

Public Health Institutes of the World

**IANPHI**

Public Health Institutes  
of the World

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**Public Health England  
(PHE)**

EVALUATION AND RECOMMENDATIONS



Part 1	Introduction
Part 2	Background: IANPHI
Part 3	National Public Health Institutes
Part 4	Background: PHE
Part 5	Evaluation Process
Part 6	Observations and Summary of Evaluation Team Recommendations
Appendix I	IANPHI Evaluation Team Members
Appendix II	The Core Attributes and Essential Public Health Functions for NPHIs
Appendix II	Interviewees and Presenters
Appendix IV	Terms of Reference

## Part 1 Introduction

This evaluation was conducted June 26-29, 2017 at the request of Public Health England's Advisory Board. The Evaluation Team was comprised of:

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Full biographical details are included as Appendix 1.

The IANPHI [Framework for the Creation and Development of National Public Health Institutes](#) and [NPHI Evaluation Tool](#) were used to support the evaluation. Strong preparation by a PHE team led by Professor Paul Cosford contributed greatly to the team's work. Terms of Reference, developed by the PHE leadership team, are attached as Appendix 4.

## Part 2 IANPHI

IANPHI ([www.ianphi.org](http://www.ianphi.org)) was launched in 2002 and chartered in 2006. An association of the directors of 108 National Public Health Institutes (NPHIs), its members include the directors of China CDC, the U.S. CDC, the public health institutes of Japan, Thailand, Brazil, Mexico, South Africa, Ethiopia, Nigeria, India, France, Germany, the United Kingdom and numerous other countries. With oversight from an Executive Board, IANPHI is managed by a Secretariat based at the French Public Health Agency and an office at Emory University in the United States. IANPHI's mission is to improve health outcomes by building capacity within and between its member NPHIs. IANPHI provides technical assistance and grants, develops policy and fosters its community through annual meetings, a website and other communications, and benchmarking and advocacy in support of strong NPHIs.

## Part 3 National Public Health Institutes

Numerous countries have established national public health institutes (NPHIs) to coordinate and lead public health systems. Some, such as the U.S. CDC, South African NICD, Brazilian FIOCRUZ, and China CDC, have developed over time

while others - including Public Health England and the Public Health Agency of Canada - were created more recently. While NPHIs vary in scope and size - from fledgling institutes focusing only on infectious diseases to those with comprehensive responsibility for all public health matters (including research, public health programs, and policy support and development) - they share a national scope of influence and recognition and focus on the major public health problems affecting the country. NPHIs use scientific evidence as the basis for policy development, program implementation and resource allocation and are accountable to national governments and the public. Their key functions - including disease surveillance, detection, and monitoring; outbreak investigation and control; health information analysis for policy development; research; training; health promotion and health education; and laboratory science - are particularly critical in low-resource nations. To provide its members with policy guidance and a roadmap for strengthening NPHI capacity, in 2007 IANPHI drafted and approved a [Framework for the Creation and Development of National Public Health Institutes](#)<sup>1</sup>. The IANPHI Framework includes Core Attributes and Essential Functions for NPHIs and has been used by NPHIs from around the world to plan for and undertake capacity-strengthening activities. The [IANPHI Evaluation Tool](#) was developed by a group of IANPHI members and key experts including RIVM from 2012-2014<sup>2</sup>. It was informed by IANPHI assessments of [China Center for Disease Control and Prevention](#) and other national public health institutes including [National Institute for Health and Wellness](#) (THL, Finland), [National Institute for Public Health and the Environment](#) (RIVM, Netherlands), and [The Scientific Institute of Public Health](#) (WIV-ISP, Belgium).

## Part 4 Background, PHE

[Public Health England](#) (PHE) is an executive agency of the [Department of Health](#) (DH). PHE is the expert national public health agency, which fulfills the Secretary of State for Health's statutory duties to protect health and address health inequalities, and executes the Secretary of State's power to promote the health and wellbeing of the nation. PHE undertakes a range of evidence-based activities that span the full breadth of public health, working locally, nationally and globally, and is responsible for four critical functions:

- PHE's first function is to fulfil the Secretary of State's duty to protect the public's health from infectious diseases and other public health hazards, working with the [National Health Service](#) (NHS), local government and other key partners in England, but also working with the Devolved Administrations and globally where appropriate;
- PHE's next function is to secure improvements to the public's health, including supporting the system to reduce health inequalities;
- PHE has a key role in improving population health through sustainable health and care services;
- PHE should also ensure the public health system maintains the capability and capacity to tackle today's public health challenges and is prepared for the emerging challenges of the future, both nationally and internationally.

1 <http://ianphi.org/documents/pdfs/frameworkfornphi>

2 <http://www.ianphi.org/documents/pdfs/evaluationtool>

As set out in the Framework Agreement with DH, PHE has operational autonomy and is free to publish and speak on those issues that relate to the nation's health and wellbeing in order to set out the professional, scientific and objective judgment of the evidence base.

The Tailored Review carried out by DH during 2016 confirmed the importance of PHE's role and functions in the health and care system, and concluded that it had made good progress with integrating the staff, cultures, working practices and physical assets of the 129 organizations from which it was created.

[PHE's business plan](#) for 2017/18 sets out the steps it will take in the second year of its current four-year strategic plan, and reflects its contribution to national policies, system-wide priorities and support for local partners, as well as how it will deliver the local objectives and shared goals of the public health system. It should be read in conjunction with [PHE's Strategic Plan: Better Outcomes by 2020](#), which builds on 'Evidence into action: opportunities to protect and improve the nation's health' and the [NHS Five Year Forward View](#).

## Part 5 The Evaluation Process

Terms of Reference were defined prior to the site visit and agreed upon by the team (Appendix 4). The evaluation team received a thorough situation analysis with historic and future perspectives outlined in responses to the Evaluation Tool. Additional materials provided included special and typical case studies (tuberculosis, air pollution, the local knowledge and intelligence services and healthcare public health). The international team spent four days on site. Using an agenda and list of stakeholders developed in partnership with the PHE leadership team (included as Appendix 3), interviews with key stakeholders were conducted and presentations by PHE's leadership team were given.

The IANPHI team was asked to assess progress in three key areas:

- Does PHE demonstrate the leadership, strategy and delivery required to fulfill its responsibilities, taking account of the UK Government Cabinet Office model of capability?
- Is PHE set up most effectively and efficiently to deliver its mission and discharge our functions?
- Does PHE have the necessary impact and influence it needs to fulfill its mission?

## Part 6 Findings of the Review Team: Observations and Recommendations

### Evaluation Question 1: Does PHE demonstrate the leadership, strategy and delivery required to fulfill our responsibilities, taking account of the UK Government Cabinet Office model of capability?

#### Observations:

In less than five years, Public Health England has, under strong and visionary leadership, transformed a geographically and functionally siloed group of 129 bodies into a strong, capable, coordinated, united and efficient public health agency that rivals any in the world.

PHE meets or exceeds the standards outlined in the [UK Government Cabinet Office Model of Capability](#) including those for delivery, leadership and strategy. The agency's experience in change management over the past five years, and its expertise in delivering the Essential Public Health Functions (outlined in the IANPHI Framework and attached as Appendix 2), should be used as a best practice by other countries wishing to conduct and organize public health at the highest level of excellence.

