Department of Health

# Government Response to the House of Commons Health Committee Report on Public Health England (Eighth Report of Session 2013-14)

Cm 8881


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# 1. Government Response to the House of Commons Health Committee Report on Public Health England (Eighth Report of Session 2013-14)

## INTRODUCTION

1.1 The Government thanks the Committee for its considered report on Public Health England (PHE). Before responding to the Committee's recommendations in detail, we will set out the background to PHE's creation and the critical role it plays in the reformed health system as a champion for the nation's health and well-being.

### The reforms to public health and the creation of Public Health England

1.2 The Coalition Government inherited a public health system with many strengths, such as a world-leading health protection system led by the Health Protection Agency (HPA), excellent knowledge systems represented by the Public Health Observatories and Cancer Registries and significant, if fragmented, expertise in health improvement and social marketing spread across both central government and different NHS bodies. However, the system was less than the sum of its parts. There was too much reliance on top-down targets that sapped local initiative, while central government was not close enough to its core role of protecting its citizens. Too many different organisations with a public health remit confused rather than clarified core public health messages. There was too little focus on the public health evidence base. The net result was a system which did not deliver the step change in public health outcomes that the country needs or secure the common understanding that health is about much more than just healthcare.

1.3 The Government's reforms were aimed at clarifying responsibilities and accountabilities, empowering people and communities and focusing on the evidence of what works. The Health and Social Care Act 2012 gave local authorities the leading role in improving their population's health and the Secretary of State the duties to protect the nation's health and reduce health inequalities. Local government is best placed to shape solutions that address local needs, tackle the causes of ill health and build healthier communities, driven by democratically accountable leadership and supported by national action. Central government must take the primary role in defending the population against threats to health and ensuring a coherent system for planning for, and responding to, threats.

1.4 The Department of Health retains the core role of setting the Government's policy on promoting and protecting the public's health, of allocating resources, and of accounting to Parliament and the public. For its part, the NHS remains critical to public health, not least through health professionals encouraging patients to live healthier lives ("making every contact count") while NHS England commissions national screening and immunisation programmes and negotiates primary care contracts.

1.5 Underpinning all these activities is the knowledge, expertise and professionalism of Public Health England, the country's public

health adviser. Through integrating the public health skills of a plethora of predecessor agencies into a coherent whole it ensures that there is a single authoritative voice speaking for public health, just as the Centers for Disease Control and Prevention offer that authoritative voice for the United States, be that in challenging central government to adopt evidence-based public health policy, supporting local government in identifying their priorities for improving the health and well-being of their local populations, or – as NHS England's public health advisor – ensuring that the NHS secures the maximum health gain from its resources. PHE's 15 local centres, each led by a senior public health professional, provide the opportunity to stay close to the local authorities and local NHS bodies charged with improving the public's health and well-being and ensure that they secure the full benefit from the national specialist capabilities that are PHE's unique contribution.

1.6 These reforms to the public health system were broadly welcomed by local government, public health stakeholders and others. They represent a profound reshaping of the public health system, and open up the potential to transform the outcomes for the people of England, driven by local political leadership, and informed by the expertise of PHE.

**PHE's first year**

1.7 The Committee has acknowledged PHE's success in managing the transition to the new system. The Government echoes that judgement. PHE has made great strides in its first year – for example, it has:

- delivered, alongside the NHS, a successful MMR vaccination catch up campaign, so that 95% of children between the ages of 10 and 14 have now had at least one dose of MMR vaccine;
- started or modified four immunisation programmes – introduction of new rotavirus vaccine, childhood 'flu vaccination, shingles programmes and removal of an infant dose and introduction of a teenage booster dose of MenC vaccine;
- launched the award winning Longer Lives website, highlighting local variations in mortality;
- created the largest cancer registration service in the world by bringing together multiple separate services;
- launched 20 social marketing campaigns covering Change4Life Smart Swaps, Stoptober, dementia and blood pressure;
- handled around 9000 local health protection issues, including outbreaks of infection, chemical radiation and environmental incidents;
- disseminated information and health advice during national air pollution incidents; and
- supported the national and local response to flooding.

1.8 Given the scale of the task facing PHE in April 2013 the Government believes that PHE can be proud of its performance so far. This conclusion is supported by PHE's external stakeholders – quantitative research carried out by Ipsos MORI in January 2014 showed that 48 per cent of stakeholders would speak highly of PHE (with a further 46 per cent neutral) and 76 per cent had a good working relationship with PHE. We believe these are encouraging results at this early stage, and they compare well with other public sector organisations. This is not to say that there is not more to do, but it is much too early to pass critical judgement on PHE.

**Independence**

1.9 The Committee has expressed concern that PHE is insufficiently independent, and has not yet found its voice. The concerns about PHE's relationship to government are not new and were debated constructively and at some length during the passage of the 2012 Act. The Government respects these concerns and has responded to that debate, but believes firmly that PHE is now appropriately designed to fulfil its mission.

1.10 That mission can be broken down into four core functions. As the nation's public health agency PHE:

- fulfils the Secretary of State's duty to protect the public's health, for example through the surveillance and management of outbreaks of infectious diseases and environmental hazards, emergency response, and specialist microbiology;
- improves the public's health, through its own actions and by supporting government, local authorities and the NHS to secure the greatest gains in health through evidence based interventions;
- supports NHS England in its commissioning and in the development of sustainable health and care services; and
- supports the capacity and capability of the public health system, through research, supporting and developing the public health workforce and publishing data that holds the system to account.

