Public Health England

Protecting and improving the nation's health

PHE Board Paper

Title of meeting	PHE Board
Date	Friday 26 June 2015
Sponsor	Alex Sienkiewicz
Title of paper	Actions from Board meetings

1. Purpose of the paper

1.1 Each Board meeting considers a public health theme. As part of this, the Board invites an expert panel to contribute to its discussion. The external panel members' observations to the Board and PHE more generally are summarised in the "watch list" in Appendix 1 to this paper. These are reviewed, monitored and acted on by the National Executive in the preparation of PHE's strategies in the respective public health areas. The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

2. Recommendation

2.1 The Board is asked to **NOTE** the paper.

3. Actions from the minutes

3.1 Conventional actions highlighted from the minutes of previous meetings are set out with dispositions in Appendix 1.

4. Recommendations from panel discussions on key public health priorities

4.1 Matters raised as recommendations in the panel discussions of key health priorities are listed in Appendix 2.

4.2 As PHE publishes its strategies and plans for particular areas of public health, the watch lists are provided to the Board for reference.

4.3 Non-executives have agreed to adopt topics individually to review progress with relevant members of the Executive and report to future Board meetings, starting with Obesity.

Victor Knight
Board Secretary
June 2015

Appendix 1

Actions from PHE Board minutes

Meeting	Minute	Action	Owner	Disposition
3 February 2014	14/056	The Board would be briefed at a future meeting on the work being undertaken to ensure total clarity on roles and funding in the new public health system for health protection	Director of Health Protection/ Deputy CEO & COO	Topic remains to be scheduled
28 January 2015	15/011	Include rurality as an agenda item for next NHS England / PHE Board to Board meeting	Board Secretary	Consider for May 2015 meeting
28 January 2015	15/024	Schedule a further review of Health and Wellbeing Marketing in 6 to 8 months	Board Secretary	Noted for September agenda
28 January 2015	15/032	Set up high level meeting for Chair on public health research issues	Board Secretary	Outstanding
22 May 2015	15/072	Receive three critical issues in air pollution from Professor Frank Kelly	Board Secretary	
22 May 2015	15/075	Follow up on obesity panel watchlist	Rosie Glazebrook/ Kevin Fenton	Scheduled for July (or September)
22 May 2015	15/079	Investigate category of awards for public health	Director of Corporate Affairs	

Appendix 2

Public Health England Board
Actions from the meeting of 22 July 2013

Obesity

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.
To be incorporated or otherwise in the PHE Obesity Strategy

External panel observation	
1.	There is no PHE strategy on 'junk food' or soft drinks.
2.	Coordination is needed across the health system tiers, with other government departments, and with schools/education.
3.	A pilot opportunity was offered by East Midlands Academic Health Science Network for an obesity project.
4.	Recognise the government's purchasing power in food.
5.	Revisit outdated research work on pregnancy and birth weight.
6.	Encourage the use of local authority planning control to restrict food outlets near schools and to promote public parks.
7.	Consider the French experience of government intervention to reduce obesity
8.	Identify profitable avenues for the food industry which do not rely on promoting unhealthy foods.
9.	Work with the Food Standards Agency to clarify roles on obesity.
10.	Pay attention to micro level nutrition (for example vitamin D) in tackling wider health issues.
11.	Improve professional education on nutrition in medical schools.
12.	Engage with the Advertising Standards Authority to protect children from unhealthy food marketing.
13.	Recognise that public health benefits alone have not been sufficient to convince government to act: cost/benefit information is essential.
	Question from a member of the public
14.	Clarify the role of the Scientific Advisory Committee on Nutrition (SACN), and of PHE, in relation to the recommended minimum intake of vitamin D.

Appendix 2

Public Health England Board
Actions from the meeting of 25 September 2013

PHE Research Strategy

The observations and suggestions are exclusively those of the external panel members and are not PHE policy. They have been considered and acted on as appropriate by the Chief Knowledge Officer in the finalisation of the PHE Research Strategy