PHE operates in increasingly complex local, national and international political arenas, including the devolution of funding, functions and services to the local level, reductions in national funding for the local authority public health ring-fenced grant, PHE's role vis-à-vis the National Health Service and the impact of exiting the EU. These challenges have been addressed and most often met by PHE with a results-focused resourcefulness and ingenuity.

Amongst the most impressive of PHE's accomplishments are:

- Ebola response: PHE was an international leader in the response at home and abroad, with more than 150 staff deployed to Sierra Leone, Guinea and Liberia. Diagnostic laboratories established in Sierra Leone tested more than 10,000 samples; domestic screening included more than 14,000 passengers.
- Immunization: In partnership with NHS England, PHE extended the childhood flu vaccination to all children aged 2-4, piloted delivery to primary school children and is currently rolling this out to primary school in all areas (up to age 8 in 2017/18). It established the world's first infant meningitis B vaccination program, with 94% coverage for the first dose, and implemented the MenACWY vaccination program for adolescents.
- [Smoking cessation](#): an internationally renowned stop smoking program supported 778,000 quit attempts through three highly successful campaigns. Smoking prevalence is declining; the UK now has the second lowest prevalence in Europe.
- The Knowledge and Intelligence service: Excellent work through evaluation and analysis of health status and intelligence and surveillance functions. For example the internationally regarded 'Fingertips' which is a rich source of indicators across a range of health and wellbeing themes designed to support commissioning to improve the public's health. A case study on disease registration functions clearly illustrated PHE's capacity and success in this area.

- Obesity and alcohol harm: PHE's ambitions and actions (including legislative measures) to reduce the level of sugar in food and drink by 20% by 2020 make it a world leader in this area. Its review on alcohol harm published by the UK government and in the Lancet<sup>3</sup> in December 2016 provided policymakers with the evidence needed to identify potential solutions.

These accomplishments illustrate, in both the fields of health protection and health improvement, that PHE's vision is concrete with strong leadership. This has been effectively translated through a shared strategy based on capacity building and a common purpose to deliver effective population based public health services guided by the best evidence and with a strong focus on outcomes.

### Recommendations

*Recommendation 1: PHE is one of the world's foremost public health institutes. A case study on its development and change management processes in a complex environment should be developed, and its successes should be highlighted and shared as best practices by IANPHI in national and international settings, including the [2017 IANPHI annual meeting](#).*

### **Evaluation Question 2: Is PHE set up most effectively and efficiently to deliver its mission and discharge its functions?**

#### Observations:

It is the team's opinion that PHE meets or exceeds the UK Government Cabinet Office model of capability standards in this area. On the whole, it is well structured and organized, its resources are allocated effectively and efficiently, it is ready for future opportunities, challenges or threats and it is a learning organization with a focus on continuous improvement.

#### *Structure and organization:*

The current structure of PHE was informed by numerous stakeholder conversations and a defined strategy for change management, led by an internal team. More than 5,000 staff from 129 organizations were consolidated into PHE in a challenging and complex reorganization. A unification of this type - disparate departments, units and agencies (further complicated by geographic separation, specialization, differing "corporate" cultures and the need to manage within a challenging financial climate) - is never easy. With a strong focus on strategy, its essential missions and operations (including the PHE People Transition Policy), PHE was able to implement the consolidation and meet efficiency targets, reducing costs by 30% (£145 million of recurrent savings) without a material detrimental impact or destabilization of services or relationships.

<sup>3</sup> Burton R, Henn C, Lavoie D et al. A rapid evidence review of the effectiveness and cost-effectiveness of alcohol control policies: an English perspective. Lancet. 2017 Apr 15;389(10078):1558-1580.

It is encouraging that staff surveys show an upward trend, although some staff do have concerns about human resource-related issues such as organizational purpose, effective change management and taking actions on results. Efforts to standardize salaries across the agency are aimed at addressing employee concerns about fairness. Change can be upsetting and the development of the new Public Health Science Campus and PHE Headquarters at Harlow has plusses and minuses for employees, particularly those who must choose between long commutes, moving to the new location or finding employment elsewhere. PHE recognized this by including transition planning as an objective for every department and working with employees to address their concerns. While periods of rapid changes are never easy, the Harlow facility will support existing work to develop a unified agency, bringing even closer together its health improvement and health protection specialists on clear missions and service delivery as well as the ability to work across departments and task areas.

The Evaluation Team noted a few ideas, related to PHE's structure and functions, for consideration.

- Local response to outbreaks: PHE's role is to lead and co-ordinate the response and there is scope for greater clarity in the responsibilities of PHE's local partners. PHE is undertaking a multi-agency audit of local arrangements which will be a spring board to take this forward
- The topics and focus areas for social marketing campaigns should continue to reflect the key causes of avoidable death and disability, where campaigns can make a positive difference, whilst also recognizing the importance of wider political, policy and health system considerations. It was noted that social marketing plan aim to develop and execute campaigns targeted to a lower sociodemographic 'C2DE' population who suffer disproportionate health outcomes, and report their success against this group to ensure measurable, long-term impact, while taking all appropriate steps to avoid increasing health inequalities.
- The public health grant funding across regions and communities – particularly those with more challenging public health problems - should be examined to make sure it is equitable.
- The Advisory Committee for Resource Allocation (ACRA) developed a formula for the distribution of the public health grant that was aimed at providing an equitable basis for allocating based on need. Whilst in the first two years of the public health grant when additional funding was provided, there was movement towards the target allocations based on this formula. In recent years as funding has reduced this movement to target (equitable need) has not been progressed. PHE does not have the lead role in determining the distribution of funding for public health work to local government. It should play an important role in supporting the Advisory Committee for Resource Allocation and helping to shape the plans from the Department of Communities and Local Government and Department of Health to help address health inequalities.
- PHE's plans to develop patents on its products and services provide essential protection to the public's investment whether such services are offered free of charge to other organizations or commercialized in order to reinvest in new or improved services for the public.

While there has been a commitment in investing in refreshed technology, it is important that resilient communications technology (such as that for teleconferences and video conferences) is available at all times to ensure good communication internationally, nationally and locally.

*Resource allocation:*

Under cross-government efficiency measures, PHE has reduced expenditure by 30% (equating to over £145m per annum, with cumulative savings of over £1/2 billion) in the past 4 years. In addition to the new facility, planning throughout the agency at the central level and in various departments has led to proactive strategies for other future opportunities, challenges and threats. PHE has a keen awareness of its future goals and a path to success. The Evaluation Team noted a few areas for future thought:

- With the fact that around a third of the agency's operating budget is externally generated (services, research, royalties and dividends) may have implications for sustainability if any of these are reduced. This should continue to be managed through PHE's financial planning processes.
- The review team noted that in some cases PHE's internal funding arrangements (for example, health protection vs health improvement) has a tendency in some cases to reflect previous priorities. A comprehensive assessment of funding and staff allocations, tied to major causes of death, disability and preventability, might be very useful to seeing where additional funding is necessary. While PHE's leadership is correct in assuming that it must have its core strength capacity in the field of infectious diseases and environmental hazard incident response, additional investments may be necessary to strengthen capacity, funding and partnerships to combat other threats. The operational funds of PHE should not be a zero-sum game; rather, a case should be made that increases in funding for programs to address non-communicable disease threats will save lives, and money, over the long term.
- The review team agrees with the observations of the PHE leadership that following the move to Harlow there will be a good opportunity to reassess internal resource allocation and equity within PHE directorates and regions.

