to feel that, because of that, the system is broken. We make the system work well.

Q230 Chair: For travel immunisation, there are resources at national level that GPs can call on for advice. Has that continued unaffected by the changes?

Dr Seddon: My understanding is that general practitioners can call on that if they subscribe. I think there is a subscription, yes.

Q231 Chair: Those resources are still available, are they?

Dr Seddon: Yes.

Q232 Chair: It is a question of whether you feel there is the advice and expertise there if people need to call on it.

Dr Seddon: I think, yes, generally you are able to find it, but the reason I was using that as an illustration is that immunisation services sounds like immunisations.

Chair: Your point would be that there are many aspects to immunisation services; right. Thank you.

Q233 Paula Sherriff: I want specifically to look at the fairly recent Ebola issue. Could you tell us briefly a little about the level of preparedness in your areas and whether you were satisfied that had there been more cases, or indeed any significant cases, you would have been prepared to offer a safe service?

Professor Arden: Yes. When we were first alerted to Ebola becoming a challenge, clearly in Greater Manchester we have an international airport and were part of the PHE screening procedures. Through the Greater Manchester resilience forum, we set up a number of exercises. We rehearsed live exercises at the airport on a multi-agency basis. We also set up a multi-agency strategic co-ordinating group exercise and rehearsed every borough in Greater Manchester. We were rehearsing people arriving through screening, the passage of transport from the airport to the regional infectious disease unit and how we activated a multi-agency response. We were particularly keen to stress test things like community cohesion, getting messages right and making sure that public awareness was appropriately raised. We used that linking into our Greater Manchester outbreak management arrangements, and we have continued, through the lessons learned from those exercises—in fact, I chaired a strategic co-ordinating group on the episode at new year when Pauline Cafferkey came back to the UK—to provide assurance back into the system that we had all the resources and capability at Manchester airport to deal with any suspect cases. We have had a number of workers coming through the north-west, as Mr Razzaq referred to, who have come through our screening procedures.

We have learned lessons from that and adapted it for MERS and other high-impact infectious diseases within the system, and every time now a suspect case potentially comes through, the system is stood up. For example, as lead DPH, I am always alerted if somebody with symptoms is picked up at the airport and taken into the infectious disease

unit. We find, in our experience, that it is much easier to stand the system up and be alert, because you can always stand down. If you are ahead of the curve and coms, you, GPs and all the people in the emergency planning response system know about it, then we can respond should tests prove to be an actual case rather than a suspected case.

Q234 Paula Sherriff: That sounds really positive. Are you sharing that practice with other towns or cities that may have an airport or ferry ports or such things where the prevalence may be higher?

Professor Ardern: Public Health England colleagues, with whom we very closely work, are sharing it through Public Health England's systems, but we would be more than happy to share it with other local authorities, because we think it is a very robust and resilient system, linked into both the lead DPH and, of course, the local authority chief exec on-call arrangements too.

Q235 Paula Sherriff: Would anyone else like to comment on the Ebola question?

Paul Davison: Yes, if I may. First—again, this came up in the first session—I would pay tribute to NHS colleagues who responded, but of course they would also say that is what they do. Ebola was not new; the scale was new. They were used to doing this. The concern was what would have happened if an outbreak had happened here or there had been significantly more cases in the UK.

I have two things to say in response. One is from a local health protection team perspective. Newcastle played a significant part in this because they were the surge capacity for the Royal Free. We worked very closely from the Public Health England health protection team with not just Newcastle Hospitals Foundation Trust but James Cook as well in order to test what would happen if their infectious disease unit became overstressed with a number of cases, not just in terms of responding to what might have been the potential Ebola threat but the day business as well. The most important thing as well as responding to any immediate threat—it grabs the headlines—is that the day job goes on at the same time. It was not just about how we responded to one or two cases and whether that was possible, but what the surge capacity would have been across the system in order to support that. For example, was moving more highly-dependent patients around possible and how would we do that? That was a piece of work that took place in conjunction with NHS colleagues in the north-east, which was very good. We wrote up an incident debrief—lessons identified—that was sent into national colleagues in response to that.

Q236 Paula Sherriff: Thank you very much. Moving on, if there was perhaps a pandemic flu or a similar other major outbreak, obviously having at the back of our minds the 2009 flu pandemic and remembering the lessons from that, are you confident that we have structures in place that would enable an effective response, and, if we do not, what do you think needs to be improved in order that we can guarantee an effective response?

