



Health Committee

Oral evidence: Public Health post-2013—Structures, Organisation, Funding and Delivery, HC 140 Tuesday 7 June 2016

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Written evidence from witnesses:

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Julie Cooper; Andrea Jenkyns; Emma Reynolds; Paula Sherriff; Maggie Throup; Helen Whately; Dr Philippa Whitford.

Questions 278-404

Witnesses: **Professor John Newton**, Chief Knowledge Officer, Public Health England, **Professor Paul Cosford CB**, Director of Health Protection and Medical Officer, Public Health England, **Richard Gleave**, Deputy Chief Executive and Chief Operating Officer, Public Health England, and **Professor Lisa Bayliss-Pratt**, Director of Nursing, Health Education England, gave evidence.

Q278 Chair: Good morning. Thank you very much for coming to this final session of the Health Committee's inquiry into public health post-2013. Welcome to our first panel. For those following from outside the room, could you introduce yourselves, starting with Professor Newton?

Professor Newton: Yes; thank you very much, and good morning. I am John Newton. I am the chief knowledge officer at Public Health England.

Professor Bayliss-Pratt: Good morning. I am Lisa Bayliss-Pratt, director of nursing for Health Education England.

Professor Cosford: I am Paul Cosford, medical director and director for health protection for Public Health England.

Richard Gleave: I am Richard Gleave, deputy chief exec and chief operating officer at Public Health England.

Chair: Thank you. Could I ask you to project your voices, because we have air-conditioning on and these microphones are for the purpose of the recording and do not project? If you would not mind speaking loudly, that would help those who are trying to follow inside the room as well as those following from outside. Helen Whately is going to start the questioning today.

Q279 Helen Whately: Good morning. My first questions are for Richard Gleave. This inquiry is looking into how well the public health system has been working since 2013. I would be very interested to hear your view on how well it is performing and the impact that is being made on public health outcomes.

Richard Gleave: Thank you very much, yes. I will talk a little about the system, but I know my colleagues, and particularly Professor Newton, would like to talk at the end about some of the benefits in terms of the improvements in health outcomes that they have been tracking.

The new system that was set up was looked at by the Public Accounts Committee about a year ago and it concluded that a good start had been made on the new arrangements. Since then, there has been a lot of work building on that about the way in which local government, as the local leaders of the public health system, can take on addressing the wider determinants. The work that we have done with the NHS in the Five Year Forward View has enabled there to be a partnership about the radical upgrade in prevention and the health and wellbeing gap. Then there is the work that we in Public Health England have done on co-ordinating the work on the health improvement agenda, about high-profile national publications and their impact upon the public's health, cigarettes and sugar, and the work that we have done that creates the spine for the health protection system that keeps the country safe.

Professor Cosford: May I chip in on some aspects of the health protection system? If I look back over the past three years, I think, too, that we have made very sound progress in a number of areas. As always, there is more that we need to do, but we have maintained the safety of the public; we have worked on floods and Ebola. You may remember outbreaks of infection in newborn babies in neonatal units in some of our hospitals a couple of years ago that we dealt with. In our first few months we dealt with some outbreaks of measles and addressed the successful programme on MMR, which dealt with much of the legacy of the Wakefield issues about MMR vaccination. We have had a 25% reduction in the number of new diagnoses of TB over the last three years, which comes on the back of a trend of an ongoing increase for some years beforehand, and we have implemented a lot of new vaccine programmes, in particular the world-leading childhood flu vaccine programme whereby we are delivering vaccinations to children in schools in all areas of the country. There is a lot that we can look at that we have done well.

Professor Bayliss-Pratt: From a workforce perspective, we know from our local offices that the specialist public health workforce remains a popular choice for people to go into; there is almost a 10:1 ratio with that. In relation to our commissioners, we have not seen any significant reductions in the demand for the workforce within that area. From our

point of view, we consider that the workforce is flourishing within the local authority arena.

Professor Newton: Shall I comment on the outcomes? You will be aware that the public health outcomes framework tracks 149 indicators. In the last three years 80% of those have been level or improving. There are problems and there are some areas that we are concerned about, but the overall picture is of continuing improvements in health. Of course, that is only two or three years in, and many of these indicators you would expect to take some time to change. Nevertheless, it is still an overall positive picture on the outcomes.

Q280 Helen Whately: Looking at the area that has been particularly the responsibility of local authorities, how well do you think local authorities are performing, and how well are they doing at delivering their statutory obligations and making good use of the grant with which they are being provided for public health?

Richard Gleave: I will kick off on that one because we have a close relationship with local government. Across PHE, our centre directors and their teams are in weekly and monthly conversations with local authorities, and we hear lots of examples of the innovations that they are bringing in. They have a very clear focus about a different set of approaches, perhaps, than those that were dominant in the pre-2013 area. There is a focus on assets and community development, a focus on prevention and getting in early, addressing those wider determinants and the broader behaviour change and lifestyle issues. There are examples of that from around the country. The Plymouth Thrive campaign and the Wigan Deal are great examples of how local government is changing the approach and getting in there at the heart of the key issues.

Q281 Helen Whately: From our previous witnesses we have also heard and seen some excellent examples of where local authorities are doing very interesting and innovative things, but we have also heard that there is wide variability in the performance of local authorities. Is that a picture that you recognise?

Richard Gleave: There was wide variation before 2013. In many ways some variation is entirely right and proper because places are very different, and so the job of the director of public health is to say what works for our locality and how we can make sure that we meet local needs. There are many issues that are consistent across the country. Tobacco control, heart disease and cancer are all themes that are important everywhere, but the translation of that into local places is really important. We are working on what might be called unacceptable variation, where there is not a logical reason why things vary. Some of the variation—and we found this in our surveys with local government—is due to the legacy that they have inherited. In some areas there is particular evidence about local need, but there are some areas where we are sure that we can level up; that the best can help the people who are still learning. The process for doing that is called sector-led improvement; the Local Government Association and the Association of Directors of Public Health have done a lot of work on it, and we support that with our tools and data.

Q282 Helen Whately: What are you doing to make a difference in the areas where there is unacceptable variation?

Richard Gleave: We do four things. First, we provide a tailored support package. We have this personal relationship between the centre director and the director of public health. They have regular conversations, and members of their teams have regular conversations. That is about being very clear on the importance of place and tailoring it to meet that place.

Secondly, we provide some very specific services to support them. The health protection service and the knowledge services that we provide are probably the clearest examples of that, but there are others as well. They get very definite things from us, and increasingly we are developing very explicit memorandums of understanding with local authorities about how that operates.

Thirdly, we act to facilitate and enable important things happening in the system. The workforce might be a good example of that; we do work that enables local authorities to work together.

Fourthly, we provide some landmark national publications, the data publications, the tools we provide, the national reports about the evidence we provide, and increasingly we are looking at return on investment because that is the biggest ask from local government. They would like more evidence about return on investment.

Q283 Helen Whately: Do you see any difference, particularly any pattern, in performance between where there is a unitary authority and where there are two tiers? I have heard that it can make very good sense with the structure in a unitary authority, but it can be more difficult when you have two tiers, where some of the potential benefits of having public health at local authority level are harder to achieve because some of the responsibilities would be at borough level as opposed to the county council level where public health sits.

Richard Gleave: That is not our experience. It is different. You would not say it is the same, but the two tiers of local government both have responsibilities that relate directly to the work around the public's health. So the environmental health officers and the relationship with them is in the district council in the two-tier levels, and the director of public health is at the county level, at the upper tier. But all the counties work well with their districts. When you go to visit a place such as Cumbria, you have both levels of local authority in the room together in the conversations that we have. I do not see that as a difference that is anything other than based on the needs of the place.

Q284 Helen Whately: My final question, before I hand over to others, is about where there is a problem with performance. You have talked about the many supportive steps that you are taking to help local authorities improve performance. Do you have the levers you need to make sure that they are effective?

Richard Gleave: Yes, I think we do. It is not for us alone. We are not the performance manager of local government. Local democracy is essential and vital, and it brings a whole added richness to the way in which the public health agenda can move forward in a local place. One important thing that we, the ADPH and the LGA put in place was the protocol for managing the risk of underperformance. So we get in early. It is the same message as that about the public's health: it is a prevention-first message. Tomorrow morning, we are going to be meeting with ADPH and LGA colleagues in order to look under that protocol at what is happening across the country and what sorts of interventions we should be

putting in place. Some of those interventions are for ADPH to lead on, because DPHs help each other through the sector-led improvement programme; some are with the LGA for their regional advisers; and some sit with us to provide particular sorts of support and advice. So there is a range of mechanisms available for us to support a particular patch. Engaging not just the DPH but the chief executive and the local political leadership is absolutely essential in that.

Q285 Chair: Can I ask a follow-up question? Mr Gleave, how easy is it for the public to see whether their local authority is an outlier?

Richard Gleave: Perhaps John Newton would like to comment a little because the public health outcomes framework is absolutely at the heart of that. Those are the metrics, and there are a number of tools that we produce using the dataset that allow for people to look at variation.

Q286 Chair: Of course, because there is going to be variation, as you say, based on, for example, deprivation within an area, but the public need to know if their authority is an outlier in how it handles that compared with comparable areas. It is very difficult for us, let alone anyone who has not had a background in any public health measures, to look at the outcomes framework. Is there an easy way for the public to tell whether their area is an outlier?

Richard Gleave: There are some process metrics that are there alongside the outcomes metrics. That would enable people to look and see how the levels of service and the range of services that are being provided vary across the country.

Q287 Chair: People tend not to look at process measures. What we have now with the CQC, for example, is ratings for different providers. Is there something comparable where the public can be told how well their area is performing?

Richard Gleave: It is very difficult to come up with a single metric that says that a local authority is doing brilliantly or not doing well, because there are so many factors. There is the starting point and the needs of the local population. It is a much harder judgment, I would guess, than making a judgment about a particular hospital, which has a much more defined purpose. I know Professor Newton wants to come in.

Q288 Chair: Indeed. A hospital can do well in one area and be underperforming in another, but I was wondering what tools there are for the public to be able to hold their local areas to account.

Professor Newton: The tool that is designed for it is My NHS. There is a local authority module of My NHS that is designed exactly for that. They are a subset of indicators that come from the public health outcomes framework but are presented in a very easy, red and green format for the public to look at local authority public health performance. It is not an ideal tool. We are still improving it, but it certainly is being used. Of course, there are other ways as well. The public learn a lot from intermediaries as well. We know that the press, people like Healthwatch, and charities such as Cancer Research UK and others, use our tools a lot to generate messages that are much more accessible to the public. We have to have a number of ways of getting out reliable messages to the public. Not all the messages that come out are reliable, but we can do a lot to help people understand what is really going on. Transparency is a very good lever.

Q289 Mr Bradshaw: Briefly, transparency is absolutely essential for the public to have confidence that this system is going as well as you and the Government are suggesting. You said, Professor Newton, that you are concerned about 20% of the public health area. Which are the ones that give you most concerns?

Professor Newton: There are probably three areas, in terms of the numbers. Some of the sexual health indicators are not moving in the right direction; breast feeding at four to six weeks has declined slightly, which is a concern—England has some of the worst breast-feeding rates in the world; and there are a couple of the cancer screening programmes where the numbers have gone down slightly, but that is still on the background of very high levels. We have the highest rate of cervical screening uptake in the OECD, and breast-cancer screening is also in the top quartile but has gone down.

Q290 Mr Bradshaw: You mentioned sexual health. That is an area where we have picked up a lot of concern from patients' groups, professionals and from organisations that are commissioned to deliver services, about not only the impact of cuts but the impact of the fragmentation of the services, with whole HIV services being decommissioned, for example. It does not seem to be a very sensible approach when you say that indicators are going in the wrong direction.

Professor Newton: Yes, indeed. I will hand over to Paul in a moment, but it is a mixed picture. If you look at the record of what local authorities are doing and have achieved, there is some strong work being done, particularly in recommissioning. I think you heard this. From reading your transcripts, a number of directors of public health have been impressed by how well the local authorities have approached contracting. There are examples around the country—Norfolk and inner London boroughs—where they are trying to get a grip on sexual health services as a whole. As you say, there are concerns about the numbers, but that is not unique to this country. Paul might like to comment on that.

