Public Health England

Protecting and improving the nation's health

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 27 April 2016
Sponsor	Alex Sienkiewicz
Title of paper	Actions from Board meetings

1. Purpose of the paper

1.1 Each Board meeting considers a public health theme. As part of this, the Board invites an expert panel to contribute to its discussion. The external panel members' observations to the Board and PHE more generally are summarised in the "watch list" in Appendix 1 to this paper. These are reviewed, monitored and acted on by the PHE's Directors in the preparation of PHE's strategies in the respective public health areas. The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

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.

Rachel Scott
Board Secretary
April 2016

Appendix 1

Actions from PHE Board minutes

Meeting	Minute	Action	Owner	Disposition
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/ Deputy CEO & COO	Topic remains to be scheduled
28 January 2015	15/011	Include rurality as an agenda item for next NHS England / PHE Board to Board meeting	Board Secretary	Outstanding
28 January 2015	15/032	Set up high level meeting for Chair on public health research issues	Board Secretary	Outstanding
24 February 2016	16/054	A paper on automated TB sequencing, a major infrastructure development, would be submitted to the Board for consideration at a future meeting	Derrick Crook	To be scheduled
24 February 2016	16/055	A paper outlining PHE's work in consent, models for data use, sharing and potential risks would be prepared for a future Board meeting;	John Newton	To be scheduled

Appendix 2

Public Health England Board

Obesity

Lead Board Member: Rosie Glazebrook
Board Review Date: Wednesday 25 January 2017

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

Board follow up meeting on obesity: 23 September 2015

Following the discussion at the September 2015 Board meeting it was proposed to add the additional items to the watchlist.

1.	Education in early years was critical
2.	The collective purchasing of the public sector could be exploited to drive change, including the control of purchasing specifications on food procurement
3.	A "health in all policies" approach had potentially significant benefits. Work was taking place with local authorities to look at how this would work at local level;
4.	The economic case for reducing obesity should be emphasised
5.	The potential health dividend was not just for children but for the adults they went on to become. Tackling obesity should therefore be considered as part of a broader approach to improving health and wellbeing;
6.	There were short, medium and long term activities for PHE and its partners in central and local government, which could usefully be set out as a framework to assist understanding the various priorities and where the benefits and impacts could be demonstrated;
7.	Future updates on key public health themes previously considered by the Board should set out the resources allocated to each theme.

Actions from the meeting of 22 July 2013 (including updates provided at the September 2015 meeting).

External panel observation	PHE Diet and Obesity response
• There is no PHE strategy on 'junk food' or soft drinks • Consider the French experience of government intervention to reduce obesity • Identify profitable avenues for the food industry which do not rely on promoting unhealthy foods • Engage with the Advertising Standards Authority to protect children from unhealthy food marketing	Actions with respect to these elements are either directly informed by the PHE sugar evidence package or will indirectly be picked up as part of broader discussions across government.
• Coordination is needed across the health system tiers, with other government departments, and with schools/education	PHE is an active participant on an 'official' basis in regular networking and policy development meetings with DfE. PHE supports DH, as systems steward, in convening high level cross Government officials to develop obesity strategy.
• A pilot opportunity was offered by East Midlands Academic Health	Noted

Service Network for an obesity project.	
• Recognise the government's purchasing power in food.	PHE recognises the opportunities that public sector spend on procuring food and catering services offers. The public sector spends about £2.4bn per annum procuring food and catering services, which represents approximately 5.5% of UK food service sector sales. PHE directly supports implementation of healthier catering across the public sector, including hospitals, schools and local government, and more widely across a range of settings, through provision of catering guidance and supporting tools for example. These support those who must, or choose to apply Government Buying Standards for Food and Catering Services (GBSF) which help ensure food is provided to higher sustainability and nutritional standards. Central government and their agencies are required to apply GBSF and others are encouraged to follow.
• Revisit outdated research on pregnancy and birth weight	PHE recognizes that maternal obesity increases health risks for both the mother and child during and after pregnancy. Statistics on the prevalence of maternal obesity are not collected routinely in the UK. PHE continues to keep a watching brief on the evidence base and public health guidance in this area.
• Encourage the use of local authority planning control to restrict food outlets near schools and to promote public parks.	PHE has helped advise government departments and local authorities on the opportunities and limitations of how the planning system might be used to support development of access to healthy food or by restricting the growth of fast food takeaways. For example, it published two briefings on Obesity and the Environment on promoting physical activity and active travel and restricting the growth of fast food outlets. PHE recognises the important role which public parks and access to green spaces can play in promoting health and helping people to maintain healthy weights. For example, in Sept 2014, it published an evidence review and briefing on the role of green spaces with the Institute of Health Equity.
• Work with the Food Standards Agency to clarify roles on obesity	Roles with the Food Standards Agency are clear and defined in England.
• Pay attention to micro level nutrition (for example vitamin D) in tackling wider health issues. • Clarify the role of the Scientific Advisory Committee on Nutrition	The Scientific Advisory Committee on Nutrition (SACN) is currently considering the adequacy of the current UK Dietary Reference Values (DRVs) for vitamin D across all population groups. As part