Paul Davison: Some things have changed since 2009. I worked at that time for the Health Protection Agency; so we were critical in co-ordinating some of the response to that. This

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

Also, we have mentioned community services, and certainly from a north-east perspective I would not want to paint them as not wanting to respond. They were absolutely vital in 2009, and, because of what we found exactly in the response to the previous question, health protection work carried on, and at the same time in the north-east we had a significant outbreak of measles in the Hartlepool area. We were managing two very significant incidents. As we continued the containment phase, in terms of trying to get antivirus treatment and all the rest of it, there was a lot of work to be done. We drew on NHS colleagues to come and train them, and they came into our response centre and did that.

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

Q237 Paula Sherriff: That is fairly similar to what we heard from the other panel. They were discussing a recent hepatitis outbreak in Leeds, and, although we talked about lots of good practice and lots of preparedness, there was an acknowledgment that capacity-wise there were indeed some challenges remaining. Finally, from me—forgive me if I read this—do you think it is a problem that directors of public health in their own right are not formally part of the response arrangements under the Civil Contingencies Act, although local authorities are as a Category 1 responder?

Professor Ardern: I am a Category 1 responder because I am a chief officer in local government. My response to that would be that DPHs are chief officers in local government. They are part of the Category 1 response. I do not think they need separate categorisation. There are challenges between Category 1 and Category 2, and I think Category 2 designation for CCGs has not always been particularly helpful because people do not necessarily recognise that Category 2 still means you have to respond and you have to be part of that strategic co-ordinating response. But, in direct response to your question, I am definitely a Cat 1 responder as a DPH.

Q238 Chair: Perhaps we should ask Mr Hardy to comment on that.

Dominic Hardy: I have been in post about 15 or 16 months now, and I have to say that, although the CCGs that I work with, historically, in my understanding, may have had some issues at the outset in understanding the responsibilities that went with being a

Category 2 responder, the work they do on a day-to-day basis to oversee surge capacity for urgent care in particular, or indeed the recent thorough testing of our response system we were able to give it during the junior doctors' industrial action, showed that they are stepping up to the plate now and playing their role in helping to organise and co-ordinate what goes on locally, or even more locally than the patch that I cover. I think they are stepping up.

Paul Davison: I think the question was also about system resilience for pandemic planning and response, so I will offer a thought on that. Systems are in place. We do have planning systems. There are plans. You heard in the previous session that those plans are exercised, stress tested and we learn from those, but if there was a pandemic you would move to national command and control. Therefore, the whole rules of engagement change, and that brings into it a kind of political sensitivity as well, which is the second thing I was going to say has changed since 2009. There is increased political awareness. I suspect there is a lower threshold, so everybody wants to know everything straightaway. Reflecting on 2009 and Ebola, there is definitely heightened political and, therefore, public sensitivities around these things, which would change the dynamic. But in terms of response, if there was a pandemic, we would have to look at the national risk register, deploy national resources and consider the health and care system in the whole rather than just in individual localities, because that would trigger a whole different level of response.

Q239 Chair: To pick up on a comment that was made that we do not have the power now, as directors of public health are not directly within the NHS, to direct an NHS response, how much concern should there be about that? We are hearing also a message that the response is good and that there is surge capacity.

Professor Ardern: I will speak on a personal basis and indeed on behalf of Greater Manchester. I do not personally have any problems commanding NHS resources when I need them. I think sometimes that goes back to relationships, being in the same room in terms of planning, doing joint exercises and training. It is very much about how you work on a day-to-day basis with your NHS partners, but I can quite assure you that, if I have an outbreak and I am not getting the right response from NHS front-line staff, then I will be straight on the phone to a chief exec to get it sorted out. It is not an issue. It is really an issue about how good people's relationships are, how good their planning mechanisms are and how well they train as organisations, but I certainly do not have a problem commanding resources when I need them.

Q240 Chair: It is very reassuring to hear that is the case for Greater Manchester, but of course what we as a Committee want to know is that it works everywhere, in which case, what key message should this Committee give to make sure that it happens everywhere?

Professor Ardern: The key message from me—and I was reflecting on what could be helpful to people—is to use the powers of the health and wellbeing board to hold people to account; to use that to support the director of public health in resolving issues; to make sure you are using also the very good emergency planning framework we have—the local resilience forums and the local health resilience partnerships. I think it must be important to ensure that we have director of public health involvement in both of those structures,

and perhaps what I am not entirely clear about is whether we have director of public health involvement in those robust statutory planning arrangements. If they are in there, that is where those kinds of discussions can happen.

