Public Health England

Protecting and improving the nation's health

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 15 July 2015
Presented by	Ann Hoskins and Viv Bennett
Title of paper	**Public health issues for children, young people and families – a life course approach**

1. Purpose of the paper

1.1 This paper:

a) describes the key public health priorities for children and young people and what steps PHE is taking to address these;
b) sets out PHE's ambition to ensure that every child has the best start in life (as set out in *Evidence into Action*[1]) and continues to thrive as they enter adulthood;
c) describes how we are using a PHE wide lifecourse approach for health of those aged 0-25; and
d) how PHE's new Children, Young People and Families (CYP&F) Forum provides the mechanism to:
   (i) Coordinate PHE work on children and young people and the interfaces with other PHE priorities and programmes, for example tobacco and alcohol;
   (ii) Enable a comprehensive integrated approach to PHE CYP to be presented to stakeholders and external CYP governance/partnerships groups;
   (iii) Make best use of knowledge, expertise and skills across PHE, including PHE Centres, and adopting a 'critical friend' approach to programmes of work; and
   (iv) Champion '*Think Children and Families*' across PHE.

2. Recommendation

2.1 The Board is asked to **NOTE**:

a) PHE's current and proposed plans to achieve its national priority;
b) PHE wide lifecourse approach to protecting and improving the health of children and young people; and
c) the role of the Forum.

3. Introduction

3.1 PHE has consistently advocated the importance of public health taking a life course approach to improve health and wellbeing outcomes and reduce

[1] https://www.gov.uk/government/publications/from-evidence-into-action-opportunities-to-protect-and-improve-the-nations-health

inequalities. In line with Professor Marmot's recommendations in *Fair Society, Healthy Lives*[2], PHE recognises the opportunities for health gains at each stage of a person's life, and conversely the impact poor health and inequalities have on the next life stage.

3.2 PHE works through a number of partnerships at national level. In particular PHE works with Department of Health (DH), Local Government Association (LGA) and NHS England on a range of priorities to improve health outcomes for children and young people and to improve the position for outcomes in England when compared with leading countries in child health. This paper sets out in summary some of those actions. The impact of these will be measured through the Public Health Outcomes Forum, various reporting systems and from 2016 the Maternal and Child Health national data set.

3.3 PHE has taken a life course approach using the following broad stages:

a) Preconception, pregnancy;
b) Early Years: Infancy (0-2 years)and Pre-school(2-5 years);
c) School age; and
d) Young people (which overlaps with school age, using the Chief Medical Officer's recommendation to recognise this stage as between 10-24 years).

Appendix A sets out some of the main health and wellbeing outcomes for this age period.

3.4 There are also important cross-cutting health outcomes and determinants of health including healthy weight/obesity, mental health and child poverty - 20.6% of children under 16 years of age live in poverty in England.

3.5 Safeguarding takes many forms and is a key foundation for all children. Protecting children includes reducing injuries in the home and on the roads, building positive parent-child relationships, peer relationships, and protecting children from physical and emotional abuse, including sexual abuse. PHE is taking action on all these points, working across sectors to develop and deliver practical resources and tools that will help keep children safe.

3.6 This report looks at each of these stages and the cross cutting issues, the main outcomes and the work PHE is doing. Throughout, PHE recognises the centrality of:

a) families and adult carers to children's health and wellbeing;
b) the role of local government and their partners to drive improvements locally;
c) the importance of supporting integrated approaches to children, young people and families especially in commissioning services where there are several commissioners involved;
d) addressing inequalities, whether these are due to deprivation or discrimination; and
e) listening and working with children, young people and families in order to understand them better as PHE develops its work.

[2] Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al.. *Fair Society, Healthy Lives: The Marmot review*. London: University College London; 2010.

4.0 Preconception, Pregnancy and Early Years

Pre-conception and pregnancy

4.1 Poor maternity mental health, obesity and smoking in pregnancy are associated with risks to mother and unborn child. For each of these there is a strong social gradient, with women from the poorest households generally experiencing the worst outcomes.

4.2 The case for intervening at this life stage is therefore very clear and makes sense from health and economic perspectives. At a national level PHE provides the professional leadership and system responsibilities for health visiting and family nurse partnership (FNP) services. These are critical in providing universal and targeted support in pregnancy, infancy and early years. The health visiting '4-5-6' model and high impact areas in Appendix B describe the role and scope of this.

