House of Commons
Health Committee

Public Health England

Eighth Report of Session 2013–14

Report, together with formal minutes relating to the report

Ordered by the House of Commons
to be printed 4 February 2014

HC 840
Published on 26 February 2014
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

Rt Hon Stephen Dorrell MP (*Conservative, Charnwood*) (Chair)[1]
Rosie Cooper MP (*Labour, West Lancashire*)
Andrew George MP (*Liberal Democrat, St Ives*)
Barbara Keeley MP (*Labour, Worsley and Eccles South*)
Charlotte Leslie MP (*Conservative, Bristol North West*)
Grahame M. Morris MP (*Labour, Easington*)
Andrew Percy MP (*Conservative, Brigg and Goole*)
Mr Virendra Sharma MP (*Labour, Ealing Southall*)
David Tredinnick MP (*Conservative, Bosworth*)
Valerie Vaz MP (*Labour, Walsall South*)
Dr Sarah Wollaston MP (*Conservative, Totnes*)

Powers

The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/healthcom and by The Stationery Office by Order of the House.

Evidence relating to this report is published on the Committee's website at www.parliament.uk/healthcom.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Martyn Atkins (Second Clerk), Laura Daniels (Committee Specialist), Stephen Aldhouse (Committee Specialist), Daniel Moeller (Senior Committee Assistant), Hannah Beattie (Committee Assistant) and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is healthcom@parliament.uk.

1 Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

Contents

Report

Summary

Transition to Public Health England

Public Health England's (PHE) written evidence stated that the creation of PHE and the transition of staff and functions to the new body had been undertaken successfully. The Department of Health shared this view and said that PHE achieved its objective of "being fully operational, with all functions transferred safely, to ensure no 'dip' in delivery."

During the process of transition PHE operated a number of national public health awareness campaigns, managed the response to local measles outbreaks, and led the national measles vaccination catch-up programme.

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. This evidence 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.

PHE's priorities for 2013–14 identified the importance of implementing a national surveillance strategy to "ensure the public health system responds rapidly to new and unexpected threats." The incorporation of the Health Protection Agency (HPA) into PHE means that PHE "will be responsible for front line health protection via its local centres which will support their local authorities." The Committee recognises that throughout the transition PHE maintained continuity of the vital work undertaken by the HPA.

Prior to being established, concerns were expressed by a number of parties regarding PHE's future ability to manage local public health emergencies. PHE provided evidence that it has worked to clarify responsibilities for emergency preparedness. 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.

Policy priorities

Duncan Selbie, PHE's Chief Executive, told the Committee that in its first six months of operation it had not attached a high priority to contributing to public health policy debates. Mr Selbie noted, however, that PHE exists to be an important voice in improving the nation's health.

In oral evidence PHE's management responded to questions about the potential impact that key public health measures such as minimum unit pricing of alcohol and the introduction of standardised packaging of tobacco products could have. PHE also discussed their report which examined the public health impact of shale gas extraction. During the evidence session the Committee questioned the PHE witnesses about the relative priorities of the work on shale gas extraction and other public health issues, and

expressed surprise at the priority given to the shale gas report.

The Committee is concerned that that from the evidence it heard the PHE Board has not yet established prioritised programmes of work which reflect the objectives of the organisation and have been endorsed by the Board. The Committee believes 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.

Relationship with Government

In their written evidence PHE acknowledged that feedback from their survey of stakeholders has told them that "more needs to be done to demonstrate that the advice and guidance PHE provides is truly independent of Government". The Department of Health also said that:

> it is important that PHE is and is seen as a trusted and impartial champion for the protection of the health of the nation and free to provide advice based firmly on the science and the evidence.

In oral evidence, the Committee asked PHE to outline Government policies which may be damaging to the nation's public health by increasing health inequalities. In response Duncan Selbie said that at this stage of PHE's development it would be too controversial to directly address this question. 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 and believes that PHE should be able to address such matters without constraint.

Concerns were also expressed by external organisations in written evidence that PHE staff do not have freedom to contradict Government policy. The Committee is concerned that there is insufficient separation between PHE and the Department of Health. 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. 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.

NHS Health Check

PHE is responsible for supporting the delivery by local authorities of the NHS Health Check programme to 15 million eligible people by 2018–19. In written evidence concerns were expressed regarding the value of the programme relative to other public health interventions and this was discussed in oral evidence. PHE explained that the programme is targeted around cardiovascular risk and that its components have been accredited by NICE.

