Public Health England

PHE Board Paper

Title of meeting	PHE Board
Date	Monday 3 February 2014
Sponsor	Alex Sienkiewicz
Presenter	Victor Knight
Title of paper	Actions from 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 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 Board and others, for example in assessing strategies developed subsequently.

Victor Knight
Board Secretary
January 2014

Appendix 1

Actions from the minutes of 27 November 2013

Minute	Action	Owner	Disposition
13/189	Include a local representative of public health at each Board meeting.	Board Secretary	To be invited through Association of Directors of Public Health, where not otherwise represented at meetings.
13/189	Prepare Terms of Reference for Global Health Committee.	Board Secretary/ Director of Health Protection	Draft prepared.

Appendix 2

Public Health England 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	Revisit outdated research work on pregnancy and birth weight.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 Board
Actions from the meeting of 25 September 2013

PHE Research Strategy

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

These observations have been shared with the Editorial Board for the Research and Academic Strategy. Following the presentation of Version 3 to the National Executive in March 2014 the strategy will go out for consultation to achieve the fullest engagement with PHE's stakeholders. During 2014 those PHE Directorates which have research interests will be planning how to address the identified Strategic Priorities and Research Questions over the next 3 to 5 years. The overall emphasis will be on the translation of this research into tangible public health outcomes at a local level through working with academic partners.

Appendix 2

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

PHE Global Health Strategy

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

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

These panel observations have been provided to the team developing the PHE Global Health Strategy and a note on the disposition of the points is expected to be available during February 2014.