Q241 Chair: Does it also help that you have a very senior position within the council, because I understand that in some areas the directors of public health are seeing their status downgraded?

Professor Ardern: Yes. I think it does help that I also have charge of the council's corporate emergency planning resource. I have a dual chief officer role. I would say to DPH colleagues that taking on the corporate emergency planning role helps in terms of engaging the rest of the council, particularly in engaging political support. I have extremely strong political support, both from the cabinet member for adult social care and health, but also, in terms of corporate emergency planning, the lead elected member is actually my council leader. Getting really strong buy-in from corporate senior management and from elected members, taking on that broader remit of emergency planning has been extremely helpful.

Chair: Thank you very much.

Q242 Dr Davies: Moving on to screening and immunisation under the new arrangements, could you collectively give your thoughts as to the challenges that face this field since the changes?

Dr Seddon: Thank you very much. As I said, I am a screening and immunisation lead. I was in a primary care trust with particularly a screening remit, not so much an immunisation remit, before that, but I have been a screening and imms lead for three years now, throughout the time of the new changes. First, I would broadly emphasise the things that have come up already. Yes, there has been fragmentation; yes, the system was complex; and, yes, there was in some areas a lack of clarity about who was responsible for what. The thing that has made it work is the relationships and the will to make it work.

Kate has outlined in Manchester a lot of the structures that they have. In the Merseyside area, we have less formed structural partnerships but just as much of a history of working together, and that has been how we have done it. Broadly, it has worked because there have been the experts there and the people committed to making it work. I was privileged to have a full team from the start, and that made a big difference. I am very aware that, added to getting to know the new system and making it work, many of my colleagues across the country had very incomplete teams. It is relevant to mention that now because there is stress in the system because of the resource reductions. As you are aware, in Public Health England we have been going through a process of tailoring the size of teams and the grades and numbers of staff to the resources available for well over 12 months now, and we are coming to the end of that in the context of the screening and immunisation function that I lead. Having a full complement of staff will make a difference, but it is fewer than it was. That particularly affects the resilience and the succession planning of the system.

We have mentioned things like surge capacity and being able to mobilise for additional things. When we mobilised for Ebola, of course, I had a couple of members of my team who helped in going to Manchester airport and screening, and we supported them from back in the office. It is difficult to see how we could do that and still be safe now because the resilience is affected now. But, broadly, it works; we make it work and we have the right people in place. We are particularly stressed by the number of experts now—the expert leaders. We started off in 2013 with four screening and immunisation leads serving the 6 million people in the north-west. We now have 1.5, so we have to acknowledge that. We have strengthened other grades in order to pick up some of that. It is not a broken system—I am not scaremongering in any way—but I am saying it does feel like it is very thin. We believe we can cope with steady state well and could cope with a certain amount of escalation, but for anything very big we would find it very difficult indeed.

Dominic Hardy: I recognise the picture that Dan paints but I want to draw out some of the opportunities that it has given us. If you look at the cold hard data around screening coverage, and I do not know how true this is across the country, it is patchy. Some programmes have really improved. Our bowel-screening coverage has improved over recent years almost in spite of whatever else has happened, so that is testament to the hard work that my team does, both the embedded screening and imms colleagues and my own public health team. I would not want to give the impression that somehow this is all a prophecy of doom. It really is not. There are some big strides being made in increasing take-up of the HPV vaccine as well in my patch.

The bit that we need to continue to reflect on is that the scope of the screening and imms programme has broadened over the last year. I think I counted eight programmes that are either new or significantly different compared with where we were even three years ago. So there is more work, with bigger populations to cover, at least a kind of constrained workforce, if not reduced, but we are still making strides to improve. That is a pretty good story to tell overall, which is not to say we cannot do an awful lot better. The other point about opportunity is that, compared with even the halcyon days of PCTs, there are some things that we do better now. It is fair to say that in the past, certainly in generic terms, the public health team in a PCT was often quite foreign to the contracting and finance team. In my team they sit together, so we get the added benefit of the insight and expertise of our screening and immunisation specialists with people who are very good at contracting, and that means we can get the most out of the work that we do for some of our biggest programmes, like the breast-screening programmes. I can think of an example where over the last year we have addressed an issue of breast-screening round length with one of our biggest providers, a big trust on the south coast, and they have worked with us through an investigation to improve the way that we provide coverage there. There is a more balanced picture here of improvement and opportunity as well as, undoubtedly, some of the challenges that Dan has mentioned and that were aired in the previous session.