1.11 To carry out these roles effectively PHE acts as part of government, to help deliver an effective and unified public health response to emergencies for example, and ensures that the voice of public health evidence is heard clearly within the policy debate. But it is also able to stand back, make an assessment of the state of the public's health, set out what the evidence shows to be the most effective interventions for meeting that need, and be very clear about where evidence is lacking. The Government's fundamental objective was to establish PHE as a credible professional body which can do this – a body required to speak authoritatively to the evidence and its professional judgement. We recognise the value of an organisation which stands outside the political fray and provides the expert analysis and judgement that can help central and local government, the NHS, civil society and the people of England to take decisions that improve the public's health.

1.12 It is for Ministers to take, and account for, final policy decisions and as part of government PHE staff are expected to first inform and then respect those decisions, which the Government as a whole must make within the broad context of its agenda and priorities. However, that does not diminish PHE's obligation to use its position within government to set out clearly the public health science and to promote evidence-based interventions wherever they are cost-effective and can make an impact. This means that PHE has to be credible and authoritative in everything it does, so that its interventions carry weight.

1.13 The Government accepts that sometimes what PHE publishes may be challenging, but there is no subject that is out of bounds. The critical point is that whatever PHE says should be soundly based in evidence, transparent about the limits of our knowledge, and focused on areas where PHE can make a unique contribution and add most value. In return, the Government looks to PHE to make real progress in improving outcomes for the most serious public health problems that we face, and will hold it to account for doing so. We want to create a culture of strong and constructive mutual challenge that allows PHE to help individuals live healthier lives, initiate important debates

and make the case for action – for example, by describing the wider economic and social benefits for local government of improving the health of their populations.

1.14 We have provided significant safeguards for this freedom to speak out. In November 2013 PHE and the Department jointly published a Framework Agreement that defines the critical elements of their relationship. This states very clearly:

> *PHE shall be free to publish and speak on those issues which relate to the nation's health and wellbeing in order to set out the professional, scientific and objective judgement of the evidence base.*

1.15 So to do its job effectively PHE has to be part of government, but operationally autonomous. As an expert public health body within government its priorities are driven by, but not limited to, immediate Ministerial priorities, as it needs to reflect the broad range of public health needs, including those met by local government and the NHS. We believe that PHE's report on shale gas extraction should be seen in this light – as an authoritative statement of the current knowledge in an area of public health concern, and the limits to that knowledge.

**PHE's developing role**

1.16 The Committee argues that PHE has yet to find its voice. To reassure the Committee, the Government is happy to reaffirm its confidence in PHE as its expert public health adviser. PHE has published its work programme for 2014/15, which sets out clear commitments to driving improvements in the nation's health. PHE is preparing to deliver significant programmes including:

- a Health and Well-being Framework, setting out how health is everyone's business. The NHS makes a relatively small contribution towards the health of the nation – PHE will set out the economic and wider societal impact of poor health and what different parts of government, the public sector, business and civil society can do to promote health. The Framework will also use sophisticated modelling to identify the impact of various unhealthy behaviours and identify evidence-based interventions that drive improvements;
- promoting evidence-based practice relating to alcohol;
- promoting evidence-based practice in relation to reducing the impact of over-consumption of sugar and carbohydrate in the light of the latest assessment of the Scientific Advisory Committee on Nutrition which will be available this summer; and
- leading the debate on the prevention of dementia, which is increasingly understood to have a significant and preventable vascular component.

1.17 PHE advises and supports the Chief Medical Officer in her role as the independent advisor to government on medical matters, and the CMO and senior PHE professionals meet regularly to discuss current issues. The CMO is also the head of the public health profession and is supported in this role by PHE through the part it plays in appointing directors of public health (DsPH) and revalidating medically qualified public health specialists, as well as through its day to day working relationships with public health professionals across the country.

1.18 The Government has set out its clear expectations of PHE for 2014-15 in a letter from the Public Health Minister which is reproduced in the Annex to this document.

## Conclusion

1.19 PHE was not created to be another commentator on public health, but rather as an integral and authoritative part of a new system for protecting and improving the health of the people and reducing inequalities in health. It provides a wide range of unique services, including surveillance, cancer registration, advice and support for delivery to local government and the NHS, and publishes the evidence and outcomes data which will help to drive improvement. Its impressive record in its first year shows that this is not an organisation which has failed to find its feet.

1.20 PHE should not be judged on headlines generated but on the evidence of improvements in the public's health, and continued effective protection of the population. It is our firm belief that its position as part of government strengthens rather than weakens it in that task. We look forward to the Committee's continuing scrutiny in the years ahead.

# 2. Government response to the Committee's conclusions and recommendations

**The meeting the Committee held with the management of Public Health England was the first opportunity for the Committee to examine the work of the agency and the transition to the new public health arrangements in England. Whilst we are satisfied that some functions are operating well, the Committee has concerns regarding PHE's policy work, the way in which policy priorities are identified and the nature of PHE's relationship with Government**.