External panel observation	
1.	Foster better links with academics, public health practitioners and civil society.
2.	Provide career opportunities for researchers, including developing junior researchers and maintain stable funding streams (especially in areas of study with perceived lacked of future and secure funding, psychosocial and behavioural research.)
3.	Facilitate research through registries, monitoring, surveillance systems, and intermittent surveys.
4.	Provide quality assurance, curation, and make information and materials available.
5.	Take a role in research on behaviours and cultures.
6.	Raise the profile of mental health research.
7.	Participate further in Department of Health cross-funding with other bodies.
8.	PHE should seek research fellowships.
9.	Invest in bioinformatics and the handling of 'big data'.
10.	Link with the major charities because of their size and role in UK research funding as well as local authorities.
11.	Redress the balance of research in non-communicable diseases and move from a focus on individual diseases to an integrated approach encompassing wider health concerns.
12.	Fill the gap in monitoring the social and environmental impact on behaviours and of behavioural change, for example, in the consumption of tobacco, alcohol and ultra-processed food.
13.	Manage growth expectations in the adoption of technologies for interpreting large amounts of sequence data.
14.	In the genomic field: Ensure PHE is outward facing and engaging with others without conditions, and supress the tendency to compete internally.
15.	Focus on applied and translational research in genomics leaving the basic science to others.
16.	The need to generate income in relation to sequencing should be reduced at first as restrictions on data sharing are created by protecting intellectual property.
17.	Make further effort to ensure scientists behave cohesively.
18.	Secure adequate investment and sustainable funding for genomics, and provide the infrastructure for the very long term, not just the next five years.
19.	Form a strong partnership with the Sanger Institute based on a comprehensive research strategy, not adventitious research relationships. Eg. a PHE portable office

	on the Sanger site with PHE staff.
20.	Strengthen links with the Sanger Institute, potentially through staff secondments.
21.	Invite the Sanger Institute to revisit, in relation to public health, its policy of not providing fee-for-service sequencing.
22.	Undertake a cost benefit assessment of a partnership between PHE and the Sanger Institute.
23.	Include the impact of economic and social determinants in research.
24.	Encourage and value joint appointments.
25.	Define priorities clearly in research design.
26.	Link academic approaches in public health with practice.
27.	Build capability as well as capacity through training.
28.	Study failures in public health initiatives as they merit more evaluation studies than the successes.
29.	Encourage horizon scanning and timely commissioning.
30.	Publish more public health information which may stimulate research proposals.
31.	Look for more international research opportunities.
32.	Play an advocacy role in facilitating access to data across the system.
33.	Work with the NIHR School of Public Health.
34.	Strengthen and formalise collaboration with the Department of Health in the area of strategic research.
35.	Develop and strengthen research opportunities globally.
36.	Promote simple interventions which are effective - for example, smoking data on death certificates.
37.	Embed noncommunicable diseases within health protection research.

During 2014 those PHE Directorates which have research interests will be planning how to address the identified Strategic Priorities and Research Questions over the next 3 to 5 years. The overall emphasis will be on the translation of this research into tangible public health outcomes at a local level through working with academic partners.

Appendix 2

Public Health England Board
Actions from the meeting of 27 November 2013

PHE Global Health Strategy

The observations and suggestions are exclusively those of the external panel members and are not PHE policy. They have been considered by PHE in developing its Global Health Strategy and will be further used by the PHE Global Health Committee for which draft Terms of Reference were adopted by the Board in March 2014.

	External panel observation
1.	Aim to build global capacity in public health, but ensure that something important is being added when building capacity, and not just filling gaps in local systems.
2.	Recognise the value and long term opportunities of students from other countries who studied in England, creating links which were an important source for subsequent collaborations.
3.	Aim for more than horizon scanning: it is valuable to have an existing relationship with other countries when incidents arise, with staff trained and ready to work internationally.
4.	Nations should recognise the health impact of all government policies.
5.	Balance the principle of only being where invited with the need to take risks to promote global health.
6.	Participate in the post Millennium Goals 2015 discussion on non-communicable diseases, for example, in mental health.
7.	Recognise that the need to reduce costs in health systems across the globe demands cost effective pathway design and offers virtuous income generating opportunities.
8.	Secondment of staff is a powerful way of playing a strong role internationally; it also invigorates those taking part and their teams on their return. It helps to leverage resources, but should be part time if it is not to lose resources to PHE.
9.	Address non-communicable diseases in developing countries to avoid the experiences of the developed world. The diseases are communicated through economic and other vectors.
10.	Recognise the global aspects of such established issues in the developed world of issues such as salt reduction and food labeling, and the impact of exporting the vectors of ill health in tobacco, alcohol and over-processed foods.
11.	Strengthening civil society, including advocacy and accountability is a key to global change.
12.	Do not over-emphasise infectious disease.
13.	Recognise the need to see achievements in and by partner countries, not just in PHE as a partner organisation.
14.	Recognise that humanitarian demands will increase, caused by both nature and conflict: PHE should be ready and able to intervene as a good world citizen.
15.	Engage with the Department for International Development (DfID) change to technical partnership in India from 2015.
16.	Keep in touch with areas of the world which are innovating fast - for example India