PHE has said that it will undertake research to assess the effectiveness of Health Checks and the Committee believes that an 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 in other proven public health initiatives.

Public Health staff

Every unitary and upper tier local authority must appoint a Director of Public Health. The appointment is made jointly with the Secretary of State but in practice it is PHE that fulfils this duty. It is also PHE's responsibility to oversee the development of the professional public health workforce and ensure there is sufficient capacity across England.

The Association of Directors of Public Health reported in written evidence that a capacity problem is beginning to emerge within local authorities. They said there is a reduced capacity within the overall public health workforce because of unfilled posts. The Committee also received evidence expressing concern that despite their statutory position, some Directors of Public Health are expected to report to another local authority Director.

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. The Committee 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.

1 Introduction

Background

1. We report on the Committee's hearing held on 19 November 2013 which examined the work of Public Health England (PHE). The Committee took oral evidence from Duncan Selbie, Chief Executive, Richard Gleave, Chief Operating Officer, Professor Kevin Fenton, Director of Health and Wellbeing, and Dr Paul Cosford, Director for Health Protection and Medical Director.

2. As of 1 April 2013 the organisation and provision of public health services and advice in England underwent substantial reform. Responsibility for the majority of public health provision now sits with local authorities who employ Directors of Public Health (DPH) and have a legal duty to improve the public's health. A number public health services are commissioned on a national basis by NHS England and it is the responsibility of PHE to advise both local government and NHS England on public health policy.

3. Introducing the new public health system the Department of Health said that:

> The new system embodies localism, with new responsibilities and resources for local government, within a broad policy framework set by the Government, to improve the health and wellbeing of their populations. It also gives central government the key responsibility of protecting the health of the population, reflecting the core accountability of government to safeguard its people against all manner of threats.
>
> Public Health England is the new national delivery organisation of the public health system. It is working with partners across the public health system and in wider society to:
>
> 1. deliver support and enable improvements in health and wellbeing [...]
>
> 2. design and maintain systems to protect the population against existing and future threats to health.[2]

4. The Department also outlined PHE's basic advisory function in relation to central government, saying that PHE:

> supports the Secretary of State in considering how the Government can best achieve its strategic objectives across the system, working in partnership with local government and the NHS.[3]

2 Department of Health, *Healthy Lives, Healthy People, Improving outcomes and supporting transparency*, (November 2013), para 1.1–1.2

3 Ibid, para 1.6

PHE's role in the new public health system

5. In written evidence submitted to the Committee, the Department of Health said that PHE was created as an executive agency of the Department in order to be:

> the national expert body providing public health expertise across the range of public health, including health protection, health improvement and healthcare public health (i.e. the population health aspects of clinical services). PHE delivers [the] Secretary of State's duty to protect the health of the population, and also carries out his statutory role in joint appointments of Directors of Public Health to local authorities. It supports local authorities in taking forward their duty to improve the health of their populations, not least through providing the evidence base and advice on best practice. Last but not least, PHE provides expertise on the population aspects of clinical commissioning and is the public health adviser to NHS England.[4]

6. The Department's written evidence also stated the three key objectives which were established for PHE in relation to the "transition to the new arrangements".[5] These were that PHE must be:

- fully operational, with all functions transferred safely, to ensure no "dip" in delivery;
- credible - capable of managing relationships with other parts of the system effectively; and
- positioned to achieve improvements in service and outcomes–with its leadership in place, setting a clear direction with clearly identified projects to develop capability and improve performance.[6]

7. Following its establishment in April 2013, PHE identified five high level priorities for the organisation that constituted its main objectives for 2013–14. They are:

> 1. Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol;
>
> 2. Reducing the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact, including dementia, anxiety, depression and drug dependency;
>
> 3. Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics;

4 Department of Health (PHE 21), para 2

5 Ibid, para 3

6 Ibid

4. Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme;

5. Improving health in the workplace by encouraging employers to support their staff, and those moving into and out of the workforce, to lead healthier lives.[7]

8. **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**.