Professor Cosford: I would not want to minimise it. Clearly, it is an issue that is taking place in other countries: the States have had increases in sexually transmitted infections and it is something that pre-dated 2013 as well. As ever, the answer lies in a complex mix of changing behaviour and making sure that the right services are easily accessible. Of course, there are always concerns when there is an apparent reduction in services or reducing numbers. There are some very significant issues we need to tackle in relation to sexually transmitted infections. We need to place this in the context of wider aspects of sexual health. We have some things going in the right direction—reductions in teenage pregnancy we know about, which we are very pleased with—but we still have far further to go than where we need to be; we have a trend in the right direction, but we are nowhere near where we need to be yet. We need to look at the most vulnerable groups or the highest-risk groups and tackle the issues of reducing numbers of sexual partners, reducing overlapping sexual partnerships and the use of condoms. We are doing a lot of work at the moment to design a digital campaign around the use of condoms, but we are also very well aware that in some local authority areas there are very good examples of changes in commissioning and contracting. It is an example of where a local authority can get to grips with something in a way that in the NHS we struggled to before, but those examples are not universal as yet, and that is where we need to work.

Q291 Mr Bradshaw: Who steps in on behalf of the public if their HIV service is decommissioned, as has happened in Oxford or the disaster that took place in Chester in sexual health? Who is the champion of the public saying, “You cannot do this; this is not acceptable”? Does anyone have that power or role?

Richard Gleave: We need to hear from the directors of public health in those patches about what has happened in those areas. Certainly, I know from the discussions we have had with Cheshire that the director of public health says it is not as has been reported in the press. In a number of the examples that we have seen reported in the media, when we have a conversation with the director of public health there is another side to the story that needs to be understood. I am not saying there are not problems; there undoubtedly are a number of challenges around sexual health services. But, by and large, the model has been moving more towards community based across a wider number of sites, and we get more intervention earlier around prevention, and that has been a theme across our discussions with the directors of public health.

Q292 Mr Bradshaw: Do you step in as a group when NHS England makes a decision such as not to commission PrEP as public health professionals? Do you say that this is not very sensible? Do you give them advice? Do you react to their decisions? Do they ask for your advice?

Richard Gleave: Shall we draw a distinction between what happens locally and what happens nationally?

Q293 Mr Bradshaw: NHS England.

Richard Gleave: As to NHS England, at a national level, we have lots of mechanisms to have conversations with NHS England and we do provide advice. We provide clinical advice and advice around effectiveness. It is not for us to comment particularly on cost-effectiveness, although we are very interested in that issue, so we do provide advice to NHS England.

Q294 Mr Bradshaw: Do they follow your advice?

Richard Gleave: They follow our advice extensively. That does not mean we always agree about everything, but the diabetes prevention programme is an excellent example of where the two organisations are bound up together in doing work on diabetes prevention and treatment.

Q295 Mr Bradshaw: What is your collective view on the non-commissioning of PrEP?

Professor Cosford: Let me give you one more example where they have—

Q296 Mr Bradshaw: Can you specifically answer my direct question, please?

Professor Cosford: My view on PrEP is that the evidence is increasing that it is an effective treatment.

Mr Bradshaw: An effective treatment.

Professor Cosford: That it is effective. The evidence is growing that that is the case, and I would be content that that is the case. John can give a formal view from the chief

knowledge officer perspective. We do not have yet the evidence that it is cost-effective, and that is a decision that needs to be considered in relation to whether it should be referred to NICE for a decision. Then, of course, there is the issue of, if it is cost-effective, who is the most appropriate commissioner to make the decision as to whether and how it is commissioned in comparison with all the other issues that we are dealing with in relation to sexual health.

Q297 Mr Bradshaw: But is it not a bit of a muddle? You seem to imply that we do not even know who is responsible for commissioning it even if it is commissioned.

Professor Cosford: There are some very specific issues around commissioning of PrEP, which I am sure you will be addressing later.

Q298 Chair: We are going to raise that later. Can I query one point? Is it not the case that NICE is not responsible for investigating sexual health prevention? Is that right?

Professor Cosford: It is not right that it is not responsible, if you will forgive the double negative. NICE will undertake the work that is provided to it through a ministerial process, as I am sure you are aware.

Q299 Chair: Some have commented that it is not their responsibility, so thank you for clarifying that that is not the case. Did you want to come in on that, Professor Newton?

Professor Newton: No; I agree.

Professor Cosford: Could I make one point about sexual health, which is that, absolutely, PrEP is an important issue to be resolved, but as to dealing with all the issues around sexually transmitted infections, we have to get to grips with the other issues we were talking about and about getting young people and children educated throughout the country in good sex and relationships education.

Q300 Chair: Could I follow on from a point that Ben made? Are you confident that if an area is decommissioning sexual health services, and you feel this is really against the public interest in that area, that you have the levers to be able to step in and tell them that they are making the wrong decision and to say so publicly?

Richard Gleave: We have some very clear levers, because many of the services that are commissioned by directors of public health and their teams are part of the mandated functions. Part of our job with Duncan Selbie, our chief executive, as the accounting officer for the grant, is to ensure that the mandated functions and the regulations are delivered on and there is a requirement about sexual health services that is in there. That can always be part of the conversation, but we are also involved because we have this role around reporting on the public health outcomes. If we have a concern that a particular proposal might have a detrimental effect on the outcomes, our centre directors are feeding that into the regular conversations they are having.

I can give you a particular example, which was in the press. In the range of options that a particular local authority—Harrow—was putting forward about 0 to 5 commissioning, it mentioned that it had an option that involved a substantial reduction in the service in the future. We engaged with them, picked up the phone and spoke to the DPH and to the local

authority. That option was removed from the decision-making process. That is an example of where we and they have worked together.

Professor Cosford: I could give you some really good examples from our national work with the NHS, where we have worked together to make sure there is a common approach. On antimicrobial resistance, for instance, we have both in the quality premium for primary care and the CQUIN quality programme for acute hospitals an incentive to reduce inappropriate antimicrobial prescribing. It is absolutely critical. We have just seen a first year's reduction in antibiotic prescribing across the country, and that, too, is the result of very detailed discussions between ourselves and NHS England about what will work best to continue that reduction and make the difference that we need to see. We do have very good discussions, links and ways of addressing them.

Chair: Thank you. Now we move on to Andrea and health protection.

Q301 Andrea Jenkyns: I have a couple of questions on the variation in quality of health protection. Have the post-2013 changes in the public health landscape affected the consistency and quality of local arrangements for health protection across the country?

Professor Newton: That is a question for our director of health protection.

Professor Cosford: Thank you. I am aware of the evidence that you have been given by Dr Cameron and others on the difficulties that they sometimes experience in who pays for what in relation to local responses to outbreaks.

I want to make two points at the outset. One is that that is not a problem that started in 2013. In fact, my memory of working in the system is that it was at the point when PCTs stopped running community nursing services that it became difficult for directors of public health to be able to mobilise nursing staff easily and they had to do it through their commissioning relationships or other relationships with other organisations. It is not just a result of 2013. We are aware that it is an ongoing problem. We were aware at the time. In 2013, we worked with the Department of Health to produce clear guidance, we felt, for local government, the NHS and Public Health England as to who does what in the circumstances of any outbreak. In principle, Public Health England runs the outbreak response. The NHS delivers the clinical aspects of that outbreak response, and local government has to absolutely assure itself, through the director of public health, that that is being done properly.

As we went through into 2014, we were aware that some places felt that was less clear than it needed to be. So we did a piece of work with all local health resilience partnerships and asked them to assure themselves that they had arrangements in place, and we produced some further guidance in 2014. It is still the case that, sometimes, in the complexity of dealing with outbreaks, it is difficult to be exactly sure who is going to respond in what way, and that gets dealt with at the time.

The second thing I want to say is that I am not aware of any circumstances—and I have read Ian's evidence carefully—where he felt there had been a delay in the actual response that needed to happen for patients or for members of the public and that we sort it out between organisations behind the scenes. Nevertheless, there was a memorandum of

understanding in place in Leeds in that circumstance, and it appears that it did not quite do what it needed to do; so we are reviewing, again, that set of processes.

Andrea Jenkyns: Thank you.

Richard Gleave: Shall I come in and say a little about what we are going to do next?

Q302 Andrea Jenkyns: I would like to probe a bit deeper on this area. I can understand you are talking about the processes and the historic elements that have also impacted them, but I would like to know what it is looking like on the ground. I want to know about the consistency and quality—the variation. What is it looking like on the ground in how you have seen changes rather than just the process?

Professor Cosford: When I go round the country and visit our local teams and their colleagues, and directors of public health in local government, it is one issue that is sometimes raised, not universally. Yet, for examples like the hepatitis A outbreak in Leeds, which, as I say, was resolved through all the clinical things that needed to happen happening, we have plenty of other examples where the NHS has stepped up and funded things. There is a good example in Dorset with an E. coli outbreak. Enhanced surveillance was needed, which has required a much greater degree of testing of all specimens going through our laboratories or NHS laboratories. That has needed extra funding, and the local NHS has simply stepped up and done that.

Q303 Andrea Jenkyns: Can I ask you a direct question? Are you saying that as to the post-2013 changes you cannot see, overall, that it has affected the consistency in quality? Has it or has it not? What would you suggest?

Professor Cosford: I would say it has not—

Q304 Andrea Jenkyns: Overall, I meant.

Professor Cosford: I do not see a reduction in the quality of the response to outbreaks as a result of the 2013 changes. I do see that there is still a need for us to work on clarifying some of the roles and responsibilities so that it can be made smoother in certain circumstances.

Q305 Andrea Jenkyns: But, overall, would you say the quality has improved, or not really?

Professor Cosford: I think we have continued to improve our response to incidents and outbreaks.

Q306 Andrea Jenkyns: Thank you. My final question is: what more do you think needs to be done to address the variation and ensure best practice in the area of health protection?

Richard Gleave: We did this substantial assurance exercise in 2014; we pulled together six national bodies and sent out a pack to all the LHRPs.

Q307 Chair: Can you clarify LHRPs for those following this who are not familiar with that?

Richard Gleave: Yes. Those are the local health resilience partnerships. I think there are 38 of them across the country based around the police footprints, and they are co-run by NHS England and one of the local DPHs. They are responsible for the forward planning

and resilience work for local health protection outbreaks and for emergency response. They are absolutely key in the system for ensuring that the arrangements are sound. We asked them to complete a questionnaire, and we reviewed those questionnaires and fed back to them in 2014. There was some very specific advice about MOUs, about clinical response—

Chair: Can you—

Richard Gleave: Memorandums of understanding.

Mr Bradshaw: Cut out the acronyms, yes.

Richard Gleave: We are going to work with NHS England. We are bringing in NHS Clinical Commissioners and NHS Improvement into that piece of work. They are new bodies in the case of NHS Improvement.

Q308 Andrea Jenkyns: This is 2014, nearly two years later.

Richard Gleave: We are going to re-do that.

Q309 Andrea Jenkyns: What have the changes impacted on the ground? Have you seen that it is improving?

Richard Gleave: We have, undoubtedly. As to the work that has gone on in the time since we have given the feedback, anecdotally, we know that people have revisited the memorandums; they know that they need to be firmer about the “Who pays?” question. We have agreed with NHS England that we are going to use their national “Who pays?” document that is going to be reissued soon to include health protection in it for the first time. That will help as well. There are specific areas, like the Ebola response, where we have a new set of experiences. There is the work that we did with local teams on resilience around Ebola and what has been called the high-impact infectious diseases that may well happen in the future; we have a whole mechanism with NHS England to plan for those as well, and we want to build that into the new assurance process.

