1. What do you think should be the key priorities and primary functions of PHE?

PHE has a broad remit, which risks leading to a loss of focus and difficulty in tracking how priorities are implemented in practice. The key priorities and primary functions of PHE and of health protection should be improving health and wellbeing and reducing inequalities, and preparing for and responding to emergencies. The latter should include protection from environmental hazards and protection from infectious disease, and be based on “All Hazards” and “One Health” approaches. Improving health and wellbeing should include supporting parity on mental health issues, as this will be the greatest burden of disease by 2030. As part of supporting and developing the public health system, PHE should ensure they monitor the health of the population by identifying emerging problems and proposing responses. For example the effects of austerity on health, which PHE has not appropriately considered.

PHE should act as an independent voice for public health, supported by evidence. Not only should it voice the evidence, but it should translate it into useful policies that protect the population’s health.

It appears to have a predominantly advisory role rather than a provider role. For example, PHE cannot require clinicians to prescribe antimicrobial drugs differently, but it can provide expert advice on health hazards.

2. Should PHE continue to undertake all of its four main functions (as set out in the 'About PHE' section)?

Yes. These four main functions are core to the health and wellbeing of a developed nation.

3. How well do you think PHE fulfils its functions?

In general it performs its functions around infectious disease control well, though financial pressures, structural reforms and workforce concerns may impact this in the future. We have some concerns about other areas such as supporting and developing the public health system. There should be clearer and louder voices articulating public health messages and evidence in debates relevant to public health, such as on alcohol and Meningitis B vaccination for example. The Agency’s recent report on sugar reduction was a good example of presenting the evidence for action in a balanced and unbiased way; although the delay in its launch was unfortunate. We believe similar approaches should be taken for presenting comprehensive evidence-based policy options for other public health areas. We recognise that potential barriers to PHE performing well are underfunding, being overly bureaucratic and the need to give politically expedient answers.

4. Does PHE demonstrate the level of scientific/medical expertise you would expect?

No, as many of the academic posts have been recently cut or are under threat, which is concerning for PHE’s future capability and capacity.

There is too much importance placed on senior managers in providing expertise. For PHE employees that do have scientific or medical expertise, too often their expertise is not called upon. PHE does
not firmly engage with experts enough or manage its network of academics to produce evidence-based advice.

In contrast to our positive comments about PHE’s sugar reduction report in response to question 3, we have previously expressed concern (in a letter to Professor Kevin Fenton in September 2015) about the Agency’s report on e-cigarettes. In our view, the review overstated the strength of the evidence by not making it sufficiently clear – in either the report or accompanying press release – how the conclusion that e-cigarettes are “95% less harmful than smoking” had been reached, and that it was supported by a single publication based on expert panel opinion.

5. Does PHE demonstrate the level of independence you would expect?

No. PHE is too strongly influenced by government agendas that require it to provide politically expedient responses. It also tries to anticipate what is wanted from the government too much. It has lost sufficient arm’s length independence and so does not speak for the population’s health. Independence of action and thinking are disincentivised and sometimes actively discouraged. This lack of independence has damaged the credibility of PHE and the advice it gives. This can be contrasted with, for example the US Centres for Disease Control, which despite being part of the US uniformed services, is still seen globally as a robust, independent provider of public health expertise, information and advice.

There is a need to clarify the relationship between the Chief Medical Officer and PHE.

6. Is PHE sufficiently accountable to the Department of Health, Parliament and/or to the public, both in terms of the work that it does and for the public money it spends?

It appears to be accountable to the Department of Health but it lacks independence, and so it is not accountable to the public.

7. Does PHE prioritise effectively?

We believe PHE finds it difficult to prioritise within its budget. It appears that budgetary management is still quite rudimentary and very centralised. The public and ministers should set priorities; but this needs to be balanced by an evidence-based approach to policy. It is ineffective and unethical implementing a policy that is not going to have the desired effect, and is a waste of the organisation’s resources.

Supplementary: what processes should support such decision-making?

The organisation needs to embrace the digital age, by leading on new ways of collecting and analysing data and by having an information strategy. PHE’s ability to monitor health is currently very weak. For example, they have only just managed to get data on the large mortality spike in January 2015. However this is partly due to the funding cuts to the ONS (Office of National Statistics).

8. PHE has a key role, alongside other agencies, in emergency preparedness for public health outbreaks. How effective is PHE at planning for contingencies?

Effective, particularly around local outbreaks and incidents. However, there remain some uncertainties around roles and responsibilities across PHE, local authorities and the NHS, especially on events that are “rare” or “severe”.
Another problem is that PHE depends on local government public health for this, especially EMOs (Environmental Health Officers), who have been vastly cut across local government.

9. How effective is PHE’s handling of public health emergencies?

Mostly effective. PHE’s performance in tackling Ebola was good, although marred by some unevidenced, politically-driven policies. For example, the Agency did not independently assess the harm (e.g. through opportunity costs, false reassurance etc.) of the action taken to implement screening policies at UK airports.