*Readiness for future opportunities, challenges and threats:*

PHE has clearly identified external and internal opportunities, threats and challenges. In the Evaluation Team's view, these are appropriate. As outlined above (resource allocation) the Evaluation Team noted several potential challenges to PHE's sustainability including its reliance on outside revenue, which it actively manages through its financial planning. While the majority of PHE's contractual income is both stable and sustainable and there are arrangements in place to mitigate risk, in most countries' NPHIs, funding for public health functions, a public good, is the sole responsibility of Government or comparable public bodies.

In respect of PHE developing patents on its products and services, the review team understands that PHE needs to protect the intellectual property and sometimes apply for patents when a product or service is the result of government-funded work of PHE staff. PHE sees this as protecting the public's investment. The review team also understands

that PHE often makes these products and services freely available to countries that are a priority for UK Government Official Development Assistance (ODA), and applies ODA funds for this purpose. Under UK Government rules PHE cannot make such products and services freely available to other countries which can afford to pay for them, nevertheless the review team feels that such products should be available globally for the public good and therefore has some concerns on this issue. The review team is aware that other NPHIs may well have the same issue. They understand the approach that PHE takes given UK Government rules, but would welcome the support of PHE in stimulating debate with other NPHIs on the circumstances in which it is appropriate for NPHIs to charge for products and services they develop.

#### *A learning organization:*

The PHE Chief Executive, Duncan Selbie, has an open, respectful and participatory leadership style, and his highly qualified leadership team, was mentioned by numerous stakeholders as setting the culture and tone of PHE from the top down. One interviewee noted, "PHE is definitely a listening and learning organization. Without exception I've been listened to and they've taken action." PHE's responsiveness to the findings of the Department of Health's Tailored Review and to stakeholder and public surveys point to its leadership's willingness to learn and listen. PHE has well-developed workforce development capacity and expertise. It developed and now leads the "Fit for the Future" strategic approach, which is aimed at addressing critical gaps in the workforce in the wider public health system. Particularly important are efforts to increase the leadership capability of Directors of Public Health in local authorities and work with local political leaders. This also applies to building additional capacity in translating research and intelligence into policy. PHE's forward-looking focus on the professional development of its workforce will yield good results. However, complicated HR processes sometimes hamper the movement of staff within both PHE and seconding outside PHE to other local and other bodies with public health responsibilities (e.g. local authorities). Where possible, these should be reconsidered to allow for a more fluid learning organization.

#### **Recommendations:**

*Recommendation 2: in next strategic planning cycle, consider a review of resource and staff allocation including the following topics:*

- *Overall allocation between departments and divisions of PHE linked to the major causes of death and disability, and their preventability in the country, in particular between infectious diseases/ health protection and health improvement. We recognize that PHE has a Medium Term Financial Plan and a financial planning process linked to strategic/business planning which allows movement of resources to priority areas. These take into account a broad range of areas, including PHE's role (and the role of others) in these different areas. The aim will be to get a balanced view on what PHE should be and do, and invest in priorities where PHE is likely to have more impact on population health and make the biggest difference.*

- *Ensure there is appropriate engagement with local government partners in the response to outbreaks and there is scope for greater clarity in the responsibilities of PHE's local partners in relation to PHE's leadership role for outbreak response.*
- *Social marketing: continue to ensure that the topics selected, and the interventions suggested, align with PHE's work/priorities and that they address unhealthy behaviors and reduce health inequalities. Social marketing activities must continue to deliver in terms of return on investment.*
- *Continue to ensure that PHE funding takes into account the greater needs of underprivileged communities through its funding formula.*
- *Continue to manage laboratory commercial services- ensuring sustainability and other funding options for core laboratory work of a PHI*
- *Whilst continuing PHE's current approach to develop patents on its products and services, to support an international workshop led by IANPHI to consider when it is appropriate for NPHIs to charge for products and services they develop.*
- *Work with partners across the system to develop an HR approach that enables inter-agency flexibility/temporary postings across the public health system.*

*Recommendation 3: Improving the resilience of PHE's communications/teleconference technology to ensure a robust system including that, which is needed for emergency operations.*

**Evaluation Question 3: Does PHE have the necessary impact and influence it needs to fulfil its mission?**

Under question 3 of the TORs, PHE asked four questions (Appendix 4) that in this evaluation report we have gathered into two parts: research to action/knowledge translation and partnerships (local, national and international) and its effectiveness. Key questions in the research-to-action area included whether PHE's work is effective and whether needs are identified and met (including developing, exploiting and translating into decision and action public health science to protect and improve the nation's health and reduce health inequalities) and whether PHE delivers outcomes that add value and influence decisions and behaviors. PHE also asked the Evaluation Team to explore whether it is making the best use of its partnerships locally, nationally and globally and whether it uses the feedback received to improve communication with partners and improve effectiveness.

Observations

*Research to action/knowledge translation:*

The importance of a strong, unbiased source of scientific advice to political leaders at the local, regional, national and international levels cannot be underestimated. An NPHI's research portfolio is crucial to decision-making and policy development capacity; NPHIs explore topics that directly relate to and support the public good and they are often the only source of unbiased scientific information on topics of national importance (versus research funded by advocacy groups or the private sector). Their results should be used to study cost-effectiveness, allocate resources, implement

interventions, develop policies and evaluate outcomes. “We need to be strong; if you get it wrong you end up in court. Scientific rigor is the only thing that can defend us,” noted a PHE expert. A few observations from the Evaluation Team in this area include:

- PHE has a strong research strategy in place; its research portfolio has been robust (more than 700 peer reviewed papers published per year) and impactful. The organization’s focus is on applied and translational research - a vital component of the national and international research infrastructure. Nonetheless, current restrictions that prohibit PHE from competing as the primary bidder for specific national fundamental research funds may inhibit progress. The potential to change such restrictions on PHE and other public sector research establishments was raised in a previous report to Government (The Nurse Report, 2015). Other recommendations are being implemented, e.g. the creation of UK Research & Innovation (from April 2018) so PHE can continue to advocate for change, including through that new structure.
- While the Department of Health is responsible for the oversight and commissioning of public health research, a dedicated research fund at PHE, or the provision of additional Government funds to address urgent implementation knowledge questions (including environmental-related conditions such as those linked to air pollution), could be considered. Numerous stakeholders suggested that PHE should have more of a leadership role in research to inform policy, particularly for air pollution. “Environmental health is young compared to other disciplines ... as scientists we’re asked a lot of questions that we can’t answer,” noted one PHE scientist.
- The National Institute for Health Research’s (NIHR) funding cycle provides important new opportunities for health protection and public health research, as will the multi-funder Prevention Research Partnership. In the field of health protection, the initiative of NIHR to fund through a competitive bid Health Protection Research Units (HPRUs)<sup>4</sup> is innovative and has great potential to translate high quality research conducted in universities - in partnership with PHE - to PHE activities and service delivery in health protection. The first 5-year cycle started in 2014, its impact on PHE outcomes are becoming evident and will be assessed.
- PHE is an important provider of research training in public health. Annually some 100 PhD students are registered with any of a range of universities on applied research programs undertaken in whole or in part at a PHE site and with cross-organizational supervisory teams. Students’ experiences ensure that they understand the context and value of research evidence for practice, services and policy advice. Diverse funding sources include PHE’s own studentship scheme that attracts well-qualified students and PHE staff, the latter on part-time doctoral programs for which PHE is an Affiliated Research Center of the Open University.
- PHE’s leadership has noted that increasing its effectiveness in both undertaking research- and using the results to inform policy development and decision-making - is a key priority. The Evaluation Team agrees. To do so the research management

4 Health Protection Research Units (HPRUs) are research partnerships between universities, Public Health England (PHE), and act as centers of excellence in multidisciplinary health protection research in England. The role of the HPRUs is to support PHE in delivering its objectives and functions for the protection of the public’s health in 12 priority areas (<https://www.nihr.ac.uk/about-us/how-we-are-managed/our-structure/research/health-protection-research-units.htm>).

system which is currently being scoped will play an important role in ensuring that data is supported by IT capacity; staff capability to translate evidence into policy is improved and dialogue continues among PHE and other decision-makers to ensure complete integration between national and local functions.

