



House of Commons
Committee of Public Accounts

Public Health England's grant to local authorities

Forty-third Report of Session 2014–15

*Report, together with formal minutes relating
to the report*

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Committee of Public Accounts

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Summary

Since it was created in 2013, Public Health England (PHE) has made a good start in its efforts to protect and improve public health. Good public health is vital to tackling health inequalities and reducing burdens on the NHS. We were impressed by the passion shown by PHE's Chief Executive, and his determination to challenge Government to consider public health in wider policymaking.

However, we are concerned that the Department of Health (the Department) is not getting local authorities to their target funding allocations for public health quickly enough, with nearly one third of 152 local authorities currently receiving funding that is more than 20% above or below what would be their fair share. The Agency decided not to change the grant distribution for 2015/16. Local authorities are also presently constrained by being tied into contracts to which the Department had previously committed, such as for sexual health interventions. It is not clear whether the public health grant to local authorities will remain ring-fenced, and they need more certainty to better plan their public health programmes. If the ring-fence is removed, there is a risk that spending on public health will decline as councils come under increasing financial pressures. There are still unacceptable health inequalities across the country, for example healthy life expectancy for men ranges from 52.5 years to 70 years depending on where they live. These inequalities make PHE's support at a local level particularly important but we are concerned that PHE does not have strong enough ways of influencing local authorities to ensure progress against all of its top public health priorities. Finally, given how important it is to tackle the many wider causes of poor public health, PHE needs to influence departments more effectively and translate its own passion into action across Whitehall.

Introduction

The Health and Social Care Act 2012 made fundamental changes to the system for funding and delivering public health. Responsibility for commissioning local public health services returned to local authorities from the NHS. Local authorities now have a statutory duty to improve the health of their populations. The Department of Health (the Department) also created Public Health England (PHE), a new national executive agency. PHE is intended to have an authoritative and expert voice on protecting and improving the nation's health. It provides local authorities, the Department and the NHS with advice and evidence on what works on public health interventions. It also directly provides a range of central services, such as social marketing campaigns and health protection. PHE is accountable for securing improved public health outcomes. In 2013–14 PHE gave local authorities £2.7 billion via a ring-fenced grant to carry out their new public health responsibilities. The public health activities expected from the grant include encouraging healthier lifestyles and reducing the very large health inequalities across England, especially in life expectancy.

Conclusions and recommendations

1. **Many local authorities do not yet receive a proportion of public health funding that fairly reflects their needs.** In 2013–14, a third of local authorities (51 out of 152) received more than 20% above or below their target funding allocation—the amount that would be their fair share taking account of relative needs. The Department has moved local authorities closer to their target allocations and, in 2014–15, has reduced the number to 41 out of 152, 13 of which remain more than 20% below their target funding proportions. However, the Department has decided not to change the distribution of monies in 2015/16, with the total amount remaining the same, meaning inequalities in funding will persist. Authorities are also locked into contractual commitments, for example on sexual health, which limits their ability to respond to local priorities. The Department has not announced longer term plans for making public health funding allocations more equitable although it has asked the Advisory Committee on Resource Allocation to review the public health funding formula.

Recommendation: *The Department should set out clear plans for how quickly it will move local authorities to their target funding allocations for public health.*

2. **The Department has not yet decided whether the public health grant to local authorities will remain ring-fenced after 2015–16.** The ring-fencing of grants to local authorities is unusual. There is a risk that spending on public health will decline if the ring fence is lifted and councils come under ever greater financial pressure. However, the Department has not yet decided whether the grant will remain ring-fenced after 2015–16 and said that this would be a decision for the new Government. The Department told us that the decision would be informed by further evidence of

what has worked in terms of outcomes, and that at the moment “the jury is out” on whether to retain the ring-fence.