7 Ibid, para 32

2 Transition to Public Health England

Transition

9. PHE's written evidence stated that the creation of PHE and the transition of staff and functions from feeder organisations were undertaken successfully.[8] The Department of Health shared this view and said that PHE achieved its objective of "being fully operational, with all functions transferred safely, to ensure no 'dip' in delivery".[9] The Department's written evidence said that:

> In the six months since its formal go-live date, PHE has successfully welcomed over 5000 staff and created a well-functioning organisation. PHE's performance in areas such as the MMR catch-up campaign demonstrates encouraging progress.
>
> Inevitably there has been a focus on setting up new systems and relationships and building a new organisation–a process which will take time. DH and PHE are working closely together to ensure that there is a robust but constructive accountability relationship between the centre and PHE.[10]

10. PHE's additional written evidence provided a breakdown of the staff transferred into the organisation. In total PHE incorporated staff from 120 "host organisations"[11] of which 3,686 staff were based in the Health Protection Agency (HPA).[12] In oral evidence Dr Cosford provided the Committee with an illustration of PHE's role in managing threats to public health using the resources inherited from the HPA. The example cited by Dr Cosford outlined the ability of PHE's laboratories to sequence a new virus brought into the country by a patient from the Middle East and to provide an "immediate response to a new, emerging, very serious potential harm".[13]

11. Since April 1 2013 PHE has been tasked with running a number of national public health awareness campaigns. PHE's evidence provided an overview of two key campaigns that they have deployed:

- "Stoptober—this is PHE's national 28 Day Stop Smoking Challenge. There were 1.25 million visits to our website during the campaign period, and nearly 500,000 Stoptober support products were ordered included packs, apps, text and email support; and
- "Change4Life—PHE's flagship obesity prevention social marketing campaign and a key aspect of our work programme now has more

8 Public Health England (PHE 02), para 11–12

9 Department of Health (PHE 21), para 3

10 Ibid, para 36

11 Public Health England (PHE 022), p 15–17

12 Ibid, p 15

13 Q70

> than 200,000 Facebook fans, more than 70,000 local supporters and more than 200 national partners, generating an in-kind contribution that has been independently valued at over £14 million per year."[14]

12. PHE's national programmes also include direct interventions. PHE's evidence stated that they were:

> leading the national and local responses to the recent upsurge in measles cases, co-ordinating with the DH, the NHS and with local government. This has included undertaking a national catch-up programme to vaccinate 10-16 year old children and the management of local cases and outbreaks of measles. Numbers of measles cases have fallen significantly, although further efforts to sustain vaccine coverage are required.[15]

13. In addition PHE is responsible for leading on vaccination programmes against rotavirus, childhood flu, pertussis in pregnancy, and shingles.[16]

14. In written evidence both the Local Government Association (LGA) and London Councils' expressed their satisfaction with the public health transition arrangements. London Councils' evidence said they "welcomed the active engagement of Public Health England [...] some pan London governance structures across health and care".[17] They added that "[s]trong personal relationships have been established and provide a sound foundation to build upon".[18] The LGA's evidence said "PHE clearly understand at the most senior level the role of local government and the importance of local government's role in the new system."

15. **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.**

Emergency preparedness

16. PHE's document outlining its priorities for 2013–14 identifies the importance of implementing a national surveillance strategy to "ensure the public health system responds rapidly to new and unexpected threats".[19] The incorporation of the Health Protection

14 Public Health England (PHE 02), para 19

15 Ibid, para 20

16 Public Health England, *Our priorities for 2013–14*, April 2013, p 9

17 London Councils (PHE 16), para 3

18 Ibid

19 *Our priorities for 2013–14*, p 9

Agency into PHE means that PHE "will be responsible for front line health protection via its local centres which will support their local authorities".[20]

17. In written evidence the UK Faculty of Public Health questioned whether the system for emergency preparedness enjoyed a proper delineation of responsibility between local authorities, PHE's 15 local centres and national bodies. Their evidence said:

> While recognising that statutory regulations give Directors of Public Health [...] responsibility for provision of information and advice, they have no direct role in response to emergencies, while the specific health protection roles and responsibilities of PHE and the local authority Director of Public Health (DPH) remain unclear. This is clearly unsatisfactory, particularly in relation to incidents and outbreaks–and unsafe.
>
> In practice Directors of Public Health find themselves in the frontline of many infection control and chemical incidents. They also commission major services which are likely to be called upon. It is necessary to further clarify who will do what in response to situations and exactly what the Secretary of State's powers to direct local authorities and Public Health England are in practice.[21]

18. In 2012, the Association of Directors of Public Health (ADPH) gave evidence to the Communities and Local Government Committee where they questioned how emergencies would be managed under the new public health system.[22] In their evidence to this inquiry, however, the ADPH emphasised the engagement and inclusiveness of PHE at a national level and said that:

> ADPH has worked closely with PHE to develop both the structures (national and local) and effective working relationships that are vital to the success of the public health system in England. In particular, detailed work was undertaken with the HPA and subsequently PHE to develop solutions to key local health protection issues, including: Infection Prevention & Control; Out of Hours arrangements for health protection; and emergency preparedness and response.[23]

19. In oral evidence, Dr Paul Cosford, Director for Health Protection and Medical Director, Public Health England told the Committee how PHE has addressed concerns regarding its ability to manage emergencies. Dr Cosford said:

> Since 1 April, we have responded as before to 4,500 incidents of various kinds across the country. They have varied up our emergency response scale. We have had three we have taken national control of. So the systems have been up and running and working.