**The Committee has received evidence that, in its first seven months of operation, PHE has established itself as a new entity whilst ensuring continuity of public information campaigns. Evidence also indicates that PHE acted effectively to address the 2013 measles outbreak by delivering the vaccination catch-up programme. This suggests that PHE met its objective of ensuring that the transition to the new arrangements did not result in a 'dip in delivery' of existing programmes. Most importantly, the Committee recognises that throughout the transition PHE maintained continuity of the vital work undertaken by the Health Protection Agency.**

2.1 We are grateful for the Committee's acknowledgement of the smooth transition from the old to the new systems. We also welcome the broadly supportive written evidence that was provided to the Committee by a range of key stakeholders across the public health system. As the Committee noted, as well as continuing the vital work of the HPA PHE also took on the staff and functions of around 120 other organisations. The success of the transition is a tribute to the commitment and hard work of over 5,000 people, mostly scientists, researchers and public health professionals, who came together for the first time in a new organisation and hit the ground running. We have highlighted a number of PHE's early achievements in the introduction to this document.

2.2 The progress that PHE has made is also recognised more widely. Last year PHE commissioned Ipsos MORI to assess how it is perceived externally and how well its stakeholder relationships are developing. The report details the findings from an initial qualitative phase of research conducted in July and August 2013. It shows that although stakeholders expect more progress to be made, the vast majority of those interviewed were positive about PHE, recognising it as well positioned and with the right leadership to achieve its aims.

2.3 We address PHE's role in policy and the nature of the relationship between it and the Government in our responses to the Committee's later recommendations.

**The Committee recognises that PHE has worked to clarify responsibilities for emergency preparedness and has addressed a number of concerns raised in advance of the organisation's launch. The Committee is concerned, however, that the Faculty of Public Health reports that**

**these responsibilities remain unclear, and recommends that the Government takes urgent steps to put these important issues beyond doubt.**

2.4 We share the Committee's recognition of the overriding need for the system to deal rapidly and decisively with localised threats to public health. The ultimate responsibility for the protection of public health in England rests unambiguously with the Secretary of State. He can use the resources and expertise of PHE, locally or nationally, to take whatever action is necessary. Last year's Ipsos MORI survey found that 83 per cent of local authorities believed PHE fulfilled its local emergency response capabilities well.

2.5 We believe that the nature and leadership of the response to threats should be determined by the circumstances and nature of the threat itself. Given that PHE handled around 9000 local health protection issues in its first year, each requiring a local response, it would not be helpful for us to attempt to impose a standard national model that placed one agency 'in charge', be it PHE, the NHS or local government.

2.6 Used well this flexibility can greatly enhance the response to incidents, but it must not be mishandled or allowed to create unnecessary confusion at the point that an incident occurs. To that end local authorities are now required[1] to work with all their potential partners to promote robust health protection arrangements that reflect a clear and shared understanding of roles and responsibilities. Any local authority which has doubts about the quality of the arrangements in place should escalate its concerns to PHE.

2.7 PHE, the Department of Health and the Local Government Association (LGA) published detailed joint guidance on this in August 2012 and updated it in May 2013.[2] To provide further assurance, in January this year the Department, PHE, the Faculty of Public Health, the Association of Directors of Public Health, the LGA and NHS England joined forces to ask Local Health Resilience Partnerships (LHRPs) to review and provide feedback on local health protection arrangements. We have provided LHRPs with a resource pack that can guide their reviews, which brings together advice on the legal requirements, case studies, guidance and agreed principles for the roles of different agencies. We asked LHRPs to respond by 11 April and their feedback is now being peer-reviewed and analysed. We will decide in the light of the findings and in conjunction with our partners what, if any, further action might be needed.

**The Committee is concerned that the responses to Committee questions on shale gas extraction suggest that PHE has not yet established prioritised programmes of work which reflect the objectives of the organisation and have been endorsed by the Board. We believe it was unwise for PHE to follow through the work on shale gas extraction which had been initiated by the HPA without first taking care to satisfy itself that this work reflected both the public health priorities of PHE, and the research quality criteria embraced by the new organisation. The resulting report did nothing to build public confidence in PHE as the premier guardian of public health in England.**

2.8 PHE published its priorities for 2013-14 in April 2013, and in them (as the Committee has noted) specified the need for it to protect the country from environmental hazards. PHE also set out specific activity to support progress towards its high level priorities,

1 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

2 'Health Protection in Local Government' updated 17 May 2013

but a forward-looking document cannot encompass all the activity the organisation actually undertakes over a full year.

2.9 In response to public concern about shale gas extraction, national and local agencies sought advice from PHE's Centre for Radiation, Chemical and Environmental Hazards (CRCE). PHE undertook its review in line with its responsibility for providing specialist advice to those responsible for public health protection, including local authorities and regulators. Delaying or abandoning the continuation of the work would have left PHE open to criticism, and its continuation had no effect on other PHE programmes. The report itself[3] is a sound and objective analysis of the evidence. The CRCE continues to advise government and others on potential risks from chemical and radiological issues including mobile phone technologies, smart meters, municipal waste incinerators and landfill sites.