Dr Seddon: I would like to echo that. Dominic has just stolen the second bit of what I was going to say, which is absolutely fine, but through the screening and immunisation teams in this we have been able to deliver for screening a systematic approach on a bigger footprint, and I could echo exactly the work that Dominic has outlined. In Merseyside, one thing we were able to do early on was recognise the low cancer screening rates that we

have in Merseyside despite having very high cancer prevalence and incidence rates. So we were able, under the umbrella of the screening and immunisation team, to pull together partners across the whole system, including some from the private sector and the charitable sector, to ask what we could do about this across Merseyside, pulling together good practice—your point about sharing practice in different areas. We were able to identify good practice in some different areas and, through some of the charity work, to take advantage of Cancer Research UK's commitment to promoting bowel cancer screening. A particular initiative we were delighted with was Jo's Cervical Cancer Trust, where they have commissioned on our behalf bus advertising that they have done in other areas and are doing in our area now, but we are adding value through evaluation.

Yes, the number of additional programmes that have been introduced is one thing, and the outcome is another in that we are still looking at the screening rates and seeking to see them improve. At present, on big population bases, they are not improving so much, but they are with individual practices. For example, we have a practice where three years ago their cervical screening rate was 80% and now it is 86%, and we are able to identify with them what they did and will seek to spread that through other practices as well.

Professor Ardern: In response, to add to Dan's point, the opportunity of working in local government is the reach out of local government into local communities, and it is both a challenge and an opportunity. The challenge is that, because you have the screening and imms team working at a bigger footprint, it has advantages in the way that has been described, but perhaps the loss is getting into the intelligence that local communities have about the way in which they receive information and the way in which you can use peer mentors. To support the uptake of both imms and screening very locally, we have used our health champions programme, which is a Royal Society for Public Health programme initially developed for health improvement, but we now use it very much for health protection, and we have merged into that a cancer-screening champion awareness.

That has helped us to get into local communities, and it is using that grassroots approach that was discussed in the previous session to engage with our local communities in ways that they want to be engaged with rather than using the poster, leaflet, health education approach. The opportunity is to marry the expertise of the screening and imms team with that kind of local intelligence and local capacity building.

Q243 Dr Davies: Are you concerned, though, about loss of links with GPs, community pharmacists and access to practice-level data?

Professor Ardern: No. I commission community pharmacists. I have a healthy living pharmacy programme in the borough, which is being used as the model for pharmacy commissioning across Greater Manchester, and something that is quite unique to Wigan but we will be rolling it out, which is called the healthy living dentistry programme. I commission services from the pharmacists and we work with both the local pharmaceutical committee and the local dental committee on screening and imms and other health improvement agendas. I do not have any problems in terms of access to their data. In the previous session, the issue around screening coverage coming back through

Public Health England, certainly in the first part of the transition, was a challenge, but that information is now coming through on a regular basis.

Q244 Dr Davies: Good, and you feel that your colleagues elsewhere in the country largely agree with that.

Professor Ardern: I am not speaking for my colleagues elsewhere in the country. I can only speak for my own borough and conurbation, but there are opportunities to work with primary care commissioners, work with your CCGs on integrated care and use the opportunities around things like shared care arrangements around sharing intelligence, which perhaps act as a route round some of the data protection challenges that arose at first. They are not challenges for us now.

Q245 Dr Davies: Okay. Clearly, incident reporting is critical to all of this process. How satisfied are you that the processes are satisfactory now in terms of directors of public health and Public Health England being aware of what is going on, on the ground?

Professor Ardern: From my own perspective, and I can only echo what Mr Razzaq previously said, I get reports of incidents that happen on my screening programmes, and indeed I am invited to all the QA visits—the quality assurance visits—that happen for local screening programmes, so I am able to be in and hear what the quality assurance team actually says about, for example, our local breast screening or cervical screening programmes.

Dr Seddon: Can I add to that from, if you like, the other side? We inform directors of public health about incidents on their patch; so does NHS England, and occasionally, because of our embedded nature in NHS England, we can be a conduit for that. It is very helpful having that, and the assurance role that the DPH holds is very useful to us in that we need to tell them, for example, about how an incident is going. Inevitably, the response is, “Thank you for telling us. Will you keep us informed?” Particularly when the incidents are politically difficult or there are major performance issues associated with them, it is very useful to have the DPH’s interest in that respect. As to QA visits, it is very helpful bringing those up, because they are an arm of the system that perhaps we have not mentioned. Those are a fantastic aspect of the system; it is an area where NHS England, clinical commissioning groups and local authorities work together and are there at the feedback session, and it is very much a drawing together of lessons about that. That applies to screening programmes, not immunisations.