Recommendation: *The Department should do all it can to provide more certainty to local authorities, by prioritising a quick decision on whether the ring-fence will remain. If the ring fence is lifted it needs to implement other levers to protect investment in public health.*

3. **PHE does not yet have a prioritised approach to influencing wider government policies.** Many local and national government actions contribute to improving public health, for example having good housing, good education and a job are fundamental to living a long life in good health. The NHS and PHE have made good progress in placing a stronger emphasis on promoting good health and preventing poor health through their ‘Five Year Forward View’ which sets out the vision for the future health service. We were also very impressed by the passion and commitment shown by PHE’s Chief Executive, and his challenge for government to take account of public health when making wider policy. PHE needs to engage Whitehall if it is to make maximum progress on its priorities. PHE has yet to be clear about its priorities for influencing Whitehall and we have yet to see whether it can achieve the impact needed. PHE has set out the evidence on some key public health issues, such as standardised cigarette packaging, but the government has yet to use all the evidence to affect its policy decisions.

Recommendation: *PHE should set out a prioritised strategy for influencing Whitehall, and the measures to review its success.*

4. **PHE does not target its support sufficiently well to those local authorities that most need it.** There are unacceptable health inequalities across England, with healthy life expectancy for men ranging from 52.5 to 70 years in different areas. There are real benefits of local authorities deciding their own local public health priorities so that they can focus on specific local needs. It is right that this will lead to variation in how local authorities choose to spend their grant, but we heard that some local authorities are not targeting their spending on areas of greatest need or where outcomes are worsening. PHE has developed tools to assist local authorities in selecting their priorities. PHE has not yet used these tools to identify those local authorities that would benefit most from PHE’s advice and support in prioritising and tackling areas of greatest need.

Recommendation: *PHE should target its advice and support on those areas which would benefit most from such support. It should encourage local authorities to use the tools it has developed to improve public health outcomes.*

5. **PHE works through influence and cannot direct local authorities to act. PHE is accountable for securing improved public health outcomes.** In October 2014 it published five health improvement priorities. Its success will be largely dependent on the work of local authorities, but its direct levers to affect local authority behaviour

are not strong enough. The Department has set out some prescribed functions which local authorities must provide. The Department can attach conditions to the PHE grant given to local authorities. However, several of PHE's public health priorities such as tackling obesity and reducing smoking are not included in either the prescribed functions or the grant conditions. From 2015–16 there will be a new premium awarded to local authorities based on performance, which is designed to incentivise further improvement; but again it does not cover PHE's priorities and, at £5 million in total, to be shared across the whole country, it is too small to make a real difference. PHE also has a 'Public Health Outcomes Framework' which covers a wide range of outcomes. The purpose is to increase transparency and accountability by bringing together disparate datasets and highlighting inequalities between local authorities. But although the majority of directors of public health are using the framework, there are still no data for some measures and data for others take a long time to collect.

Recommendation: *The Department and PHE should identify how they will improve PHE's influence with local authorities, focusing on how to make progress on PHE's five health improvement priorities.*

6. **PHE does not provide local authorities with sufficient evidence or support to drive better decision making at the local level.** Given the current financial constraints on local authorities it is important for them to make decisions based on good evidence about what works best. They want the evidence to know which interventions are most effective, for example in encouraging people to stop smoking or in reducing alcohol abuse. Local authorities have good access to national tools and reports with locally selectable data, for example the Longer Lives tool. But local authorities would value more assistance on economic appraisal and return on investment tools, to understand the relative impacts of different interventions and what works best.

Recommendation: *PHE should continue to improve its support to local authorities, including helping local authority staff to understand the evidence base for what works best, and addressing the recommendations detailed in the NAO report.*

7. **The profile and impact of public health work in local authorities is undermined by high staff vacancy rates, particularly for directors of public health.** PHE's remit includes developing and supporting a skilled public health workforce. A strong director of public health in local authorities is vital to promote public health locally. However, about 20% of director of public health positions are filled by interim appointments, which weakens their impact and undermines consistency, training and development. PHE has developed a programme for aspiring directors of public health, and had some success in building a pipeline, but further progress is required. One problem with recruitment is unfavourable pay and conditions compared with previous terms for staff moving from the NHS. The Association of Directors of Public Health told us that there were issues with maintaining continuity of service

which needed further work to encourage healthy movement of people between local government, PHE and the NHS.