---

20 Communities and Local Government Committee, The role of local authorities in health issues, HC 694–I (2012–13) Ev 166

21 UK Faculty of Public Health (PHE 020), paras 7–8

22 HC 694–I (2012–13), para 111

23 Association of Directors of Public Health (PHE 013), para 6

> There have been some concerns about precisely who is responsible for what at a local level. [...] The principles are that Public Health England leads on the specialist health protection response. It will chair an outbreak control committee, for instance, if there is an outbreak, make sure that the right specialist advice is provided on how to control an outbreak of infectious disease or mobilise our air quality monitoring cells when there is a fire that is spewing noxious chemicals across a community. The NHS is responsible for responding and providing the clinical response. The local authority is responsible for making sure that those plans work properly and are working in effect for the local population.[24]

20. Richard Gleave, PHE's Chief Operating Officer, added that PHE has:

> put together a group that has the Faculty of Public Health, the Local Government Association, the Association of Directors of Public Health, NHS England and us. We are coming together to address the specific issue of what happens with the individual responsibilities in different sorts of incidents, because the range of incidents is enormous. [...] The breadth of knowledge that we need to provide as Public Health England to support the local teams is crucial.[25]

21. Mr Gleave also explained the level of authority PHE enjoys in emergency situations and outlined how the relationship between PHE and local authorities should operate. He said:

> What we provide is clear and unequivocal advice about how an incident should best be managed. We also feel that, because of the Secretary of State's powers that oversee the whole of the system, if we had a substantial concern that an incident was being mismanaged locally we would take a more active role in it. The best solution is that people locally—the key agencies locally—draw upon our expertise and support and manage it properly. That is the purpose of the whole planning and resilience system—to set up those systems and processes so that people know how to respond in those situations. Then we provide the expert support.[26]

22. Mr Gleave further confirmed that PHE has the ability to intervene in managing a local crisis. He told the Committee that the legal power to do this originates from the Secretary of State:

> but we do not need to go to the Secretary of State in order to engage. If that led to a judicial review with the advantage of hindsight, so be it, but we would say that protecting the public's health is of absolutely paramount importance in these situations.[27]

24 Q99 (Dr Cosford)

25 Ibid (Mr Gleave)

26 Q101

27 Q102

23. **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.**

3 Policy priorities

Initial policy work

24. Duncan Selbie, PHE's Chief Executive, told the Committee that in its first six months of operation it had not attached a high priority to contributing to public health policy debates. Mr Selbie said:

> there is some humility coursing through us about not making pronouncements and leading a debate until we are in a position to do so. Our first priority has been to secure safe health protection arrangements, to address the concerns that this Committee raised and that others were concerned about at the point of transition and to get the new public health system under way.[28]

25. Mr Selbie noted, however, that PHE had been established to:

> be a voice—an important voice—in furthering a conversation and a narrative as a country that is about improving health.[29]

26. In oral evidence to the Committee, PHE's management responded to questions from members of the Committee about the potential impact that key public health measures such as minimum unit pricing (MUP) of alcohol[30] and the introduction of standardised packaging of tobacco products.[31]

27. PHE also initiated a discussion at the evidence session on their report which examined the public health impact of shale gas extraction. Mr Selbie told the committee that "the genesis of the report was from 2012" and in written evidence PHE explained that:

> Our predecessor, the Health Protection Agency (HPA), initiated the review in early 2012 in response to requests for advice on the potential health impacts of shale gas extraction from a wide range of stakeholders including Local Authorities, Directors of Public Health, NHS bodies and members of the public. The HPA proposal for a review, and its proposed scope, was endorsed by a range of UK public health bodies and environmental regulators. On 1 April 2013 PHE took on the functions of the HPA. PHE agreed the review should continue, and that PHE would publish the results.[32]

28 Q16

29 Q16

30 Q87–Q89

31 Q85–Q86

32 Public Health England, (PHE 022) para 15

Establishing priorities

28. During the evidence session the Committee questioned the PHE witnesses about the relative priorities of the work on shale gas extraction and other public health issues, and expressed surprise at the priority given to the shale gas report.