**The Committee welcomes this objective** *[reducing preventable deaths and ill health associated with unhealthy behaviours]* **and believes it should be the foundation for establishing PHE's policy priorities. Within the work of PHE there is a clear distinction between its responsibility to operate established programmes and campaigns – such as Stoptober, change4life and vaccination programmes – on behalf of the Department of Health and broader work to promote or support specific policy priorities, some of which may be regarded as contentious. The Committee is concerned that there is inadequate clarity about how the organisation will approach crucial policy issues such as obesity, minimum unit pricing of alcohol, and standardised packaging of tobacco products. The public expects PHE to be an independent and forthright organisation that will campaign on behalf of those public health objectives and policies which it believes can improve the nation's health. We note that PHE focused in the first instance on achieving a smooth transition to the new arrangements and the Committee believes that PHE has so far failed to set out a clear policy agenda.**

2.10 We welcome the Committee's support for the objective and have given PHE a challenging remit in this field. The continued delivery of innovative and high impact public campaigns such as Change4Life and Stoptober are important in helping people to take steps to improve their own health.

2.11 We agree that PHE should be open and transparent about the expert advice it provides to government. It can and should also provide advice directly to the public – the Framework Agreement between PHE and the Department is explicit about that:

> *PHE's credibility will be based on its expertise, underpinned by its freedom to set out the evidence, science, and professional public health advice it presents without fear or favour.*
>
> *PHE is therefore free to publish or speak on issues relating to the nation's health and well-being in order to set out the professional, scientific and objective judgement of the evidence base.*

2.12 PHE's priorities for 2014-15 encompass a number of potentially contentious areas, including tobacco control and alcohol, and we expect PHE to set out very clearly – in line with the Framework Agreement – the evidence for what works.

2.13 The practice of public health, just like health care in general, can by its very nature be political. It is concerned with fundamental

3 PHE-CRCE-002 –'Review of the potential public health impacts of exposures to chemical and radioactive pollutants as a result of the shale gas extraction' October 2013

questions of how each of us chooses to live our lives and in some cases how society agrees to restrict individual freedoms to protect and promote our health. That is why we believe it is critical that decisions in relation to the public's health are taken in the light of the evidence. PHE has been established to provide the evidence-based professional analysis and judgement that can enable Ministers, local councillors, NHS leaders and others to make informed decisions on improving the public's health.

2.14 We expect to see PHE making a full contribution to the development of the evidence-based policy agenda in public health over the coming months. Its contributions will include the publication of a Health and Wellbeing Framework charting the state of the public's health, the possible futures and our understanding of the evidence based interventions, and major reports on the public health impacts of alcohol and over-consumption of sugar and carbohydrates and the evidence based solutions which may be available.

2.15 So PHE has a vital role in advising the Government on the evidence and supporting the development of its policies and priorities. We want the national public health policy agenda to emerge from discussions between the Department, PHE and other stakeholders – but Ministers remain accountable for final decisions on the priorities for central government and its executive agencies, taking into account the full range of policy considerations across government. This is an important point that we expand on below.

2.16 As well as its direct relationship with Ministers, PHE also has its own relationships with NHS England and local government. This gives it a central part to play in making sure that public health activity across the system as a whole stays co-ordinated and complementary.

**The Committee is concerned that that the Chief Executive of PHE should regard any public health issue as 'too controversial' to allow him to comment directly. For similar reasons that the Government is committed to an independent voice for the Care Quality Commission, the Committee believes that PHE should be able to address such matters without constraint.**

**We are concerned that there is insufficient separation between PHE and the Department of Health. The Committee believes that there is an urgent need for this relationship to be clarified and for PHE to establish that it is truly independent of Government and able to "speak truth to power".**

2.17 We agree that PHE cannot function properly if it is unable to speak its mind. We note that the Chief Executive's comment which the Committee quotes was in the context of explaining the need for some humility, only six months in to the new system, and the need for PHE to build a compelling track record. PHE not only needs to be free to make comment but it must be credible when it does so.

2.18 Since 2010, when we first began to discuss reforms to the health care system, we have been guided by a fundamental and clear principle – that protecting the health of the people of England is properly the business of central government.[4] The Health and Social Care Act 2012 created the statutory framework for the new system by abolishing the HPA and conferring on the Secretary of State (and only on the Secretary of State) a new duty to take appropriate steps to protect the health of the population.

2.19 In 2013 we established PHE as an executive agency of the Department of Health to play the leading role in putting into

4 Healthy Lives, Healthy People, Department of Health, November 2010

practice the Secretary of State's new duties. The Secretary of State is – quite rightly – accountable for everything that PHE does, but this does not mean that it will ever be simply expected to carry out a set of detailed instructions. We have emphasised repeatedly that PHE can only play its part in full if it is free to use its expertise in the ways that it knows are the most effective in achieving our shared objectives. It now has that freedom, but it remains critically important that PHE is seen to be credible and authoritative, and that its positions are based on the best available evidence, analysis and professional and scientific judgement.

2.20 The Government built significant safeguards into PHE's governance arrangements to preserve its freedom to speak and publish on the basis of the evidence and its professional judgement. These safeguards are written into both the Framework Agreement, which sets out the accountability arrangements for the organisation, and the code of conduct which is a contractual requirement for all PHE staff. We believe these arrangements are robust, provide PHE with the necessary operational autonomy and allow PHE to establish itself as a credible evidence-based professional body.

2.21 In other words it is essential that PHE plays a major and influential part in the debate about the public health policy agenda. It is equally essential that PHE, the Department and the Government as a whole work together to deliver that agenda once it is defined. These imperatives are not incompatible, and we do not believe that it is meaningful to judge the quality of PHE's operational autonomy only by the frequency with which it contradicts government policy.