Q310 Chair: Thank you. At this point could I take the opportunity to thank you, Professor Cosford, your whole team and all the volunteers, for everything that was done around Ebola? It was an extraordinary success, but one point in relation to that has been raised with us during the course of this inquiry. During the outbreak you had sufficient staff to be able to flex to do the work that was carried out at airports, for example. It has been raised with us that the workforce now has been reduced to the point that there is not the same degree of flex were that to happen again. I know, Professor Bayliss-Pratt, you mentioned earlier that everything was going well as far as the workforce was concerned. That is not something that was reflected to us from witnesses, who have expressed concerns about the workforce. We are going to come very specifically to that in a minute, but can you comment on this point about whether we have the capacity to respond in the way that we did during the Ebola outbreak?

Professor Cosford: First, thank you for your comments, and I will take them as comments for the whole team because the whole organisation contributed enormously, including many different parts of the organisation, and colleagues in local government and in the NHS.

It was a very significant effort that we put in, for instance, to put in place our programmes at ports of entry. The truth is that, when you move into that sort of mode, you have to make such a difference to the way you are operating across the organisation that a small reduction in staff, whether it is 5% or whatever it is, although that is significant, is not going to be the game changer in whether we can respond or not. When there is such a significant response and it is similar in the next flu pandemic, or, as Richard has said, whatever the next high-consequence infectious disease programme is, we have to change what we do so much and reprioritise things that we would do in order to make the response that was required, and I am clear that we would do so. Our issue is always about what else we are not doing in order to deliver a major response, and we look very carefully at the business continuity angles at any time. I am confident that we have a safe and secure system.

Q311 Maggie Throup: I want to explore the workforce in a bit more detail. Professor Bayliss-Pratt, you mentioned earlier that public health is a popular choice. That seems to conflict with some of the evidence that we have heard, and concerns have been raised about the public health workforce, following the move to local authorities, and it is particularly about workforce mobility, career progression, cuts in posts and downgrading of posts. How are you responding to these concerns?

Professor Bayliss-Pratt: On the ground, our information tells us that we have a lot of interest from people wanting to work within the public health arena and to work very close to the people within their communities, in particular nursing. When we had the significant increase in health visiting, we identified that most of those health visitors were local people who liked to work in local areas; to work with their local communities. We do not have lots of information that tells us that people do not want to work in those environments or, indeed, have significant career ambitions to progress up a career ladder that is incredibly structured. Many health visitors work as health visitors for many years and enjoy their role.

In relation to the workforce make-up and skill mix, we really welcome the idea of variation of health professionals working within public health and within that arena, because we strongly believe that the public's health is everybody's business and having a variety of different people with different knowledge and skills at different levels is a wonderful opportunity to ensure that people are energised to work in public health, despite their different backgrounds and their education and training. Our key focus is on making sure that the education and training produces the right competencies and outcomes to deliver the care to the communities that they serve.

Q312 Maggie Throup: Your focus, from your point of view, seems to be on the health visitors. What are you doing about the wider workforce to make that sustainable?

Professor Bayliss-Pratt: One of our greatest successes, working with colleagues across the system, has been "Making Every Contact Count". That is about ensuring that everybody is aware of public health, from receptionists through to practice nurses and school nurses—that whole communities are aware of the public health agenda. Some of the real successes that we have seen in relation to this have been around the dementia initiative—the number of dementia friends that we have, the people who are trained in dementia awareness and the impact that that is having on the communities.

Q313 Maggie Throup: We also heard evidence, because obviously now it is the local authority, about posts being cut. What are you doing about that?

Professor Bayliss-Pratt: In relation to the posts that are being cut, we have not seen significant cuts in posts across the country, from the information that we get from our local offices. It is not a significant issue that is coming through to us at Health Education England. If you look at our national workforce plan—I won't go into the details—you can see that there are no significant cuts in the public health workforce within that national workforce plan.

Professor Newton: I think your question is particularly aimed at the specialist public health workforce perhaps and the comments. We know that there were a significant number of knowledge and intelligence staff—about 600—who moved into local government from PCTs, and our information is that they are still there, but it is a different role. Many of them have a broader remit, working across different areas of the council, looking at housing data and transport data as well as their own data. I think that is true for the Specialists—with a capital S—as well. The role in local government is different from the role that it was in PCTs, and some people have absolutely thrived in that situation and developed, and others have not. Whenever you get a change, you get a movement of the workforce at the margins, but if you look at the overall figures, as Lisa was saying, there is not a big decline. Paul may want to comment more, particularly on the medical workforce.

Professor Cosford: One thing I am struck by, again, as I go visiting around the country meeting directors of public health—and I think it was reflected in your evidence from directors of public health—is the confidence that they have now developed in working within local government. I think, of course, there is a period of difficulty when you shift a large workforce from one organisation to a different type of organisation, and that will lead to people feeling less confident about being wanted or understood as professionals.

The figures are quite interesting. In terms of substantively appointed directors of public health, we are back to the position we were in before 2013. In the small number of authorities where there is not a substantive appointment, we have directors of public health in post or in acting arrangements, and half of those are under active recruitment at the moment. We had a stocktake from the Centre for Workforce Intelligence over the last year, which identified around 1,210 public health specialists, and we know there are 1,500 who are registered, either with the GMC or with the voluntary register. The last Faculty of Public Health survey in the previous system, in 2009, identified 900, and that is almost certainly an underestimate. It is very difficult to know exactly what the precise numbers are underneath there, but there is no evidence that I see that we are getting significant reductions in numbers of trained public health specialists in post. If you put that alongside the fact that for every training place there are 10 applicants this year—the previous year was eight applicants—it is at the high end of medical specialty demand for people to go into. It feels as if that data is telling us really quite a positive picture, but, of course, we are still hearing some of the uncertainties that people have. So we are trying to navigate our way through and make sure we really understand what is going on underneath it. I think there is ground for us to be very optimistic.

Q314 Maggie Throup: Do you think it could be to do with the workforce losing their identity with public health because they are now under the local authority badge?

Professor Bayliss-Pratt: We do not have evidence of that, but we do understand that we need to understand it better. So we are implementing a national minimum dataset for the public health workforce that we expect to have in place by 2017, and we are currently piloting that so that we do understand the situation in much greater detail; but we do not have that evidence on the ground telling us that.

Professor Newton: I think you are right; there is an ethos of public health, which is important to people and to their effectiveness, and we want to try and strengthen that. Richard mentioned the fact that Public Health England is very close to our colleagues in local authority, and we have done a lot to make that apparent. I think in your evidence you have heard that people in local government feel that we are there for them; we are there alongside them. That helps, but also the opportunity for people to work in different environments, for people to move from local government to PHE and back again, is important and we want to try to make that happen wherever we can. It is easier in my area, where we have technical people in knowledge and intelligence; they can easily move backwards and forwards. It is a little more difficult with people who had NHS terms and conditions in the past.

Q315 Maggie Throup: That leads nicely on to my last question, which is: how are you improving training in public health for the wider NHS workforce and beyond?

Professor Bayliss-Pratt: As I mentioned earlier, the “Making Every Contact Count” initiative that we have developed across the system provides people with information at different levels in relation to public health—health promotion, health prevention awareness—and we have a strong network of champions who are out there. We have e-learning tools out there and we are influencing the curriculum of all the professionals to ensure that we get health promotion and health prevention within the undergraduate curriculums. It is most definitely front and centre of what Health Education England is doing to ensure that people are well aware of health promotion and health prevention initiatives and techniques.

We have also done a lot of work to ensure that we keep the health visiting workforce buoyant and we have worked closely with the Institute of Health Visiting to develop continuing professional development programmes on a number of areas, which include mental health, perinatal and mental health, sexual health and child obesity. We are very proactive in online learning materials to help people to continue to keep up to date and develop public health initiatives and techniques to ensure they care for people appropriately.

Q316 Dr Whitford: One thing that we heard quite often in the evidence that we took was the difficulty of directors of public health accessing their local data. Obviously, Public Health England, as was mentioned by Richard, produces national reports, but a local director of public health, as we heard, faces local challenges—mortality rates, immunisation uptake and screening uptake. How do we get round that?

Professor Newton: First, I completely agree that at the moment directors of public health do not have good enough access to the data that they need to do their jobs. It is variable across the country. Again, it is one of those things that varies, but nevertheless there is a problem. It is in two categories. The first is getting access to data on healthcare activity for their population. These are the hospital episode statistics, A&E data and so on. The second

is in getting access to operational data about the public health services that they commission—things like vaccination and screening services. Those are two completely different problems, both of which I will briefly cover.

As to the hospital activity data, this is not a consequence of public health being in local government. That is the first thing to say. There is nothing about public health being in local government that should be an obstacle to this. There was a Department of Health policy on information, which was published in 2012 and introduced in the legislation in 2013. It was intended, quite rightly, to protect patient confidentiality. There was a policy that the personal identifiable information would be held much more centrally by the Health and Social Care Information Centre and that it would only be passed out to the health service, or any other users, on a strictly controlled basis where there was an explicit legal basis. This is an issue that has affected not only public health but healthcare commissioners as well at exactly the same time. It is that which is playing out. The directors of public health do not currently have a legal basis to process identifiable data about their population.

In fact, I saw some evidence that came from Wolverhampton that was given to you. They were envisaging there that the director of public health had a full set of data that had the names and addresses of all the people who lived in Wolverhampton, which they could analyse for, essentially, whatever purpose they felt was right at the time. That is simply inconsistent with the current policy around information governance and certainly would be inconsistent with the output of Dame Fiona Caldicott's review.

Having said that, what we can do and have emphasised is access to the anonymised datasets, and we can now provide local government with a full set of hospital activity data, which is pseudonymised. This is record-level data; it meets a large proportion of the needs of local government for, for example, producing joint strategic needs assessments—JSNAs—and providing advice on activity, and we know about a third of local authorities have access to that data already and others are working on it. It has taken far too long to get there, but we have got there now.

Q317 Dr Whitford: Obviously, they fed back to us that they felt that this change to protect people's information meant that because they are not part of the NHS they had a particular issue. You feel that you have already come up with the solution to that.

Professor Newton: I have not quite, but these obstacles are surmountable; we can do something about them. It requires focus and co-operation. There are, in fact, legal gateways for local authorities to get data locally. Kent is a good example where they are obtaining data from their local health service provider; so they can do that.

Q318 Dr Whitford: Is that by them bending the rules in some way or are other areas misinterpreting the rules, because you say about a third are doing it and obviously some of the places that we took evidence from had come up with workarounds, which seem a very clumsy way of doing anything?

Professor Newton: The local approach is not bending the rules at all; it is a different set of rules, but it is a cumbersome approach. It is not an ideal approach. We would like to see more support from the Health and Social Care Information Centre providing access to local government for data, which is linked by them, or another approach would be for

them to work more closely with Public Health England. We have very good relationships with the Health and Social Information Centre and we think this is a good way forward. It is all perfectly possible within the current governance policy, within the current law, but we need to revisit the policy that linkage will only happen centrally. What local public health wants to do, particularly in the current climate of devolution and the way in which local government's public health is evolving, is to do linkage locally, and we need to help them do that.

Q319 Dr Whitford: Do you not think that perhaps a definition within the governance is required? If public health has moved into local authority, do we not then have to take the access to data with it? You talk about things going through central and back out. I know from my own background in the NHS that, in Scotland, the local hospitals owned the data, because otherwise you would have to wait a whole year and you get back what they chose to analyse, and, as we have just heard, different areas have different issues.

Professor Newton: I completely agree. It is a matter of policy as to whether the data linkage occurs centrally, primarily, and then datasets are made available, or linkage occurs locally in multiple areas. The obvious place to do that would be around the new sustainable transformation plans, which have certain footprints, and I know that areas such as east London are working on ways of bringing data together. The important thing for local authority public health is to have those good relationships with the NHS organisations that do have access to the data, and so the more they can work in partnership, the more these things really don't matter.

Q320 Dr Whitford: If the definition is that the data must not leak outside the NHS, surely just saying, "Work together and we will share it with you in a back room," is not really the solution they want.

Professor Newton: It is not the case that it cannot, because the data is already going out. For example, the general practice providers who provide the general practice computer software programs all get the data. The data is going out to people who have an agreement to process the data and hold it securely. Local government need to have the right connection; they need the so-called N3 connection, which is perfectly possible, and many local authorities have that. They need to comply with good standards of governance, which is absolutely right—the data needs to be secure—and they need to be able to account for who has access to the data. The worst thing in the world would be for us to give data to local government and for it to be leaked out and to have some big data loss; that would be very bad for reputations. So they need to comply with that. If they can do that, then there is no reason why they should not be able to get the data, but it does require a rather subtle but important change in policy.