	experimenting with new business models and technologies.
17.	Engage with the National Institute for Health and Care Excellence on global issues.
18.	Work on mass gatherings helps to raise the international profile of public health.
19.	Learn from other partnerships – such as Wales' work with African countries
20.	Look for the gaps and let other countries fill them where they have the skills - encouraging neighbouring countries where that is more acceptable than resourcing from the UK.
21.	Identify global health capabilities in which the UK has a lead or strength.
22.	Work on how PHE collaborates effectively.
23.	Identify English health sector priorities – such as multi drug resistant tuberculosis which are also global health priorities.
24.	Recognise the need in events such as the Philippines typhoon for international co-operation both in the acute phase and in the post-acute-phase.
25.	Ensure that global health staff participation in committees and conferences represents good value for money.
26.	Review global health activities regularly and discontinue those which are no longer appropriate.
27.	Publicise how collaborative work is prioritised and the basis on which projects are declined when they do not meet relevant criteria.
28.	Note that some global health activities recover costs and some attract grants and this can be a viable operating model. Humanitarian work and academic exchange have different bases.
29.	Consider 'jigsaw' and 'patchwork' funding to get other organisations to join projects.
30.	Be alert to the large number of global initiatives and benefactors and the danger of overloading the health administrations of developing countries.
31.	Encourage governments to work at the local level and regional levels in their countries, not just national and supranational levels.
32.	Value the role of midwives in England and internationally. Childbirth remains a major cause of death in young women in developing countries.
33.	Avoid undue focus on hospitals in collaborations.
34.	Recognise importance of the Commonwealth in Africa
35.	Learn from the global health experience of the UK Devolved Administrations.
36.	Understand the contrasting role and methods of the US in global health.
37.	Recognise the gradual transition of public health relationships would from International Development to Foreign & Commonwealth Office.
38.	Note the significance of climate change as a global public health issue.
39.	Note that Middle income countries are becoming high income countries and losing aid, but many of the poorest people still live in them.

Appendix 2

Public Health England Board
Actions from the meeting of 3 February 2014

Tobacco

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	New and emerging products require evidence on health effects.
2.	Action on Smoking and Health's CLeaR standard could be used to implement evidence based local action.
3.	PHE should provide national leadership and needs to act with pace to realign its resources to address this.
4.	PHE should provide evidence-based support and should encourage Directors of Public Health at the local level.
5.	Helping people stop smoking should remain a priority including those who did not wish to stop smoking or found it very hard to do so. Better access to properly regulated nicotine substitution products would assist.
6.	There is little evidence as yet about the potential for harm from electronic cigarettes.
7.	e-cigarettes should only be promoted to existing smokers.
8.	e-cigarettes regulation was necessary and should be pursued.
9.	Promoting e-cigarettes to non-smokers and particularly to the young should be prohibited.
10.	There should be consistency with NICE guidance on harm reduction, which supported the use of licensed nicotine products as an aid to cutting down or quitting smoking and as a substitute for smoking.
11.	There should be surveillance of the market so that any normalisation of e-cigarette use would be apparent.
12.	England should consider matching the ambitious targets set for becoming tobacco free in Ireland (2025) and Scotland (2034)
13.	Endgame thinking has generated a number of academic papers and conferences and had proved attractive to governments wanting to make a bold health policy commitment.
14.	A tobacco-free target would require commitment, accountability, careful planning and modelling. Different types of strategies would need to be employed, for example reducing the nicotine content of tobacco products, reducing the number and concentration of retail outlets and setting limits on the volume of tobacco that could be imported and sold.
15.	For the UK to make significant progress, there would need to be a policy environment more receptive to step changes in tobacco control.
16.	Shift the narrative and address the influence of the tobacco industry, in light of Article 5.3 of the WHO Framework Convention on Tobacco Control.
17.	PHE leadership is needed to continue to reinforce the tobacco control role for many years ahead, to tackle health inequalities and to work towards the endgame for