2.22 Nor do we accept that there is any conflict between PHE's direct accountability to the Secretary of State and its ability to provide him with frank, impartial and objective advice. In fact it is incumbent on PHE staff to do precisely that. We would regard anything less as a serious failure of professional standards that could put the Secretary of State at risk of breaching his statutory duties.

**As part of this process the research priorities of PHE should be based on an analysis of public health priorities in England undertaken by PHE. PHE should not look to the Department or to other parts of Government to prompt its research or, still less, to authorise its findings. PHE can only succeed if it is clear beyond doubt that its public statements and policy positions are not influenced by Government policy or political considerations.**

2.23 PHE is currently developing a research and academic strategy that will align its activity with public health need and with PHE's particular skills and expertise. This will identify the long and mid-term priorities that are most appropriate for health protection and health improvement in England. The strategy is being developed in collaboration with key stakeholders – including local government, public health practitioners and the university, voluntary and commercial sectors – to provide the intelligence that local authorities and the local NHS need.

2.24 PHE can also work with funding partners to identify and, where feasible, take forward individual research priorities but otherwise the Department of Health and its agency the National Institute for Health Research retain the resources and responsibility for commissioning health research, including public health.

2.25 Organisations working to address public health in England operate in a complex system. We believe that public health researchers, practitioners and policy makers need a closer working relationship than they have at present. However, we do not expect

PHE to routinely seek government approval for its research proposals, and there are no circumstances in which PHE would be expected to make a public statement that did not accurately reflect its views. PHE will follow standard research governance and publish peer-reviewed findings. It is also sensible for PHE to discuss and share information about its research activity more widely, if only to avoid duplication of effort and to ensure that it is exposed to the full range of opinion on any given subject. We do, though, reserve the right to make suggestions or commission particular projects from PHE.

**Duncan Selbie told the Committee that PHE had given an unambiguous view on minimum unit pricing of alcohol, but the Committee does not believe that PHE has yet struck the right tone in its public comments. Given the toll alcohol misuse takes on the nation's health, if PHE believes that MUP is necessary, and the evidence base supports it, then PHE must be unequivocal in expressing such a view.**

**If PHE believes that the Government's policy approach to alcohol pricing will not produce the best public health outcome the Committee believes it is under an obligation to set out its view in public and draw attention to the relevant evidence. In short, the Committee believes that Public Heath England was created by Parliament to provide a fearless and independent national voice for public health in England. It does not believe that this voice has yet been sufficiently clearly heard.**

2.26 PHE has achieved a great deal since last April, but we accept that in its first months of operation it had priorities higher than developing a national voice – including a safe transition for the health protection system and supporting local authorities in taking on their new public health responsibilities. Nevertheless it does have a voice, and one which we expect to grow stronger along with its credibility and authority as an organisation. When it has assessed the evidence on subjects such as minimum unit pricing PHE is free to express its conclusions clearly and unequivocally, both publicly and directly to Ministers. However, it is important to remember that PHE was established to advise and act as a leading agency within the public health system, not as a commentator on public health policy.

**PHE has said in relation to the Health Check programme that it will undertake research to "generate the evidence we need to look at the impact and effectiveness of the programme". The Committee believes that this process is essential and that analysis of the clinical and economic benefits of health checks should be fundamental to this. As part of this process, PHE should consider the opportunity cost of investing in Health Checks instead of other proven public health initiatives.**

2.27 The NHS Health Check programme offers an outstanding opportunity to reduce the growing burden of non-communicable disease related to behavioural and physiological risk factors. It is the only comprehensive programme of its type in the world but it is critical that PHE continues to evaluate the programme's impact and cost effectiveness, and we are confident that it will do so.

2.28 In July 2013 PHE published *NHS Health Check: our approach to the evidence* which outlined its intentions for strengthening the scientific rigour of the programme. Through a new national governance structure, including an expert scientific and clinical advisory panel, PHE will ensure that the evidence for the programme is kept under review so that it can make recommendations to government on its future evolution. This panel is now

developing a research and evaluation strategy so that PHE can be confident that the Health Check programme is thoroughly evaluated and has the most comprehensive evidence base available.

**The Committee is concerned by the reports in written evidence of a capacity problem in the public health workforce. It is also concerned that some Directors of Public Health do not enjoy a direct relationship with the Chief Executive and Cabinet members of their local authority. The Committee does not believe that it is possible for Directors of Public Health to drive public health reform if they are subordinate to other officials within local bureaucracies.**

2.29 PHE is monitoring the vacancy rate for DsPH and with the Department has commissioned the Centre for Workforce Intelligence to conduct a survey of all practising public health specialists to ascertain their career intentions and aspirations over the next five years. The survey was conducted in November 2013 and published in May 2014[5].

2.30 The age profile of the specialist public health workforce and the changes to the public health system indicates a risk that a number of senior public health specialists could be retiring or leaving public health practice. The Department and PHE are co-operating to mitigate this risk and have created a suite of leadership initiatives to support the development of the next generation of DsPH and other public health leaders. In 2014-15 we will offer support to public health professionals at all levels post-qualification as they enhance their effectiveness both within local government and across their local communities.

2.31 A key element of our approach is the Aspirant Director of Public Health Programme, designed in conjunction with local government. Both elected members and local government officers lead sessions on the programme. Its aim is to build a credible and talented pool of aspiring DsPH with the necessary knowledge, capability, experience and leadership skills to take on the role. The programme was launched in autumn 2012 and has run twice so far. Of the 38 participants in the first cohort 13 have already secured a permanent or acting DPH position. A second cohort of 27 completed the programme in March 2014 and two participants have already secured DPH roles. Plans are in place for a third cohort in 2014-15.