Dr Davies: You are satisfied in your areas and you do not have any particular suggestions to improve incident reporting on a national level across other parts of the country. No; thank you.

Q246 Chair: Before I come on to Philippa, could you clarify, Professor Ardern, what has happened to screening rates across Greater Manchester?

Professor Ardern: Unfortunately, I am not the screening lead, so I would not be able to answer that question in detail. I can tell you that across my own patch in Wigan we have maintained our screening rates; in fact, we have improved our immunisation rates and

have particularly good uptake of MMR, for example, in Wigan. But I would have to send back some information about the whole of Greater Manchester.

Chair: Yes, apologies; I should have said Wigan.

Q247 Dr Whitford: In the opening section from the Chair we touched on the issue of training, which is easy to do within the NHS; we have all the structures. What exactly do you feel the issue with training is and how do we provide the skills going forward? You need a stream of people coming through. I am not sure who wants to start.

Professor Ardern: I will start because I raised it. The issue for training is that, clearly, you have colleagues in primary care who have access to training and need to keep up their skills, both in immunisation and screening, and that is particularly true for cervical screening training. It was probably clearer in the previous arrangements about how they accessed that training and who paid for it; but I am not so clear, given the number of requests my team gets to deliver immunisation training, for example, where that responsibility lies or where the resources to fund practice training actually happen. It is a very specific local example I am giving you, but I suspect that is an issue in other parts of the country too.

Q248 Dr Whitford: That is something that is not yet resolved.

Professor Ardern: Yes.

Q249 Dr Whitford: Does anyone else want to add on that?

Dr Seddon: Can I expand on that? As a ballpark statement, that is fair. When we came into the new arrangements, there was very little provision elsewhere in the system for training front-line immunisers. For people who worked in screening, there was most of it apart from cervical screening. So as to front-line immunisers in general practice, principally, and the cervical screeners in general practice, we had to make sure it was a safe system. My colleagues and I, as screening and immunisation leads, approached it in different ways across the country. I am aware that some of my screening and immunisation colleagues said to general practitioners, "This is your responsibility as an employer. I am not going to provide the training." In those circumstances, training markets have developed.

The decision we took in Merseyside and Cheshire was that we needed to maintain a safe system and needed to continue to provide some of that training, and to nurture the market. We had some success so that we have a robust cervical screening training system now, for example, which is paid for by the employers. But with immunisation training, I am describing the same system as Kate, although in a slightly different patch, in that we have a situation where it is clearly not our remit to fully fund and pay for training, but at the same time there is not a market of excellent training around, and, if there was, how could we be assured that the standards in that were excellent? That is still an area where it is not broken in the sense of being a danger but it is an area that stretches us and that we find a challenge.

Q250 Dr Whitford: So it is not quite sorted either.

Dr Seddon: Not quite sorted is fair, yes.

Q251 Dr Whitford: From the point of view of the public health workforce, many of whom are now inside the local authority, what about the training and skills that they get?

Dr Seddon: I will mention the public health workforce in screening and immunisation now. We will train people coming in, and one opportunity that the approach to cost reductions in Public Health England has allowed us is to have a broader range of grades within the teams so that there are more entry-level grades. That is reasonable for us. We can train our own staff. There is not training in immunisation and screening to local authority staff or to other Public Health England staff particularly.

Q252 Dr Whitford: As to people—not just immunisation and screening, but all the other parts of health protection—who now live inside the local authority, what kind of support do they get for training to climb the ladder or maintain their skills?

Paul Davison: The discussion has been about screening and immunisations in the last few years. In health protection teams—

Q253 Dr Whitford: I am talking about all the skills now.

Paul Davison: Our health protection teams in Public Health England, as opposed to local authorities, comprise of consultant level and nurses and practitioners. Through the public health training scheme, they get exposed to health protection as a discipline, and many like the discipline. We have found that, generally speaking, we have been able to recruit. It feels a bit thin sometimes, but we are holding. Historically, the health protection teams were staffed by nurses, often with an infection control or community hospital background. Some years ago the decision was taken to broaden that skill mix, to have practitioners, some from environmental health backgrounds and some from scientific backgrounds, whose aptitude was tested through a rigorous selection process.