29. Dr Cosford said it was "not a reflection of our priorities to say that this was our highest priority, over and above smoking, alcohol, obesity and all the other public health harms".[33] Challenged that this research had been undertaken without the explicit consent of the PHE board, Duncan Selbie told the Committee that the Chairman of PHE had been aware of the work being conducted.[34]

30. **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.**

31. As outlined in paragraph 7, PHE's first objective is:

> Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol[35]

The Committee welcomes this objective 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.

33 Q19

34 Q21

35 Department of Health, (PHE 21) para 32

4 Relationship with Government

Independence from the Department of Health

32. PHE's written evidence outlined its status in government and the degree of independence it claims to enjoy. PHE said that it:

> has been established as an Executive Agency of the Department of Health (DH), it is led by its Chief Executive, supported by an Advisory Board with a Non-Executive Chairman and Non-Executive Members. PHE has operational autonomy, as set out in its framework agreement, and is free to publish and speak out 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.[36]

33. However, the notion that PHE staff members are free to challenge national policy is questioned by the evidence submitted by British Medical Association (BMA). The BMA's evidence argued that PHE's status as a civil service body limits the ability of medical professionals within PHE to speak out on matters of public health and to challenge government policy. The BMA's evidence said:

> BMA members who are employed by PHE report that the requirement to adhere to civil service rules and regulations is having an impact on their ability to do their work. Particular concerns have been raised about [...] the ability to publicly discuss or criticise public health policies.[37]

34. In their written evidence PHE acknowledged that feedback from their formal survey of stakeholders had told them that "more needs to be done to demonstrate that the advice and guidance PHE provides is truly independent of Government".[38] Similarly, the Department of Health's evidence recognised that the operational autonomy of PHE had been questioned. The Department said that:

> it is important that PHE is and is seen as a trusted and impartial champion for the protection of the health of the nation and free to provide advice based firmly on the science and the evidence.[39]

35. Speaking in reference to PHE's report examining the impact of shale gas extraction, Mr Selbie told the Committee that the report was "checked in the normal way, through consultation with other Government Departments, and was published in agreement with the Department of Health".[40] The Department of Health's written evidence said that the

36 Public Health England (PHE 02), para 6

37 British Medical Association (PHE 011), para 4

38 Public Health England (PHE 02), para 23

39 Department of Health (PHE 21), para 28

40 Q21

Department and PHE "are working closely together to ensure that there is a robust but constructive accountability relationship between the centre and PHE".[41]

36. The Department's written evidence reiterated that as "part of DH (Department of Health) but operationally autonomous, PHE has the opportunity to influence but still "speak truth to power".[42] The Department also cited Earl Howe's comments during the third reading of the Health and Social Care Bill in the House of Lords on 19 March 2012. The Earl Howe said:

> It will be good practice for PHE and the department to consult each other about communications on public health matters, but with a view to agreeing the content, not censoring it. PHE data will be subject to the code of practice on official statistics, which severely restricts access to certain material by Ministers or officials before it is published. Within three years of PHE becoming operational we will undertake a review of its governance to ensure that it is entirely appropriate and effective.[43]

37. In oral evidence, the Committee asked Duncan Selbie which Government policies might be damaging to the nation's public health objectives by increasing health inequalities. In response Mr Selbie said that at this stage of the organisation's development it would be too controversial to directly address this question.[44] He added that:

> As an agency, we are not in a position, from the evidence, to say about specific policies. If you ask a general question about whether Government action is helping or not, there are aspects of what the Government will be doing that are not helpful.[45]

38. **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.**

39. **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".**

40. **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**

41 Department of Health (PHE 021) para 37

42 Ibid

43 Ibid, para 28

44 Q106–108

45 Q113

statements and policy positions are not influenced by Government policy or political considerations.

Minimum Unit Pricing policy

41. The Committee believes that the example of policy on the minimum unit pricing of alcohol (MUP) serves as a useful case study for demonstrating the necessity of a genuinely independent voice to promote improved public health in England.