2.32 Other initiatives include:

- Skills for System Leadership, a DH-funded programme which has been piloted since the end of March 2014. The programme will support public health leaders from across a local system or community in improving public health outcomes for the population they serve. The programme has three components – working effectively with elected members and local government officers, creating a compelling public narrative, and leading across local communities. It was co-designed by PHE, the Association of Directors of Public Health (ADPH) and local government, and will be delivered by the local government Leadership Centre. The first wave is targeted at DsPH and a second wave later in 2014 will focus on all public health professionals within a specific geographical area;
- the Leadership for Change programme, launched in February 2014. PHE has been instrumental in developing and helping to create this joint initiative which brings together leaders within

5 http://www.cfwi.org.uk/publications/the-cfwi-public-health-consultant-and-specialist-staff-survey-2013

a 'patch' from public health, children's services, adult social care and the NHS. It enables them to learn and lead together, strengthening the officer team within health and wellbeing boards; and

- a Talent Management initiative for the public health system which is being developed and funded by PHE. This involves leaders from across the public health system, including ADPH, the LGA, and PHE. In the first instance the initiative is focusing on a cadre of individuals at the mid-point of their career, with the potential to take on leadership roles that influence the health and well-being of the population.

2.33 DsPH are supported by public health teams with a wide range of experience and capability including specialist commissioning, knowledge and intelligence and healthcare public health. This means that many public health functions are delivered by experienced practitioners who are not DsPH: environmental health officers, health promotion specialists, school nurses, infection control nurses and many others, and the national public health speciality training programme remains popular. For 2014 Health Education England are expanding the number of training posts by 12, and there were 686 applications for 2013's intake of 78 places. The Faculty of Public Health is reviewing the curriculum to make sure that public health specialists are equipped with the right skills to operate effectively in the new system.

2.34 Our position on lines of management accountability for DsPH is set out in statutory guidance – i.e. guidance that local authorities must have regard to.[6] This states:

> *To… deliver real improvements in the public's health the DPH needs both an overview of the authority's activity and the necessary degree of influence over it…*
>
> *This may or may not mean that the DPH is a standing member of their local authority's most senior corporate management team. That should be determined locally, not least because the scope of the DPH role can also vary locally…*
>
> *However, it does mean that there should be direct accountability between the DPH and the local authority chief executive (or other head of paid service) for the exercise of the local authority's public health responsibilities, and direct access to elected members.*

2.35 PHE has worked closely with local authorities and their DsPH as they have developed their own reporting and governance arrangements. The results of the most recent survey of its members by the ADPH[7] showed that most believe they have influence and impact across the local authority: 90 per cent say they have appropriate access to elected members and 67 per cent that they have appropriate influence across all directorates. We will work with the LGA, PHE and the ADPH to improve those numbers.

6 Directors of Public Health in Local Government: Roles, Responsibilities and Context Department of Health, updated October 2013

7 English Transition 2013 '6 months on' Survey ADPH, January 2014 (survey undertaken in October 2013)

2.36 The Aspirant Director of Public Health Programme specifically addresses the influencing and leadership skills that DsPH need to lead local health services in the new corporate and political environment of local government.

**Public health is now an important function of local government, but PHE has an explicit duty of oversight over the public health function at both national and local level. The Committee therefore recommends that PHE should announce on its own authority that it intends to make a formal report to Parliament if it believes that the public health function in a particular local authority area is unable adequately to discharge its responsibilities.**

2.37 Generally speaking local authorities are not accountable for their public health function to PHE, the Secretary of State or Parliament. They are each answerable to their own electorate, and we see this element of democratic accountability as a significant strength of the new system.

2.38 PHE's main role is to make expert support and advice available to local authorities and their DsPH, to monitor local authorities' use of their ring-fenced funding and to provide the transparency we need for local accountability by publishing comparative data. This includes regular updates on all the indicators in the Public Health Outcomes Framework for every local authority with public health duties. PHE already works in close partnership with local government. The Ipsos MORI stakeholder survey found that 83 per cent of DsPH are in contact with PHE each week and 75 per cent of local authority chief executives and DsPH say they have a 'good' or 'very good' working relationship with PHE.

2.39 PHE is ideally placed to help local authorities to shape their public health priorities to address local needs and reap the full range of the economic and social benefits of better public health. For example, working with the Association of Directors of Public Health, PHE has recently reviewed drugs and alcohol services across England. One of the themes emerging from that review was the value that local authorities placed on PHE's advice in seeking to strengthen services and improve outcomes.

2.40 If any local authority has serious difficulties the most effective interventions are likely come from within the local government sector itself, drawing as necessary on the expertise of PHE. For example, the Department is funding the LGA to provide a sector-led improvement programme offering advice, training and 'peer challenge' – bespoke teams of peers from a range of organisations working on site with a council and its partners for four days.

2.41 The Department will continue to fund sector-led improvement programmes, working with the LGA, PHE and other stakeholders to make sure that all local authorities have access to high quality support. PHE will publish its own annual reports and the Secretary of State will continue to report annually to Parliament on the performance of the comprehensive health service, which includes local government public health services.

