Public Health England

Protecting and improving the nation's health

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 26 April 2017
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 2 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 2017

Appendix 1

Actions from PHE Board minutes

Meeting	Minute	Action	Owner	Disposition
28 January 2015	15/011	Include rurality as an agenda item for next NHS England / PHE Board to Board meeting	Board Secretary	To be scheduled for next meeting with NHS England
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

Appendix 2

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Obesity

Lead Board Member: Rosie Glazebrook

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 the forward watchlist was reviewed:

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.

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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.	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
3.	Provide quality assurance, curation, and make information and materials available.	Ongoing - routine business of the Research, Translation & Innovation (RTI) division of CKO
4	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
5	In the genomic field: Ensure PHE is outward facing and engaging with	Ongoing – in line with drive to collaborate and compete for external funding; focussed and boosted through NIHR Health Protection Research Units (NIHR HPRUs)

	others without conditions, and supress the tendency to compete internally.	
6	Make further effort to ensure scientists behave cohesively.	Ongoing, eg focussed activities in NIHR HPRUs and planning for Science Hub
7	Include the impact of economic and social determinants in research.	Ongoing – eg new expertise in NIHR HPRUs and Health Economics
8	Link academic approaches in public health with practice.	Ongoing – a range of events and engagements
9	Build capability as well as capacity through training.	Ongoing – eg through new research and evidence considerations in Knowledge and Skills Framework
10	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
11	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
12	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

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

PHE Global Health Strategy

Lead Board Member: Sian Griffiths

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.

		Update September 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.	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. PHE is jointly leading the development of a UK Public Health Rapid Support Team for international response
3.	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.
4.	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.

5.	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.
6.	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).
7.	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.
8.	Do not over-emphasise infectious disease.	PHE's Global Health Strategy recognises Health and Wellbeing and NCDs as a priority for engagement.
9.	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.
10.	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.
11.	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.
12.	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.
13.	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.
14.	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.
15.	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.
16.	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.
17.	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.
18.	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.
19.	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).
20.	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.
21.	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.
22.	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.
23.	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.
24.	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.
25.	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.

Public Health England Board

Tobacco

Lead Board Member: Paul Lincoln

Following the discussion at the April 2016 Board meeting the forward watchlist was reviewed:

1.	The financial environment for local authorities should be carefully reviewed, in particular, the impact of the reductions to the local public health grant and the measures being taken locally to encourage smoking cessation.
2.	There could be greater emphasis on the steps being taken to ensure that people, particularly children, didn't start smoking in the first place
3.	Clear guidelines should be developed for working with those in mental health settings, through working in partnership with the voluntary sector to ensure there was appropriate engagement and that interventions were evaluated and the results widely shared.
4.	Work should take place to fully understand the rates of smoking and the impact of tobacco control measures in diaspora groups, particularly among the eastern European community.
5.	Existing initiatives such as *Making Every Contact Count* should be used to full effect when developing smoking cessation programmes

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Alcohol

Lead Board Member: Sir Derek Myers

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Board follow up meeting on Alcohol: Wednesday 27 April 2016

Following the discussion at the April 2016 Board meeting the forward watchlist was reviewed:

1.	One measure of success or otherwise was the trend in alcohol-related hospital admissions, although it was recognised that this did not take into account those who had not yet started drinking and the measures being taken to avoid heavy uptake.
2.	Further work should take place to highlight the macro-economic consequences of excessive alcohol consumption, including the costs to the NHS, the wider emergency services and the business sector.
3.	It would be important to ensure that there was traction when the evidence review was published and that marketing campaigns suitably aligned in terms of public messaging
4.	Health inequalities were an important consideration, in particular, the treatment provided to homeless and other under-served communities
5.	In the same way that it had developed clear messages to the public on smoking and eating, PHE should develop clear messages on alcohol

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Tuberculosis

Lead Board Member: George Griffin

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<u>Board follow up discussion on TB: Wednesday 25 May 2016</u>
Following the discussion at the May 2016 Board meeting the watchlist was reviewed and updated as below:

1.	There had been good progress across a number of indicators and it was essential to maintain the momentum to ensure that progress continued.
2.	It was key to ensure that people were getting into treatment earlier. PHE should continue to work on raising awareness in primary care on how to identify and diagnose TB.
3.	The economic analysis and perspective of different partners in the delivery of the strategy should be presented.
4.	Evaluation was key and should be embedded through the delivery of the strategy.

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

Antimicrobial resistance

Lead Board Member: Martin Hindle

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).