- PHE's evidence-based frameworks for national strategies (including [Change4Life](#), [Everybody Active, Every Day](#) and [place-based public health](#)) were mentioned by several stakeholders as important ways in which scientific research has guided the development of national strategies that are, in turn, implemented in partnership with PHE's technical assistance experts. PHE's work on developing national guidance on the cost effectiveness and efficacy of the programs of the National Institute for Health and Clinical Excellence is a good example of how PHE experts can contribute to national decision-making processes.
- The reorganized Health Improvement Directorate, which brings together PHE's interventions and policy work with its data analysis group, is impressive. The use of PHE's intelligence-translation tools and its Local Knowledge and Intelligence Service could be increased, with further investment. An innovative research-based TB program bringing together the work of several PHE directorates and using the latest genomics technology is world class and may be replicated for other topics throughout the country. PHE should continue its work with the various government agencies it supports to define roles for knowledge brokering and the role of knowledge and information. It is hoped that longstanding issues around data access, including between local authorities and the NHS, would also be addressed.
- PHE's leadership and its stakeholders recognize that the agency provides important evidence, but this is sometimes not enough to inform and push decisions at the political level. For example, several stakeholders in government noted that they would appreciate PHE's assistance and leadership with key research questions, including those related to air pollution. It was noted that PHE has a cadre of senior-level staff who understand the context in which government decisions are made, allowing them to effectively determine how research and data can be used and translated as policy recommendations for Government, whatever its level (national, regional or local). Ensuring that PHE maintains a group of staff with these skills is an important part in maintaining and building on its influence. In addition, once policy decisions are made, an evaluation of the impact of more controversial issues, such as those on e-cigarettes, may be merited. A key stakeholder in Government noted PHE's important role in "presenting science in a way that is useful and helpful for policy officials and understanding the political climate- contextualizing advice within the political climate but not changing it." A recommendation from the Tailored Review report, currently being implemented by PHE, was that PHE should develop a plan to build capability to ensure the organization worked effectively with the Department of Health and Other Government Departments.
- There is concern about the impact of European (under Brexit) and U.S.-based research funding policies and potential reductions in funding.

**Recommendations:**

*Recommendation 4: PHE should discuss with partners ways to increase research funding for PHE in critical areas of concern such as air pollution, including expanding PHE's ability to lead research projects and a potential new pool of funds at PHE. PHE could be given a larger role in activities related to air pollution research and policy.*

*Recommendation 5: Continue with the development of the range of skills required to transfer knowledge and evidence into both policy and practice including policy advice to key decision makers and communication skills to politicians, professionals and the public.*

**Partnerships:**

PHE has a well-defined strategy and has made impressive headway on efforts to link with and understand the needs of the various agencies, academia, NGOs, public bodies, partners and politicians it serves. Its public surveys and People Panel are innovative ways to incorporate public feedback into decision-making. The Pharmacy and Public Health Forum is another good example of stakeholder inclusion.

Stakeholders interviewed were universally complimentary of PHE's leadership. Numerous examples were given of how well PHE's Chief Executive and his team have worked to build good relationships that have resulted in measurable results. Some stakeholders felt that there were some cases where earlier engagement between national and local leads would improve implementation/outcomes. A few interviewees noted instances in which key stakeholders at various levels were not consulted early enough in the policy development process including policies on hepatitis A, child health and electronic cigarettes. Some stakeholders felt that PHE subject matter experts at the central level do not always understand local contexts and, as experts, can appear to consider themselves superior to those working on the local level.

Key points noted by the Evaluation Team include:

- Because there are no levers for PHE to enforce benchmarking and limit variability in quality across locales, personal relationships are very important to convincing local politicians and community leaders of the importance of public health. The Greater Manchester Devolution work exemplifies the process and initiative needed to develop real cooperation and partnership on multiple layers and sectors of government, including public health experts. This experiment/pilot/vanguard project should be further studied and evaluated to see if it can be replicated across other areas. This is particularly important given that the role of PHE vis-à-vis local public health varies by region and locality and will be further challenged by the planned end of the ring fence grant funding- it will be a challenge to ensure the best evidence are considered to achieve good health outcomes with limited resources. PHE will have to convince localities of the importance and benefit of public health activities at a time when funds will be reduced and local priorities may vary. Working with political and community leaders has been successful some regions and could be replicated. The National Health Service's nation-wide STP approach, though less advanced than the Manchester project, has promise as well.

- PHE's strategy to engage local community leaders as champions – such as in Coventry and elsewhere – should be expanded. PHE should encourage and support funding bodies and commissioners to provide incentives such as competitive grants or block funding could be considered to stimulate public health partnerships, at the local level, across entities. PHE produces Health Profiles for all local authorities each year, with an online tool that is updated quarterly. PHE should consider gathering best practices that can be shared with the public and stakeholders to effect improvement.
- On the national level, PHE's collaborative priority setting and planning with the Department of Health has led to objectives that are aligned and understood. Stakeholders on all levels are consulted through several methods including an annual survey. PHE's leadership knows well that engaging local, national and international leaders in policy development at the earliest level is important and has taken steps to do so.
- PHE's successful partnerships include initiatives with NHS England and Diabetes UK on diabetes, the first wave of which will cover 26 million people. The PHE Mental Health Team, with the NHS, is galvanizing local and national efforts to reduce health inequalities and improve public health. This important work will bring a holistic approach to the social determinants of mental health and its impact on well-being and productivity. PHE's new partnerships with police and fire and rescue associations are also promising.
- PHE's cross-governmental relationships strategy could continue to be strengthened through formal framework agreements with other ministries and other public bodies, as is also done in the Netherlands by RIVM with 5 ministries and a National Authority. The formalization of PHE membership of inter-ministry working groups, for example, on global health and healthcare/public health, and the DEFRA/DFT Joint Air Quality Unit (JAQU).
- The National Health Service is a huge opportunity to work across government to increase health outcomes in England. Any structural and political barriers to this need to be addressed. Several key stakeholders stated that in practice, short-term curative efforts overwhelm long-term health efforts. It is important for PHE to continue to maximize the engagement mechanisms with the NHS, including the Professional Leadership, National Quality Board and the NHS Prevention Board. There are not always the levers for the NHS to include a public health perspective in NHS delivery. While groups such as GPs are systematically reached with preventive measures, these measures are not always used or implemented. It is an important role for PHE to encourage an improved focus on prevention within the NHS, including through general practice and primary care. There is an urgent need for a concrete movement forward from the Government to harness the opportunity of a stronger NHS-PHE relationship. Public health ambitions or targets should be a part of all NHS activities, including STPs (Sustainability and Transformation Plans), where prevention outcomes should/could be included in each plan. Stakeholder discussions should be undertaken, resulting in agreement at the national level between PHE and the NHS on a joint strategy, roles, and commitments. PHE should continue to be represented on high level NHS groups (nationally and locally) and vice versa. Other opportunities for prevention should be explored – for example, the NHS's 1.2 million staff could be developed into health and wellbeing champions and PHE could receive additional funds for prevention and screening activities in partnership with the NHS.