(SACN), and of PHE, in relation to the recommended minimum intake of vitamin D.[Question from a member of the public]	of this review, SACN is considering the evidence for the links between vitamin D and a range of health outcomes. The role of SACN is to review the DRVs for vitamin D intake and to make recommendations after considering the evidence. PHE will review its advice on vitamin D after considering the recommendations in the SACN report. As part of the series of PHE 'Evidence into Practice' events, the PHE Diet & Obesity team held an event in November 2014, built around new NICE public health guidance on improving implementation of current government recommendations for the prevention of vitamin D deficiency.
• Recognise that public health benefits alone have not been sufficient to convince government to act: cost/benefit information is essential.	PHE Chief Knowledge Officers Directorate have established a programme of work to explore the existing evidence base relating to effective interventions and approaches and their cost effectiveness and potential return on investment.

Public Health England Board

PHE Research Strategy

Lead Board Member: Martin Hindle

The observations and suggestions are exclusively those of the external panel members and are not PHE policy. They have been considered and acted on as appropriate by the Chief Knowledge Officer in the finalisation of the PHE Research Strategy

Board follow up meeting on research: Wednesday 27 January 2016

Following the discussion at the January 2016 Board meeting it was proposed to add the additional items to the watchlist.

1.	PHE's research resource to be appropriately marketed.
2.	The co-location as part of PHE's activities as part of the PHE Science Hub would generate new opportunities for research. It would be essential to ensure that established links with local and regional teams were maintained.
3.	Engagement and focus in PHE's work should have a focus across all disciplines to ensure there was a comprehensive approach.

Actions from the meeting of 25 September 2013 (including updates provided at the January 2016 meeting).

External panel observation		PHE Research Team response
1.	Foster better links with academics, public health practitioners and civil society.	Ongoing - routine business of the Research, Translation & Innovation (RTI) division of CKO
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.)	Considered through rolling review programme of PHE research areas and recommendations made as appropriate; strengthened links with PHE Workforce development / Knowledge & Skills Framework; PHE PhD studentships extended to PHE staff; Behavioural Insights team incorporated into RTI with support from CKO and H&WB.
3.	Facilitate research through registries, monitoring, surveillance systems, and intermittent surveys.	Ongoing through enhanced interaction across CKO – National Disease Registration Service and Knowledge & Intelligence divisions; Office for Data Release facilitating academic interaction with PHE-held data
4.	Provide quality assurance, curation, and make information and materials available.	Ongoing - routine business of the Research, Translation & Innovation (RTI) division of CKO
5.	Take a role in research on behaviours and cultures.	Ongoing - routine business of the Behavioural Insights team in RTI division of CKO, including engagement with academics
6.	Raise the profile of mental health research.	Ongoing support for Mental Health team, including academic engagement events to highlight evidence gaps and advocate research project development; ongoing advocacy through interaction with research funders
7.	Participate further in Department of Health cross-funding with other bodies.	Ongoing – close working with DH R&D division, NIHR, MRC etc, charities