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Mental Health

Lead Board Member: Poppy Jaman

Board follow up discussion: Wednesday 20 July 2016

Following the discussion at the July 2016 Board meeting the watchlist was updated as below:

1.	PHE should consider developing performance metrics to track progress on achieving its aims and demonstrating impact in the field of mental health and wellbeing.
2.	There were likely to be several opportunities related to mental health as part of PHE's global public health work, and PHE could play an important leadership role across the global health system
3.	There needed to be well coordinated effort within PHE and across the health and care system on addressing children's mental health. For example at a system level one important area was access to mental health services, including the waiting time for full assessment.
4.	The impact of financial and related scams on mental health and wellbeing was an emerging issue for consideration. Others included arts and health.
5.	PHE had a potential role to play in supporting partners in delivering other recommendations from the Mental Health Taskforce, including suicide prevention, workforce planning, access standards, health and justice care, challenging stigma and innovation for devolved areas.

Rural Health

Lead Board Member: Richard Parish

Board follow up discussion: Wednesday 22 February 2017

Following the discussion at the February 2017 Board meeting the watchlist was updated as below:

External panel observation	
1.	Depravation was widely dispersed in rural areas, the work on the new models of care and the role of community pharmacies should help address these inequalities.
2.	The role of small business in rural communities was highlighted, particularly when distributing information and implementing toolkits, for example, work was taking place with Business in the Community to share PHE's mental health toolkit through its membership, including those in rural areas.
3.	The role of research and providing support for local authorities in future was highlighted, in particular sharing best practice and what works. It was recognised that there was a great deal of emerging evidence and evaluation would continue.

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

Air Pollution

Lead Board Member: Sian Griffiths

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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	

Children Young People and Families (including engagement with young people)

Lead Board Member: Rosie Glazebrook

Board follow up discussion: Wednesday 25 January 2017

Following the discussion at the January 2017 Board meeting the watchlist was updated as below:

External panel observation	
1.	The extension of the Best Start in Life scope to 24 years was welcome and it would be important to ensure that vulnerable young people above this were supported appropriately.
2.	An area of potential future focus was how to reduce re-offending rates, which was often linked to deprivation.
3.	A multi-disciplinary approach was needed to reduce health inequalities and improve outcomes, for example, on housing.
4.	Further work was required on timeliness of data reporting and identifying opportunities to integrate data wherever possible.
5.	Young people were a diverse group with differing needs. Recent workshops had highlighted a range of issues, including mental and emotional health and ensuring that there was a safe and secure way in which to raise health-related issues and concerns.

Public Health England Board
Actions from the meeting of 24 February 2016

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 National Key Performance Indicator (KPI) on place of death should be kept under review. It should be clear that this is only a proxy measure for quality of end of life care and patient choice. For some patients hospital is the right place to die. The KPI – Death in Usual Place of Residence (DiUPR) is a composite indicator combing death at home and death in care homes. It was initially adopted to take into account that many older adults live and then die in care homes. However, close monitoring of disaggregated data by the National End of Life Care Intelligence Network (NEoLCIN) shows that a significant and increasing proportion of patients who die in care homes were resident in their own homes prior to admission during a short terminal illness.

Public Health England Board
Actions from the meeting of 23 March 2016

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

Public Health England Board
Actions from the meeting of 25 May 2016

Health Inequalities: Support for action to reduce inequalities in England

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.	The non-traditional public health workforce should be engaged when addressing health inequalities as this was a valuable resource.
2.	Devolution provided opportunities for delivery change at scale.
3.	The impact of early intervention in reducing health inequalities should be considered, particularly in educational settings.
4.	Further work was required to tailor interventions for those in the lowest quartile, together with a balanced approach which addressed both behavioral and environmental factors.
5.	Further work should take place with Health and Wellbeing Boards to explore the practical steps which could be taken locally to reduce health inequalities.

Public Health England Board
Actions from the meeting of 23 November 2016

Data Access for Public Health

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.	It was important for local authorities to be made aware of what data was available and for the appropriate amount of support to be provided in order for them to access it.
2.	Secondments and other opportunities should be explored to ensure the knowledge and intelligence workforce was flexible.
3.	Potential learning from the commercial sector should be explored, especially in relation to the use and management of big data.
4.	More work was required to ensure that the data flow was secured. This included ensuring that there was safe access to each data set, linking health and social care data, and that there was the flexibility to do this at local level. Approaches were also being developed for handling novel data sets such as those derived from smart technology as well as more traditional data sets.
5.	Data sharing and data security needed to be considered as one to ensure they were beneficial for individual patient care as well as the efficient and effective running of health systems.