Public Health England

Enclosure PHE/14/10

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 26 March 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
March 2014

Appendix 1

Actions from the minutes of 27 November 2013

Meeting	Minute	Action	Owner	Disposition
27 November 2013	13/189	A local representative of public health to be invited to each Board meeting.	Board Secretary	Invitation made through Association of Directors of Public Health.
27 November 2013	13/189	Prepare Terms of Reference for Global Health Committee.	Board Secretary/ Director of Health Protection	On Board agenda for 26 March 2014. Paper PHE/14/11.
3 February 2014	14/048	Arrange a meeting to brief Professor Griffiths on the Science Hub Programme.	Chief Operating Officer	Science Hub material provided, meeting arranged and Programme Director alerted.
3 February 2014	14/052	Board to be briefed on the transfer from NHS England to local government from 2015 of responsibility for commissioning of public health services for children aged 0-5 years.	Deputy Director of Nursing & Midwifery	Scheduled for 30 April 2014 agenda.
3 February 2014	14/055	A copy of the National Sustainable Development Strategy, launched jointly by PHE, local government and NHS England, to be circulated to the Board.	Director of Health Protection	Completed.
3 February 2014	14/056	The Board would be briefed at a future meeting on the work being undertaken to ensure total clarity on roles and funding in the new public health system for health protection.	Director of Health Protection/ Chief Operating Officer	Proposed for 23 May Board meeting.
3 February 2014	14/068	Add timescales for the completion of actions to the action list.	Board Secretary	Provisional dispositions and timescales shown under main heading for each priority.

3 February 2014	14/069	PHE Board and National Executive to discuss how the watch lists would be fully used by the executive.	Board Secretary	For discussion at meeting of Board and National Executive on 26 March 2014.
3 February 2014	14/076	The Finance and Commercial Director to send information about the impact on programmes to non-executive board member Martin Hindle.	Finance & Commercial Director	Information provided 24 February.

Appendix 2

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

Obesity

Disposition of observations with timescale: Publication of PHE 2014/15 business plan deliverables due in May 2014.

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

Disposition of observations with timescale: To be incorporated or otherwise in the PHE Research Strategy expected to be issued for consultation by June 2014.

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 presentation to the National Executive 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

Disposition of observations with timescale: The observations have been fed into the development of the PHE Global Health Strategy, which was circulated tin draft to the Board and *ad hoc* expert panel in February 2014 for comment. The resulting strategy will be received by the National Executive in April 2014.

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.

Appendix 2

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

Tobacco

Disposition of observations with timescale: Publication of PHE 2014/15 business plan deliverables due in May 2014.

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

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

	children.
36.	A clear, simple message the use of e-cigarettes needed to be communicated to the public and implemented into policy effectively.
37.	There was a great need to gather an evidence base on the role of electronic nicotine delivery systems in normalising smoking behaviour.
38.	A single, overarching, message is lacking on e-cigarettes. It was very important that this was simple and enforced. Whatever was decided on the cigarettes had to be clear, simple and enforceable in practice and there should be agreement on de-normalisation.
39.	PHE Board to discuss standardised packaging of tobacco products after Sir Cyril Chantler report due in March 2014