8.	PHE should seek research fellowships.	Ongoing advocacy across all directorates
9.	Invest in bioinformatics and the handling of 'big data'.	Engaging with initiatives such as Farr Institute (MRC); strategic planning and investment via CKO and NIS
10.	Link with the major charities because of their size and role in UK research funding as well as local authorities.	Ongoing – directly with charities individually, eg CR-UK, ARUK, Alzheimer's UK, Alcohol Research UK etc and via Association of Medical Research Charities
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.	Ongoing – advocacy and support across PHE and with externals eg academics and funders; building capacity to address oppportunities
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.	Ongoing – both through advocacy and support for research as well as the identification of evidence gaps as a component of evidence products
13.	Manage growth expectations in the adoption of technologies for interpreting large amounts of sequence data.	Responsibility lies with NIS
14.	In the genomic field: Ensure PHE is outward facing and engaging with others without conditions, and supress the tendency to compete internally.	Ongoing – in line with drive to collaborate and compete for external funding; focussed and boosted through NIHR Health Protection Research Units (NIHR HPRUs)
15.	Focus on applied and translational research in genomics leaving the basic science to others.	Ongoing – emphasised in RTI strategy; discussed during reviews of PHE research centres; evident in work programmes of NIHR HPRUs
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.	Responsibility lies with NIS and Business Development
17.	Make further effort to ensure scientists behave cohesively.	Ongoing, eg focussed activities in NIHR HPRUs and planning for Science Hub
18.	Secure adequate investment and sustainable funding for genomics, and provide the infrastructure for the very long term, not just the next five years.	Responsibility lies with NIS, support from RTI and business development in seeking external funding
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.	Strong current relationship via NIHR HPRUs and individual projects; physical proximity will be enhanced through Science Hub
20.	Strengthen links with the Sanger Institute, potentially through staff secondments.	Strong current relationship via NIHR HPRUs and individual projects
21.	Invite the Sanger Institute to revisit, in relation to public health, its policy of not providing fee-for-service sequencing.	Operational issue for specific research groups
22.	Undertake a cost benefit assessment of a partnership between PHE and the Sanger Institute.	Strong current relationship via NIHR HPRUs and individual research groups, funded predominantly from external sources

23.	Include the impact of economic and social determinants in research.	Ongoing – eg new expertise in NIHR HPRUs and Health Economics
24.	Encourage and value joint appointments.	A number in place and being facilitated
25.	Define priorities clearly in research design.	A range of activities with academics, NHSE, charities, funders, lay people etc to define priorities in PHE priority areas and activities
26.	Link academic approaches in public health with practice.	Ongoing – a range of events and engagements
27.	Build capability as well as capacity through training.	Ongoing – eg through new research and evidence considerations in Knowledge and Skills Framework
28.	Study failures in public health initiatives as they merit more evaluation studies than the successes.	Support for evaluation of public health interventions endorses study of all initiative that may contribute to system learning
29.	Encourage horizon scanning and timely commissioning.	Commissioning of research is through engagement with major funders; support is provided to PHE staff to commission high quality studies from academic partners
30.	Publish more public health information which may stimulate research proposals.	A major area of focus, particularly with regard to surveillance and other data collated / analysed by PHE; establishment of Office for Data Release to share registry data with researchers in line with appropriate information governance
31.	Look for more international research opportunities.	Ongoing – eg increasing numbers of staff involved in consortia to apply for EU funding; success with NIH; Global Health opportunities
32.	Play an advocacy role in facilitating access to data across the system.	Ongoing – Office for Data Release operational for registry data (cancer, congenital anomalies, rare diseases), aiming to expand across PHE
33.	Work with the NIHR School of Public Health.	Substantial ongoing engagement, ranging from collaborative partnership (Public Health Practice Evaluation Scheme) through project steering / advisory groups and individual projects. Current member of review panel.
34.	Strengthen and formalise collaboration with the Department of Health in the area of strategic research.	Excellent ongoing interaction with DH, eg decision-making on policy-relevant research
35.	Develop and strengthen research opportunities globally.	Advocating and facilitating boosting research as part of the Global Health Strategy Delivery Group activity; managing PHE Ebola Biobank Governance Group to achieve best use of samples for research especially to benefit the sender country; NIHR Rapid Reaction Team Research Unit – competition underway
36.	Promote simple interventions which are effective - for example, smoking data on death certificates.	Ongoing – Knowledge Management Platform is accessible across whole public health system, includes Case Studies and Evaluation Steering Group resources; Behavioural Insights team conducts trials of the potential benefits of 'simple' interventions
37.	Embed noncommunicable diseases within health protection research.	Eg the two cross-cutting NIHR HPRUs - Evaluation of Interventions and Modelling – have extended studies beyond infectious disease; PHE Centre for Radiation, Chemical and Environment (Chilton) have strong research relevant to NCDs and are expanding their internal collaborations eg

		with disease registries.

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

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

PHE Global Health Strategy

Lead Board Member: Sian Griffiths
Board Review Date: Wednesday 24 February 2016

The observations and suggestions are exclusively those of the external panel members and are not PHE policy. They have been considered by PHE in developing its Global Health Strategy and will be further used by the PHE Global Health Committee for which draft Terms of Reference were adopted by the Board in March 2014.