4.3 PHE actions to address poor outcomes include:

a) Working with NHS England and DH to reduce prevalence rates for smoking in pregnancy;
b) Reviewing the Information Service for Parents to ensure that we optimise opportunities to get key health messages to new parents; and
c) Ensuring that as part of our wider work on obesity, that particular focus is given on the preconception and maternity periods.

Infancy (0-2 years)

4.4 Children who do not thrive at in their early years have increased risks of poor outcomes throughout childhood and long-term ill health - including adult obesity, drug and alcohol misuse, heart disease, dental decay and poor mental health.

4.5 Positive attachment to parents, building resilience, communication and physical development, including a healthy weight, are all key health and wellbeing assets for infants. Health protection afforded through immunisation programmes remains a cornerstone of the work of local public teams. PHE actions to address poor outcomes are set out below under Best Start.

Pre-school (2-5 years)

4.6 Currently only 60.4% of children in England (2013/14) achieve a good level of development at the end of reception as measured by the Foundation Stage Profile[3]. This rate falls for those children who are entitled to free school meals to 45%, compared with 64% who are not. There are also variations according to ethnic background. The assessment considers personal, social and emotional development, physical development, communication and language, and maths and literacy. PHE actions to address poor outcomes are set out below under Best Start.

5.0 Evidence into Action Best Start for all our Children

5.1 PHE has committed to increasing the numbers of children who are:

a) 'ready to learn at two' and
b) 'ready for school at five.'

5.2 Drawn from *Milestones of normal child development age ~4years* in Mary Sheridan's *From Birth to Five Years*, some of the key features of being school

[3] *Department for Education, Foundation Stage Profiles England 2014,* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/376216/SFR46_2014_text.pdf

ready include:

a) A child has reached a level of emotional development which enables every child to:
   i) Communicate their needs and have good vocabulary
   ii) Be independent in getting dressed and going to the toilet
   iii) Be independent in eating
   iv) Be able to take turns, sit still and listen and play
   v) Able to socialise with peers and form friendships and separate from parent/s

b) They have physical good health and:
   i) Be well nourished within normal weight for height range
   ii) Have good dental health
   iii) Be protected against infectious illness having received all childhood immunisations

5.3 In *Evidence into Action,* PHE has set out eight specific actions:

a) Support local authorities in developing integrated children and young people's services as they take on commissioning responsibilities for the Healthy Child Programme for 0-5s;
b) Promote the importance of high-quality universal services as a foundation for good health for all our children and as a platform for early intervention and targeted support;
c) Develop and strengthen the evidence, including working with the Early Intervention Foundation as a 'What Works Centre for Early Intervention';
d) Expand the Start4Life Information Service for Parents from 0-2 years to 0-5 years and sign up over 200,000 more parents;
e) Expand newborn bloodspot screening to include four new inherited metabolic disorders;
f) Work with the National Institute for Health and Care Excellence (NICE) on the implementation of the quality standards and pathways for emotional and social wellbeing in early years;
g) Lead and co-ordinate the Childhood Flu Programme, working with NHS England; and
h) increase coverage of measles, mumps and rubella immunisations for all children at five years.

PHE directorates and Centres have made good progress on the initial Best Start priorities and this is shown in Appendix C.

5.4 The transfer of the commissioning of Healthy Child Programme 0-5s is the last part of the transfer of public health commissioning and has been a major system wide priority in which PHE has played a major role. Supporting the transition and new commissioners is central to sustainable services and progress by PHE is given in the next section.

6.0 Supporting Commissioning – Healthy Child Programme 0-5s

6.1 The transfer of commissioning responsibilities of the Healthy Child Programme from the NHS to local authorities from October 2015 presents new opportunities to give every child the best start in life. PHE has played a major role in supporting local authorities to prepare for commissioning and to facilitate local agreement to be reached to enable Financial Allocations to be made by the Department of

Health for 150 of 152 authorities

6.2 PHE will be the lead national body for supporting this programme to closedown (Programme Senior Responsible Officer (SRO) is PHE Chief Nurse), and for supporting local authorities in sustainability. The Department of Health will commission PHE to review mandated service elements in 2016.