	tobacco.
18.	PHE needs to reinforce the evidence base on the impact of tobacco use on health inequalities and the gap in life expectancy.
19.	A clear specific focus on tobacco cessation support, proactive regulatory services, implementation of NICE guidance across the NHS and good amplification of national media campaigns is necessary.
20.	Regional programmes that could provide significant benefits to PHE could: • provide expertise across all aspects of tobacco control; • allow local commissioners to benefit from economies of scale, • provide leadership, vision and strategy; • foster a continued social movement around smoking; and • lead on advocacy.
21.	Note NICE model of favourable economics of a level of tobacco control between local and national..
22.	Address concerns over e-cigarette marketing: using the marketing of nicotine containing products to promote the core business of tobacco. Nicotine too easily accepted in e-cigarettes. The advertising of e-cigarettes is just like tobacco cigarettes with packaging and lifestyle images. It is clear that marketing has a huge influence over social norms.
23.	The key drivers of success in tobacco control are policy measures, such as smoke-free places and taxation, and the de-normalisation of smoking.
24.	Nicotine addiction cost money and impacted most on disadvantaged communities.
25.	Do not disempower smokers who hope to overcome their addiction through use of e-cigarettes.
26.	Health promotion has a straightforward message: that how people live their lives directly affects their health and life expectancy.
27.	Adults rarely take up smoking: the majority of smokers start when they are children. Educating children about the dangers of smoking is crucial.
28.	e-cigarettes use risks renormalising smoking in public places.
29.	Note Scottish initiatives: • The 2014 Commonwealth Games in Scotland will be e-cigarette free • After successful resolution of tobacco industry legal challenges, the Scottish Government has implemented a ban on self-service tobacco vending machines and a tobacco display ban in shops.
30.	Smokers who wish to quit or reduce their smoking, should be advised to access one of the free NHS services providing scientifically proven support including a range of tested nicotine replacement products.
31.	e-cigarettes (and electronic nicotine delivery systems) should be strictly limited to smokers only: they should not promote the concept of safe smoking and should only be used as a way to cut down and quit. Whether any marketing should be allowed at all requires urgent review.
32.	e-cigarette use should be prohibited in workplaces, educational and public places to ensure their use did not undermine smoking prevention and cessation by reinforcing and normalising smoking.
33.	Electronic nicotine delivery systems should not be available to people under 18. Anything that might increase their appeal to children should be avoided, for example, flavouring or packaging.
34.	Electronic nicotine delivery systems promotion should not appeal to non-smokers, in

	particular children and young people.
35.	Research is needed to increase the understanding of electronic nicotine delivery systems with particular regard to their safety, effectiveness, role in normalising smoking behaviour and role as a gateway to nicotine addiction and smoking, particularly in children.
36.	A clear, simple message the use of e-cigarettes needed to be communicated to the public and implemented into policy effectively.
37.	There was a great need to gather an evidence base on the role of electronic nicotine delivery systems in normalising smoking behaviour.
38.	A single, overarching, message is lacking on e-cigarettes. It was very important that this was simple and enforced. Whatever was decided on the cigarettes had to be clear, simple and enforceable in practice and there should be agreement on de-normalisation.
39.	PHE Board to discuss standardised packaging of tobacco products following the Chantler review

Public Health England Board
Actions from the meeting of 26 March 2014

Alcohol

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Examine the relationship between alcohol and mental health and the impact on acute services.
2.	PHE should be at the heart of actions to reduce alcohol consumption, and suitably resourced.
3.	Review and consider the interventions identified by WHO as being the most effective (price, availability and promotion)
4.	Review the publication *Health First: An evidence based alcohol strategy for the UK*
5.	Support data collection and dissemination through Local Alcohol Profiles and the Alcohol Learning Centre.
6.	Support research on alcohol and drinking behaviour including alcohol and inequalities, high risk groups
7.	Improve clarity on alcohol unit guidelines at point of sale and use
8.	PHE marketing team to continue to support the annual *Dry January* campaign by *Alcohol Concern.*
9.	Improve public understanding of the health harms of alcohol other than liver damage, such as cancer.
10.	Support provision of higher level of treatment services than present 6% of those dependent on alcohol, and a rational share for drug and alcohol treatment resources.
11.	Promote alcohol 'Identification and Brief Advice' (IBA) for frontline health and social care staff.
12.	Use National Institute for Health and Care Excellence guidance CG115
13.	Promote to employers the benefit of occupational health provision in relation to alcohol.
14.	Consider closer PHE links with the Faculty of Occupational Health Medicine.
15.	Follow the precautionary principle, for example on not drinking during pregnancy.
16.	Pursue the introduction of 'protection and improvement of public health' as a fifth licensing objective.
17.	Have good evidence and 'Questions and Answers' to change social norms on drinking.
18.	Provide surveillance of alcohol marketing and the adequacy of the regulatory code, including protection of young people from digital marketing of alcohol.
19.	Use social media to raise awareness of the negative effects of alcohol.
20.	Fund public awareness and behavior change campaigns on alcohol.