- Within the international arena, PHE has continued to strengthen its global health portfolio including the recruitment of a strong new leader to develop a focused and value-added strategy. PHE's work in Nigeria (meningitis), Ethiopia (Cholera), Sierra Leone, Guinea and Liberia (Ebola), China (salt and sugar reduction) and elsewhere is exemplary. Internal and external cooperation and measurable results can be further strengthened with a new, central team that leads across all directorates. The large number of staff volunteering their time for international efforts, at short notice, is commendable; one important stakeholder noted employees' call to public service as "the hallmark of the ethos of the organization."

*Recommendation 6: Continue to strengthen national and international partnerships.*

- *Air quality is one area in which this should be explored.*

*Recommendation 7: Explore opportunities to strengthen and develop local partnerships:*

- *PHE should highlight its benchmarking of local level outcomes in its Public Health Outcomes Framework and Local Health Profiles including a thorough follow-up on the impact of devolution/ring fence grants*
- *The Greater Manchester Devolution should/could be evaluated from a PH perspective and potentially replicated when the PH delivery is superior to the conventional approach*
- *PHE could expand the best practices from the Coventry initiative, working with local leaders on messages and social marketing; engaging local leaders in championing strategies*
- *PHE should facilitate and stimulate cooperation between localities, local business and the voluntary sector*

*Recommendation 8: Broaden cooperation with the NHS, including priority setting.*

- *Undertake stakeholder discussions to develop agreement at the national level between PHE and the NHS on a joint strategy, roles, and commitments. As part of this, other opportunities for prevention at and in partnership with the NHS should be explored, including additional prevention/screening funds at PHE.*
- *PHE should continue to be represented on the high-level NHS groups (nationally and locally) and vice versa.*

## **Summary of Recommendations**

*Recommendation 1: PHE is one of the world's foremost public health institutes. A case study on its development and change management processes in a complex environment should be developed, and its successes should be highlighted and shared as best practices by IANPHI and in national and international settings, including the 2017 IANPHI annual meeting.*

*Recommendation 2: In next strategic planning cycle, consider a review of resource and staff allocation including the following topics:*

- *Overall allocation between departments and divisions of PHE linked to the major causes of death and disability, and their preventability in the country, in particular between infectious diseases/ health protection and health improvement. We recognize that PHE has a Medium Term Financial Plan and a financial planning process linked to strategic/business planning which allows movement of resources to priority areas. These take into account a broad range of areas, including PHE's role (and the role of others) in these different areas. The aim will be to get a balanced view on what PHE should be and do, and invest in priorities where PHE is likely to have more impact on population health and make the biggest difference.*
- *Ensure there is appropriate engagement with local government partners in the response to outbreaks and there is scope for greater clarity in the responsibilities of PHE's local partners in relation to PHE's leadership role for outbreak response.*
- *Social marketing: continue to ensure that the topics selected, and the interventions suggested, align with PHE's work/priorities and that they address unhealthy behaviors and reduce health inequalities. Social marketing activities must continue to deliver in terms of return on investment.*
- *Continue to ensure that PHE funding takes into account the greater needs of underprivileged communities through its funding formula.*
- *Continue to manage laboratory commercial services- ensuring sustainability and other funding options for core laboratory work of a PHI*
- *Whilst continuing PHE's current approach to develop patents on its products and services, to support an international workshop led by IANPHI to consider when it is appropriate for NPHIs to charge for products and services they develop.*
- *Work with partners across the system to develop an HR approach that enables inter-agency flexibility/temporary postings across the public health system.*

*Recommendation 3: Improving the resilience of PHE's communications/ teleconference technology to ensure a robust system including that, which is needed for emergency operations*

*Recommendation 4: PHE should discuss with partners ways to increase research funding for PHE in critical areas of concern such as air pollution, including expanding PHE's ability to lead research projects and a potential new pool of funds at PHE. PHE could be given a larger role in activities related to air pollution research and policy.*

*Recommendation 5: Continue with the development of the range of skills required to transfer knowledge and evidence into both policy and practice including policy advice to key decision makers and communication skills to politicians, professionals and the public.*

*Recommendation 6: Continue to strengthen national and international partnerships.*

- *Air quality is one area in which this should be explored.*

*Recommendation 7: Explore opportunities to strengthen and develop local partnerships:*

- *PHE should highlight its benchmarking of local level outcomes in its Public Health Outcomes Framework and Local Health Profiles including a thorough follow-up on the impact of devolution/ring fence grants*
- *The Greater Manchester Devolution should/could be evaluated from a PH perspective and potentially replicated when the PH delivery is superior to the conventional approach*
- *PHE could expand the best practices from the Coventry initiative, working with local leaders on messages and social marketing; engaging local leaders in championing strategies*
- *PHE should facilitate and stimulate cooperation between localities, local business and the voluntary sector*

*Recommendation 8: Broaden cooperation with the NHS, including priority setting:*

- *Undertake stakeholder discussions to develop agreement at the national level between PHE and the NHS on a joint strategy, roles, and commitments. As part of this, other opportunities for prevention at and in partnership with the NHS should be explored, including additional prevention/screening funds at PHE.*
- *PHE should continue to be represented on the high-level NHS groups (nationally and locally) and vice versa.*

## Appendix 1 IANPHI Evaluation Team Members



Professor Dr. André van der Zande (Chair) - Director-General, National Institute for Public Health and the Environment (RIVM), Netherlands

Professor Doctor André van der Zande, PhD (1952) is Director-General, National Institute for Public Health and the Environment (RIVM). He has held this position since 1 January 2011. André van der Zande studied biology at Leiden University and graduated with distinction in 1976. In 1984, he was awarded his PhD from the same university on the subject disturbance by recreation of breeding bird population. In the period 1982 until 1996, he worked in the field of nature conservation, with the Province of Gelderland, as a Regional Officer in South Holland for the State Forestry Service, and at the Ministry for Agriculture, Nature and Food Quality.

From 1996 onwards he managed various large knowledge institutes in Wageningen, among them Alterra. In addition, he was a part-time professor of Spatial Planning and Cultural History under the Belvedere program at Wageningen University (2005-2009). In 2002, Van der Zande made the changeover back to the former Dutch Ministry of Agriculture, Nature and Food Quality. Until 2007, he was Director-General at the LNV and his responsibilities included agricultural policy, nature and biodiversity, manure policy and general environmental policy. In 2007, he became Secretary-General there, until the merger of the LNV with the Dutch Ministry of Economic Affairs.