	External panel observation	**PHE response February 2016**
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.	PHE's Global Health Strategy prioritises improving global health security and building public health capacity internationally. Major programmes (e.g. in Sierra Leone and Pakistan) support system level development
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.	Visits and secondments to PHE develop institutional and professional links internationally. Where known and as appropriate, overseas partners' links with UK universities are recognised in visits / meetings. PHE representative joined events in relation to Chevening supported overseas students and alumni of UK universities.
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.	PHE has institutional and professional links with a wide range of countries directly via networks, multinational organisations, and its IHR communication function; strengthened through inward and outward visits and secondments and collaborative working.
4.	Nations should recognise the health impact of all government policies.	This is noted.
5.	Balance the principle of only being where invited with the need to take risks to promote global health.	When considering work with other countries, thought is given to whether assistance has been requested and to public health

		need.
6.	Participate in the post Millennium Goals 2015 discussion on non-communicable diseases, for example, in mental health.	This is noted. PHE is engaging with DH on discussions around the successor to 'Health is Global', which reflected HMG support for the Millennium Development Goals. PHE is also in the process of mapping its current and expected contribution towards the Sustainable Development Goals.
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.	PHE is developing domestic and international income streams in line with its Global Health Strategy and commercial strategies.
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.	PHE supports fixed term international deployments and secondments, and part-time global health assignments in the UK.
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.	One of the five strategic priority areas in PHE's Global Health Strategy is the development of international engagement on non-communicable diseases (NCDs).
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.	PHE is engaging with international partners on health and wellbeing and NCDs (including on salt/sugar reduction). PHE is working with Department of Health in establishing an Official Development Assistance (ODA) funded international programme on tobacco.
11.	Strengthening civil society, including advocacy and accountability is a key to global change.	This is noted.
12.	Do not over-emphasise infectious disease.	PHE's Global Health Strategy recognises Health and Wellbeing and NCDs as a priority for engagement.
13.	Recognise the need to see achievements in and by partner countries, not just in PHE as a partner organisation.	PHE provides development assistance which is primarily focused on supporting achievements by partner countries, and engages in activities (e.g. as a member of the International Association of National Public Health Institutes (IANPHI)) encouraging mutual

		development.
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.	PHE's Global Health Strategy prioritises responding to outbreaks and incidents of international concern, and supporting the public health response to humanitarian disasters. PHE is developing a rapid response team capability, which will be funded by ODA. PHE contributes to global disaster risk reduction work.
15.	Engage with the Department for International Development (DfID) change to technical partnership in India from 2015.	PHE is engaged in several technical partnerships with India and links with UK government partners in this area.
16.	Keep in touch with areas of the world which are innovating fast - for example India - experimenting with new business models and technologies.	PHE Chief Executive visited India in September 2015 strengthening and developing institutional links, including signing an MOU with the Public Health Foundation of India. PHE is developing a portfolio of work with China.
17.	Engage with the National Institute for Health and Care Excellence on global issues.	PHE and NICE collaborate on hosting international visits of mutual interest.
18.	Work on mass gatherings helps to raise the international profile of public health.	Mass gatherings is recognised as a priority in the PHE Global Health Strategy. PHE's WHO Collaborating Centre on Mass Gatherings and Global Health Security was re-designated in August 2015.
19.	Learn from other partnerships – such as Wales' work with African countries	PHE is developing links with the International Health Coordination Centre linked to Public Health Wales.
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.	This is an area for development and a guiding principle behind PHE's support for international workshops – for example on AMR – and encouragement of peer-to-peer work through IANPHI.
21.	Identify global health capabilities in which the UK has a lead or strength.	PHE's international public health development and emergency response capability statement lists PHE's strengths, in particular for work with low and middle income