6.3 To support the transfer PHE published a review of the evidence base for the Programme 0 – 5[4] and, with the Department of Health and NHS England, published the model for a transformed health visiting service setting out 4 levels of service, 5 universal health reviews and 6 high impact areas[5].

6.4 Through its national work, and through Centres, PHE is working with the Local Government Association and local authorities to realise the ambitions of the transfer including integrated services for under 5s and a public health lifecourse approach for 0-19 including delivery of the Healthy Child Programme. National and local leadership for health visitors and school nurses, alongside knowledge dissemination are supporting improved quality of services to family and outcomes in areas such as

a. Maintaining high quality universal population level programmes such as health visiting and immunisation programmes;
b. Targeting additional support and early intervention to families who need more help, working closely across health, social care, early years and education;
c. The Family Nurse Partnership[6] (for teenage parents) in 135 local authorities in England; and
d. The Troubled Families Programme - working with the Department of Health and Department for Communities and Local Government to support an enhanced health offer to vulnerable families and their children part of the expansion of the programme to 400,000 more families.

7.0 School age and Young People (5-24)

7.1 As children start school, and through to adolescence and young adulthood (to 24 years), risks and opportunities to embed positive health behaviours and lifestyles present themselves.

7.2 There are associations between health and educational attainment which mean that for not insignificant numbers of children, poor health is having a detrimental impact on their educational outcomes and can limit opportunities throughout adult life.

7.3 In addition to poor outcomes for children from the poorest households, for other groups, including for disabled children, LGBT young people, and BME groups, inequalities are much in evidence and persistent, again extending beyond childhood. These include, for some, higher rates of mental illness and obesity for example.

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[4] *Rapid review to update evidence for the healthy child programme 0 to 5*. PHE. 2015. https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence

[5] *Early Years High Impact Areas: documents to support local authorities in commissioning children's public health services*. PHE. 2014. https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children

[6] http://fnp.nhs.uk/

7.4 PHE's work with school age children includes:

a) Co-publishing a range of resources and tools for local government, school and colleges to make more effective use of the evidence and the data;
b) The role of school nursing is a critical one and the transfer of the professional leadership for the service from DH to PHE in April 2015 is already significantly strengthening our work with this professional group;
c) Building resilience and positive mental health, maintaining downward trends in poor health outcomes from use of alcohol, substance misuse, and unsafe sexual health, and teenage pregnancy;
d) Increasing take up of the HPV vaccine; and
e) Developing advice to public health teams on actions they can take to support preventative work on child sexual exploitation.

8.0 Child Obesity

8.1 Children and young people's rates of obesity and overweight continue to be of national concern and are linked with adult rates of obesity. PHE is working with the Department of Health and NHS England on the development of programmes of work to support local action, alongside action that can only be done, or is done optimally, at a national level.

8.2 From the 2013/14 National Child Measurement Programme data we know that:

i) Over 132,000 (22.5%) 4-5 year are olds are overweight or obese;
ii) Over 172,000 (33.5%) 10-11 year olds are overweight or obese; and
iii) 10-11 year olds from the most deprived decile are more than twice as likely to be obese than children in the least deprived decile.

8.3 The evidence indicates that environmental and social factors are significant contributing factors, alongside consumption of excess calories (carbonated drinks, fast food etc) and more sedentary lifestyles.

8.4 PHE is currently working closely with the Department of Health on actions that can support reductions in rates of both overweight and obesity. This work is at an early stage of development and the Board will receive a report later in 2015 setting this out in more detail. PHE's approach will continue to consider the wider structural and social issues that promote obesogenic environments, alongside empowering and supporting individual behavioural change.

9.0 PHE's Children, Young People and Families Forum

9.1 This paper demonstrates the complexity and breadth of PHE's work, expertise and responsibilities for child public health. Across the organisation PHE has teams and individuals contributing to protecting and improving child health, and reducing inequalities in childhood.

9.2 To marshal PHE's resources and expertise more effectively, the Children, Young People and Families Forum has been established. Chaired by the PHE Chief Nurse and supported by the Director of Health and Wellbeing, the Forum has brought together the appropriate key teams and leaders to support matrix working across the organisation (see Appendix D for membership). Directorates retain full responsibilities for their teams.

