Public Health England

Enclosure PHE/13/18

PHE Advisory Board Paper

Title of meeting	PHE Advisory Board
Date	Wednesday 27 November 2013
Sponsor	Alex Sienkiewicz
Presenter	Victor Knight
Title of paper	Actions from Advisory Board meetings

1. Purpose of the paper

1.1 The paper summarises the actions raised and panel observations made at previous meeting.

2. Recommendation

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

3. Actions from the minutes

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

4. Recommendations from panel discussions on key public health priorities

4.1 Matters raised as recommendations in the panel discussions of key health priorities are listed in Appendix 2. These are not necessarily the view or policy of PHE and are recorded for future reference by the Advisory Board and others, for example in assessing strategies developed subsequently.

Victor Knight
Board Secretary
November 2013

Appendix 1

Actions from the minutes of 25 September 2013

Minute	Action	Owner	Disposition
13/098 & 13/102	Draw up a list of panel recommendations so that the Advisory Board can track progress, with standardised format.	Board Secretary	Actions paper PHE/13/18.
13/103	Include the recommendation to inform ministers of Advisory Board views on standardized tobacco packaging and minimum unit pricing.	Board Secretary	Chief Executive confirms that ministers are fully aware of PHE views.
13/118	Provide information to Advisory Board members regarding engaging with staff regionally.	Director of Communications	Regional contacts provided.

Appendix 2

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

Obesity

Panel observation	Initial PHE comment
1. There is no PHE strategy on 'junk food' or soft drinks.	PHE has a position on what constitutes a healthy balanced diet as represented by the 'eatwell plate'. PHE encourages the swapping of sugary drinks to more healthy alternatives such as sugar-free drinks, low fat milk or water and also encourages people to eat high salt, fat, and sugary foods in moderation.
2. Coordination is needed across the health system tiers, with other government departments, and with schools/education.	This is being considered.
3. A pilot opportunity was offered by East Midlands Academic Health Science Network for an obesity project.	This proposal has been discussed and taken up locally in the region.
4. Change the supply side of the food industry.	This is led by DH.
5. Recognise the government's purchasing power in food.	PHE is working to encourage procurement of healthy food across the public sector.
6. Revisit outdated research work on pregnancy and birth weight.	The monitoring of pregnant women's weight is current currently being considered by NICE.
7. Encourage the use of local authority planning control to restrict food outlets near schools and to promote public parks.	PHE will produce guidance on this.
8. Learn from the French experience of government intervention to reduce obesity, including taxing sugared drinks.	This has been followed up. Currently there is no impact data available from France. PHE will keep a watch on this.
9. Identify profitable avenues for the food industry which do not rely on promoting unhealthy foods.	
10. Work with the Food Standards Agency to clarify roles on obesity.	The FSA has no responsibility for nutrition or obesity in England. Nutrition was transferred out of the FSA after the last general election.

11. Pay attention to micro level nutrition (for example vitamin D) in tackling wider health issues.	PHE is doing this and has asked NICE for advice on how to improve the uptake of vitamin D supplements by at risk groups. PHE promotes a balanced diet to support micronutrient intakes more generally.
12. Improve professional education on nutrition in medical schools.	PHE agrees but this is mainly led by the Royal Colleges.
13. Engage with the Advertising Standards Authority to protect children from unhealthy food marketing.	This is currently being taken forward by DH.
14. Recognise that public health benefits alone have not been sufficient to convince government to act: cost/benefit information is essential.	This has always been part of policy development.
Question from a member of the public	
15. Clarify the role of the Scientific Advisory Committee on Nutrition (SACN), and of PHE, in relation to the recommended minimum intake of vitamin D.	SACN is currently reviewing dietary recommendations on vitamin D. When the recommendations are finalised PHE and DH will consider them.

Appendix 2

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

PHE Research Strategy

Panel observation	Initial PHE comment
1. Foster better links with academics, public health practitioners and civil society.	
2. Provide career opportunities for researchers, including developing junior researchers and maintain stable funding streams (especially in areas of study with perceived lacked of future and secure funding, psychosocial and behavioural research.)	
3. Facilitate research through registries, monitoring, surveillance systems, and intermittent surveys.	
4. Provide quality assurance, curation, and make information and materials available.	
5. Take a role in research on behaviours and cultures.	
6. Raise the profile of mental health research.	
7. Participate further in Department of Health cross-funding with other bodies.	
8. PHE should seek research fellowships.	
9. Invest in bioinformatics and the handling of 'big data'.	
10. Link with the major charities because of their size and role in UK research funding as well as local authorities.	
11. Redress the balance of research in non-communicable diseases and move from a focus on individual diseases to an integrated approach encompassing wider health concerns.	
12. Fill the gap in monitoring the social and environmental impact on behaviours and of behavioural change, for example, in the consumption of tobacco, alcohol and ultra-processed food.	
13. Manage growth expectations in the adoption of technologies for interpreting large amounts of sequence data.	
14. In the genomic field: Ensure PHE is outward facing and engaging with others without conditions, and supress the tendency to compete internally.	
15. Focus on applied and translational research in genomics leaving the basic science to others.	
16. The need to generate income in relation to sequencing should be reduced at first as restrictions on data sharing are created by protecting intellectual property.	

17. Make further effort to ensure scientists behave cohesively.	
18. Secure adequate investment and sustainable funding for genomics, and provide the infrastructure for the very long term, not just the next five years.	
19. Form a strong partnership with the Sanger Institute based on a comprehensive research strategy, not adventitious research relationships. Eg. a PHE portable office on the Sanger site with PHE staff.	
20. Strengthen links with the Sanger Institute through staff secondments.	
21. Invite the Sanger Institute to revisit, in relation to public health, its policy of not providing fee-for-service sequencing.	
22. Undertake a cost benefit assessment of a partnership between PHE and the Sanger Institute.	
23. Include the impact of economic and social determinants in research.	
24. Encourage and value joint appointments.	
25. Define priorities clearly in research design.	
26. Link academic approaches in public health with practice.	
27. Build capability as well as capacity through training.	
28. Study failures in public health initiatives as they merit more evaluation studies than the successes.	
29. Encourage horizon scanning and timely commissioning.	
30. Publish more public health information which may stimulate research proposals.	
31. Look for more international research opportunities.	
32. Play an advocacy role in facilitating access to data across the system.	
33. Work with the NIHR School of Public Health.	
34. Strengthen and formalise collaboration with the Department of Health in the area of strategic research.	
35. Develop and strengthen research opportunities globally.	
36. Promote simple interventions which are effective - for example, smoking data on death certificates.	
37. Embed noncommunicable diseases within health protection research.	