Q321 Dr Whitford: You mentioned that about a third of areas have that. Are you working with the other two thirds until they achieve that, because clearly data is knowledge, and a public health director needs that to know what their priorities are?

Professor Newton: Absolutely. We have established now that the Health and Social Care Information Centre is meeting directly with the Association of Directors of Public Health to understand their priorities. It is quite a big task. As I say, a third are actively investigating this. Other authorities simply do not have the capacity to deal with this data. It is a very large dataset. For example, in Leeds, the local authority is providing a service

for other local authorities because they do have the capacity to deal with the data. As long as all the authorities have access to the ability to interrogate data, that seems appropriate.

Q322 Dr Whitford: You are saying it is a very large dataset. Does it not make some sense to have, if you like, the slimmed-down core data that people can access and handle more easily?

Professor Newton: Indeed.

Q323 Dr Whitford: If it all has to come centrally, whether it is the Health and Social Care Information Centre or some big authority near you, it still means you cannot say, “I wonder if we have a problem with uptake of immunisation in that area,” because you are way back in the queue for whoever it is you are asking to analyse your data.

Professor Newton: Yes. On immunisation and screening, there are different arrangements for different datasets. Again, those datasets are available to NHS England screening and immunisation teams; they are public health specialists. So they get data at practice level. In fact, I believe Dr Seddon, who came to see you, was quoting some data on practice level, but they are not always available to the directors of public health. So we are working very hard to help people understand how they can get them, but again there is no reason why those data should not be available to the directors of public health. I think it has been a bit of a blind spot that it has not been realised that they need them just as much as anybody else. There are various things, which we probably do not have time to go into, that we are doing to make that happen.

Q324 Dr Whitford: But obviously you recognise that it has been an issue and you are working on it.

Professor Newton: Yes, indeed.

Q325 Chair: You mentioned that there needs to be a rather subtle change in policy. Can you articulate what that should be?

Professor Newton: The policy was set out very clearly. In fact, in “The power of information”, which is the information strategy published in 2012, there is a diagram on page 18 that has all the data from the various health service sources flowing into the centre, and in the centre—in the Health and Social Care Information Centre—all the linkage will take place there, and then only linked data will flow out.

That does not take account of two things: first, the fact that the Health and Social Care Information Centre is not yet set up to be able to deliver those services. Their data services platform is not planned to start delivering until late in 2017, so we need to do something now that allows people to get access to the data; and it does not allow for the fact that local area public health, exactly as you were saying, wants to do ad hoc studies.

The situation we have is that the information—the data—is in one place and the people who have the capacity and capability to use it is in another place. We need to look at that sensibly and try to work it out. Public Health England is very well placed to help there because we can provide the service that you were talking about of an analysed hospital episode statistics service, which is made available to people who do not have the capacity to do it themselves. Public Health England would like to have a role in meeting that need.

Q326 Chair: For areas where this linkage is not happening and you are aware that it is not happening, how are you stepping in to give practical support to those areas?

Professor Newton: We have done a number of things. We have worked very hard with the HSCIC to get the pseudonymised dataset out, including in fact paying for it. We also made the argument with their governance committee for the legitimacy and the governance of it; we have put a lot of work into that. We have also stepped up our own hospital episode statistics analysis service and have written out to the directors of public health explaining how they can get access to that. We have been providing our own analyses to help directors of public health. We have also been providing guidance and circulating good practice about how they can get access to data locally. As you know from your evidence, it has not been a satisfactory position. It is a lot better, as I think, again from your evidence, directors of public health would say. For example, Ian Cameron in Leeds now feels he is getting the data that he needs, but not everybody would say that.

Q327 Chair: How concerned are you about there being a shortage of data analysts at local level, of which we have heard evidence? How much does that get in the way of the system working?

Professor Newton: There will never be enough people. There are so many data and so many questions that we might ask that we will never have enough capacity to analyse all that we want. Some authorities have very strong teams. In fact, this was the case before in the NHS, and we know from the workforce work we did during what we called the transition—the period up to 2013—that the distribution of capacity was very variable; that probably explains the third, a third, a third relationship. We are working with the workforce, which is very important. There was a Centre for Workforce Intelligence report on the intelligence workforce itself, and there are some good recommendations in there as to how we could build the intelligence workforce.

Q328 Chair: I am very concerned to hear that you are still having problems for directors of public health getting practice-level data on vaccination. To illustrate why that particularly concerns me, I had a notification late last night that we have had a couple of cases of measles in my constituency. There is a huge variation in my constituency in levels of immunisation for measles. So it is a great concern if the director of public health still cannot access practice-level vaccination data. How are you going to change that?

Professor Newton: They can access it. They are published. There is a software program called PREP¹—I am afraid I do not know what the acronym stands for—which provides access to local government to practice-level vaccination rates. They do need to register for it, and not all directors of public health have registered for it. We are launching a new PREP platform on 1 June, which will be better and easier for them.

In general, mainly we need to help people understand how they can access these data. I should say that they are also published, so the practice profiles that we publish every year have practice-level screening uptake rates and vaccination rates per practice are available to the public, not just to directors of public health; but they are published annually. The directors of public health want monthly data—even weekly—for flu, and those come through the PREP system.

¹ The software package referred to throughout Q328 is called ImmForm, not PREP.

Q329 Chair: So that is going to improve. If we ask you the same question in two years' time, it will be a different answer.

Professor Newton: I think much sooner than that.

Chair: Thank you.

Q330 Mr Bradshaw: Professor Newton, do you agree with Professor Cosford's judgment that PrEP, given what the WHO and all the HIV charities have said, is not cost-effective?

Professor Newton: This is a different PrEP, of course.

Mr Bradshaw: Yes.

Professor Cosford: I am sorry, but I did not say it was not cost-effective.

Q331 Mr Bradshaw: It is not proven to be cost-effective.

Professor Cosford: I said I did not know whether it was cost-effective.²

Professor Newton: I have nothing to add; it is not a subject I have looked into personally, except that we are aware of the research, and Paul has summarised it very well.

Q332 Mr Bradshaw: In public health terms, how sensible is it to cap the number of patients in England, although not in Scotland, who are eligible for drug treatment for hepatitis C?

Professor Newton: Again, that is not something I have looked at. I do not know whether Paul has a view about it.

Professor Cosford: Hepatitis C, as you know, is an example of a disease for which we need to increase first of all our diagnosis rates and our awareness rates, and then get as many people into treatment as possible. The plans around making treatment available for people with hepatitis C who are not yet asymptomatic are to gradually pick off those who are most significantly impaired: to pick off those with cirrhosis or pre-cirrhotic conditions first, and then, as the system and NHS resources allow, to bring that number of people forward so that we are gradually increasing the prevention that is available for the harmful consequences of hepatitis C. It is a detailed issue that we may not have time to go into.

Q333 Mr Bradshaw: The point I am getting at—and it is my final question, Chair—is that I think you will all agree that, when it comes particularly to sexually transmitted diseases but also other transmittable diseases, stigma is really damaging in public health terms, and we are seeing decision after decision at the moment, whether on PrEP or on capping drug treatment for hepatitis C, which is fuelling stigma for those patient groups. How on earth can that be helpful in public health terms?

Professor Cosford: I am not going to comment on whether it is fuelling stigma. We are clear that there is a very important role for treatment as prevention in a number of different conditions. When it comes to specific treatments, there is a complex set of decisions that needs to take place, and on the PrEP issue NICE has to identify whether something is cost-effective for the NHS in the UK's circumstances.

² Amendment by Professor Cosford: "I said I did not yet know whether it was cost-effective."

Chair: Thank you. The final question is from Philippa before we go to our next panel.

Q334 Dr Whitford: It is going back to hepatitis C. Just treating people when they have quite advanced hepatitis C and liver damage means that you still have a stream of people who are going to come down the line and develop it, whereas the aim in Scotland is to get the viral load in the community down so that you have fewer cases. Is that not something that Public Health England should be fighting harder on?

Professor Cosford: Hepatitis C is a very important public health issue and we are clear about that. There are four things that we do about it. One is—now I have to remember the four, of course—make sure that there is as much awareness as possible, that people are being diagnosed, testing is available and then treatment.

Q335 Dr Whitford: But do people not feel that it is pointless to be diagnosed if they are not going to access treatment, because all they get is a label? They may get ostracised, but they are not actually going to get a personal gain, unless they get so bad that their liver is packing up.

Professor Cosford: It is a very important point. There are some people I have spoken to who think it is still worth while having the diagnosis even if the treatment is not available. You will find a range of different views on that, and you have expressed a view that I think is a clear one and one with which I would agree. The difficulty with hepatitis C is that, of the group that is infected, it is very difficult to know which will continue to get the adverse consequences. The first thing is to hit those with the most adverse consequences already and then we have to get into as much as possible of the treatment to avoid consequences.

Q336 Dr Whitford: But surely from the point of view of spreading the disease to elsewhere, it is the people who feel okay who are at greater danger of spreading the viral load within the community.

Professor Cosford: That is exactly right.

Q337 Mr Bradshaw: You say it is not impossible. We are talking about quite a small fraction of HIV-infected people being eligible for treatment, are we not?

Professor Cosford: Again, our role is to speak to what the evidence says around the benefits of treatment for hepatitis C. There is then the issue of both cost-effectiveness and the decisions about implementation and commissioning, and those commissioning decisions are ones that are rightly taken by the NHS through their specialist commissioning routes.

Q338 Dr Whitford: I assume you feed into that.

Professor Cosford: We do, yes, absolutely.

Q339 Chair: Did you get to the end of your four points?

Professor Cosford: I did: awareness raising, diagnosis, awareness of treatment options and then providing the treatment.

Q340 Chair: But this is an area you are going to be keeping under review.

Professor Cosford: We are very strong on this area, yes, and will keep it under review.

Q341 Mr Bradshaw: Finally, NHS England has said it is not responsible for commissioning PrEP, so this goes back to this whole confusion about who is responsible. They have on their website, “We are not legally able to commission PrEP,” and local authorities are never going to do it.

Professor Cosford: That is a discussion that I think needs to continue around who is the responsible commissioner, and I know NHS England has had that legal advice.

Q342 Chair: This is something we can raise with our next panel.

Mr Bradshaw: Absolutely.

Professor Cosford: I think that is right.

Chair: Thank you very much for coming this morning.

Examination of Witnesses

Witnesses: **Jane Ellison MP**, Parliamentary Under-Secretary of State for Public Health, Department of Health, **Simon Stevens**, Chief Executive of NHS England, and **Duncan Selbie**, Chief Executive, Public Health England, gave evidence.

Q343 Chair: Good morning and thank you for coming to our second panel. Could I start by asking you to introduce yourselves to those following from outside the room, starting with you, Minister?

Jane Ellison: I am Jane Ellison, public health Minister since October 2013.

Simon Stevens: I am Simon Stevens, chief executive of NHS England.

Duncan Selbie: I am Duncan Selbie, chief executive of Public Health England.

Chair: Thank you. Helen is going to start the questioning.

Q344 Helen Whately: Thank you very much. The Five Year Forward View called for a radical upgrade in prevention and support for wider public health measures. Coming to you, Simon Stevens, first, what assumption was made in the Five Year Forward View on the investment in public health that was required and the NHS demand that would be avoided as a result?

Simon Stevens: Possibly the last time we were together we set out the detail around the demand management assumptions in the Five Year Forward View, and a part of that, as you rightly say, comes from a recommendation in the forward view that we should be upping our game on prevention. That includes many of the things that no doubt we will talk about this morning, but with a particular focus on obesity, recognising that we are now spending more on obesity-related conditions in this country than we are on the police or the fire service, and a good place to start would be childhood obesity. The sugar tax in the budget is a key building block of that, but there is a lot more that needs to be done. So when the Government bring forward the childhood obesity strategy shortly—one hopes—there are a range of things that we want to see in there as well.