42. On 17 July 2013, Jeremy Browne MP, then Minister of State in the Home Office announced that the Government would not be proceeding with introduction of a minimum unit price for alcohol. In response to this PHE published a statement which said:

> Public Health England shares the disappointment of the public health community that the introduction of a minimum unit price (MUP) for alcohol is not being taken forward at this point, although it recognises that this remains under active consideration.[46]

43. In oral evidence Professor Kevin Fenton, PHE's Director of Health and Wellbeing, told the committee that tackling alcohol misuse "is a top priority for Public Health England"[47] and "anything that can limit the widespread availability of cheap strong alcohol within our communities is a good thing".[48] In response to the Government's announcement of July 2013, PHE said:

> There is strong evidence that MUP would make cheap and higher-strength alcohol less available, with the greatest impact being in younger and in heavier drinkers. [...] PHE will take forward a comprehensive and scientific review of all the available evidence to inform the Government's final decision on implementation of this measure".[49]

44. **Duncan Selbie told the Committee that PHE had given an unambiguous view on minimum unit pricing of alcohol[50], 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.**

45. **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**

---

46 Public Health England, *Public Health England responds to the Government's decision on minimum unit pricing*, 17 July 2013, https://www.gov.uk/government/news/alcohol-strategy-consultation-report-phe-response

47 Q87

48 Ibid

49 Public Health England, 17 July 2013

50 Q3

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.

5 The landscape of public health

The NHS Health Check programme

46. PHE is responsible for supporting the delivery by local authorities of the NHS Health Check programme to 15 million eligible people by 2018–19. The PHE Health Checks action plan notes that from April 2013 local authorities have been mandated to provide the NHS Health Check programme. Funding has been included in the ring fenced public health allocation to local authorities of £5.45 billion over two years. The action plan added:

> PHE will support those LAs (local authorities) taking on challenging programmes. It will work with local authorities to achieve offers to 20% of the target population annually with a vision to realise at least 75% uptake per year. This will support local authorities to achieve offers to 100% of their eligible population over five years.[51]

47. In August 2013 it was reported that Professor Clare Gerada, then Chair of the RCGP Council, had criticised the Health Check programme. Commenting on a study by the Cochrane Collaboration, Professor Gerada said:

> the team's evidence showed population screening would not reduce deaths, and said the programme risked overtreatment and wasting NHS resources that would be better put into other public health projects such as cutting smoking rates. [...]
>
> We run the risk of putting people on unnecessary medication or worrying them unduly. At a time when the NHS is having to slash its budgets and GPs and practice nurses are already at breaking point as a result of rising workloads and dwindling resources, this is not the best use of time or money that should be spent on caring for people who are sick or at high risk of illness.[52]

48. In their evidence the BMA indicated that PHE employees had been restricted in what they could say regarding the Health Check programme. They said that:

> The health check programme is a deeply contentious issue among public health professionals. Many are of the opinion that the programme lacks a robust evidence base and will divert money from proven schemes and may even be harmful; other public health professionals have expressed the opinion that despite the lack of conclusive evidence in support, health checks are a worthwhile experiment, the results of which will need to be carefully

51 Public Health England, *NHS Health Check implementation review and action plan*, July 2013, p 4

52 "Gerada: Scrap health checks programme", Pulse, 20 August 2013, http://www.pulsetoday.co.uk/clinical/therapy-areas/cardiovascular/gerada-scrap-health-checks-programme/20004025.article

> evaluated. A number of our members have reported that they were actively discouraged from expressing their professional opinions publicly.[53]

49. Answering these concerns, Professor Fenton told the Committee that the relevance of the Cochrane Collaboration work to the current Health Check programme is limited. Professor Fenton said:

> The health check programme has come under some controversy, in part because of a systematic review that was done by the Cochrane Collaboration and published last year. It looked at about nine randomised control trials of general health checks that were offered between the late 1960s and the early 1990s—so the most recent study was nearly 20 years ago. [...]
>
> The Cochrane study was unable to demonstrate any impact on mortality. The systematic review also tried to look at the impact on morbidity—what happened with disease outcomes; did it make any difference? Unfortunately, the quality of the studies, because they were so old, did not allow it to look at those intermediate determinants.[54]

He added that the views of those within PHE who were sceptical about Health Checks had been heard[55], but PHE:

> feel that the health check programme as it is currently designed is very different from the health checks that are in the systematic review. We are not doing a general health check—we are doing a health check that is really focused on cardiovascular risk. We are doing a health check whose individual components have been reviewed and approved by NICE.[56]