		countries.
22.	Work on how PHE collaborates effectively.	Working in partnership and collaboration is a key strand of the PHE Global Health Strategy.
23.	Identify English health sector priorities – such as multi drug resistant tuberculosis which are also global health priorities.	PHE recognizes that there is significant overlap between public health priorities in England and global health priorities. This is one of the key drivers for PHE's international activity.
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.	PHE recognises the need to provide support in both acute and post-acute phases of disasters – for example, through its continued commitment to working with Sierra Leone on delivering a 'resilient zero' following the Ebola outbreak.
25.	Ensure that global health staff participation in committees and conferences represents good value for money.	Heads of department / directors have a responsibility for authorizing overseas travel for staff in their departments, with consideration of cost estimates. PHE staff are encouraged to consider whether travel is necessary and where appropriate can contribute internationally from the UK using communications technology.
26.	Review global health activities regularly and discontinue those which are no longer appropriate.	PHE's Global Health Review is now in response implementation phase. PHE is currently reviewing progress on PHE's Global Health Strategy Delivery Plan 2015-16, which will support planning for 2016-17. Updates on global health activities are provided regularly to the Global Health Committee and the Global Health Strategy Delivery Group.
27.	Publicise how collaborative work is prioritised and the basis on which projects are declined when they do not meet relevant criteria.	PHE's Global Health Strategy sets out the basis for, and approach to, prioritisation. The approach will be developed further in collaboration with the Department of Health.
28.	Note that some global health activities recover costs and some attract grants and this can be a viable operating model. Humanitarian work and	Recognised in PHE's Global Health Strategy.

	academic exchange have different bases.	
29.	Consider 'jigsaw' and 'patchwork' funding to get other organisations to join projects.	PHE has coordinated funding from multiple partners – e.g. to support an AMR workshop in the Caribbean.
30.	Be alert to the large number of global initiatives and benefactors and the danger of overloading the health administrations of developing countries.	These are recognised as important considerations for significant international engagements.
31.	Encourage governments to work at the local level and regional levels in their countries, not just national and supranational levels.	PHE works with some oversees partners at sub-national levels within their countries (e.g. in China PHE is linking with provincial-level partners on AMR research).
32.	Value the role of midwives in England and internationally. Childbirth remains a major cause of death in young women in developing countries.	PHE is currently exploring the development of a collaboration with WHO in the area of public health nursing and midwifery.
33.	Avoid undue focus on hospitals in collaborations.	PHE's Global Health Strategy supports public health system strengthening.
34.	Recognise importance of the Commonwealth in Africa	Supporting projects with Commonwealth countries such as Sierra Leone and Kenya. Exploring development of an AMR workshop for Southern Africa and East Africa as part of the Commonwealth laboratory twinning initiative. Hosted Commonwealth fellows from Seychelles and Nigeria.
35.	Learn from the global health experience of the UK Devolved Administrations.	Devolved Administrations represented on the Global Health Committee. PHE is developing links with the International Health Coordination Centre linked to Public Health Wales.
36.	Understand the contrasting role and methods of the US in global health.	PHE Executive team visited US CDC (June 2014) and engages with US CDC as a partner.
37.	Recognise the gradual transition of public health relationships from International Development to Foreign & Commonwealth Office.	PHE is strengthening relationships with DFID and FCO for global health work.
38.	Note the significance of climate change as a global public health issue.	Climate change recognised as an area of focus in the PHE Global Health Strategy.
39.	Note that middle income countries are becoming high income countries and losing aid, but many of the poorest people still live in them.	This is noted.

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

Tobacco

Lead Board Member: Paul Lincoln
Board Review Date: Wednesday 27 April 2016

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External 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 following the Chantler review

Public Health England Board
Actions from the meeting of 26 March 2014

Alcohol

Lead Board Member: Sir Derek Myers
Board Review Date: Wednesday 27 April 2016

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Examine the relationship between alcohol and mental health and the impact on acute services.
2.	PHE should be at the heart of actions to reduce alcohol consumption, and suitably resourced.
3.	Review and consider the interventions identified by WHO as being the most effective (price, availability and promotion)
4.	Review the publication *Health First: An evidence based alcohol strategy for the UK*
5.	Support data collection and dissemination through Local Alcohol Profiles and the Alcohol Learning Centre.
6.	Support research on alcohol and drinking behaviour including alcohol and inequalities, high risk groups
7.	Improve clarity on alcohol unit guidelines at point of sale and use
8.	PHE marketing team to continue to support the annual *Dry January* campaign by *Alcohol Concern.*
9.	Improve public understanding of the health harms of alcohol other than liver damage, such as cancer.
10.	Support provision of higher level of treatment services than present 6% of those dependent on alcohol, and a rational share for drug and alcohol treatment resources.
11.	Promote alcohol 'Identification and Brief Advice' (IBA) for frontline health and social care staff.
12.	Use National Institute for Health and Care Excellence guidance CG115
13.	Promote to employers the benefit of occupational health provision in relation to alcohol.
14.	Consider closer PHE links with the Faculty of Occupational Health Medicine.
15.	Follow the precautionary principle, for example on not drinking during pregnancy.
16.	Pursue the introduction of 'protection and improvement of public health' as a fifth licensing objective.
17.	Have good evidence and 'Questions and Answers' to change social norms on drinking.
18.	Provide surveillance of alcohol marketing and the adequacy of the regulatory code, including protection of young people from digital marketing of alcohol.
19.	Use social media to raise awareness of the negative effects of alcohol.
20.	Fund public awareness and behavior change campaigns on alcohol.