Q345 Helen Whately: Could you possibly be a bit more specific, though, in response to my question on the investment that was envisaged and included in the model, and then the activity or value of activity that was expected to be prevented?

Simon Stevens: Yes. Some of it is investment, but some of it also, frankly, is regulatory action. That does not in itself have a price tag, but action to take added sugar out of foods and drinks in the same way as we have successfully done with salt over the course of the last 15 years will show up as reduced rates of type 2 diabetes and reduced rates of diabetic-related blindness and amputations. If you look at the conversation I was having in this room yesterday afternoon with the Public Accounts Committee on the subject of social care and the emergency hospital admissions and delayed discharges, you can see that the NHS has benefited enormously over the course of the last 15 years from the fact that each generation of older people has been healthier than its predecessor generation. We have been able to accommodate a 52% increase in emergency admissions with the same number of emergency hospital beds because those people are healthier than their predecessor generations.

This is a slow-burn, high-impact set of changes, some of which are around our public health environment, some of which are regulatory, and some of which rely on the availability of preventive health services, for which there is a price tag. In the context of the spending review, we were pleased that the core public health programmes of which NHS England has stewardship through the section 7A arrangement were protected—that budget was protected—and indeed will allow us to increase some of the preventive activities we want, such as bowel scope screening, over the course of the next two or three years.

Q346 Chair: Could I cut in, because the question was quite a specific one? I wonder whether you could answer the question.

Simon Stevens: I think I have, inasmuch as I have said it is a combination of preventive health services plus regulatory action on a range of fronts, including obesity, diabetes prevention, tobacco, alcohol, and the other principal health risks, given that about 40% of the workload of the NHS is related to modifiable health risk factors.

Q347 Helen Whately: Was there a figure for the amount that you envisage would need to be invested in public health, and some figures for demand that would be avoided as a result?

Simon Stevens: Yes. Again, if you look at the recap briefing that we provided to the Committee last time, it shows that £4.3 billion-worth of the demand offset is a combination of demand management activities, service redesign and public health-related gains.

Q348 Helen Whately: Within that figure—because I know the figure you are referring to, as I was looking at it in fact just yesterday afternoon—what is the breakdown between the categories, because, as you say, it was a combination?

Simon Stevens: Yes. It is between £0.5 billion and £1 billion, potentially.

Q349 Helen Whately: That is of demand that would be avoided through prevention.

Simon Stevens: Over this timeframe, and obviously there is a sort of back-ended nature to that, but seen over a five, 10, or 15-year period the benefits are potentially much greater than that. We calculate—or perhaps Duncan and PHE have calculated—that the NHS has saved £1.5 billion as a result of the 15% reduction in salt in our diet since 2001, for example. Doing the same with sugar will produce the same kinds of benefits stretching out over the next five, 10 or 15 years.

Q350 Helen Whately: I appreciate the point that it is back-ended, that there is only so much you can do within a five-year period, although some, as you have indicated, is expected, but is there an investment in public health measures—prevention—that was required to achieve that?

Simon Stevens: At the very least, we wanted the availability of preventive services to be sustained relative to need. An area where you get very quick payback, or indeed a worsening of the situation if those services are not there, for example, is drug and alcohol services and sexual health services. If those services diminish, that shows up as extra demand in more expensive parts of the national health service within 12 months, not within 10 years.

Q351 Helen Whately: Some of the evidence that has been provided to the Committee as part of this inquiry is that many local authorities are cutting back on exactly those services you mentioned—smoking cessation and alcohol services. Are you concerned about the reductions in those services?

Simon Stevens: To the extent that they have an impact on downstream demand, clearly, yes. That said, when we were last discussing this point, I referenced the testimony I think you had had from Lord Peter Smith of Wigan where he, for example, went on record saying that, as a result of the local authority's ability to commission smoking cessation prevention services, they were, in their opinion, driving much more value out of the money that was being spent and, as a result, were able to square that circle. As to whether the squaring of the circle can continue indefinitely, I defer to Duncan.

Q352 Helen Whately: Mr Selbie, you have been keen to contribute.

Duncan Selbie: This needs more work, but if we look at diabetes prevention, which is funded by Simon jointly with Diabetes UK and Public Health England, Public Health England did the evidence review for this. If we look at the longer-term impact savings to the NHS, it is about £1.2 billion. There might be a bit of spurious accuracy to that and it needs more work, but it flows from the number I am working to, as I chair the NHS prevention board, which is one of the, if you like, Five Year Forward View overall arrangements. We are working to a sum of £0.5 billion over five years, looking at programmes about reducing alcohol harm, reaching long-term smokers who are in hospitals, avoiding second falls in the elderly, and health at work—a hugely important opportunity. So there is a number, and obviously we would like that number to be bigger, but in a realistic, practical way we think it is about £0.5 billion over the course of the five years.

I also want to say that, if we think about this just in terms of money, we miss the opportunity. In the Five Year Forward View we have three gaps, which is the health gap you have been talking about with my colleagues, the efficiency gap and the care gap. We

have never had such a conversation, as a system. I have been in the health service for 37 years—it is difficult to tell that, but it has been about that—and we have never had this conversation before. We have planning guidance for the NHS, jointly issued, that emphasised those three gaps, and prevention is at the heart of it; and with STPs, this way of trying to organise on a scale that will make sense—

Chair: Sustainability and—

Duncan Selbie: Apologies—sustainability and transformation plans. They are essentially the planning footprint, if you like. Four out of five of the 44 emphasised that their No. 1 priority was prevention, and we have given them a menu of interventions. Because we have done this jointly, everything goes out in our names together, saying, “If you do these things, you can expect to see this impact.”

Jane Ellison: I want to make a comment about the issue of outcomes versus spend. We have asked a lot of local authorities, since 2010 in particular, in terms of retendering a whole series of services, to reinvent the way they do certain things. Public health stands hugely to benefit from the imagination and rethinking that local government has brought to a lot of the things they do, and you can see from 2013 onwards that local government has brought that fresh pair of eyes to bear on a lot of the services, many of which had previously not been retendered for many years and questions had not been asked, the system had not been stress-tested and things had just rolled along. Over the last few years we have begun to kick the tyres on local services and I have heard the same conversation, the same evidence you have heard, of people saying, “We might be doing less of this or spending less on that.”

I am completely focused on outcomes. Duncan is monitoring this like a hawk, but we do not see across the board a drop-off in good outcomes. We see people looking at old problems in new ways. While I would not ever be complacent and would always be very mindful to check that we are not losing services, that is not the pattern overall that I see. I see a pattern of people coming at old problems in fresh ways and in many cases looking at how they embed solutions right across a local government system rather than seeing it as simply in a health silo. From my point of view, that is exactly why public health has landed in the right place, to end up back with local government leading the way.

Duncan Selbie: May I, with a singular passion, say that it is about the public’s health, if you like, not public health as a profession, a discipline, or a source of expertise, as important as that is. It is about what it takes to improve the public’s health being embedded in local government, to take Simon’s risk factors of, “Do you smoke? Do you drink? What do you eat? Do you ever take any exercise?” and applying that whether that is to diabetes, heart disease or dying in a fire. They are the same risk factors; they matter and we need to pay attention to them. I can talk to local government about what they have been doing about that.

You have also listened to my colleagues this morning, but the wider point about the importance of economic prosperity and how that creates new jobs, crucially, that local people can get is at the heart of how we close the gap. As much as we want to put into the public health grant, get the resources out there and focus on prevention and avoiding healthcare, if you like, more positive still is how we avoid it in the first place, which is how we get people into decent work and homes. In my coinage, it is about jobs, homes

and friends. Those are critical responsibilities of local government; we want to be seen as a system, not as individual parts.

Q353 Helen Whately: I think you have an audience here in this panel who are receptive to that message—absolutely. I also appreciate the Minister’s point that what is most important is outcomes rather than the amount that is spent, albeit that, clearly, the amount that is spent is a means to some of the outcomes. I want to bring us back to that and ask the panel’s view on whether we have the right balance between the amount being spent on public health and prevention versus on care and treatment.

Jane Ellison: I will start, Helen. I would certainly echo Duncan’s point that, depending on how upstream you want to go on public health, there are a lot of things that local government will do that you would never think traditionally of being in a health category—the planning and regeneration of a large estate, for example, as I have seen in my local area, where the public health director is there at the outset as people begin to imagine it. You have that whole kind of macro approach.

In terms of the cash, we are giving local authorities more than £16 billion over the spending review period. That is a lot and is just the public health grant, but you cannot see it in isolation. There is also the section 7A funding, which was £1.07 billion in 2016-17: that is mainly immunisation, vaccination and screening, many of those with very significant preventive benefits of course. Then we in the Department of Health also spend £300 million on the vaccines themselves and there are other investments we do. So there is a lot more than just the public health grant, important though it is, in terms of how we invest in prevention.

Overarching that, there is what we do at a national level in terms of system leadership or national legislative change, which Simon has referred to, which amplify the efforts of what is happening on the ground, potentially not just now but for many years to come, such as the sugar-sweetened beverages levy, the forthcoming childhood obesity strategy, the tobacco plan that ended last December and the new tobacco plan that we are working on. There are things at all levels of Government that can be done that are all about the prevention agenda and, to a greater or lesser extent, they are about going as far upstream as you can to invest in prevention. But some of it is about the here and now, and PHE in particular has identified a number of relatively inexpensive but very effective interventions that will pay back over this spending review period: things like alcohol, nurse interventions at the right moment and falls prevention. These are not 10 or 15-year payback but payback here and now.

Duncan Selbie: Simon is doing this work on health at work and how we help our own staff to get healthy, using mechanisms like the CQUINs and so on. Does anybody know what that—

Q354 Helen Whately: I know we want to cover a lot of ground and I was trying to specifically focus on the funding questions in this bit. I have one final question, which is particularly to have your view, Duncan, on how the funding is going to evolve as we move from the current system to the funding being through the redistribution of business rates, how you think that is going to play through, and the role that Public Health England will play in influencing that.

Duncan Selbie: It is a hugely important question and very much on the minds of local government and directors of public health, because the grant, if you remember, or the ring fence, was never intended to be ad infinitum, and by the time we complete the grant and ring fence it will have been five years, which was at the edges of where I thought we would get to. It was only ever about making sure that it got a good landing and that people had time to think through how this might work. Thinking beyond is something we would have had to have done in any event.

We have the first of these big sessions tomorrow. We have about 12 directors of public health, ADPH and the Faculty involved, the Department of Health, of course, is hugely involved, and the Department for Communities and Local Government is involved as well, to begin to think this through. We need to achieve two things. We need to make sure that business rate retention, which we think could be quite a good thing in generating additional resource—it could be spent on improving the public's health—is fair. It will not work for everywhere, so we will need to ensure there is a fairer way of resourcing, because when the grant was happening it only ever reflected what the NHS had been spending before, which was about a sevenfold variation. In the first couple of years we managed to close that a bit. In fact, some of your local authorities got a maximum of 21%. Nobody got less than 5.5% in the first two years, which was ahead of NHS growth. That closed the gap a bit, but you still have an upwards of sixfold variation against the formula. We do not think that is sustainable. We need to do something about that and make sure that business rates retention works in those places. It is not through lack of effort; it simply is not going to work.

Q355 Helen Whately: Is there a risk that the areas of greatest public health need may end up with less money?

Jane Ellison: Can I give the Committee my assurance that we are acutely conscious of that concern? We know that that is out there. It is something Duncan and I have spoken about very regularly since the move to business rate retention was announced, and clearly across Government thought is being given to how we deal with that challenge because—you are quite right—there will be some areas of significant deprivation and, therefore, a particular public health challenge, which may also be challenging in terms of the ability of the local economy to generate business rates. We are very conscious of that, and we will be working through that across Government with colleagues as we move towards that change in the system.

Q356 Helen Whately: Briefly to you, Simon Stevens, is there a knock-on risk to the delivery of the Five Year Forward View from this change in funding for public health, and, given the need to avoid some of that demand that is included in the Five Year Forward View plans, are you factoring in that risk in some of the forward planning?