50. Professor Fenton explained that because the programme is targeted around cardiovascular risk, patients are "screened for high blood pressure, cholesterol, weight, alcohol intake, physical exercise"[57], and as part of this they are made aware of the signs and symptoms of dementia.[58] Professor Fenton confirmed that the programme does not, however, screen patients for dementia.[59]

51. The PHE Health Checks action plan stated that Health Checks could:

- prevent 1,600 heart attacks and save 650 lives;
- prevent 4,000 people from developing diabetes; and

53 British Medical Association (PHE 011), para 5
54 Q44
55 Q49
56 Ibid
57 Q58
58 Q55
59 Q50

- detect at least 20,000 cases of diabetes or kidney disease earlier.[60]

In addition it noted that

> The estimated savings to the NHS budget nationally are around £57 million over four years, rising to £176 million over a fifteen-year period. It is estimated that the programme will pay for itself after 20 years as well as having delivered substantial health benefits.[61]

52. **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."[62] 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.**

Public Health staff

53. One of the key achievements PHE identified in their written evidence was the recruitment of Directors of Public Health (DsPH) as part of transfer of responsibilities to local authorities. They said in their evidence:

> By 1 April 2013, 104 Directors of Public Health had been appointed covering 114 of the 152 authorities. Interim arrangements are in place in all local authorities without permanent arrangements. [...] That not all authorities had DsPH in place on 1 April in part reflected the inherited position and that some established DsPH made a decision to not transfer to local authority and take on the new leadership role of a local authority Director of Public Health. Currently 116 out of 152 local authorities have substantive arrangements and interim arrangements for the remainder. Local authorities with interim arrangements are actively discussing with PHE the recruitment plans for appointing substantive DsPH.[63]

54. Every unitary and upper tier local authority must appoint a DPH and the appointment is made jointly with the Secretary of State. In practice, however, it is PHE that fulfils this duty on behalf of the Secretary of State. The Secretary of State must also be consulted in cases where a DPH is to be dismissed and, whilst the Secretary of State cannot veto the dismissal, PHE should be consulted on the matter and will provide the Secretary of State's response.[64] The Department of Health outlined the responsibilities of the Director of Public Health as follows:

60 *NHS Health Check implementation review and action plan*, p 7

61 Ibid, p9

62 Q67

63 Public Health England (PHE 02), para 14

64 Department of Health, *Directors of public health: roles and responsibilities guidance,* October 2013, p 12

> The DPH is a statutory chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health—health improvement, health protection and healthcare public health.[65]

55. The BMA, however, questioned the authority of some DsPH and reported in their written evidence that:

> Conversations with DPHs from across the country reveal that a significant minority of them are expected to report to another local authority Director. This is likely to have a negative impact on future public health professional recruitment.[66]

Commenting on these concerns, Richard Gleave told the committee that PHE did not:

> have the data about precisely who reports to whom within the structure, but we are absolutely clear, in terms of the statutory guidance that we put out recently, about them having a direct relationship with the chief executive and access to councillors. We are seeking an assurance from everyone about that.[67]

56. PHE identified as one its objectives the need to:

> Implement the public health workforce strategy and develop the PHE workforce to ensure: the continued development of directors of public health and public health professionals across the system.[68]

This ambition represents the objectives established for PHE within the Government's workforce strategy. The strategy stated:

> PHE will have the lead role in supporting and developing the specialist public health workforce, including DsPH, and building public health capacity in the wider workforce. Professional workforce development is one of PHE's core functions; across the organisation and at national, regional and centre levels there will be people with responsibility for supporting professional public health workforce development across the health and social care system.[69]

57. The Department's evidence highlighted the role that PHE will play in developing the public health workforce so that there is an adequate supply of DsPH in the future. They said:

> DH and PHE are working together to design and deliver leadership development programmes for aspirant Directors of Public Health to ensure a

65 Ibid, p 5

66 British Medical Association (PHE 011), para 13

67 Q136

68 Public Health England, *Our priorities for 2013–14*, p 11

69 Department of Health, *Healthy Lives, Healthy People, A public health workforce strategy*, April 2013, p 18

> future supply of highly skilled professionals equipped for working in local government.[70]

PHE added in oral evidence that the latest figures showed that there were seven people for every position within the public health workforce training programme.[71]

58. The UK Faculty of Public Health argued in written evidence that there was a disparity in the types of people applying to public health roles in different organisations. They said:

> Data, though incomplete, around applications for posts has begun to show a clear trend towards greater numbers of non-medically qualified specialists applying for LA posts, and greater numbers of medically qualified applying for posts in PHE. Indeed, some LA posts receive no applications from medically qualified specialists at all.[72]

They attributed this to the failure by local authorities to match NHS terms and conditions in the posts they advertise.[73]

59. The Association of Directors of Public Health reported in their evidence that a capacity problem was beginning to emerge within local authorities. They said there is a reduced capacity within the public health workforce overall because of unfilled posts[74] and noted:

> significant movement within the public health workforce across England– with each element of the local public health system effectively competing for staff within a limited pool. [...]
>
> Succession planning for DsPH and other senior PH professionals; and ensuring seamless career pathways for Public Health professionals to move between organisations (e.g. local government/PHE/NHS), will be vital to support the long term success of the public health system, and to ensure current and future PH expertise and capacity for PHE, public health in local authorities, and the NHS.
>
> The workforce development role of PHE is therefore critical to ensuring a strong and resilient public health system now and into the future.[75]

60. **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.**

---

70 Department of Health (PHE 21), para 7

71 Q138

72 UK Faculty of Public Health (PHE 20), para 17

73 Ibid, paras 16–19

74 Association of Directors of Public Health (PHE 013) para, 12

75 Association of Directors of Public Health (PHE 013) para, 15

61. **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.**

Conclusions and recommendations

PHE's role on the new public health system

1. 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 (Paragraph 8)

Transition

2. 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. (Paragraph 15)

Emergency preparedness

3. 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. (Paragraph 23)

Establishing priorities

4. 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. (Paragraph 30)

5. The Committee welcomes this objective 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. (Paragraph 31)

Independence from the Department of Health

6. 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. (Paragraph 38)

7. 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". (Paragraph 39)

8. 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. (Paragraph 40)

Minimum Unit Pricing Policy

9. 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. (Paragraph 44)

10. 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. (Paragraph 45)

NHS Health Check

11. 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. (Paragraph 52)

Public Health Staff

12. 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. (Paragraph 60)

13. 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. (Paragraph 61)

Formal Minutes

Tuesday 4 February 2014

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper	Andrew Percy
Andrew George	Mr Virendra Sharma
Barbara Keeley	David Tredinnick
Charlotte Leslie	Valerie Vaz

Draft Report (*Public Health England*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 61 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eighth 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 Tuesday 11 February at 2.00 pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/public-health-england/?type=Oral#pnlPublicationFilter.

Tuesday 19 November 2013

	Question number
Duncan Selbie, Richard Gleave, Professor Kevin Fenton and **Dr Paul Cosford**, Public Health England	Q1-138

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/public-health-england/?type=Written#pnlPublicationFilter. INQ numbers are generated by the evidence processing system and so may not be complete.

1 Royal Society for Public Health (PHE0001)
2 Public Health England (PHE0002) and (PHE0022)
3 Natural Environmental Research Council (PHE0003)
4 National Institute for Health and Care Excellence (PHE0004)
5 UK Public Health Register (PHE0005)
6 National LGB&T Partnership (PHE0007)
7 Ovarian Cancer Action (PHE0008)
8 Arthritis Research UK (PHE0009)
9 Breast Cancer UK (PHE0010)
10 British Medical Association (PHE0011)
11 Royal College of Nursing (PHE0012)
12 Association of Directors of Public Health (PHE0013)
13 Food Standards Agency (PHE0014)
14 Novartis Pharmaceuticals UK Limited (PHE0015)
15 London Councils (PHE0016)
16 Academy of Medical Sciences (PHE0017)
17 Denplan (PHE0018)
18 British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSTH) (PHE0019)
19 UK Faculty of Public Health (PHE0020)
20 Department of Health (PHE0021)

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

Session 2013–14

First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13	HC 154
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee's Ninth Report of Session 2012–13	HC 581
First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584 (Cm 8735)
Second Report	Urgent and emergency services	HC 171 (Cm 8708)
Third Report	After Francis: making a difference	HC 657
Fourth Report	Appointment of the Chair of Monitor	HC 744
Fifth Report	2013 accountability hearing with the Nursing and Midwifery Council	HC 699
Sixth Report	2013 accountability hearing with the Care Quality Commission	HC 761
Seventh Report	Public expenditure on health and social care	HC 793

Session 2012–13

First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)
Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality Commission	HC 592
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and Midwifery Council	HC 639

Tenth Report	2012 accountability hearing with Monitor	HC 652
Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)

Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)