Recommendation: *The Department and PHE should set out how they are addressing vacancy rates in local authority public health teams, including tackling disincentives in the terms and conditions for public health staff moving from the NHS to local government.*

1 Central government policies and the grant to local authorities

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department), Public Health England (PHE) and the Association of Directors of Public Health about Public Health England's grant to local authorities.¹ Public health is about helping people to enjoy good health and protecting them from threats to their health. Protecting and improving health and wellbeing creates a more economically and socially active population and reduces the burden on the NHS and the economy.²

2. The Health and Social Care Act 2012, implemented from 1 April 2013, made fundamental changes to the system for funding and delivering public health. Responsibility for commissioning local public health services returned to local authorities from the NHS. Local authorities now have a statutory duty to improve the health of their populations. The Department is responsible for public health policy. It created a new expert national executive agency, Public Health England.³

3. PHE is intended to have an authoritative voice on all public health issues. It provides advice and evidence to others on what works best in protecting and improving public health as well as directly providing a range of central services, such as social marketing campaigns and health protection actions. PHE will be held accountable for securing improved public health outcomes and in October 2014 it set out its 7 priorities, 5 of which focus on health improvement. These are obesity, smoking, harmful drinking, best start for children, and dementia. In 2013–14 PHE gave local authorities £2.7 billion (£2.8 billion in 2014–15) via a ring-fenced grant to carry out their new public health responsibilities. Much of this expenditure is constrained in the early years by contractual commitments for services signed by predecessor authorities.⁴

4. Before the transition the Department estimated Primary Care Trusts' (PCTs) public health spending to establish a baseline for the first public health grant. The Department told us that prior to the transition it did not know how much money was spent on public health as there had been no widely accepted definition of what constituted public health spending. The amount formed part of a wider single allocation given to PCTs.⁵ The baseline exercise revealed significant variation in PCT's spending on public health. In the first year, the Department ensured that all local authorities had increases in public health spending. The Department told us that this is because it wanted to ensure that local authorities had sufficient funds to continue the contracted services they inherited from the

1 [C&AG's Report, Public Health England's grant to local authorities, Session 2014-15, HC 888, 17 December 2014](#)

2 [Q 137; C&AG's Report, para 1](#)

3 [Qq 18-20, 131-132; C&AG's Report, para 2](#)

4 [Q 55](#)

5 [Qq 6-8; C&AG's Report, para 2.3](#)

NHS. Overall public health funding increased by 5.5% in 2013–14 and then a further 5.0% in 2014–15.⁶

5. Basing the public health grant on previous spending means many local authorities are not receiving the proportion of public health funding that fairly reflects their needs. The Department uses a formula devised by the Advisory Committee on Resource Allocation (ACRA) to calculate the target funding proportion that each local authority should receive for public health. The formula is based on area population with an adjustment for relative health needs based on factors such as mortality under 75. In 2013–14, 51 of 152 local authorities were more than 20% above or below their target funding allocation. The Department tried to improve fairness by giving those furthest below their target larger funding increases to move them closer to target allocations. This resulted in movement towards target allocations in the first two years and the Department has made some progress for those local authorities which were most under target; in 2014–15, 13 local authorities were more than 20% below target, compared with 20 (out of the 51) in 2013–14. But for 2015–16 the Department has not increased its public health funding, leaving 41 local authorities still more than 20% from their target allocation. Significant movement will be required year on year to get those under target to reach their targets within a reasonable time.⁷