9.3 The Forum has deliberately been set up as an internal group, building on the

positive findings of a Department of Health audit of its predecessor, the Corporate Programme Board 4[7]. This found that the group was providing an important synergy role in bringing teams together and reinforcing the life course approach to:

a) Coordinate PHE work on children and young people and the interfaces with PHE programmes for example tobacco and alcohol;
b) Enable a comprehensive integrated approach to PHE CYP to be presented to stakeholders and external CYP governance/partnerships groups;
c) Make best use of knowledge, expertise and skills across PHE including being 'critical friend' to programmes of work; and
d) Champion 'THINK CHILDREN' across PHE.

9.4 Additionally the CYP&F serves as the interim programme governance group for the Best Start priority. The formal Department of Health led programme governance for 0-5 closes in December 2015. Prior to this PHE will put in place appropriate governance to ensure sustainability and the delivery of the *From Evidence into Action* priority.

9.5 PHE's relationship with external partners is again a complex one and is a mixture of thematic and generic. PHE teams will be working directly with relevant stakeholders (Other Government Departments, academics, the Local Government Association, national professional associations etc) on specific themes, e.g. drugs and alcohol. More generically, PHE is active in two key national oversight system groups:

a) Children and Young People Outcomes Board
b) Children and Young People's Partnership Board

9.6 Both supported by the Department of Health, the groups provide an important route for PHE's work to be grounded in system-wide activity on children's outcomes, consisting as they do of officials, academics, clinicians, children's voices, local government and the voluntary and community sectors.

10.0 Conclusion

10.1 PHE fully recognises the importance of giving every child both the best start in life, as well as maintaining this throughout childhood, adolescence and into young adulthood. Health assets developed in this stage of the life course are strong foundations for the rest of their lives.

10.2 The approach PHE is taking, summarised in this paper, is one that builds on national and local assets, is based on the evidence, and considers the immediate and long term benefits of investment. Central to this is PHE's engagement with the workforce and children, young people and families themselves.

Eustace de Sousa
National lead: children, young people and families
July 2015

[7] DH Internal Audit, unpublished, 2014

Appendix A:
Key health and wellbeing outcomes for children and young people

Child Health Profile Key Indicator	Best performing Local Authority in England	England Average	England Worst
PRECONCEPTION AND PREGNANCY			
Teenage mothers [1]	0.2	1.1	2.5
Smoking status at time of delivery [2]	1.9	12.0	27.5
Low birthweight of all babies [3]	4.6	7.4	10.4
Under 18 conceptions [4]	9.2	24.3	43.9
Breastfeeding initiation [5]	93.0	73.9	36.6
Breastfeeding prevalence at 6-8 weeks after birth [6]	77.4	-	19.4
EARLY YEARS			
Infant mortality [7]	1.7	4.1	7.5
Child mortality rate (1-17 years) [8]	3.0	11.9	22.8
Obese children (4-5 years) [9]	5.5	9.5	14.2
Children achieving a good level of development at the end of reception [10]	75.3	60.4	41.2
MMR vaccination for one dose (2 years) [11]	98.3	92.7	78.3
Dtap / IPV / Hib vaccination (2 years) [12]	99.1	96.1	81.6
A&E attendances (0-4 years) [13]	252.7	525.6	1,684.5
SCHOOL AGE AND YOUNG PEOPLE			
Obese children (10-11 years) [14]	11.0	19.1	26.8
Children with one or more decayed, missing or filled teeth [15]	13.0	27.9	53.2
Children in care [16]	20	60	153
Children in care immunisations [17]	100	87.1	27.3
New sexually transmitted infections (including chlamydia) [18]	1899.8	3,432.7	8,098.4
Children killed or seriously injured in road traffic accidents [19]	8.2	19.1	48.3
Hospital admissions caused by injuries in children (0-14 years) [20]	64.4	112.2	214.1
Hospital admissions caused by injuries in young people (15-24 years) [21]	69.6	136.7	291.8
Hospital admissions for asthma (under 19 years) [22]	54.6	197.1	509.1
Hospital admissions for mental health conditions (10-24) [23]	25.6	87.2	391.6
Hospital admissions as a result of self-harm (10-24 years) [24]	119.1	412.1	1,246.6
Hospital admissions due to alcohol specific conditions [25]	0.0	40.1	100.0
Hospital admissions due to substance misuse (15-24 years) [26]	22.8	81.3	264.1
GCSEs achieved (5 A*-C inc. English and maths) [27]	73.8	56.8	35.4
GCSEs achieved (5 A*-C inc. English and	42.9	12.0	8.0

maths) for children in care [28]			
16-18 year olds not in education, employment or training [29]	1.8	5.3	9.8
First time entrants to the youth justice system [30]	171.0	440.9	846.5
Children in poverty (under 16 years) [31]	6.6	19.2	37.9
Family homelessness [32]	0.1	1.7	10.8