Public Health England Board
Actions from the meeting of 27 May 2014

Tuberculosis

Lead Board Member: George Griffin
Board Review Date: Wednesday 25 May 2016

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Find and treat' capability was good but walk-in TB facilities would be beneficial.
2.	Direct observation of therapy for example by family or community members would improve compliance with treatment regimens.
3.	TB resources needed mandated leadership and to be adequately funded.
4.	Basic tests by GPs for new migrants should include testing for latent TB.
5.	The traditional social determinants of health in terms of better housing and conditions applied to TB.
6.	Awareness amongst General Practitioners and nurses could be improved.

Public Health England Board
Actions from the meeting of 24 September 2014

Antimicrobial resistance

Lead Board Member: Martin Hindle
Board Review Date: Wednesday 22 June 2016

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Consider behaviour and behavioural change programmes - in the media, professional and school curricula. (The profile of antimicrobial resistance could be powerfully raised with the public, for example, through television soaps and social media. PHE was looked to in leading behavioural change.)
2.	Determine when it is right to use antimicrobials and course length. (Professionals in both human and animal healthcare could be better informed in their education and training, but their overriding concern for their patients meant that having point of care diagnostics, and rapid diagnosis of infections would greatly improve the right use of antimicrobials, and the correct length of antibiotic course.)
3.	Consider economics of point of care diagnostics for some infections (with NICE).
4.	Consider incentives and disincentives for use of antimicrobials. (Internationally prescribing practice and patient expectations varied widely, including models where doctors and hospitals were rewarded in proportion to drug spend.)
5.	Include veterinary science aspects of antimicrobial resistance in PHE, especially surveillance and action.
6.	Look at the global antimicrobial scene and its impact on the UK.
7.	Measure the right things and publish.
8.	The surveillance base of people with severe resistance should be considered.
9.	Post-genomics applications. (Genomics might identify infections that could still be susceptible to earlier generation antibiotics.)
10.	Consider penalties in addition to the ‘three Ps’ (prevent, preserve and promote).

Public Health England Board
Actions from the meeting of 26 November 2014

Mental Health

Lead Board Member: Poppy Jaman
Board Review Date: Wednesday 20 July 2016

The observations and suggestions are exclusively those of the external panel members and participants and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Mental health is not taken sufficiently seriously. With disproportionately smaller shares of health and local authority public health spending on mental health than physical.
2.	Improving Access to Psychological Therapies (IAPT) is effective and targets for accessing IAPT should be more ambitious, and are a basis for other interventions.
3.	Data on mental health is poor compared with data on physical ill-health and healthcare provision. It is hard to use and needs to be local and accessible to citizens. Data is essential to measures of progress and effectiveness. PHE should support local leaders to do their job with evidence and a mental health intelligence network.
4.	Child and adolescent mental health services (CAMHS) need to be credible. The lack of a set target is a weakness particularly for mental health. PHE was asked to push for a 33% annual target for the proportion of children seen annually by CAMHS. NHS England and PHE could provide a specification for a good service and crisis intervention.
5.	Black and minority ethnic provision is disproportionately lacking in mental health strategies.
6.	Note the five World Psychiatric Association themes: domestic and gender-based violence, agenda, child-abuse, prisoner mental health care, under-served groups and mental health promotion.
7.	Many adult psychiatric disorders start young and should be targeted for prevention and health promotion.
8.	Minimum unit pricing of alcohol would have the biggest impact on violence, misery and demand on hospital emergency services.
9.	Mental and physical well-being are not separate issues.
10.	Those affected by mental health died younger.
11.	All government departments need to be engaged.
12.	Engage in schools to improve children's identification of conditions and familiarity with them. (There are good examples from across the world.)
13.	Parenting skills are needed for parents under pressure, including those with learning difficulties and mentally disordered: intervening before trouble occurs.
14.	Early interventions were required in the over 65s where physical ill-health combined with mental health issues to cause misery. Age psychiatry is under resourced.
15.	There is confusion in local authorities over what public mental health is and in identifying spend.
16.	Mental health was not getting parity with other health issues at a local level and should be part of local strategies and Joint Strategic Needs Assessments, with public data on progress.
17.	Ensure that national public health targets, for example for smoking prevalence, and alcohol use, would are benefit the mentally ill.
18.	PHE should develop a well-being impact assessment tool as part of the Green Book for assessing all policies nationally against mental health.
19.	An evidence based social marketing campaign to help people at the population level to