That is the official answer, but getting people through the door is when the learning really starts. A lot of that is done through in-team support—coaching and mentoring people through different situations so that they feel competent. From our health protection point of view, there is an expectation that they will be on call as well and have to work independently out of hours. So we have people on probationary periods, and test and expose them to increasing complexities of work until we are sure that that is okay. In the north-east we have fewer people within the local authority public health section workforce who are directly health protection. I do not know whether we will discuss in a moment the issue of health and wellbeing boards and all the rest of it, and the differences between that and the picture that Kate has been painting of Manchester and Ian of Leeds, which are big metropolitan authorities. It is different sometimes in other areas and it would be useful for the Committee to understand some of those at some point.

Q254 Dr Whitford: Sure. We will follow that, but obviously there was a description in the earlier panel of some of these, like infection-control nurses or vaccinators or whatever, actually living within the local authority.

Paul Davison: And it is variable.

Q255 Dr Whitford: Obviously, learning is an ongoing thing. We all know the expense of going on training courses and so on. Is there a budget for those who are not Public Health England and not NHS England but who are now within the local authority? How easily can they access ongoing training?

Professor Ardern: Again, I can only speak for Greater Manchester, as you will understand, but one reason we set up the health protection confederation was precisely to ensure that these staff who were employed in infection prevention control and health protection across Greater Manchester got the opportunity both in continuing professional development—and clearly if you are a nurse you have to keep up your registration—and access and shared good practice. Public Health England's health protection team strongly supports and is part of that confederation. There is the opportunity to work-shadow within the health protection team as well. We make sure that teams within local authorities get the expert mentoring and support from Public Health England; similarly, within the emergency planning system, we have a series of training programmes run by the civil contingencies and resilience unit, which involve, of course, outbreak planning and response too. Training for outbreaks is part of that process, both within boroughs but also at a Greater Manchester level, and that of course is open to health protection staff.

Q256 Dr Whitford: In a way, you are largely providing it in-house, using a very big house.

Professor Ardern: We are, yes, absolutely. Where necessary, I have a training budget within my own budget that enables me to supplement the local authority training budget. Clearly, things that can be done within the corporate training budget are done, but if it is something like specialist health protection, then I will do that.

Q257 Dr Whitford: You do have access. I would like to come back, Paul, to your point about the structure. That was a comment I had made on the first panel. It does seem very fragmented and sounds as if each place is having to slightly reinvent the wheel. As you touched on, the big conurbations can more easily do that. I am always a bit worried about all the bits that are not a big bit. Do you think the idea of the health protection board sitting under the health and wellbeing board is something that is widespread, or what kind of solutions are there? Or do you think there are places that maybe have not worked it out because they have not had a crisis in the last three years?

Paul Davison: There are two responses I have to that, and I was trying to work out, if you asked me the question from the previous session, what my response would be. I think there is a practical issue. For example, in the north-east, our population size is probably pretty similar to Greater Manchester, but we have 12 local authorities. The devolution combined authority discussion is taking place within the north-east quite strongly for a north and south, but if every local authority had a health and wellbeing board and a health protection

committee that reported to the health and wellbeing board, other consultants in my team and I would have to attend 12 sub-committees, meeting three or four times a year. That is 48 meetings a year. You start to think what the value of that is that could also be got in different ways. I would personally urge caution about having a structural approach to a problem and saying, “This seems to fit. We will just have that everywhere.”

Another common theme has been the nature of the relationships. They are by and large very strong and I would certainly have to report that in the north-east. The Committee was a bit concerned earlier about it resting on goodwill. The relationship is important because it is a relationship built on a common set of values—our single-minded determination to serve the public, because that is who we are here to serve. Therefore, there is a kind of unifying effect of wanting to do the best you possibly can for the populations that you are here to serve. In the north-east we do not have those sub-boards but we meet regularly with directors of public health. We have annual update sessions for them on incident outbreaks, STAC training, which was mentioned earlier, and an ongoing discussion with all of them about notification of incident outbreaks or just things such as, “This is going on. It is probably not going to go anywhere, but just be aware.”

Of course, when we get to incident outbreak management, when there is something very specific to control and mitigate, directors of public health are members of the outbreak control team. So there are different ways of doing things without making a suggestion that it needs to be the same. It is critically important that it is understood locally and that the process is delivering the right outcome, if not by the same process.