6. The Department told us that it is trying to help local authorities to get their fair share of funding. It told us that it is involved in discussions with PHE about the grant and that it has asked ACRA to review the public health formula. As well as looking at under-75 mortality, it has asked ACRA to consider public health priorities such as sexual health, alcohol and drugs and services for children ages 0–5, shifting the balance more towards younger people.⁸

7. PHE pointed out that the only way to move faster towards target allocations without increasing overall funding would be to take funding away from local authorities that had historically chosen to spend more on public health. But the Department and PHE had decided not to do this as they said total public health spending was only about 3% of health funding so they did not believe that any local authority had more funding than needed. The Department told us that public health funding after 2016–17 will be decided during the next spending review and we voiced concerns about the uncertainty this created for local authorities.⁹

8. Local authorities have some flexibility in how they spend the public health grant, although they are tied to contractual commitments, have to provide 6 prescribed services and spend their money in support of improving public health outcomes. We believe it was not intended that local authorities should spend their ring-fenced money on services they were already funding and providing from other budgets. We therefore asked how much of

6 [Q 55; C&AG's Report, para 2.3](#)

7 [Qq 44, 51-53, 55-59, 70; C&AG's Report, paras 8 & 2.4-2.5](#)

8 [Qq 42-43, 47, 49-50, 66, 70, 77, 99-100](#)

9 [Qq 40, 57, 59, 67-69](#)

the ring-fenced money had been diverted to support services previously funded by local authorities, but neither PHE nor the Department could give us a figure. We commented that, if the ring-fenced funding had all been additional to existing local authority funding it could have been used to build up public health and to strengthen those objectives which PHE believes are key priorities.¹⁰

9. One justification for the Department's decision to ring-fence public health grants was to ensure that existing public health services passed smoothly from the NHS to local authorities. The ring-fence has also enabled local communities to see what local authorities spend on public health.¹¹ Protecting money with a ring-fence can be a good way of ensuring it is spent for the purposes intended but is now fairly unusual for central government to fund local authorities in this way. The Department told us that "the jury is out" over whether or not to continue to ring-fence public health funding to local authorities and that it will be for the new Government to decide. When making the decision the Department said it will look at qualitative evidence and the outcomes indicators from the first two years.¹²

10. PHE has a clear remit to present evidence on public health issues, using its professional judgement and authority even in controversial areas. For example, PHE has set out its positions on standardised packaging for tobacco and on sugar consumption. PHE told us that it is for the government to determine the policies, informed by the compelling evidence PHE provides. The Department has asked PHE to do an evidence-based review on minimum unit pricing for alcohol. The Department said it is keeping an open mind on the Government's policy position until it has seen the evidence.¹³

11. Wider public spending and policy, for example on housing, education, economic development and town planning are all important to people's health and wellbeing. PHE told us that it wants to influence all of the NHS and wider public spending, as the public health grant alone will not achieve enough.¹⁴ The new NHS Five Year Forward View, published in October 2014, sets out a vision for the future health service and has a strong focus on public health.¹⁵ However we were concerned about PHE's influence across Whitehall, especially where a government department may develop a policy that cuts through a public health priority. The Department told us that it works across government on public health, including through a cross-government group that includes relevant departments. PHE accepted that its work across government has not been as well co-ordinated or closely connected with its five priorities for health improvement as it should be, and that there should be a public health voice in major government departments. PHE

10 [Qq 1-6; C&AG's Report, paras 1.6 & 2.7](#)

11 [Qq 2, 126](#)

12 [Qq 124-127](#)

13 [Qq 93-96, 104-109, 122-123](#)

14 [Qq 92, 138](#)

15 [Qq 31, 64; C&AG's Report, para 4.11](#)

plans to address this through attaching regional directors of public health to major government departments.¹⁶

2 Maximising impact through working with local authorities

13. There are significant health inequalities across England, for example, healthy life expectancy for men ranges between 52.5 and 70 years in different areas and the North of England has poorer public health outcomes than the South. There are therefore different concerns and priorities for local authorities in different parts of the country. PHE told us that local authorities are best placed to co-ordinate public health activities in their areas so they can respond to specific local needs, and that they have their own priorities set out in their local strategy documents.¹⁷