	support their own mental health and wellbeing and resilience.
20.	Public social marketing could emphasise the importance of infant mental health.
21.	Mental health in pregnancy and birth are areas with little or no provision.
22.	Only PHE can impact people rather than patients, as many people did not approach health care with mental health issues.
23.	Many sources of the information available to the public lack an evidence base.
24.	PHE should be a partner in All Party work on Mindfulness with academics.
25.	Terminology for mental health, mental wellbeing, mental illness or disorder needs to be standardized and agreed in the sector.
26.	A balance between prevention and promotion must be struck in mental health – because resources are easily diverted to respond to suffering.
27.	The medical profession needs more respect for mental health and its integration with physical health. The medical attitude would then affect the general public.
28.	What constitutes evidence? Is the Randomised Controlled Trial approach suitable for assessing changes in complex systems?
29.	Local partners want evidence of return on investment and impact.
30.	PHE can lobby and spread information – both to aid prevention and early intervention. PHE should persuade schools and the NHS as the main institutions that can be influenced.
31.	Persuade schools that the well-being of children is an objective of schools with Ofsted and the schools themselves: having measures of success; evidence-based teaching of life skills; all teachers should have mental health training.
32.	PHE should spell out what works to convince local leaders of effective actions (eg. in reducing the £26 billion a year costs estimated for mental health in London)
33.	Integrate medical and scientific communities with mental health issues to get cross-discipline of education and money.
34.	The Faculty of Occupational Health works with employers an opportunity to make NHS staff and patients aware.
35.	A living wage has impact on self esteem, and discrimination and stigmatisation.
36.	There is a community role in recovery.
37.	The criminalisation of drugs links to prisons, suicide etc.
38.	There is a lot of data in different services but that this is not shared. We should identify and share the available data, identify best practice, and pursue efficiency to save money.

Public Health England Board
Actions from the meeting of 28 January 2015

Rural Health

Lead Board Member: Richard Parish
Board Review Date: Wednesday 28 September 2016

The observations and suggestions are exclusively those of the external panel members and participants and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	There is opportunity for greater collaboration between NHS England and PHE on rural health issues, for example, identifying potential gaps in delivery with respect to access, choice and distance.
2.	There is scope for PHE to assist local authorities in their efforts to increase levels of daily physical activity in rural areas.
3.	There is scope for local government, PHE and others to work together to address the issue of empty (rural) housing stock.
4.	PHE and its partners could work together to strengthen the “green deal” to further incentivise landlords to undertake remedial work to damp and/or uninsulated properties.
5.	The design and delivery of research and development programmes in health and care organisations serving rural areas could enhance the career options for their staff.
6.	PHE could explore how it could support and mobilise small and medium-sized enterprises in providing workplace health and wellbeing services.
7.	The workforce should be trained to address the needs of rural communities and individual career paths, including nurses, general practitioners and specialist clinicians.
8.	Consider models in other countries with large rural populations in adapting healthcare training to their needs.
9.	Enhance the value of detailed epidemiological data for localities provided by PHE, through research to interpret the data.