Public Health England Board
Actions from the meeting of 27 May 2014

Tuberculosis

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Find and treat' capability was good but walk-in TB facilities would be beneficial.
2.	Direct observation of therapy for example by family or community members would improve compliance with treatment regimens.
3.	TB resources needed mandated leadership and to be adequately funded.
4.	Basic tests by GPs for new migrants should include testing for latent TB.
5.	The traditional social determinants of health in terms of better housing and conditions applied to TB.
6.	Awareness amongst General Practitioners and nurses could be improved.

Public Health England Board
Actions from the meeting of 24 September 2014

Antimicrobial resistance

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Consider behaviour and behavioural change programmes - in the media, professional and school curricula. (The profile of antimicrobial resistance could be powerfully raised with the public, for example, through television soaps and social media. PHE was looked to in leading behavioural change.)
2.	Determine when it is right to use antimicrobials and course length. (Professionals in both human and animal healthcare could be better informed in their education and training, but their overriding concern for their patients meant that having point of care diagnostics, and rapid diagnosis of infections would greatly improve the right use of antimicrobials, and the correct length of antibiotic course.)
3.	Consider economics of point of care diagnostics for some infections (with NICE).
4.	Consider incentives and disincentives for use of antimicrobials. (Internationally prescribing practice and patient expectations varied widely, including models where doctors and hospitals were rewarded in proportion to drug spend.)
5.	Include veterinary science aspects of antimicrobial resistance in PHE, especially surveillance and action.
6.	Look at the global antimicrobial scene and its impact on the UK.
7.	Measure the right things and publish.
8.	The surveillance base of people with severe resistance should be considered.
9.	Post-genomics applications. (Genomics might identify infections that could still be susceptible to earlier generation antibiotics.)
10.	Consider penalties in addition to the ‘three Ps’ (prevent, preserve and promote).

Public Health England Board
Actions from the meeting of 26 November 2014

Mental Health

The observations and suggestions are exclusively those of the external panel members and participants and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Mental health is not taken sufficiently seriously. With disproportionately smaller shares of health and local authority public health spending on mental health than physical.
2.	Improving Access to Psychological Therapies (IAPT) is effective and targets for accessing IAPT should be more ambitious, and are a basis for other interventions.
3.	Data on mental health is poor compared with data on physical ill-health and healthcare provision. It is hard to use and needs to be local and accessible to citizens. Data is essential to measures of progress and effectiveness. PHE should support local leaders to do their job with evidence and a mental health intelligence network.
4.	Child and adolescent mental health services (CAMHS) need to be credible. The lack of a set target is a weakness particularly for mental health. PHE was asked to push for a 33% annual target for the proportion of children seen annually by CAMHS. NHS England and PHE could provide a specification for a good service and crisis intervention.
5.	Black and minority ethnic provision is disproportionately lacking in mental health strategies.
6.	Note the five World Psychiatric Association themes: domestic and gender-based violence, agenda, child-abuse, prisoner mental health care, under-served groups and mental health promotion.
7.	Many adult psychiatric disorders start young and should be targeted for prevention and health promotion.
8.	Minimum unit pricing of alcohol would have the biggest impact on violence, misery and demand on hospital emergency services.
9.	Mental and physical well-being are not separate issues.
10.	Those affected by mental health died younger.
11.	All government departments need to be engaged.
12.	Engage in schools to improve children's identification of conditions and familiarity with them. (There are good examples from across the world.)
13.	Parenting skills are needed for parents under pressure, including those with learning difficulties and mentally disordered: intervening before trouble occurs.
14.	Early interventions were required in the over 65s where physical ill-health combined with mental health issues to cause misery. Age psychiatry is under resourced.
15.	There is confusion in local authorities over what public mental health is and in identifying spend.
16.	Mental health was not getting parity with other health issues at a local level and should be part of local strategies and Joint Strategic Needs Assessments, with public data on progress.
17.	Ensure that national public health targets, for example for smoking prevalence, and alcohol use, would are benefit the mentally ill.
18.	PHE should develop a well-being impact assessment tool as part of the Green Book for assessing all policies nationally against mental health.
19.	An evidence based social marketing campaign to help people at the population level to support their own mental health and wellbeing and resilience.
20.	Public social marketing could emphasise the importance of infant mental health.