14. While local authorities should obviously be free to choose their own priorities, we were concerned that for some issues such as smoking prevention, some local authorities have relatively poorer outcomes and were spending relatively less. Further, there are some local authorities where spending in some areas, such as alcohol misuse, is not targeted to where outcomes are worsening. The Department responded that it is only just starting to understand the impact of local government commissioning public health, as initially most contracts were transferred across from the NHS. PHE accepted that that there should be a relationship between outcomes and local authority spending, and that it should act to help local authorities if these are not well matched. PHE has developed a tool that compares health spending and outcomes but it has not yet used the tool to inform and prioritise its approach to helping local authorities.¹⁸

15. PHE has set out five priorities for public health improvement, which it told us are based on evidence about what is making people ill and miserable and killing them early.¹⁹ The Department and PHE can influence local authorities, by prescribing particular services, imposing specific grant conditions, making incentive payments, and reporting on public health outcomes. PHE told us it believes it has the levers it requires to help get the right outcomes. But we were concerned about whether these mechanisms are effective and whether the agency had real ‘teeth’ to bring about the necessary changes at a local level.²⁰

16. The Department has stipulated that local authorities must provide six prescribed public health functions.²¹ PHE told us that these prescribed functions were chosen by government. The Department and PHE told us that they were chosen to ensure a consistent approach across the country, for example, to measuring children’s weight.²² The Department added that some functions were prescribed because their implementation was critical, for example providing public health advice to clinical commissioning groups or for

17 [Qq 1, 19-20, 39, 89, 102; C&AG’s Report, para 2.8](#)

18 [Qq 11-14; C&AG’s Report, paras 2.11-2.12 and 4.5, 4.9- 4.10](#)

19 [Qq 14, 27](#)

20 [Qq, 1, 28-29, 123; C&AG’s Report, para 3.7](#)

21 [C&AG’s Report, para 1.6 & Figure 3](#)

22 [Qq 33, 134](#)

commissioning NHS Health Checks. The six prescribed functions do not cover most of PHE's priorities for public health such as obesity, smoking, and harmful alcohol.²³

17. The Department can also attach conditions to its grant. It told us that there is now a new grant condition that asks local authorities to demonstrate that they are getting year-on-year improvements in take-up of, and outcomes from, their drug and alcohol misuse treatment services.²⁴ PHE noted that the recovery rates for both alcohol and drugs have improved in 2013–14, although it said that local variation had led to the grant condition.²⁵ We asked whether it would apply more grant conditions if it had concern in another area of public health. The Department responded that there is a grant condition for reducing inequality which is already wide-ranging, but that it could choose to impose grant conditions if there was a particular concern.²⁶

18. From 2015–16 the Department will introduce a new health premium which will be awarded to local authorities showing good progress. The premium is intended to be an additional incentive for local authorities to improve public health outcomes, and awards are assessed through two specific indicators. The first indicator is on completion of drugs treatment, and second is chosen by local authorities from an approved list. But the health premium is small, at only £5 million for the whole country in 2015–16, and it does not cover all of PHE's priorities. The Department said that this was the first year of the scheme and that it is piloting its approach. It told us that the spending review will decide when or by how much the premium will be increased in future years.²⁷

19. Local authorities are also required to think about the Public Health Outcomes Framework when deciding how to spend their grant. The Public Health Outcomes Framework, created by the Department in 2012, brings together many disparate datasets to enable local authorities to assess their needs and monitor their progress by comparing performance between authorities, which increases accountability. The outcomes framework includes a wide range of indicators from social factors such as employment to health protection, health improvement and healthcare. It is still developing, as some measures do not have any data and some others take a long time to collect. The majority (83%) of directors of public health use the framework frequently, but PHE told us it would like even more to use it.²⁸