Q258 Dr Whitford: Is there a national forum within which these different solutions can be shared? Kate, you were saying that, for you, the data sharing around immunisation and screening is not an issue. We have heard evidence from public health practitioners and DPHs who say it is an issue. The thing that strikes me is that everyone is having to find their way and we have been lucky that something catastrophic has not happened in that time. Is there a way of accelerating everyone to arrive at solutions, even if it is different ones? Do you have a national space in which all of this learning can be shared?

Professor Ardern: Yes, there is.

Paul Davison: We could definitely do that. Going back to the funding issue we talked about earlier, Kate said she had no problem commanding the resource, and that is fine, but she is not the one who is going to pick up the tab sometimes for those resources—

Professor Ardern: Oh I am.

Paul Davison: That is by discussion. I think what you are reflecting on is the complexity that we now find ourselves in, and we are still working our way through that in terms of how we share good practice. But, hand on heart, I do not think, nationally, we are terribly good at that. We are good at learning it in localities; at a national level we find that more difficult.

Q259 Dr Whitford: Sometimes an event where everyone is in a room saying, “This is how we did it. We are big.” “This is how we did it; We are small”—

Paul Davison: We do that through exercising and things like pandemic flu and Ebola. For those high-intensity, high-level things, we do do that, but for a lot of the day job we could learn from each other as well. We do that through quality programmes.

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

Q260 Dr Whitford: Was that not just within Greater Manchester?

Professor Ardern: No; it is a national English programme. For example, I have recently done Hull and I previously did Peterborough. Using that process, and I think adding in a very strong element around the health protection and emergency planning, would be a good route to go down. That would make sure we have a conversation between PHE and the LGA, and, of course, the LGA’s focus with local authorities is extremely helpful. They are fully engaged also in things like the emergency planning agenda.

Dr Whitford: Thank you very much.

Q261 Chair: You may not wish to answer this, Professor Ardern, but in your national role with peer review are there some areas where you identify that things are not working well?

Professor Ardern: In terms of when I have done peer challenges, one thing I certainly have observed is the need for health and wellbeing boards to be assured about health protection and emergency planning. That could be reinforced through the health and wellbeing board chairs network.

Q262 Chair: Thank you. Mr Davison, could I ask you to reflect on something that the north-east was well known for, which was the public health observatory work on alcohol? Is that something you would like to make a comment on in terms of the changes since 2013?

Paul Davison: It is not something I am involved with on a day-to-day basis, so I would prefer not to, if that is okay.

Q263 Chair: That is fine. Members of the panel, are there any areas that you have not been asked about that you feel you would like to comment on and recommendations you would like to see from this inquiry?

Dr Seddon: Yes. There are two areas that I would like to mention. One is in response to the last discussion around learning from events and people getting together nationally. One thing that has happened within screening and immunisation since 2013, a little ad hoc early on and now much more consistently, is national meetings of screening and immunisation leads with the central people in PHE and NHS England. Those are particular

areas where there is a lot of learning and sharing of good practice, sharing of solutions and challenges, and it is a tribute to the work of NHS England. If I can be frank, initially, NHS England and PHE looked like they talked at the top and there was no talking at all between the two organisations all the way down. That is how it felt, but it is not like that at all now, and the two organisations are talking to each other at each level and work together. What Dominic said about screening and immunisation performance illustrates that really. That is one area.

Then can I just clarify my perception and what I would say is the national picture around the data analysis? Yes, there is a question and some barriers around sharing of practice-level data in its unpublished form. NHS England and Public Health England are working on that at a senior level. There are some restrictions around the way the data is collected, which affects how it can be shared routinely. However, the other aspect around data and data availability to our DPH colleagues, in particular, is our ability in screening and immunisation teams to handle and process that data. That is the more important barrier. Again, it is something that we are all aware of in the system and working on with NHS England colleagues, and a different solution has been found in different teams.

Q264 Dr Whitford: Did you have that problem before? The way the problem was described to us was that it was much more to do with data protection and DPHs now being outside the NHS. Do you suddenly now have a problem analysing or processing it that you did not have before?

Dr Seddon: Yes; the screening and immunisation teams have little data-handling capacity.

Q265 Dr Whitford: They had that before.

Dr Seddon: In the past they were part of primary care trusts, which owned the data anyway and could handle it; so, yes. We are finding solutions to this, all of us in different ways, but it is fair to say that it remains a challenge.

Q266 Chair: What would you like to see that would make it easier for this to happen, not with workarounds in different local areas? What would make it easier?

Dr Seddon: NHS England and Public Health England at the local team level need to continue to work to find solutions to providing the data-handling capacity that is necessary to provide regular detailed data reports to DPH.