The Agency is very good at providing top-level advice on public health emergencies, but it has a limited capacity to act. For example, during recent flooding episodes the capacity of PHE was stretched to the limit attending local emergency planning meetings. However it had very little to add at these meetings, to the advice that had been posted on its website before the flooding started. This was not a good use of resources.

10. In 2014-15 PHE generated commercial revenues (from the provision of laboratory and other services, royalties, and research grants) of around £170m. Do you see scope for PHE to further develop commercial opportunities to support other activities?

Yes, there is further scope for revenue generation especially in global health. However this needs to be transparent and should not divert efforts from other core activities.

11. PHE works at the international, national, regional and local levels. In your opinion, are these tiers necessary for PHE to perform its functions effectively?

Yes, as all the levels are interlinked. However it could do more to actively engage with these levels in a two-way dialogue, as this is essential. For the international levels, activity focuses too much on mass gatherings such as the Hajj for example, and there is very little engagement with other international agendas. There also needs to be more clarity in relation to responsibilities for the dependent territories.

12. Specifically in relation to its work to improve public health, how well does PHE balance national priorities with the differing needs of local areas?

Poorly. The balance between national and local level has been skewed in favour of national issues. It does not have the tools to do both, which could be due to resource constraints. For example, it lacks decent local websites. The ongoing structural reforms, with increasing regionalisation in PHE worsens this problem.

13. PHE has to work effectively with partners both nationally and internationally to meet its objectives. How well do you think PHE influences and supports other bodies?

Average. A difficult relationship is with local authorities, as their different training and value systems often conflict. PHE is usually orientated to evidence-based decision making whilst local authorities are more influenced by democratic accountability and electoral considerations.

There is also a lack of relationship between PHE and the international part of the Department of Health which is problematic.
Supplementary: where relevant, and in your experience, how well does PHE engage with your organisation?

With some notable exceptions, PHE has not engaged well with the BMA; for example pulling out the agreed keynote speakers from the public health annual conference due to concerns about ‘purdah’, and not providing a speaker on sugar due to political sensitivities. PHE are invited members of the Public Health Medicine Consultative Committee, a joint committee of the BMA and Faculty of Public Health, and an agreed mechanism for raising and discussing professional issues in public health. We would like PHE to prioritise its involvement with this group more.

Whilst there can, at times, be conflict between PHE and the BMA acting in its trade union role, this should not prevent PHE from engaging positively with the BMA as a professional association. There are many areas, such as health policy research, advocacy, ethics and international work where PHE and the BMA could form fruitful partnership working.

14. How well does PHE communicate and engage with the full range of its stakeholders?

Average, partly because of decreasing resources. PHE provides wider messages and exhortations, but more targeted engagement requires more sophisticated tools and processes. The process for communications approval at times stifles PHE’s ability to communicate effectively, rapidly and in the best interests of the population.

15. How effective is PHE at operating within, and supporting, the rest of the health and care system?

Ineffective. Only in traditional health protection areas such as infection control has PHE demonstrated some efficacy at working within the NHS.

16. PHE has a key role in influencing public attitudes and behaviours to support health improvements. To support this it has a significant marketing function. How effective is PHE’s marketing function at delivering such change?

Effective. PHE has made some bold statements with the sugar app for example, but the Department of Health often acts as a block for these new initiatives. The entire approval process for digital products takes about two years, which is too long for innovation to happen.

The PHE marketing function is too focused on individual actions/personal responsibility, rather than societal actions. This fails to recognise the factors that strongly influence health risk factors, such as the wide accessibility, availability and promotion of alcohol and unhealthy food and drink products.

17. Are there any measures you believe PHE could take to deliver further efficiencies from within its agreed budget (whether reduced costs, spend to save proposals, or improved use of resources)?

Efficiency savings in public health are a false economy. As a key part of the Five Year Forward View, public health needs to be sufficiently funded.

18. Is PHE sufficiently strategic and forward-looking in its approach?

The many internal changes forced by budget cuts and reorganisations have left little time for strategic forward-thinking. Whilst PHE does try to create strategic direction in some areas, the
drivers of unforeseen incidents and events (Ebola, pandemic flu) and short-term political cycles can limit the effectiveness of forward planning.

Comments not included

“When I responded to the original request I said I thought that PHE was good in addressing major issues such as the Ebola outbreak, but less good in promoting public health in people’s everyday lives. For example, I think they could do more to encourage personal hygiene as a factor in containing infections spread across communities, on the basis that individuals have a responsibility to the public as a whole e.g. by hand-washing, containing colds, coughing and sneezing in public places and improved food hygiene at home and in public distribution of food. I think some reference to the personal element would be a useful addition under Q3 of the response.” – Dorothy May from Patient Liaison Group.

We left out this comment as we are not sure if personal hygiene is a problem in our population that PHE needs to address.