Dr Jean- Claude Desenclos (panel member) - Secretary General of IANPHI

Deputy Director for Scientific Affairs, Santé Publique France (The French Public Health Agency). After several years of medical general practice and humanitarian involvements through Médecins Sans Frontières, Jean-Claude Desenclos moved to public health. After working 3 years at the US Centers for Diseases Control and Prevention as a medical epidemiologist, he integrated the newly created national French Surveillance Institute (Institut de Veille Sanitaire [InVS]) in 1993. He has been the head of the department of infectious diseases for 12 years and became the scientific director of the InVS in 2007, position in which he remains since the creation of Santé Publique France.

Jean-Claude Desenclos is the author or co-author of 200 international scientific publications and editor of a French textbook in epidemiology (*Epidémiologie de terrain*, Edition John Libbey, 2012). He is affiliated to the Paris doctoral school of public health where he supervised PhD students. He is member of numerous scientific committee and advisory board in France or Europe. He is associated editor for the *European Journal of Epidemiology*, *Current Outbreak* and *BMC Infectious Diseases*. He is the Secretary General of the International Association of National Public Health Institute



Dr. Mauricio Hernández-Ávila (panel member) - President of IANPHI and Adjunct Professor, National Institute of Public Health, Mexico

During 2011-2017, Dr. Hernandez was Dean of the Mexico School of Public Health and Director General of the Instituto Nacional de Salud Pública of Mexico (the National Institute of Public Health, Mexico). His Medical degree is from the National Autonomous University of Mexico, his Master and Doctoral studies are from the Harvard School of Public Health. Between 2006 - 2011 Hernandez was appointed Under-Secretary for Disease Prevention and Health Promotion in the Ministry of Health, and in 2012 was elected Director General of the National Institute of Public Health.

Dr. Hernandez is a foreign associate of the Institute of Medicine (IOM) of the National Academies in the U.S.A. and, currently, is Secretary General of the International Association of National Institutes of Public Health (IANPHI). He is also a member of the National Academy of Medicine and the Mexican Academy of Science. With more than 450 scientific publications, Dr. Hernández-Ávila is a world-renowned researcher whose work has influenced important public policies benefiting Mexican health such as the Law for Tobacco Control and innovative multi-sectoral policies for obesity control. He has received prestigious recognitions such as the Miguel Aleman Award, the Academic Merit Award from Harvard University and in 2014, and the National Prize for Arts and Sciences (Mexico) in Physics, Mathematics, and Natural Sciences, among others.



Dr. Lothar H. Wieler (panel member) - President, Robert Koch Institute, Germany

Dr. Lothar H. Wieler is the President of the central Public Health Institution responsible for disease control and prevention in Germany. He is also a Professor at the Center for Infection Medicine, Institute of Microbiology and Epizootics of the Freie Universität (FU) in Berlin. After obtaining his doctoral degree, he had a first Post-Doc position at the Pathology Department, Universität Ulm, and further on at the Institute of Hygiene and Infections of Animals at the Justus-Liebig-Universität, Gießen. Two sabbatical stays, a first one at the Center for Vaccine Development, University of Maryland in Baltimore, USA, the second at the Wellcome Trust Sanger Institute, Hinxton, further inspired his research interests. Dr. Wieler has received the Young Researchers award from the German Veterinary Association and the Main Award of the German Association for Hygiene and Microbiology.

His research focuses around infections caused by zoonotic agents as well as drug-resistant and multi-drug resistant bacterial pathogens. Molecular pathogenesis and risk assessment based on molecular functional infection epidemiology – utilizing latest molecular technologies - of bacterial pathogens is a discipline that has been moved ahead by him. He is author of more than 215 peer-reviewed papers. Since 2010, he has been an elected member of the German National Academy of Sciences Leopoldina, since 2016 Senator of the Section “Veterinary Medicine”.



Dr. Johan Carlson (panel member) - Director-General of the Public Health Agency of Sweden

Johan Carlson (M.D., Ph. D., D.T.M.& H), took up office as Director-General of the Public Health Agency of Sweden on January 1 2014. He is the former Director General of the Swedish Institute for Communicable Disease Control (2009-2013). He has a background in clinical medicine (infectious diseases and tropical medicine). In addition, he has held research positions at the Karolinska Institute in the 1990s and has served as an expert in the field of public health and communicable diseases at the European Commission (1998-2001). He is also member of the Management Board of the ECDC (European Center for Disease Prevention and Control) and of the Swedish National Veterinary Institute.



Dr Natalie Therese Mayet (panel member) - Chair of IANPHI Africa and Co-Director of South African Regional Global Disease Detection Center

Dr Natalie Mayet has established the Center in South Africa together with the National Department of Health, the National Institute for Communicable Disease (NICD) and the Center for Disease Prevention and Control in Atlanta. She is currently serving as the Chairperson of IANPHI Africa. Dr Mayet qualified as a medical doctor from the University of Natal in 1983 and obtained further qualifications from the University of the Witwatersrand in Tropical Medicine and Hygiene, Public Health, Health Services Management and Occupational Health. She has been involved in Public Health for 34 years and has extensive experience in both the Public and Private sector environment. She has experience working with Local, Provincial and National Departments of Health and works across all sectors including the NGO and CBO entities.

She participated in setting up the Crises Management Center for dealing with all Hazards in the automotive industry and was part of the International Crises Management Team in the industry for managing the Pandemic Preparedness and Response plans. She set up the Emergency Operations Center at the NICD.

Dr. Mayet is currently responsible for the South African Field Epidemiology Training Program and has facilitated the establishment of Epidemiology Special Interest Group at Public Health Association of South Africa, and serves as the PI for Co-operative agreements. She is involved in the re-engineering the Notifiable Medical Condition Surveillance system and is supporting the development of the National Public Health Institute for South Africa. She has supervised and mentored various undergraduate and postgraduate students, holds professional memberships with the Health Professionals Council of South Africa and the South African Society of Travel Medicine. Dr. Mayet has presented at local and international conferences and is the recipient of the following awards - the 1997 James Gear Medal and Prize, the Best paper award at the International Safety Conference in 2000, and the Global Health Initiative of World Economic Forum Award for best workplace HIV/AIDS Program.



Dr Anne-Catherine Viso, PhD (Secretariat member) - IANPHI France Secretariat and Deputy Director, Science and International Office, Santé Publique France

Anne-Catherine Viso has a PhD in Toxicology and a Master Degree in Technology and Innovation Management. Since May 2016, she is deputy to the Director of the Science and International Office at the French Public Health Agency, Santé Publique France. From 2010-2016, she was deputy to the director of the Science and Quality Management Office at the French Institute Public Health Surveillance, InVS. From 2006-2010, she was in charge of European affairs at the French Institute Public Health Surveillance, InVS. She has been the National Coordinator for ECDC in France, and alternate member at the Management Board of ECDC since 2006. Since 2006 she has been in charge of the secretariat of the Scientific Board of the InVS and of Santé Publique France and of the secretariat of the Public Health Ethics and Deontology Committee (from 2012-2015) at InVS. Since 2014, she has been in charge of the IANPHI secretariat activities carried out by the IANPHI Office based in France under the supervision of the IANPHI Secretary General and the IANPHI Executive Board. From August 2003 to 2006, she was responsible for European and international collaboration and responsible for expert committees at the French Agency for Environmental and Occupational Health Safety (AFSSET). From 1993- 2003 she worked for a French private company in charge of European projects related to water quality and was responsible for the French mirror group of CEN (European Committee for Standardization) to identify pre- normative research priorities to be funded by the European Commission programs.