Simon Stevens: If that risk crystallises, it would be extra pressure over and above what was envisaged when the Five Year Forward View was set out, but, as Jane and Duncan have said, an enormous amount of work was going on to seek to reduce the likelihood of that risk crystallising and instead to capitalise on the potential benefits that come from local authority leadership, which can often go beyond just the commissioning of preventive health services but into a broader array that no NHS body itself would probably be able to tackle. I was struck, for example, by the report in *The Observer* on 8 May that Liverpool City Council was going to start naming and shaming fizzy drinks brands across

Liverpool, given that they have rightly clocked the fact that it is driving tooth loss, weight gain and diabetes for their children. They have some of the highest rates of childhood obesity. So they are going to start naming and shaming heavily sugared drinks and warn parents about the health dangers. A local authority can do that. It would be harder for part of the local NHS to do that.

Q357 Mr Bradshaw: It may help the Committee, and also you, in terms of time, to know that we do not need to have the virtues of Marmot or the idea of public health being in local government extolled; the Committee is pretty clear on that. It would be more fruitful for us to examine where some of the challenges are, and some of the perhaps unforeseen consequences of the new landscape have created some problems, which we have heard about in our evidence.

First, on the money, Mr Stevens, you were very clear in your Five Year Forward View that it could not be delivered without public health and prevention getting a greater proportion of overall spend, and that has not happened. There have been big cuts, both last year, in-year and in the CSR. So how do you square that circle?

Simon Stevens: To the extent that that pressure expresses itself on the ground, that plus the pressures in social care, about which I was speaking very frankly to the Public Accounts Committee yesterday, are additional pressures over and above the scenarios that were set out in the Five Year Forward View. There is no doubt about that at all.

Q358 Mr Bradshaw: So it makes your Five Year Forward View, as you stated at the time, undeliverable.

Simon Stevens: If that is what comes about, it would make it harder to deliver within the low end of the funding scenarios that we set out there.

Q359 Mr Bradshaw: Can we move on to the issue of fragmentation, which has been raised fairly consistently among patient groups, user groups and organisations delivering care on the ground—the suggestion that the new landscape, in spite of all its potential benefits in terms of local government and Marmot, has led to more variation and the decommissioning of some services, particularly in the non-sexy areas of alcohol, drug treatment, smoking cessation and sexual health?

Jane Ellison: Duncan, do you want to come in? We were just talking about this yesterday.

Duncan Selbie: The Committee has heard from my colleagues about the sexual health services, so shall I concentrate on drugs and alcohol? There was a concern at the outset that there would be disinvestment in drug and alcohol services in two respects—one in access to treatment and then the outcomes of treatment. Local government has paid huge attention to this and we have not seen that disinvestment. Population-level outcomes have remained stable, which the outcomes framework would support, and access has improved.

Q360 Mr Bradshaw: Let us move on to sexual health.

Duncan Selbie: If I may say so, I think it is important in that local government has managed to not only sustain but to improve—

Q361 Mr Bradshaw: That is great, so what are you going to do about the areas where there are problems?

Duncan Selbie: In drugs, I think it was in 44 areas that we have been working; one of them was yours and in Dr Wollaston's area we have been working on drugs and alcohol. We worked in 40 or 44 different parts of the country in the last year on drugs or alcohol, where we were concerned with local government that access or outcomes were falling away in some way. In your part of the world, both for drugs and alcohol we saw an improvement, as a consequence, in completion of treatment, which is the principal measure. If I can use that as an example—and my colleagues did it—we do get engaged, in a sense. This is a contact sport. We are not sitting at a distance just watching this or enumerating numbers. Where we see concern, we get involved. Of course there are areas where, for whatever reason, there is concern. The point is: do we know about it? The answer is: yes. Do we get engaged? Yes, we do. Do we make a difference? Yes, we do.

Q362 Mr Bradshaw: Are you doing the same on sexual health as on drugs and alcohol?

Duncan Selbie: Yes, we are. We did a full review on sexual health, and we are about to do a further review on sexual health, but we did a full review in 2014-15, and that led to a whole series of interventions. I could dazzle you with examples from around the country where they are not doing it in the same way. So, if you look at it through an NHS lens, you will not quite see the same thing because they are more focused on outcomes. The Minister made the point; they are just more focused on outcomes and they take advantage of being in a place that thinks in a wider way.

I will give you an example. Birmingham had three different approaches, three CCGs or PCTs, looking at the different approaches, and they were essentially paid on activity. The more STIs, the more income they could earn. They have moved to an outcome-based model, covering the whole of the city, including Solihull, and they are concerned with teenage pregnancy, connections with drugs and alcohol, homelessness and second unwanted pregnancies—the wider set of circumstances, if you like—and they are doing it for less money. That has involved change. That has involved a different way of doing things and a loss for traditional providers. Inevitably, that is difficult, but the eye of the tiger has been on the outcome, which is reducing teenage conception. That is an example. Leeds is another example, as is Norfolk. Under section 75, without going through procurement, they have been able to bring together in a collegiate way health and local government services. Croydon has done the same thing. I could go round the country.

Q363 Mr Bradshaw: Don't worry about that. The outcomes, as we heard earlier, on sexual health are going badly in the wrong direction.

Duncan Selbie: They are not on teenage conception, but they are on STIs, and we are very concerned about that. Professor Newton said there were three areas that we were concerned about: one was STIs. I am happy if you want to take me further on that, but we have been very transparent about where we see the concerns.

Jane Ellison: Before you move on to press that, can I add three quick comments? Of course there are going to be areas of challenge, stress and strain, and we absolutely accept that. One advantage of the way the system is set up now is that we have much greater transparency of outcomes and what is happening in given areas. The National Audit Office

review of 2014 was clear that we have completely and vastly improved and increased transparency of public health outcomes, and that does allow us to act. That brings me to my second point, which is the capacity of PHE to be nimble and swift. If someone raises something at a conference in a speech that I listen to or comes to talk to me and says, “This is happening,” or if there are things colleagues have raised with me over the last two and a half years, such as, “I am concerned about x in my area,” I can literally speak to Duncan and say, “Can we find out what is happening on the ground?” If we do not already know—I have to say that 99% of the time PHE already knows and tells me what it is doing about it—it gives us that capacity to act swiftly because we have that transparency, and, as I say, we can then look to deal with it and support local areas.

The third thing, just to pick up what Duncan said, is that it has been a difficult time for some traditional providers of services, and sometimes the people who have not been successful in retendering of arrangements, or people who have always done it the same way and then find that the world has moved on a bit and things have been reinvented and done a different way, feel badly about it, and I understand that.

Q364 Mr Bradshaw: Of course, and that is part of the process, but, going back to my question, what are you doing about sexual health specifically—the explosion in STIs?

Duncan Selbie: You heard from Professor Cosford. What can I add? The big event for this next coming year is not about further and better understanding of the problem but, “What can we do?” We think it is about reaching 15 to 24-year-olds—it might end up being 15 to 19-year-olds, but we are exploring this at the moment—using digital platforms across all sorts of activity that the young get involved in, about condom use and raising awareness, and then, of course, getting access to condoms. Much as the work that we do on things like Change4Life, Stoptober, Sugar Smart and so on is important, we are turning our mind to how we can raise awareness and then act on condom use, particularly in the young. There is a whole range of other things about men having sex with men, which, frankly, I would rather you did not ask me hugely about, but it is a big part of getting this right.

Q365 Mr Bradshaw: Is that not part of the problem? I am going to come on to this in a minute. This is exactly the problem that a lot of these organisations and charities who work in the field warned about. You fragment the system; there are certain services that local government will never support and never commission because they do not want to talk about it.

Duncan Selbie: No, I did not mean it like that. I meant please do not ask me technical questions about HIV because you had the opportunity to ask Professor Cosford.

Mr Bradshaw: Okay; I am sorry.

Duncan Selbie: We believe completely in integration of sexual health services. We promote that. The guidance that we have issued with NHS England is all about integration at a local level. If you like, it overcomes, “What does the legislation say?” We want to see integration at a local level.

Q366 Mr Bradshaw: That leads me on to the role of NHS England, Mr Stevens. In that case you said, whenever it was, that the NHS itself had to be at the forefront of public health. But when you look at a decision like your decision not to commission PrEP, which is widely

shown to be effective and cost-effective in reducing infection rates and therefore in reducing costs to the NHS hugely in the long term, how does that square with the commitment you made and what Mr Selbie has just said?

Simon Stevens: PrEP has great potential, and all of us would like to see it made more widely available in this country. A specific legal question has arisen about the legal powers of NHS England; and the external legal advice that we have had, and transparently and openly published and shared, suggests that it would be ultra vires for us to do that. Were we to commission in a way that was ultra vires, we would be subject to censure by the National Audit Office and others. There are differences of opinion about that, naturally, and we expect to have those resolved through the agreed legal process with the relevant advocacy organisations within the next six to eight weeks.

But even when it is resolved one way or another, whether we do have those powers to commission or whether the responsibility sits with local authorities, given their sexual health prevention functions, or the Department of Health through section 7A arrangements, whichever the right answer is—there will be an answer, a clear answer—then the question will be what the investment and the roll-out of those kinds of programmes should be.

The fact is that there are a number of stages that would have to be got right before that could be automatically assumed. In particular, even if NHS England was the responsible commissioner, it would mean that PrEP would go into a prioritisation programme this year alongside lots of other candidate treatments, and, as is no secret to this Committee, the finances of the national health service are rather constrained at the moment, so it is going to be a very difficult process of selecting the most impactful of the candidate treatments. In that scenario, PrEP would be up against cystic fibrosis treatments, organ rejection following heart transplantation treatments, Parkinson's disease, other HIV therapies, kidney disease and multiple sclerosis. We have published the whole list. We have made all this perfectly transparent. I do not think one should assume that, even if NHS England specialised commissioning was the responsible commissioner, it would automatically mean there would be £10 million-plus to spend on this this year.

Q367 Mr Bradshaw: Are you as confused as to who is responsible for commissioning treatments for those diseases as you are for HIV?

Simon Stevens: There is no legal doubt there. It is pretty clear that those have been specifically assigned to NHS England through the prescribed specialised services regulations.

Q368 Mr Bradshaw: So what is the problem? It is not acceptable, surely, that no one knows who is responsible for commissioning a treatment.

Simon Stevens: Yes, and the 2013 regulation specified that responsibility for sexual health preventive services sits with local authorities. That has been challenged, and that challenge will be resolved, we hope, with our support, within the next six to eight weeks.

Q369 Mr Bradshaw: You would support it coming to you.

Simon Stevens: I would support resolving that uncertainty one way or another. It will then be clear. Let us also recognise that at the moment, as proposed, this particular drug is not

yet licensed for prophylactic treatment for HIV, and, frankly, the prices that the manufacturer is seeking to charge probably also need to take a substantial haircut to represent good value for patients and for taxpayers in this country. A number of things have to be got right in partnership with patients' organisations and others in order to make this intervention available.

Q370 Mr Bradshaw: What is the public health Minister's view as to where this responsibility should sit?

Jane Ellison: We know PrEP can make a difference to some of those at risk of contracting HIV and so we do need to get a full understanding of all the issues surrounding it. I do not think we have that full understanding yet. Simon is right to say we will resolve this issue, but there are a lot of things we need to work through first. That is why the Government have called for an evidence review. We have asked NICE to conduct that evidence review of TRUVADA and its use in HIV in high-risk groups, and that will help us inform decisions about future commissioning.

The other thing is that we need to see it in the context of a health service cost-effectiveness view. There has been the PROUD study, but we have not looked at it in the broader context of how it sits alongside other cost-effective interventions.

To go to your earlier point about STIs, it still leaves us with a very significant challenge around rising STI rates, for example. Clearly, we recognise that PrEP has a role. Other countries around the world are also going through this process of understanding what that role is and how it is to be commissioned. I had a conversation very recently with the chief medical officer of Australia. They have just launched a major trial. The NHS has said it is putting £2 million into a trial. So, alongside calling for the evidence review from NICE, we are planning to move ahead with a trial, and we want to give an assurance to those people who were on the PROUD study that we are looking to make sure that they are picked up as we go forward as part of that trial.

