Public Health England

Protecting and improving the nation's health

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 25 May 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.

1.2 Following the review sessions led by members of the Board for Obesity and Research those items which have been completed have been removed from the watchlist and the additional items raised by Board members have been added. Those items where progress will be reviewed at a future session have been marked as **AMBER**. This will be applied to all other reviewed lists for future meetings.

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
May 2016

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
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	Full presentation on PHE's data work to be provided at the October meeting.

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 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.

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) not yet complete

External panel observation		PHE Research Team response	Complete
1.	Foster better links with academics, public health practitioners and civil society.	Ongoing - routine business of the Research, Translation & Innovation (RTI) division of CKO	**A**
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	**A**
3.	Provide quality assurance, curation, and make information and materials available.	Ongoing - routine business of the Research, Translation & Innovation (RTI) division of CKO	**A**
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	**A**
5	Manage growth expectations in the	Responsibility lies with NIS	**A**

	adoption of technologies for interpreting large amounts of sequence data.		
6	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)	**A**
7	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	**A**
8	Make further effort to ensure scientists behave cohesively.	Ongoing, eg focussed activities in NIHR HPRUs and planning for Science Hub	**A**
9	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	**A**
10	Include the impact of economic and social determinants in research.	Ongoing – eg new expertise in NIHR HPRUs and Health Economics	**A**
11	Link academic approaches in public health with practice.	Ongoing – a range of events and engagements	**A**
12	Build capability as well as capacity through training.	Ongoing – eg through new research and evidence considerations in Knowledge and Skills Framework	**A**
13	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	**A**
14	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	**A**
15	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	**A**

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	When considering work with other countries, thought is given to

	health.	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 academic exchange have different bases.	Recognised in PHE's Global Health Strategy.
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	Climate change recognised as an

	global public health issue.	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

Tobacco

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

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

Public Health England Board

Alcohol

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

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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

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

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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

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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

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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

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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