Public Health England Board
Actions from the meeting of 22 May 2015

Air Pollution

Lead Board Member: Sian Griffiths
Board Review Date: Wednesday 19 October 2016

The observations and suggestions are exclusively those of the external panel members and participants and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Encourage Directors of Public Health to ensure that air quality measures are included in Joint Strategic Needs Assessment frameworks.
2.	Exploit opportunities in urban design to address air pollution, particularly in London, which can be used to demonstrate a healthy town effect.
3.	Increase both public and professional awareness of air pollution, including what denotes a pollutant, how best this can be explained to the public, and what can and cannot be influenced.
4.	Include the impact of air pollution in rural areas, and with local authorities less familiar than urban authorities on the air pollution consequences of their decisions.
5.	Bring together the resources of PHE from the Chief Knowledge Officer (CKO) Directorate and the outcome and exposure data prepared by the Centre for Radiation, Chemical and Environmental Hazards (CRCE).
6.	PHE should continue: (i) to raise awareness of air pollution issues in the healthcare and public health sector through sustained engagement with local authorities and wider stakeholders. (ii) To provide evidence on the health effects of air pollutants and develop a practical framework for local authorities to evaluate the health benefits of local interventions, such as active travel and reducing exposure to air pollution.
7.	Work with partners across the Devolved Administrations.
8.	Assist localities to develop air pollution narratives distinct to their different priorities and variations.
9.	Extend awareness of air pollution beyond being the traditional concern of Environmental Health Officers to Directors of Public Health.
10.	Work with NHS England on opportunities to take air quality into account in the delivery of the *Five Year Forward View*.

Frank Kelly's three key points to PHE:

- No one Government Department is taking responsibility for bringing together the necessary expertise across Government to deal with public health challenge of air pollution. Defra is seen as being responsible, but Department of Health/PHE suffer the impacts, while DfT is responsible for much of the air pollution generated in urban areas.

- Given the combined health burden associated with PM and NO2 exposure PHE needs to examine the resource it allocates to this major public health issue. It appears that both climate change and radiation exposure still have higher profiles/staff allocations in PHE.

- With additional resources allocated to the topic PHE could lead on a major public awareness campaign to both highlight the impact of poor air quality on health as well as encouraging the public to become part of the solution.

Public Health England Board
Actions from the meeting of 15 July 2015

Children Young People and Families

Lead Board Member: Rosie Glazebrook
Board Review Date: Wednesday 23 November 2016

The observations and suggestions are exclusively those of the external panel members and participants and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	A population approach is required, as well as providing targeted support to the most vulnerable families.
2.	It is important to listen to children and young people when planning services and interventions.
3.	Social media, and its benefits and challenges in terms of children and young people's health and wellbeing need to be better understood.
4.	The development of better outcome measures is required for health visiting, as well as improved ways of measuring their impact.
5.	The impact of children on older people's health should be taken into consideration, including the success of the children's flu pilots and "pester power" to stop adults smoking and to encourage healthier diet.
6.	The development of an all systems approach should be considered. For example with Making Every Contact Count, environmental health officers who visit housing and premises as part of their work could support this agenda.
7.	The role of the private rented sector in relation to houses needs to be taken into consideration.

Children Commissioner's Takeover Day

Lead Board Member: Rosie Glazebrook
Board Review Date: Wednesday 23 November 2016

The observations and suggestions are exclusively those of the external panel members and participants and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Young people should be more involved and engaged in the development of all PHE's programmes of work.
2.	There should be a continuous dialogue between PHE and the contributors to the discussion, with updates provided throughout the year.
3.	Information to young people should be of consistently high quality and easily available.
4.	Senior leaders should be more approachable, and it should be easier to discuss the issues.
5.	Young people were under-represented on PHE People's Panel and this would be addressed.

Public Health Approaches to End of Life Care

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	End of life care should be embedded in workforce planning to ensure appropriately skilled staff were available, with suitable career paths and development open to them.
2.	The impact on carers and volunteers should be better understood, for example, the mental and physical impacts.
3.	The clinical effects of grief should be better understood and PHE's health improvement role in this explored further.
4.	The place of death indicator should be considered carefully as some people classified as dying at home were care home residents, in other words, they were not living in their own homes when they died. Moving people between care homes should be carefully monitored, in particular, the negative impact this might have on quality of end of life care.

The Public Health Workforce of the Future

The observations and suggestions are exclusively those of the external panel members and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation	
1.	Ensuring that staff were motivated was essential, particularly on prevention and the benefits this would bring. The prominence of this agenda provided real opportunities
2.	The public health workforce needed to be equipped with the appropriate skills and capabilities to fully participate in changes such as devolution and moving to place-based approaches.
3.	There should be flexibility for staff to move across the system. Career frameworks should be developed to allow staff to have portfolio careers and, in their formative years, provide apprenticeship opportunities
4.	There should be a focus on skills and capabilities of public health staff and ensuring the highest standards across the system
5.	A social movement should be created locally and to ensure that public health was embedded across all staff groups in the workforce. Tools such as *Making Every Contact Count* should be rolled out systematically across local areas