There is a lot of work going on, out of which will come a better understanding of the role that PrEP can play, but, while it is important, it is not a silver bullet, and I think it is important to say that. We have very significant challenges, as you have said, around rising STI rates in the MSM community; we have growing challenges around, for example, drug-resistant gonorrhoea and some other really difficult and challenging diseases; and we need to think about how we address those in the round. PrEP alone is not a silver bullet in response to all those things.

Q371 Mr Bradshaw: It might be helpful to have slightly shorter answers, but, finally, on this section, Chair, there is the problem of stigma, which I am sure you would all recognise is really dangerous when it comes to public health policy. There is a feeling out there, whether you are talking about the decision on PrEP or your capping, Mr Stevens, of the availability of a new drug treatment for people with hepatitis C, that we are going back to the bad old days of certain sections of the community being stigmatised, and that will make the problem a heck of a lot worse. How do you respond to that?

Jane Ellison: Can I come in first on that? I absolutely reject that. I would say that in the last two and a half-plus years that I have been public health Minister, one thing I have been most acutely conscious of is the need to give system leadership in talking to

communities and groups that sometimes do not get that attention. For example, I held a summit just before the last general election on TB, specifically looking at the needs of communities affected by TB in the homeless community. I have gone out of my way to support things like Find & Treat services. I am told I am the first Government Minister to go on a platform and talk regularly about chemsex and the challenges that that has brought to the MSM community. Only last week, we announced the roll-out of a very major trial in the use of the HPV vaccine for MSM.

I understand why people might have those concerns, but I absolutely reject them. I am very conscious, as public health Minister, of the need to do the opposite—to seek out those groups of people whose healthcare needs are perhaps not spoken about as often, to make sure that those get due publicity.

Q372 Mr Bradshaw: Mr Stevens, what about your decisions on hep C treatment in this context?

Simon Stevens: We are following NICE's recommendations in this area, and let us just be clear about this—

Q373 Mr Bradshaw: They did not recommend a cap, though, did they?

Simon Stevens: They recommended the phased roll-out. Hepatitis C treatments will be the single biggest new investment the national health service made last year and this. We are putting in £200 million of extra funding in order to roll out this treatment, starting with those patients who are most severely ill. We treated the first 5,000 and are working through the backlog of patients with chronic health problems on a phased basis. Frankly, in the real world, if we had said, "We are going to spend £1 billion or £2 billion this year on hepatitis C," the NHS would have been cutting lots of other services to do so. So it is perfectly reasonable, as NICE recommended, that we, having made this big investment of £200 million a year, do so on a phased basis.

Q374 Julie Cooper: During the course of our evidence-gathering sessions we have had some mixed or split opinions about the movement of public health functions to local authorities, but one area where there has been universal agreement has been around embedding health in all policies in local government. We have also seen a great variety in roll-out on this. We have seen some really good provision in Coventry, for example, where they are doing excellent work. What is your view, perhaps starting with you, Duncan, on whether we should be doing more via legislation to make sure that some best practice is embedded? For example, should we be introducing material health considerations in all licensing and planning decisions by way of legislation?

Duncan Selbie: That is interesting. Coventry is not unique, but it is pretty good, is it not? My mind has immediately gone to the work that is going on around devolution in a number of different parts of the country. In Greater Manchester—everybody talks about them—there are five or six public health outcomes that are truly cross-everything, if you like: things like reducing the number of low-birthweight babies and raising the number of parents who are in work, that sort of thing, much more than about traditional—

Q375 Julie Cooper: There has been lots of good practice, and we have heard about that. Specifically, do you think we should be legislating to make sure that this good practice is shared where authorities are not being quite as proactive sometimes as others?

Duncan Selbie: No, I think it is happening. The conversations are going on all over the country. In the north-east, I chair the commission on health and care integration; in London and the west midlands, it went live last week. All over the country these conversations are happening. In fact, the planning that we are doing together is about emphasising something from Scotland. If I may say so, once the pound reaches Scotland it loses its identity, in a sense and is not an NHS pound, a local government pound or a police pound but a place pound, so we are emphasising taking the totality. Sheffield is an example. If you take the public health grant, it is £32 million; if you take the local government spend it is £1.4 billion. If you take Sheffield's spend, it is £4.5 billion. They need to be concerned with the £4.5 billion.

On specific things that local government is asking for, the most consistent is around a health objective in licensing. Our evidence review on sugar talked about the importance of helping local authorities have more influence over proximity and intensity of fast food and things like that. I cannot pre-empt what the Government are about to say on that, but, of course, in public health terms we are very keen to support local government in helping people to make these changes. Does that help?

Q376 Julie Cooper: Thank you. That is helpful. Minister, do you want to comment on that?

Jane Ellison: There are considerable powers that local authorities already have, and, interestingly, in conversations we have had with local authorities and through the LGA it is clear that different authorities use the powers they have differently and some have demonstrated the ability to use their planning powers. For example, they have become very proactive already. That being said, as you would expect, we are looking right across the piece at what every part of society—national Government, local government, industry, families, schools and local communities—can do to address the issue of childhood obesity, and we will be saying more when we publish our strategy this summer.

Q377 Julie Cooper: We might be hearing about legislation yet in the pipeline.

Jane Ellison: There is more for all to do. It is a huge societal challenge and we believe that all sections of society can be part of the solution.

Q378 Julie Cooper: Moving on from that, we have talked about local government embedding health in all its policies, but are national Government doing enough and what progress is being made interdepartmentally in every policy the Government make? Is health a material consideration?

Jane Ellison: Yes, I think very much so. Let me give you some specific examples. We work very closely with other Government Departments on a whole range of policies. One example is health in work, which Duncan alluded to earlier. There is a joint unit between the Department of Health and DWP recognising that mutual relationship between health and wealth. There is the Government's life chances strategy; I sit on the cross-Government steering group for that. We have been working for many months on a significant health component of that, looking, for example, at the sort of issues that help a child to be school

ready. Now it is really accepted that what you do in early childhood has an effect throughout one's life. I do not think in 2010 that was necessarily embedded at the heart of our thinking and it is now. Health runs through the life chances strategy like a name through a stick of rock.

As to childhood obesity, the childhood obesity strategy is a Government strategy. It was a manifesto promise last year. It is a Government strategy, and we are working with, at my last calculation, at least five or six other Government Departments, if not more, to look, as I said, at all the factors that contribute to children becoming overweight or obese. So, yes, I think that more and more we are working right across Government, and not just talking the talk, in a way that embeds it and acts on it.

Q379 Julie Cooper: How often does this cross-Government group on public health meet to consider the issues cross-Government, and how are the conversations or how is the work documented? Is it formally documented?

Jane Ellison: Let me say a word about how I work, but then I want to ask Duncan to comment because he is doing great work across Whitehall. In terms of how we work and the issues I have just mentioned, those are specific pieces of work with specific outcomes to come out of them. The work is documented in the normal way the work of Government is documented, and you will judge us by the output. Before my time as public health Minister, there was a Cabinet sub-committee. I have never sat on that; I think it stopped meeting before I was appointed. But my own view is, sitting on quite a number of sub-committees as I do, that I prefer to work, in many ways, with a very defined outcome, a policy objective, a strategy or a new policy to deliver, and then we can be judged by our output and the outcomes. I do not think that talking for its own sake is always the best thing. It is better to meet with a purpose, and those are three areas in which I can say that we are meeting across Government with clear purpose. Duncan perhaps can say more about the work he is doing at official level.

Duncan Selbie: Briefly, as to health in all policies, of course health is about more than healthcare, so all these Departments have a fundamental contribution to make. I have met 10 permanent secretaries in the last six months. When you go into Transport, they want to talk about active travel and air quality. When you go into DCMS, they want to talk about the sports strategy. If you go into education, they want to talk about the No. 1 thing that would help if a head teacher had 20 minutes more in a day. How would they use it? The answer is to get the children moving more. It goes back to these risks that we talked about before.

One new thing that might be of interest to the Committee is that, if you went back two reorganisations ago, when you had regional directors of public health embedded within the Department of Health, they used to have, if you like, another Department that they partnered with. What I have been offering as I have been going around Whitehall with the permanent secretaries is whether we can reinvent that so that education has a senior public health professional, likewise DWP, BIS—there is quite a range of them—and the Ministry of Justice on what happens in prisons. That is what we are doing at the moment. I am writing, as we speak, to all of the 10 I have met to make them that offer. This is not to say, “This is what we want you to do.” It is to listen hard to what they are trying to do and ask if there is some way in which we can help, and also join things up.

Jane Ellison: The MOJ is another good example.

Duncan Selbie: The MOJ is a cracker.

Jane Ellison: Only last week we had meetings with colleagues in the MOJ looking at the support for prisoners' health, and in particular people's pathways out of prison back into the community and how we are trying to smooth that pathway in terms of their healthcare needs, if, for example, they have substance abuse issues.

Q380 Julie Cooper: This all sounds like pockets of really good work, but it seems that local government is still leading the way on this. In the best authorities, health and wellbeing underpin every policy, and surely that would be the ultimate outcome. It would be really useful, it strikes me, for example, for the Minister for the Department of Work and Pensions to have at the heart of every policy that they bring forward within that Department a consideration of the health effects and wellbeing of the policy. Do you agree that to formalise this very good practice that is already going on in pockets would be the next step forward?

Jane Ellison: I would say it is formal already. You cannot get more formal than a joint unit between the Department of Health and DWP, for example, to look at health and work.

Duncan Selbie: I am going on tomorrow to be part of the joint committee about getting people back into work and how to get people who have a job but are unwell back to work even faster. We are doing similarly across Government on air quality. It is a journey we are on. I think local government has been at it for longer and has done it really well. It is inspirational, I know, but inspirational in parts of the country, and we want to level up. I am seeing, even in a short period of time, that the ambition and appetite for doing this across Government is genuine. We will see that in child obesity, but there are other areas. The most obvious of those is about getting people back into work.

Q381 Dr Whitford: Still on that, Marmot and all the evidence always shows that the biggest killer and health impact is deprivation, as you have mentioned yourself, Duncan. Talking about supporting people who are working and getting them back into work, what about the changes that we have had for people who are not working or are not able to work? The UK Faculty of Public Health's report that they did with one of the cross-party groups here, "Health in All Policies", was suggesting that we were seeing poverty rising and that we were going to see it rising further. That might be fine for the people who are in work or can work, but the problem is that, if we leave a whole chunk of the population behind, due to disability, mental health or whatever else, how will we tackle the problems that causes?

Jane Ellison: At the heart of the Government's life chances strategy is a simple proposition that we want to tackle every single underpinning factor that prevents a child getting on and making the most of their life. That means a real deep dive on the drivers of poverty—issues like debt, addiction and family break-up, all those things. It might be a point of political difference, but my own view is that attacking those key underpinning drivers of poverty is absolutely critical to how you tackle this in a way that is transformational. We have tested to destruction the idea that money alone is the answer to the problem in previous Administrations, and I do not believe it is. I think that at the heart of the life chances strategy is the very proposition that you say—which is looking at the poorest people and the least advantaged in our society, particularly children, and

understanding what are the things that can affect their life chances as they grow up and that will give them the best chance to be successful in life.

Q382 Dr Whitford: I do not think any of us in this room thinks that money is the whole problem, but it is certainly a chunk of the problem. If you do not have money, if you are struggling to keep a roof over your head or food on the table, it overshadows thinking about whatever else you are doing, and certainly their view in the evidence that we heard in that inquiry was that they see child poverty rising because children live in disabled families, in unemployed families, and many of those families are seeing their income going down. Is that not a combination of the Treasury and DWP not hearing “Health in All Policies”, because those people will cost more in the longer term?

Jane Ellison: We are straying beyond my portfolio. I would simply say that work is vital to health—

Q383 Dr Whitford: Is that not the point?

Jane Ellison: —and we have record numbers of people in employment, and the number of children in unemployed households has dropped over recent years. All those things help us to drive change in this area.

Q384 Dr Whitford: But surely we have increasing in-work poverty. Two thirds of children who are defined as living in poverty have a working parent.

Jane Ellison: I think we might have to agree to disagree on that.