[1] % of delivery episodes where the mother is aged less than 18 years, 2013/14
[2] % of mothers smoking at time of delivery, 2013/14
[3] Percentage of live and stillbirths weighing less than 2,500 grams, 2013
[4] Under 18 conception rate per 1,000 females age 15-17 years, 2013
[5] % of mothers initiating breastfeeding, 2013/14
[6] % of mothers breastfeeding at 6-8 weeks, 2013/14
[7] Mortality rate per 1,000 live births (age under 1 year), 2011-2013
[8] Directly standardised rate per 100,000 children age 1-17 years, 2011-2013
[9] % school children in Reception year classified as obese, 2013/14
[10] % children achieving a good level of development within Early Years Foundation Stage Profile, 2013/14
[11] % children immunised against measles, mumps and rubella (first dose by age 2 years), 2013/14
[12] % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2013/14
[13] Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2013/14
[14] % school children in Year 6 classified as obese, 2013/14
[15] % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
[16] Rate of children looked after at 31 March per 10,000 population aged under 18, 2014
[17] % children in care with up-to-date immunisations, 2014
[18] New STI diagnoses per 100,000 population aged 15-24 years, 2013
[19] Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2011-2013
[20] Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2013/14
[21] Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2013/14
[22] Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2013/14
[23] Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2013/14
[24] Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2013/14
[25] Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2011/12-2013/14
[26] Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2011/12-2013/14
[27] % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2013/14
[28] % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2014 (provisional)
[29] % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2013
[30] Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2013
[31] % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2012
[32] Statutory homeless households with dependent children or pregnant women per 1,000 households, 2013/14

Appendix B:
Health Visitor 4-5-6 model

Appendix C:
Progress Log on 8 key actions for Best Start in Life

1 Support local authorities in developing integrated children and young people's services as they take on commissioning responsibilities for the Healthy Child Programme for 0-5s

PHE was a major contributor to the recent government Major Projects Authority review resulting in successful feedback and an Amber/Green rating.

A series of cross-sector national and local consultation events has been carried out as well the development of a conceptual model to inform the co-produced plan.

Health Visitor fellows have been commissioned to write case studies for HVs on each High Impact Area and additional areas including children with complex health needs, attachment and school readiness.

A series of regional consultation events has been held in London, Manchester and the South-West with local commissioners and providers, others are planned, to ensure full engagement as the long-term Best Start in Life strategy is developed.

2. Promote the importance of high-quality universal services as a foundation for good health for all our children and as a platform for early intervention and targeted support

PHE has taken a leadership role through Regional Directors and regional oversight groups in supporting local authoriteis, including in state of readiness assessments.

PHE has professional leadership responsibility for health visitors and their teams and has continued work on supporting professionals on service transformation and embedding the 'Health Visitor 4 -5- 6' model.

The *Due North*[8] report on health equity in the North of England was independently commissioned by PHE and summarises the latest evidence for reducing inequalities tailored to local government's public health role. It has early years as one of four overarching recommendations. PHE is publishing its final response in mid-July, and an interim PHE response was published in November 2014.[9]

3. Develop and strengthen the evidence, including working with the Early Intervention Foundation as a 'What Works Centre for Early Intervention'

PHE is working with the Early Intervention Foundation to develop the evidence further and to improve its accessibility to commissioners and providers. This work will be sense checked with external stakeholders and other Government departments.

4. Expand the Start4Life Information Service for Parents (S4L ISP) from 0-2 years to 0-5 years and sign up over 200,000 more parents

Four demonstrator sites have signed up to be S4L ISP point-of-care demonstrator sites. One non-technical site signed up to be S4L ISP demonstrator site. PHE has engaged with 10 major Maternity IT System Suppliers. Two suppliers are fully engaged and working towards going live in

[8] https://www.gmcvo.org.uk/system/files/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final.pdf
[9] https://www.gov.uk/government/publications/due-north-report-phe-response

August 2015 serving 4 NHS Trusts.

