Duncan Selbie

If it isn't already, the name **Duncan Selbie** is set to become very familiar to those of us working in the drug and alcohol sector. The Chief Executive of Public Health England spoke to **Harry Shapiro** about his plans.

The NTA is being abolished and its 'key functions' transferred to Public Health England. Could you summarise what the functions of PHE will be in regards to drug and alcohol services?

The NTA has had its critics, but as a body it was tasked with championing drug treatment both nationally and locally. PHE will be a substantially larger organisation, with substance misuse just one of a number of responsibilities. How do you respond to concerns that PHE will not provide the same leadership for, and give sufficient priority to, drug and alcohol treatment? Will PHE be a national champion for treatment and recovery?

How will PHE's responsibilities for drug and alcohol treatment be reflected in its senior management and decision making structure? Will there, for example, be a clear 'champion' within PHE for drug and alcohol treatment?

First, I'd like to say that it is with great delight and ambition that I take on the role of chief executive of Public Health England. I've learnt from previous responsibilities in the NHS and the Department of Health that the important all too easily gets swamped by the urgent. And nothing could be more important than protecting and improving the nation's health and wellbeing.

In terms of drugs and alcohol, the Government is clear in its ambition for everyone with a problem to have access to treatment and every opportunity to recover. To translate this into action on the ground, local authorities will want to develop an understanding of their population's needs so they can shape responses which take account of local circumstances. Our role in Public Health England is to be the link between that local and national aspiration, and championing this.

Public Health England will have dedicated drug and alcohol expertise at every level to offer practical know-how and advice to local government and the NHS.

Current investment in drug and alcohol services represents up to half of local public health service ring-fenced budgets. Given, for example, local authority spending cuts, the number of responsibilities for Health and Wellbeing Boards and the ending of the pooled treatment budget, what safeguards (if any) will be in place to prevent reductions in spending for drug and alcohol treatment?

It is important to emphasise that our commitment to local action led by local government is absolute, and our objective in Public Health England is to support this in every way we can.

There will of course be competing demands for resources in public health, as in all aspects of the public service. The Department of Health has already announced its intention to build drug treatment need into the formula that will determine local allocations. This will be based on the current pooled treatment budget methodology. The practical effect of this will be to give local areas an incentive to continue to provide high quality drug services that leads to successful completion of treatment and reduced relapse.

Directors of Public Health in local authorities will be taking over responsibility for commissioning clinical drug and alcohol services from the NHS. Will the NHS Constitution be binding on public health commissioners and services – and, generally, what levers will you (i.e. PHE) have to ensure that clinical (and other) standards are maintained?

It is vital that high standards of evidence and clinical governance continue to apply.

The Health and Social Care Act 2012 made it clear that local government must have regard to the NHS Constitution when carrying out their public health functions. A full public consultation on potential changes to the NHS Constitution will be launched later this year.

Will PHE have a role in supporting and improving the commissioning of treatment and recovery services? If so, how will it seek to do this?

What information will PHE require local authorities and service providers to provide in terms of data recording and monitoring of service provision and treatment outcomes? Will, for example, NDTMS continue?

Good quality data has helped drive improvement and continues to be vital.

Public Health England will support commissioners by providing expertise, bespoke support, benchmarking performance and through sharing best practice. I have spent my first weeks in post meeting people across the country to build our understanding of how Public Health England will best do this.

Local authorities will be able to access similar, high quality information and intelligence about drugs and alcohol as now, including NDTMS, but this may be enhanced through greater integration with other public health functions, for example understanding the drug and alcohol issues in a wider context of the social determinants of health. This will be made possible through closer working with other public health knowledge and intelligence expertise, such as those currently in public health observatories and the cancer registries.

While DrugScope members welcome the potential opportunity for more investment in addressing alcohol misuse and dependency, there are concerns that investment may be directed to more locally high profile – and popularist or media driven – issues such as binge drinking at weekends. What will PHEs position be on this?

Action on alcohol and drugs is not limited to addressing problems of dependence. Local authorities have a responsibility to address the wide range of issues resulting from alcohol and drug misuse. It will be Public Health England's role to support them in this.

What role, if any, will PHE play to ensure that drug and alcohol treatment is provided by services and staff with the necessary competences, skills and knowledge?

Public Health England will have a workforce development role and will continue to support the Substance Misuse Skills Consortium. However, this will not replace the central role of providers and the professions, who will continue to have lead responsibility for ensuring their people have the necessary competences, skills and knowledge.

The drug strategy recognises that recovery requires access to a range of services and support, including accommodation, training and employment. How will PHE work with other national bodies and government departments to ensure that this ambition for supporting recovery is achieved?

Everything important that will happen in public health will happen locally. Locating public health responsibilities with local government offers the exciting opportunity of integrating treatment with the local factors that sustain recovery – access to jobs, stable homes, education opportunities and children's services.

The NHS drug services in Manchester have recently lost out to the third sector competitors. This is not the only example and is causing concern that NHS clinical expertise is being priced out of the market to the ultimate detriment of service users. How do you respond to such concerns?

Across England over the past decade, the growing involvement of the voluntary sector has been a vital catalyst to securing improvements.

There are 149 local drug treatment systems configured according to local need, circumstances and evolution. Public Health England will work with local government and providers to ensure that treatment systems continue to be resourced, supported and led to achieve the best possible outcomes for service users.

If treatment systems are to deliver the best health improvements for their populations, they need to be built on evidence of what works. This is unlikely to be achieved if either price or incumbency is seen as having primacy.