20. Part of PHE's role as an expert body is to provide support to local authorities in their efforts to seek better local outcomes. PHE has produced national tools and reports for local authorities to use, such as the Longer Lives tool, which provides data on premature mortality for every local authority. Another tool compares public health spending and outcomes, helping local authorities to prioritise their spending. PHE acknowledged that it

23 [Qq 134, 137-138](#)

24 [Qq 29-31](#)

25 [Qq 34-37](#)

26 [Qq 38-39](#)

27 [Qq 97-98; C&AG's Report, paras 3.11-3.12 & Figure 11](#)

28 [Qq 1, 20, 24-25, 27; C&AG's Report, paras 12, 13, 3.8 & 3.9](#)

needs to be more relevant and practical; supporting local authorities at a local level in how to use the tools it has produced. The NAO also found a number of areas where more support for local public health staff would be valuable, and made recommendations to PHE, including: to improve its responsiveness to local authority requests for support; to improve advice to local authorities on their support to clinical commissioning groups; and to help local authority teams understand the evidence base and cost implications of different public health interventions, including sharing best practice.²⁹

21. The Association of Directors of Public Health spoke of good access to information on what works through PHE and the National Institute of Clinical Excellence (NICE). But directors of public health would value more assistance on economic modelling and better advice on return on investment tools to forecast the financial impact of particular interventions. This means they need evidence about which types of intervention are most effective to reduce future costs, for example whether group or individual sessions on smoking cessation are more effective. PHE acknowledged the need to provide evidence on effectiveness, using the example of tobacco. It stated that half of the inequality in life expectancy across the country is accounted for by tobacco but tackling smoking can involve anything from tackling counterfeiting to national smoking cessation campaigns.³⁰

22. PHE's remit includes supporting and developing a skilled public health workforce, but there have been difficulties in recruiting permanent directors of public health to local authorities. The Association of Directors of Public Health told us that since April 2013 the number of vacancies has dropped from about 35 to 26. But there are still vacancies for about 20% of directors of public health posts. Although interim staff are in place, substantive post holders are far more likely to be able to influence the management team in the council.³¹

23. The Association of Directors of Public Health said that the programme for aspiring directors of public health, funded by PHE, has been quite successful in building the pipeline of people for director of public health posts. PHE added that 20 of those who have completed the programme are now in substantive posts. But there is likely to be more turnover in the next few years given the age profile of directors of public health. Problems with recruitment include a lack of parity of pay and conditions for those staff moving from the NHS to local government. The Association of Directors of Public Health told us that further work was needed to tackle issues with continuity of service and terms and conditions for staff moving through their careers from local government into PHE, the NHS and back again.³²

29 [Qq 12, 20, 91; C&AG's Report, paras 20a, 1.8 & 4.5](#)

30 [Qq 14-17, 91, C&AG's Report, para 4.7](#)

31 [Qq 118-120; C&AG's Report, paras 4.19 & 4.21](#)

32 [Q 120, C&AG's report, para 4.21](#)

Formal Minutes

Monday 2 March 2015

Members present:

Mrs Margaret Hodge, in the Chair

Mr Richard Bacon
Mr David Burrowes
Meg Hillier
Stewart Jackson

Dame Anne McGuire
Austin Mitchell
Stephen Phillips

Draft Report (*Public Health England's grant to local authorities*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 23 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Forty-third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 9 March at 3.00 pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at www.parliament.uk/pac

Monday 19 January 2015

Question number

Janet Atherton, President, Association of Directors of Public Health;
Michael Brodie, Finance and Commercial Director, Public Health England;
Dr Felicity Harvey CBE, Director-General, Public and International Health, Department of Health; and **Duncan Selbie**, Chief Executive, Public Health England

[Q1-147](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at www.parliament.uk/pac. PHE numbers are generated by the evidence processing system and so may not be complete.

- 1 British Medical Association ([PHE0001](#))
- 2 Unite ([PHE0002](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/pac.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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