21.	Mental health in pregnancy and birth are areas with little or no provision.
22.	Only PHE can impact people rather than patients, as many people did not approach health care with mental health issues.
23.	Many sources of the information available to the public lack an evidence base.
24.	PHE should be a partner in All Party work on Mindfulness with academics.
25.	Terminology for mental health, mental wellbeing, mental illness or disorder needs to be standardized and agreed in the sector.
26.	A balance between prevention and promotion must be struck in mental health – because resources are easily diverted to respond to suffering.
27.	The medical profession needs more respect for mental health and its integration with physical health. The medical attitude would then affect the general public.
28.	What constitutes evidence? Is the Randomised Controlled Trial approach suitable for assessing changes in complex systems?
29.	Local partners want evidence of return on investment and impact.
30.	PHE can lobby and spread information – both to aid prevention and early intervention. PHE should persuade schools and the NHS as the main institutions that can be influenced.
31.	Persuade schools that the well-being of children is an objective of schools with Ofsted and the schools themselves: having measures of success; evidence-based teaching of life skills; all teachers should have mental health training.
32.	PHE should spell out what works to convince local leaders of effective actions (eg. in reducing the £26 billion a year costs estimated for mental health in London)
33.	Integrate medical and scientific communities with mental health issues to get cross-discipline of education and money.
34.	The Faculty of Occupational Health works with employers an opportunity to make NHS staff and patients aware.
35.	A living wage has impact on self esteem, and discrimination and stigmatisation.
36.	There is a community role in recovery.
37.	The criminalisation of drugs links to prisons, suicide etc.
38.	There is a lot of data in different services but that this is not shared. We should identify and share the available data, identify best practice, and pursue efficiency to save money.

Public Health England Board
Actions from the meeting of 28 January 2015

Rural Health

The observations and suggestions are exclusively those of the external panel members and participants and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	There is opportunity for greater collaboration between NHS England and PHE on rural health issues, for example, identifying potential gaps in delivery with respect to access, choice and distance.
2.	There is scope for PHE to assist local authorities in their efforts to increase levels of daily physical activity in rural areas.
3.	There is scope for local government, PHE and others to work together to address the issue of empty (rural) housing stock.
4.	PHE and its partners could work together to strengthen the “green deal” to further incentivise landlords to undertake remedial work to damp and/or uninsulated properties.
5.	The design and delivery of research and development programmes in health and care organisations serving rural areas could enhance the career options for their staff.
6.	PHE could explore how it could support and mobilise small and medium-sized enterprises in providing workplace health and wellbeing services.
7.	The workforce should be trained to address the needs of rural communities and individual career paths, including nurses, general practitioners and specialist clinicians.
8.	Consider models in other countries with large rural populations in adapting healthcare training to their needs.
9.	Enhance the value of detailed epidemiological data for localities provided by PHE, through research to interpret the data.

Public Health England Board
Actions from the meeting of 22 May 2015

Air Pollution

The observations and suggestions are exclusively those of the external panel members and participants and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Encourage Directors of Public Health to ensure that air quality measures are included in Joint Strategic Needs Assessment frameworks.
2.	Exploit opportunities in urban design to address air pollution, particularly in London, which can be used to demonstrate a healthy town effect.
3.	Increase both public and professional awareness of air pollution, including what denotes a pollutant, how best this can be explained to the public, and what can and cannot be influenced.
4.	Include the impact of air pollution in rural areas, and with local authorities less familiar than urban authorities on the air pollution consequences of their decisions.
5.	Bring together the resources of PHE from the Chief Knowledge Officer (CKO) Directorate and the outcome and exposure data prepared by the Centre for Radiation, Chemical and Environmental Hazards (CRCE).
6.	PHE should continue: (i) to raise awareness of air pollution issues in the healthcare and public health sector through sustained engagement with local authorities and wider stakeholders. (ii) To provide evidence on the health effects of air pollutants and develop a practical framework for local authorities to evaluate the health benefits of local interventions, such as active travel and reducing exposure to air pollution.
7.	Work with partners across the Devolved Administrations.
8.	Assist localities to develop air pollution narratives distinct to their different priorities and variations.
9.	Extend awareness of air pollution beyond being the traditional concern of Environmental Health Officers to Directors of Public Health.
10.	Work with NHS England on opportunities to take air quality into account in the delivery of the *Five Year Forward View*.