Q385 Dr Whitford: But surely whether you and I agree is not going to change the fact that those children are living in an impoverished family.

Jane Ellison: I have given you my answer.

Q386 Emma Reynolds: To what extent does Government policy join up on this, though, having regard to the policies of the Treasury and particularly the Department for Communities and Local Government? Mr Selbie, you made the point about how the worst health inequalities are found in the most deprived areas. What kind of join-up is there between the different Departments? There is only so much you can do as a public health Minister if the other Departments are working against you.

Jane Ellison: I made the point earlier that, if you take something like the life chances work that is going on, there are 10 or 12 Government Departments all represented in looking at that. It is a completely cross-cutting strategy, with a view to looking not just at the different factors that drive poverty and lack of opportunity but how those policies interact and how the Departments interact. That is the point of getting everyone round the table. I agree with you about working in silos; you can never hope to tackle the most intractable problems, but we are not working in silos any more.

Duncan Selbie: That is what will close the health gap over five, 10, 15 or 20 years. We know how much this matters.

Q387 Dr Whitford: Do you feel you are focusing and breaking down these barriers?

Duncan Selbie: Yes; I see it at a local level and at a national level. I am not sure anybody would have thought three years ago that it was possible that we would have a child obesity strategy or plain packaging for cigarettes. The focus that we have now is on health at work, with the DWP and the DH, supported by Simon and me, and on how you get the million or so people who really struggle to get to back into work. That is the forecast, because we know that is what will make the biggest difference. Children in very low-income, poverty-in-work income homes, do better than those in homes that have no work at all. We need to see work as a public health objective. It is a public health objective.

Q388 Dr Whitford: I totally agree with that. Can we move on, because we are running out of time. Some of the comments we heard from people who gave evidence to us were that, now that public health had moved into local authorities, it was as if the NHS was washing its hands of it. This is particularly to Simon really. Do you recognise that? What proportion of trusts do you think have a really proactive preventive agenda?

Simon Stevens: Of trusts, of hospitals or the CCGs?

Q389 Dr Whitford: Pure NHS, if you like.

Simon Stevens: I do not recognise that because I do not think this is a zero-sum situation. I do not think, because you have enhanced local authority leadership, that means you have diminished NHS involvement necessarily. The Association of Directors of Public Health have pointed out that there are in some places issues around the extent to which directors of public health are able to influence what the CCGs or the NHS are doing, but I do not think that is intrinsic to the model as evidenced by what we have seen in some of the other great local authorities where this has worked well.

Q390 Dr Whitford: Do you think there should be a strategy laid down where they have a commitment to go on, as in “Making Every Contact Count” and so on, rather than feeling this is now no longer their business?

Simon Stevens: Yes; I absolutely agree that it continues to be their business, and if you think about what we are doing, as Duncan said earlier, through the local implementation process for the Five Year Forward View, we are focusing, in all 44 of the communities that have come together in England to do this, on the health and wellbeing gap as well as the care and quality gap, and the financial sustainability and efficiency challenge.

So I think this is better understood now in the NHS than it was perhaps five years ago, and in quite interesting ways. I think about the conversation I had with the deputy director of public health for the Royal Free Hospital. Since when did teaching hospitals have directors of public health? It turns out that some of them are clocking the fact that this is an important part of the impact that they have in their local communities, and indeed with their own staff. So, as Duncan said, the NHS as an employer, as the biggest employer in Europe, has a responsibility to put our own house in order when it comes to workplace health, which traditionally we have not done. This year, which we are now in, we have the world’s biggest incentive programme for employee health in our health system, with up to £450 million of incentives tied to improving workplace health for nurses, therapists, ancillary workers and others across the NHS.

Duncan Selbie: They get picked up through the NHS prevention board, so this is us working together. PHE supports a provider network; there are about 30 or 40 hospitals that have invested in public health specialists. Barts has a director of public health—and Oxford, Addenbrooke’s and West Birmingham—because they know that their part in prevention is going to help them in managing demand as well.

Q391 Dr Whitford: Do you think that sustainability and transformation plans are going to help to change the kind of negative feedback loop of how trusts have been paid up till now? Certainly what we heard was that the NHS providers are paid by work they do, not work they prevent, and one problem is that local authorities invest the money, but the saving goes to the NHS. Are you hoping to tackle and change that structure so that they both share in the benefit of the work they do?

Simon Stevens: We are. Obviously it is a slightly more nuanced picture than that, given that there are different funding incentives in different parts of the health service, let alone between the NHS and local authorities. But if you take Ben’s area—Devon, for example—they are coming together now as a collective care system in a way that even 12 months ago would probably have seemed implausible. We have styled it “The Devon success regime”. Maybe after a little bit of a slow start, I do think now they are motoring. I stand to be corrected by Mr Bradshaw, of course, but that is an example of beginning to think more holistically across individual organisations, and, indeed, the chief executive of Mr Bradshaw’s own hospital has become the leader of that collective endeavour for Devon.

Mr Bradshaw: She is doing an excellent job.

Q392 Dr Whitford: So we are moving back more to, in essence, place-based management of the issues.

Simon Stevens: Yes.

Q393 Chair: Thank you. Time is rather short, and I know that, Simon, you have to leave at a quarter to 12. One of the purposes of this inquiry was to look at the changes that have happened since the Health and Social Care Act. Are there aspects of the legislation that you think need to be revised in the light of your experience since becoming the chief executive?

Simon Stevens: That is a nice little poisoned chalice to sip from at the end of this inquiry. There is a bit of a sense that, wherever we have got to, there is not a huge appetite for throwing all the cards up in the air and starting again. So, to the extent that there are elements of the system that are evolving, there are some de facto workarounds that are being put in place, going with the grain of what people can see is needed and focusing on the practical stuff rather than the administrative reorganisation again. My mantra on this is that there is no right answer as to what these arrangements look like, but the wrong answer is to keep changing your mind.

Q394 Chair: But are there aspects of the legislation that you feel need to be revised because the workarounds simply cannot take place or they are too cumbersome? Are there recommendations that you would like to make to this Committee?

Simon Stevens: Do you mean particularly on public health?

Q395 Chair: Particularly on public health, but if you want to expand it further, that would be fine too. The focus of this inquiry is on public health. I know you are coming back at a later date and we will perhaps have more time to expand on the other aspects of the legislation, but, particularly as regards public health, are there aspects of this where you are finding that a workaround is proving very cumbersome or that the Government should be tweaking the legislation?

Simon Stevens: This new system is bedding in. There is opportunity, created particularly by the local authority leadership role, but that comes at the expense of some complexity, given the way some of the different funding streams connect; and so there is a trade-off there. Rather than relitigating that trade-off, I think we should go full strength to make these current arrangements work as best we can and then, in the fullness of time, properly answer your question.

Q396 Chair: Thank you. I know that you have to leave us at this point, so perhaps I could expand that to you, Minister, and Duncan Selbie.

Jane Ellison: I am getting slightly short of time, because, as you know, I have an urgent question to add to my two debates from last night. Parliament's appetite for public health knows no bounds. No, I do not think so, and I would concur with the view just given. I do not think there does need to be legislative change. We face some challenges as it is a new system bedding down, but we have seen, from my own perspective, enormous potential in just a few years of the way the public health arrangements sit now. At the heart of all the frustrations it is about bedding in good relationships, and I think, in the end, you do not legislate for good local relationships and great leadership. Key relationships and great leadership are the key to making it all work, and that would be true in any system construction. That is why we are investing heavily in the public health workforce, in senior management and senior leadership, and why we have to keep working at those local relationships. When we see people crack it at a local level, we see its enormous potential.

Q397 Chair: The difficulty comes where those relationships are not good. What levers and mechanisms are there to step in for the benefit of local communities?

Jane Ellison: I understand that challenge, Chair, but I do not think you would ever legislate for that. That is about making sure that we have the right system leadership, from the Department, from the head of Public Health England, and from the top of the NHS, to make those things work.

Q398 Chair: But do you have the levers if that is not happening at local level? I accept you cannot legislate for that, but do you have the levers you need?

Jane Ellison: We have a number of levers, but I am a sceptic as to the extent to which you would pull a lever in Whitehall in any system and something would change hundreds of miles away. In the end, you will always need to put your key system leaders on the ground to identify where the local leadership stands and how you bring people together in a health system that perhaps was struggling to work.

Q399 Chair: Can I just raise one example where some concerns have been expressed by the Institute for Government and others, for example, about the status of Public Health England

as an Executive agency? We have had a number of witnesses tell us that it should be at greater arm's length, and I wonder whether both you and Duncan could comment on that.

Jane Ellison: I have heard that too, but I just do not see that. I know there was a very active debate during the passing of the 2012 Act around the status of Public Health England and how it would operate, but I think it is operating well. The Department does need an Executive agency to be able to take forward the kinds of things that parliamentarians raise, all those things, but at the same time I look at the time Duncan has spent, for example, just in the field over the last couple of years. He has met every head of every authority over the last two years. Is it two years, Duncan?

Duncan Selbie: It is two and a half years.

Jane Ellison: I think that, while the system is still settling down, Public Health England is settling down in that system very well and performing well.

Q400 Chair: It is performing well, but does Public Health England have sufficient independence to be able to challenge—

Jane Ellison: Chair, we gave that a good run-out last summer, did we not, when in fact your Committee asked for the evidence and we had a little bit of a delay, but then you got the evidence on the impact that could be made on sugar consumption? That evidence was presented. It has sat there. It has been an incredibly useful reference point.

Q401 Chair: It was helpful indeed, I think, having it in the public domain at the end of the day.

Jane Ellison: I absolutely concede that, and it was helpful, has been helpful and continues to be helpful as a reference point to Government as we look to formulate policy.

Q402 Chair: Perhaps turning to you, Duncan, do you feel you should now have a different status?

Duncan Selbie: Can I be very blunt? I am not interested in whether it is an Executive agency, non-departmental or executive—all these different things. What we are independent to is the evidence, and that includes professional judgment, because there is not evidence about everything. We are not constrained. I said that to you when we had the conversation. There was a wider set of issues that I was seeking to convey. The ultimate arbiter of my independence was the right to choose, and I was choosing not to in that particular circumstance. It was uncomfortable but necessary. The critical thing for public health and for the public's health is the independence, the freedom to speak and to publish evidence. That is irrelevant to organisational form. For the record, can I pay a huge tribute to local government for what they have done in the last three years? I do not think we say sufficiently just what a fantastic embracing they have done of this new duty. It is apolitical. It does not matter where you go. As the Minister says, I have been to pretty much everywhere, and there is an inseparable partnership—it is really good that you had Simon with us today—with the NHS.

Jane Ellison: I echo Duncan's words. I do not get out as much as I would like to, but everywhere I go in the country, irrespective of political leadership, I am so impressed by

what local government is doing with these new powers and I have great faith in the fact that they can be better still.

Chair: Thank you very much. I know Ben has a final point and then we will finish.

Q403 Mr Bradshaw: It is one I wanted to make to Mr Stevens, but instead I will have to make it to you, Mr Selbie. The Minister has made quite clear that she thinks Brexit would be very damaging to the NHS and to public health. Mr Stevens has made it quite clear that he thinks Brexit would be very damaging to the NHS. We heard quite a lot of evidence from leading experts in public health that they thought it would be disastrous for public health, given the role of environmental impacts and so forth on public health. What is your view on the potential impact of Brexit?

Duncan Selbie: I am not getting into it. Our first duty is to protect the health of the people, which we will do irrespective of whatever. It is the drop dead, No. 1 priority. You have heard a lot about that this morning, so, whatever happens in the world, that is what we are for, No. 1. Secondly, we will improve the health of the people, and that is a system-wide thing, which is exactly what the Minister and Simon are talking to. It is not owned by us, but, by heavens, we have a contribution to make and we are very proud of it.

Q404 Mr Bradshaw: So do you not have a view on the impact of Brexit?

Duncan Selbie: I have answered. It is of no consequence to me as the leader of the public health system in England—we will work with the world in protecting the people of this country irrespective of the governance arrangements. I really do not want to go further.

Chair: That is fine. You have made that clear. Thank you very much, and thank you both for coming today.