# Annex: Public Health England's Remit in 2014-15

This letter sets out the role that the Government expects Public Health England (PHE) to play in the health and care system. It also sets out Ministers' expectations of PHE in the period from April 2014 to March 2015.

**PHE's role**

PHE is the expert national public health agency which fulfils the Secretary of State for Health's statutory duty to protect health and address health inequalities, and executes the Secretary of State's power to promote the health and wellbeing of the nation. The range of activities for which PHE is responsible is set out below.

PHE's first function is to fulfil the Secretary of State's duty to **protect the public's health** from infectious diseases and other public health hazards, working with the NHS, local government and other key partners in England but also working with the Devolved Administrations and internationally where appropriate. This will mean providing the national infrastructure for health protection, including:

- an integrated surveillance system capable of detecting changes in patterns of disease or its determinants;
- providing specialist outbreak investigation of communicable disease, chemical, radiation and other environmental hazards, and co-ordinating the management of outbreaks of infectious diseases and environmental hazards;
- ensuring effective emergency preparedness, resilience and response for health emergencies;
- providing specialist, diagnostic and reference microbiology services;
- developing the application of genomics technologies to support the control of disease;
- evaluating the effectiveness of immunisation programmes, procuring and supplying vaccines, and providing expert advice and guidance to commissioners and providers; and
- lead for the UK on the International Health Regulations including protecting the UK from international health hazards, most notably communicable diseases.

PHE's next function is to secure **improvements to the public's health**, through its own actions and by supporting government, local authorities and the NHS to secure the greatest gains in health through evidence-based interventions. This will mean:

- supporting individuals to change their behaviour through social marketing campaigns promoting healthy lifestyles;
- providing government, local government, the NHS, Parliament and MPs, industry, public health professionals and the public with evidence-based, professional, scientific and delivery expertise and advice;

- supporting local government and, through them, clinical commissioning groups, in their legal duty to improve the public's health; and
- supporting the system to reduce health inequalities.

PHE's role is not limited to supporting the delivery of the public health system. The Government expects PHE to play a key role in **improving population health through sustainable health and care services** through, for example:

- promoting the evidence of the return on investment for the health and care system of public health interventions;
- providing an analysis of future demand in order to help shape the services of the future;
- providing advice to NHS England on securing health care services that will achieve the greatest impact for the population's health. This will include presenting the evidence for effective preventative interventions and early diagnosis;
- supporting NHS England to develop its strategies and models of care through its expertise in health economics and health care public health;
- national co-ordination and quality assurance of screening programmes in order to reduce the burden of disease and disabilities; and
- running national data collections for disease registration and analysing available data to help quality assure services for a range of conditions, including cancer and rare diseases.

PHE should also ensure the public health system maintains the **capability and capacity** to tackle today's public health challenges and is prepared for the emerging challenges of the future. This will mean:

- undertaking and contributing to research and development in areas relevant to its functions;
- supporting and developing a skilled public health workforce capable of meeting the challenges to the public's health;
- supporting local government to improve the performance of its functions; and
- enabling the system to be held to account for its performance, for example by publishing public health outcomes data and exposing variation in performance.

### How PHE should perform its role

As an Executive Agency of the Department of Health but with operational autonomy, PHE is ideally placed to provide the public health system at the national level with strong leadership, make evidence-based contributions to the policy debate, and support those responsible for delivery with the evidence and the tools to make a real difference to the health of their communities. The Government expects PHE to be an authoritative voice speaking for the public's health and acknowledges that this can include constructive mutual challenge between PHE and central government, with PHE providing advice on the public health evidence-base, supporting local government in identifying its priorities for improving the health and well-being of local populations, or – as NHS England's public health advisor – ensuring that the NHS secures the maximum health gain from its resources. The Government is clear that fulfilling this role will involve adopting a culture of strong and constructive mutual challenge.

In carrying out its role, PHE should:

- make a regular assessment of the state of the public's health, identifying the scale and nature of present and future health need in England;
- speak to what the evidence shows to be the most effective interventions for meeting that need;
- make recommendations to central government, local government, the NHS and others on the basis of the evidence and its professional and scientific judgement. Its advice should be focused on areas where PHE can make a unique contribution and add most value. This can include recommendations based on an assessment of the impact of improving health on the economy and society;
- provide accessible advice, information and support products to the public to help them make the best choices for their health and wellbeing;
- assess the effectiveness of the implementation of interventions by government, local government and the NHS;
- take a life course approach to its work programmes, such as support work to give children and young people the healthiest possible start and building their resilience as they grow older;
- play its part in promoting parity of esteem between physical and mental health;
- shape the debate on the leading-edge science and underlying determinants of health; and
- mobilise support for tackling the major challenges to the public's health.

**The Government's priorities for 2014/15**

Ultimately, PHE is expected to realise genuine improvements in healthy life expectancy and reductions in health inequalities.

As part of this, the Government will set out a number of priorities for PHE each year, each of which will contribute to the Department of Health's own priorities for the health and care system.

To galvanise and focus its efforts, PHE is also expected to set a small number of strategic priorities aimed at delivering the Government's ambition for the public's health. In setting these priorities, the Government expects PHE to use its professional expertise and judgement alongside its understanding of the evidence in order to focus its efforts where it can have the greatest impact on the public's health.