A series of internal of internal expert workshops has been held to support the expansion of the S4L ISP content up to five years and to improve the focus on key behaviour-change priorities.

5. Expand newborn bloodspot screening to include four new inherited metabolic disorders

This was successfully completed in 2014-15.

6. Work with NICE on the implementation of the quality standards and pathways for emotional and social wellbeing in early years

A dissemination plan has been agreed – this includes two events targeting children's services (early years) commissioners and providers, with two main events arranged in London and Manchester in November and December.

7. Lead and co-ordinate the Childhood Flu Programme, working with NHS England

Last winter (2014/15) the following groups were offered the childhood flu vaccine:

- Healthy Children aged 2 – 4 years, with 830,000 children vaccinated out of 2.2m eligible
- Healthy Children up to the age of 13 years in a total of 13 areas in England piloting the programme for all primary and some secondary school age children, with 382,000 vaccinated out of 718,000 eligible

This winter (2015/16) sees a significant expansion of the programme, with the programme being extended to all 5 and 6 year olds (primary school Years 1 and 2) in England. This means that a further 1.2 million children will be offered the vaccine.

The lessons learnt from the pilot in terms of operationalising the programme are being incorporated into delivery for the 15/16 season by providers and commissioners.

Uptake of the childhood flu programme was published in May 2015.

Results of the evaluation of the impact and effectiveness of the childhood element of the routine flu programme were presented to the June 2015 JCVI meeting and will be published in the summer.

Planning is underway to evaluate the uptake, impact and effectiveness of the LAIV programme in 2015-16.

Work is also underway with NHS England on the planned extension of the childhood flu programme to all primary schools in 2015/16 The commissioning arrangements are being finalised by local NHS England teams.

8. Increase coverage of measles, mumps and rubella immunisations for all children at five years

- National data for January to March 2015 quarter: MMR1 = 94.5%; MMR2 = 88.6%
- Very similar to previous quarter – October to December 2014: MMR1 = 94.6%; MMR2 = 88.5%
- Increased coverage compared to data a year ago (January to March 2014 quarter): MMR1 = 94.2%; MMR2 = 88.2%

Appendix D

Membership of the Children Young People and Families Forum

Name	Team	Job title
Viv Bennett (Chair)	Nursing	Director of Nursing
Paul Johnstone (Deputy Chair)	PHE Centres	Regional Director, North of England
Ann Hoskins	Healthy People	Deputy Director
Eustace de Sousa	Children Young People and Families	National Lead, CYP&F
Alison Tedstone	Diet and Obesity	National Director, Diet and Obesity
Annmarie Connolly	Health Equity and Mental Health	Director, Health Equity and Mental Health
Radhika Sriskandarajah	Strategy	Head of Planning
Helen Duncan	CKO, CHIMAT	Programme Director
Wendy Nicholson	Nursing	Lead Nurse - Children, young people and families
Lily Makurah	Mental Health	National Programme Manager - Public Mental Health
Alison Burton	Children Young People and Families	Maternity & Early Years Lead
Alison Hadley	Children Young People and Families	Consultant, Teenage Pregnancy
Sheila Mitchell	Health Marketing	Health Marketing & Public Engagement Director
Alexia Clifford	Health Marketing	Deputy Director - Marketing Activation
Mamoona Tahir	Operations and Chair of SCAVA, PHE Safeguarding group	Consultant in Communicable disease Control
Jez Stannard	Alcohol, drugs and tobacco	Senior Programme Manager
Jane Anderson	Sexual Health	Consultant in HIV, Sexual and Reproductive Health
Owen Brigstock-Barron	Sexual Health	Programme Manager - HIV, Sexual and Reproductive Health
Geoff Dent	Immunisation, Hepatitis and Blood Safety	Senior Project Manager (Immunisation)
David Green	Immunisation, Hepatitis and Blood Safety	Nurse Consultant - Immunisations
Robert Sheriff	National Screening Programmes	National Operations Lead
Jenny Godson	Dental Public Health	Regional Consultant in Dental Public Health (North of England)
Linda Hindle	AHP	Lead Allied Health Professional
2 x TBC	PHE Centres	TBC post strategic review