Q267 Chair: It is the data-handling capacity rather than, now, the barrier being with them being prevented from sharing the information.

Dr Seddon: Yes. There are some restrictions on sharing information, which PHE and NHS England are working on in terms of being able to process and handle the data at a local level.

Q268 Chair: They are seeking to do it. It has not been solved yet.

Dr Seddon: Yes. It is fair to say it is not solved yet, but I know that everyone is aware of it and working hard on it.

Q269 Chair: To be absolutely clear, because it would be helpful to have clarity here, if you were starting from now and designing how it should look, what changes would you be recommending are made?

Dr Seddon: I would ensure that there is explicit data-handling capacity within screening and immunisation teams in NHS England. The agreement between Public Health England and NHS England was that that element would be provided by NHS England. It was not really in place at the start of the three years. There are many ways in which it is being put in place now, but it is not consistent.

Q270 Dr Whitford: What happened to all the data-processing people who were in the primary care trusts? Were these people who were let go, who are not doing it, or are they doing something else?

Professor Ardern: Most of those types of individuals went into the commissioning support units, so they were neither transferred into the sort of team that Dr Seddon leads nor, indeed, into local government.

Chair: Thank you.

Paul Davison: I have two things, briefly, if I may: to promote the work of health protection teams and Public Health England, full of skilled, inquisitive people, who are not just doing incident case management but are contributing to research and doing academic studies. Picking up a point that Dan made much earlier, resource reduction is starting to eat into the capacity. What will happen is that we will just default more to doing case and incident outbreak management, which is the more visible bit, but we run the risk of losing, as we reduce capacity, that additionality, which, as an aspiring world-class organisation, PHE needs to keep in its armoury.

Secondly, in terms of assuring the Committee on a whole range of response issues, I still need to say that the funding issue for incident outbreak management and response is not sorted out yet uniformly. I know that Public Health England is working at a national level to support and provide evidence to NHS England on their new or revamped “Who Pays?” documents. So we will be making our contributions to—

Q271 Chair: The “Who pays for what?” question that was raised in the panel.

Paul Davison: Yes.

Q272 Chair: That works well in your own area, Professor Ardern.

Professor Ardern: Yes.

Q273 Chair: You are seeing variation in that.

Paul Davison: Yes.

Q274 Chair: Thank you very much for coming this afternoon.

Professor Ardern: I have a couple of things, if I may. This afternoon we have not touched on the subject of antimicrobial resistance. That is a significant opportunity and a challenge. We have put it into our risk register for Greater Manchester and are working through that as part of devolution, but that is a challenge we need to focus on and, in terms of a risk to the system, it is a big health protection challenge for us. Making use of both integrated care organisations and the opportunities for working with local government on AMR is an important subject perhaps to come back to.

Secondly, there are the opportunities we have not just around the specialist workforce but to broaden out and use the very recent workforce report that has come out of both PHE and the Royal Society for Public Health, looking at the workforce to 2035, looking at where we might need to skill up people in terms of health protection and use a skills escalator: what skills do the community need to have, through to that specialist workforce element? That is a challenge because I do not think we are necessarily that good at workforce planning.

There is succession planning in terms of the demographics of the existing workforce. Through Greater Manchester, we are looking at how we work with Health Education England to look at succession and workforce planning around the whole gamut of health protection skills. That brings in, for example, the environmental health workforce and the trading standards workforce too.

Q275 Chair: Thank you. Was the interest in the drug resistance triggered partly because of resistant gonorrhoea? Was that one of the issues in your area?

Professor Ardern: No. CPE is an issue for Greater Manchester, but the real trigger—

Q276 Chair: Can you say CPE in full for those following from outside this room?

Professor Ardern: I apologise. I am going to look at Paul now because he is the expert on this.

Paul Davison: It is an organism that is resistant to normal antibiotics.

Professor Ardern: Oral antibiotics. That has been a challenge for Greater Manchester, but the bigger push for Greater Manchester was recognising the work of the O'Neill report and linking antimicrobial resistance into the economic agenda for Greater Manchester, recognising it as a challenge to the economy and building it into our UN resilient cities programme.

Q277 Chair: Thank you. Just to clarify the acronym, what does that stand for?

Paul Davison: I will try and get this right. It is Carbapenemase-producing Enterobacteriaceae

Chair: It was just for people following from outside the room. Thank you very much for coming this afternoon. We really appreciate it.