Courtenay M. Dusenbury (Secretariat member) - Director, IANPHI US Secretariat

Courtenay Dusenbury has served as the Director of the International Association of National Public Health Institutes (IANPHI) U.S. Office at Emory University's Global Health Institute in Atlanta since its founding in 2006. In this position, she guides the operations of IANPHI including public health system strengthening projects in over 45 countries around the world. Prior to her current position, she served as the Director of Federal Affairs for Emory University. She worked in the U.S. Congress as a legislative director, senior health policy advisor and budget negotiator for members on the House Ways and Means and Energy and Commerce committees from 1994-2000, including work on annual budget bills, Medicare and Medicaid reform bills and public health legislation. From 1988 to 1991, she was special advisor for federal policy to the director of the Puerto Rico Economic Development Agency in San Juan and from 1991 to 1994 was the federal health policy advisor to the Governor of Puerto Rico and assistant director of his office in Washington, D.C. She began her career as a health policy analyst and press secretary in the Pennsylvania State Senate. She is a graduate of the Pennsylvania State University; attended Georgetown University's Public Policy Institute and earned her MPH in health policy/health economics from Emory University. She has served on the governmental affairs boards of several major U.S. advocacy groups including the American Association of Medical Colleges, the American Association of Universities and the Association of Academic Health Centers.

## Appendix 2 The Core Attributes and Essential Public Health Functions for NPHIs

### Core Attributes

- National scope of influence
- National recognition
- Limitations on political influence
- Scientific basis for programs and policies
- Focus on the major public health problems affecting the country
- Adequate human and financial resources
- Adequate infrastructure support
- Linkages and networks
- Accountability

### Essential Public Health Functions

- 1. Evaluation and analysis of health status:** Collect data to understand the health status of the population, set priorities, and suggest interventions. Gather or have access to data on vital statistics, potential threats to health, risk factors for disease and injury, and access to and use of personal health services. Use the data to guide policies and programs.
- 2. Public health surveillance, problem investigation, and control of risks and threats to public health:** Collect data on an ongoing basis to monitor for public health problems, and, when problems are identified, take action to control them. Conduct ongoing monitoring for outbreaks and other Public health problems. Make sure that samples can be tested for organisms or chemicals that cause public health problems. Investigate outbreaks or other public health problems, and make sure that interventions are put in place to address them.
- 3. Prevention programs and health promotion:** Take action to create the conditions that promote health in the population. Inform and educate people about how to improve their health. Support legislation and regulations to promote health. Support environmental changes to promote health
- 4. Social participation in health:** Strengthen the power of the community to play an active role in public health. Involve the community in developing and designing programs to promote health Provide assistance and information to organizations that work to promote health.
- 5. Planning and management:** Develop and implement a strategic plan, policies, and programs for the NPHI, as well as systems to ensure efficient operations. Have a clear vision and mission statement. Conduct periodic strategic planning, using data to identify priorities and set measurable goals. Employ staff who are trained in the systems needed for efficient functioning of an NPHI.
- 6. Regulation and enforcement:** Ensure that regulations and rules that support public health are passed and enforced. Provide data to help regulators make evidence-based decisions. Evaluate the impact of regulations and rules on public health.
- 7. Evaluation and promotion of equitable access to necessary health services:** In close collaboration with government and nongovernment agencies, monitor access to health care, including access for vulnerable populations, identify barriers to care and strategies to overcome barriers.

- 8. Human resource development and training:** help develop and retain a public health workforce that is adequate for national needs. Monitor the capacity and needs of staff. Provide training and continuing education. Provide fulfilling opportunities and other incentives to encourage staff to remain in the public health workforce.
- 9. Quality assurance in personal and population-based health services:** Work with the health care system to improve health services. Conduct surveillance for healthcare-related infections. Collect data on or make recommendations about patient safety. Conduct evaluations or review data to assess the quality of services.
- 10. Public health research:** Conduct research on high-priority issues. Characterize the country's most important health problems. Provide other data important to decision-making. Evaluate the effectiveness of interventions. Make sure that research findings are translated into decisions, policies, and programs.
- 11. Reduction of the impact of emergencies and disasters on health:** Conduct planning for emergencies, and be part of government-wide planning efforts. Determine in advance what services the NPHI will provide in an emergency. Provide materials and training to ensure smooth functioning during an emergency. Develop agreements with organizations that will be involved in a response.

## Appendix 3: Interviewees and Presenters

Monday 26 June 2017

Session attendees
Richard Gleave, Chief Operating Officer, Public Health England Paul Cosford, Director for Health Protection and Medical Director, Public Health England Adrian Masters, Director of Strategy, Public Health England
Duncan Selbie, Chief Executive, Public Health England
Adrian Phillips, Director of Public Health, Birmingham City Council
Sarah Anderson, Head of National Tuberculosis Office, Public Health England Lynn Altass, National Tuberculosis Strategy Program Manager, Public Health England
Alexia Clifford, Deputy Director Marketing, Public Health England
Graham Jukes OBE, Former Chief Executive of CIEH, Chartered Institute of Environment Health Tony Lewis, Head of Policy, Chartered Institute of Environment Health
Andrew Furber, President and Chief Executive Officer, Association of Directors of Public Health, The Association of Directors of Public Health
Sir Derek Myers, Interim Chair, Public Health England Advisory Board Richard Gleave, Chief Operating Officer, Public Health England
Bernie Hannigan, Research, Translation & Innovation Director, Public Health England
John Newton, Director of Health improvement, Public Health England Peter Bradley, Director of Knowledge and Intelligence, Public Health England
Viv Bennett, Chief Nurse, Public Health England
Ajit Lalvani, Chair of Infectious Diseases, National Institute of Health Research Senior Investigator and Wellcome Senior Clinical Research Fellow at Imperial College (NIHR HPRU)

Tuesday 27 June 2017

Session attendees
<p>Peter Bradley, Director of Knowledge and Intelligence Services, Public Health England            Jake Abbas, Head of Local Knowledge and Intelligence Services, Public Health England</p>
<p>Alison Tedstone, National Director of Diet and Obesity, Public Health England            Rosanna O'Connor, Director of Alcohol, Drugs &amp; Tobacco, Public Health England            Ann Marie Connolly, Director of Health Equity and Mental Health, Public Health England</p>
<p>Paul Cosford, Director for Health Protection and Medical Director, Public Health England            Adrian Masters, Director of Strategy, Public Health England            Richard Gleave, Chief Operating Officer, Public Health England</p>
<p>Naima Bradley, Head of Environmental Hazards and Emergencies Department, Public Health England            Houda Al-Sharifi (DPH Lead), Director of Public Health, Richmond and Wandsworth Council</p>
<p>Clara Swinson, Director General, Global and Public Health, Department of Health            Helen Shirley Quirk, Director, Emergency Preparedness and Health Protection Policy &amp; Global and Public Health Group, Department of Health</p>
<p>John Middleton, President, UK Faculty of Public Health</p>
<p>Onn Min Kon – NHS England Consultant Respiratory Physician, Chest and Allergy Clinic, St Mary's Hospital</p>
<p>Peter Kelly, Center Director, North East, Public Health England</p>