For 2014/15, the Government has set a number of priority actions for PHE to deliver, or support the delivery of across the public health system, for each of its four functions. These are:

| | Priority | Deliverable |
|---|---|---|
| *Protecting the public's health* | Application of cutting edge science | • Publish the first report of the English Surveillance Programme for Antimicrobial Utilisation and Resistance by October 2014.<br>• Develop plans with Genomics England to offer sequencing for patients with severe sepsis, and work with NHS England and Genomics England to use improved disease registry data to support main phase sequencing by March 2015 |
| | Extend and improve the world-class immunisation programmes | • Support the cost effective procurement of the Meningococcal B vaccine<br>• Extend childhood flu vaccination programme to all children aged 2-4<br>• Pilot delivery of flu vaccinations to primary school aged children and to children in secondary school years 7 and 8<br>• Aim to achieve 75% uptake for flu vaccine for 65's and over<br>• Reduce the range of variation in local levels of performance, while improving or at least maintaining the national levels of performance for national immunisation programmes |
| | Effective response to a pandemic | • Make a full contribution to the cross-government exercise on pandemic flu preparedness |

| | Priority | Deliverable |
|---|---|---|
| *Improving the public's health and wellbeing* | Preventing people dying prematurely by improving mortality rates | • Meet the deliverables set out for PHE in the *Living Well for Longer* delivery plan on smoking, blood pressure, screening, earlier diagnosis of symptomatic disease, NHS Health Check, alcohol, obesity and physical activity<br>• Deliver a marketing campaign on smoking in cars with children in advance of the smoke free legislation<br>• Expand the Longer Lives webtool to include performance of drug and alcohol treatment recovery at Local Authority and Clinical Commissioning Group level by December 2014 |
| | Supporting people with dementia to live well | • Recruit 1 million dementia friends by March 2015 |
| | Improving outcomes for people with long-term conditions | • Expand the Longer Lives webtool to include care indicators for diabetes by August 2014 and cancer by October 2014 |
| | Giving our children and young people a healthy start | • Support progress towards achieving a downward trend in the level of excess weight in children by 2020<br>• Increase the number of eligible families receiving services from Family Nurse Partnerships to 16,000 by March 2015<br>• Work with Local Authorities and NHS England to ensure readiness for the transfer of commissioning responsibilities for 0-5 child health services, in particular supporting: the assurance process and guidance on information requirements. |

| | Priority | Deliverable |
|---|---|---|
| *Improving population health through sustainable health and care services* | Reducing pressures on the system | • Support a reduction in avoidable emergency admissions over the winter through enabling local authorities to minimise winter pressures<br>• Provide advice to NHS England on the public health contribution to ensuring the long-term sustainability of the health and care system |
| | Introduce new screening programmes and maintain performance of existing programmes | • Achieve at least 60% of centres providing bowel scope screening by March 2015<br>• Pilot and evaluate the addition of pulse oximetry to the newborn screening programme<br>• Pilot 40,000 kits of the Faecal Immunochemical Test for faecal occult blood bowel cancer screening and publish results by March 2015<br>• Extend newborn blood spot screening to test for four additional disorders by April 2015<br>• Make significant progress towards reaching a chlamydia detection rate of 2,300 per 100,000 by March 2015<br>• Improve quality and coverage, and reduce inequality in uptake, of routine cancer and non-cancer screening programmes |
| *Building the capacity and capability of the public health system* | Developing the public health workforce | • Develop a skills passport for the public health workforce |

In addition to this, PHE has an important role in developing and publishing the evidence base for public health. The Government has formally commissioned PHE:

- to review the evidence and provide advice on the public health impacts of alcohol and possible evidence-based solutions;
- to review the emerging evidence on e-cigarettes to ensure that local action on smoking cessation and tobacco control is informed by best evidence and provide evidence-based recommendations to inform the Government's future thinking, complementing the work of NICE and the MHRA;
- following publication of the draft Scientific Advisory Committee on Nutrition report on carbohydrates, provide draft recommendations to inform the Government's future thinking on sugar in the diet; and
- to review the impact of obesity as a cofactor (with alcohol and Hepatitis C) in other chronic liver disease and provide advice on evidence-based interventions and practice.

The Government has asked PHE to report back in spring 2015.

### PHE as an effective organisation

PHE was established from over 100 different bodies and completed the transition very effectively. For PHE to ensure it remains capable of meeting the challenges to the public's health, it will be critical in 2014/15 to complete the organisational design of the agency so that it is fully aligned with the organisation's core purpose of effectively and efficiently leading the public health system at the national level. It will also need to continue to establish and build authority and credibility, working collaboratively with others in the health and care system and other partners, building on its early successes. The Department will assess the strength of PHE's relationship with its key partners on a regular basis.

### Reporting on success

The Government looks to PHE to make real progress in improving outcomes for the most serious public health problems that we face, and will hold it to account for doing so. In recognition of the fact that securing the improvements in healthy life expectancy and health inequalities will take time, the Government expects progress to be kept on track against the key commitments outlined in this letter, and against the indicators of the Public Health Outcomes Framework.

PHE is accountable to the Secretary of State for Health and the Parliamentary Under Secretary for Public Health for delivering or supporting delivery of these key commitments. Regular contact and quarterly and annual accountability meetings will allow progress to be monitored and address any risks to delivery.

PHE will be expected to continue to report transparently on health outcomes and on progress across the Public Health Outcomes Framework.

I, as lead Minister for public health, will continue to meet senior leaders of PHE regularly to discuss progress.

**JANE ELLISON**

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