Wednesday 28 June 2017

Session attendees
<p>Dame Anne Johnson, Chair and Vice- Dean, External Relations, Faculty of Population Health Sciences, UCL Institute of Epidemiology and Health Care            Carol Brayne, Professor of Public Health Medicine, Cambridge University and Director, Cambridge Institute of Public Health            Ashley Adamson, Professor of Public Health Nutrition and Director, NIHR School for Public Health Research</p>
<p>Sue Ibbotson, Center Director, West Midlands, Public Health England            Debra Laphorne, Center Director, South West, Public Health England</p>
<p>Bill Parish, National Air Quality Evidence Team Lead, Department of Environment, Food &amp; Rural Affairs, (DEFRA)</p>
<p>Quentin Sandifer, Executive Director of Public Health Services and Medical Director, Public Health Wales            Richard Parish, Professor of Health Development, University of Chester and in addition Advisory Board Member of Public Health England, Chair of MOCHA Board</p>
<p>Neil Squires, Director of Global Public Health, Public Health England            Sian Griffiths, Non-Executive, Public Health England Advisory Board            Gemma Lien, Head of Global Health Strategy, Public Health England</p>
<p>Paul MacNaught, Director of European Union and International and Public Health Systems, Department of Public Health</p>
<p>Stephen Holgate, Clinical Professor of Immunopharmacology Faculty of Medicine Clinical and Experimental Sciences</p>
<p>Raymond Jankowski, Head of Healthcare Public Health, Public Health England            Rashmi Shukla, Regional Director, Midlands and East of England Regional Office, Public Health England            Celia Ingham-Clark, Medical Director for Clinical Effectiveness, National Health Services</p>
<p>Anne Mackie, Director of PHE Director of Screening, Public Health England</p>
<p>Chris Whitty, Chief Scientific Adviser, Department of Health</p>
<p>David Rhodes, Director Environmental Public Health, Public Health England</p>
<p>Paul Cosford, Director for Health Protection and Medical Director, Public Health England            David Rhodes, Director, Environmental Public Health, Public Health England            Derrick Crook, Director, National Infection Service, Public Health England</p>
<p>Derrick Crook, Director, National Infection Service, Public Health England</p>

Thursday 29 June 2017

Session attendees
Jenny Harries, Regional Director, South, Public Health England Meng Khaw, Center Director, South West, Public Health England Diana Grice, Center Director, South East, Public Health England
Yvonne Doyle, Regional Director, London, Public Health England
Peter Bradley, Director of Knowledge and Intelligence Services, Public Health England Jake Abbas, Head of Local Knowledge and Intelligence Services, Public Health England
Martin Reeves, Chief Executive, Coventry City Council
PHE Executive Team

## Appendix 4 Terms of Reference (developed by the PHE leadership team)

- 1. Review context:** Public Health England (PHE) is entering its fifth year of operation and has undergone significant change processes since establishment. This is an opportune time to review the progress PHE has made. The IANPHI external peer-to-peer evaluation will provide an international benchmarking exercise to help guide our development across the full range of what we do as we mature in our role and identify areas for improvement.
- 2. Overall aim:** To understand and demonstrate what PHE can learn from international peer-to-peer evaluation so that we can be the best national public health institute that we can possibly be.
- 3. Scope and objectives of the review:**

Question 1: Does PHE demonstrate the leadership, strategy and delivery required to fulfill our responsibilities, taking account of the UK Government Cabinet Office model of capability?

### Delivery:

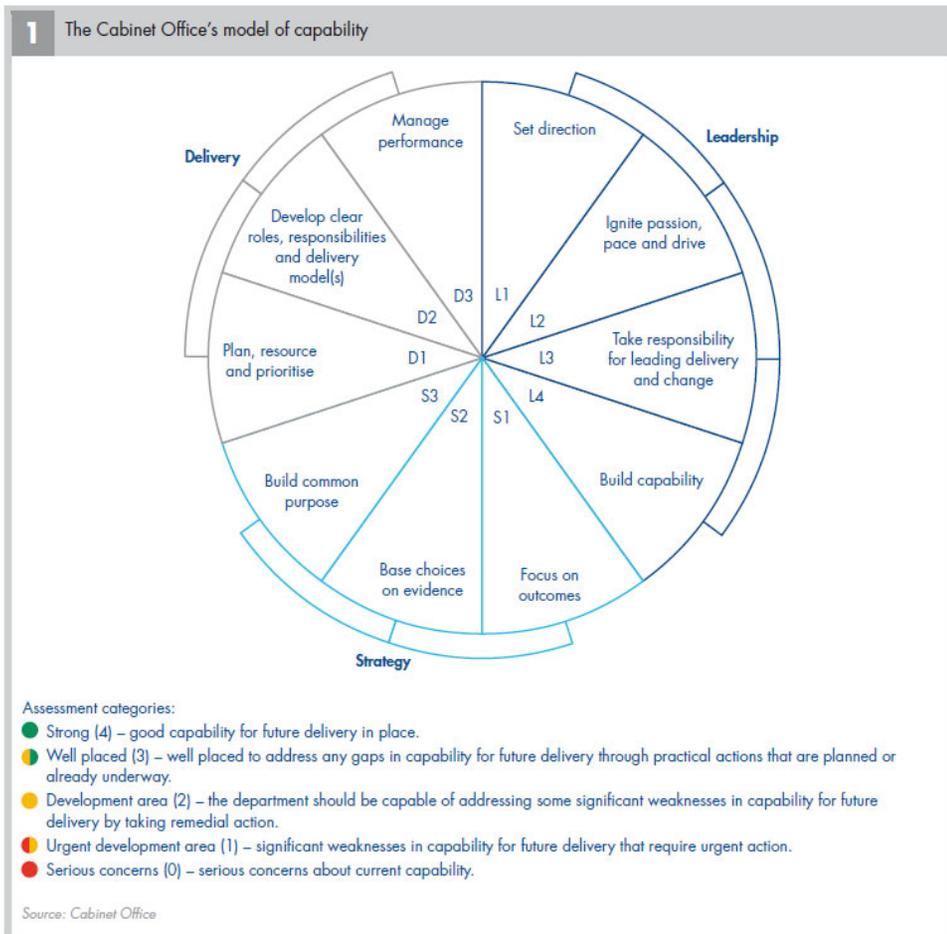
- Plan, resource and prioritize
- Develop clear roles, responsibilities and delivery models
- Manage performance

### Leadership:

- Set direction
- Ignite passion, pace and drive
- Take responsibility for leading delivery and change

### Strategy

- Build capacity
- Focus on outcomes
- Base choices on evidence
- Build common purpose



Question 2: To demonstrate this, is PHE set up most effectively and efficiently to deliver our mission and discharge our functions?

- i. Are we structured and organized most efficiently?
- ii. Are our resources allocated effectively and efficiently?
- iii. Are we ready for future opportunities, challenges or threats?
- iv. Are we a learning organization with a focus on continuous improvement?

Question 3: Does PHE have the necessary impact and influence it needs to fulfil its mission?

- i. Do we develop, translate and exploit public health science to protect and improve the nation's health and reduce health inequalities?
- ii. Are we effective? Do we identify needs and meet them? Do we deliver outcomes that add value? Do we influence decisions and behaviors?
- iii. Do we make the best use of our partnerships locally, nationally and globally?
- iv. Do we use the feedback we get to improve our communication with partners and improve its effectiveness?

