Public Health England

Protecting and improving the nation's health

Minutes

Title of meeting	Public Health England Board	
Date	Friday 22 May 2015	
Venue	PHE Headquarters (Wellington House) London	
Present	David Heymann	Chair
	Rosie Glazebrook	Non-executive member
	George Griffin	Non-executive member
	Sian Griffiths	Associate non-executive member
	Martin Hindle	Non-executive member
	Paul Lincoln	Associate non-executive member
	Richard Parish	Non-executive member
	Duncan Selbie	Chief Executive
In attendance	Alan Andrews	Client Earth
	Viv Bennett	Chief Nurse, PHE
	Roger Barrowcliffe	Institute of Air Quality Management
	Michael Brodie	Finance and Commercial Director, PHE
	Paul Cosford	Director for Health Protection and Medical Director, PHE
	Yvonne Doyle	Director - London, PHE
	Jeanelle De Gruchy	Vice- President, Association of Directors of Public Health
	Kevin Fenton	Director of Health and Wellbeing, PHE
	Paul Holley	Scientific Policy Manager, Department of Health
	Frank Kelly	Professor of Environmental Health, Kings College London
	Anthony Kessel	Director of International Public Health, PHE
	Victor Knight	Board Secretary, PHE
	John Newton	Chief Knowledge Officer, PHE
	Quentin Sandifer	Observer for Wales
	Rachel Scott	Corporate Secretary, PHE
	Alex Sienkiewicz	Director of Corporate Affairs, PHE
	Elliot Treharne	Greater London Authority
	Sotiris Vardoulakis	Health Protection and Medical Directorate, PHE
Apologies	Poppy Jaman	Non-executive member
	Sir Derek Myers	Non-executive member

There were four members of the public present.

1. Announcements, apologies, declarations of interest

15/065 Apologies for absence were received from Poppy Jaman and Sir Derek Myers.

15/066 No interests were declared in relation to items on the agenda.

2 Panel discussion: Air Pollution

15/067 The Director of Health Protection and Medical Director introduced the discussion on public health aspects of air pollution in England, and the expert external panel. The panel made the following points to the Board:

a) the problems of air pollution were well defined, and the responsibilities for dealing with its consequences were collective. Collaborative working was required as air pollution levels were affected by industry, agriculture, transportation, construction and power generation. Some sources were very localised, others crossed international borders.

b) tackling air pollution was a substantial priority for the London Mayor. It was recognised as a competitive aspect in attracting talent and commerce compared to other world cities. The cost of air pollution disproportionately affected the most vulnerable groups in society. Action taken by the Greater London Authority included:
   i. Ensuring that the London bus fleet was carbon neutral. It was also proposed to ensure that London taxis were carbon neutral by 2018 and the process for decommissioning high polluting taxis had commenced.
   ii. the establishment of both congestion and clean emission zones.
   iii. introduction of cycle zones and electric car charging points.
   iv. Ensuring targeted local action. A £20 million fund had been established to allow local councils to bid for local projects.
   v. A new requirement had been introduced to the planning system to ensure that all construction sites were carbon neural (construction accounted for 15% of London's total air pollution).

c) Advocacy was important, for example, encouraging Directors of Public Health to ensure that air quality measures were included in Joint Strategic Needs Assessment frameworks.

d) Client Earth, a charity and Non-Governmental Organisation which primarily used the law to improve human health and the environment, had established the Healthy Earth campaign. A Supreme Court ruling in 2013 found that the UK was in breach of the European Directive on Quality regulations for nitrogen oxides. A new air quality plan would be submitted to the European Commission by the end of 2015, and compliance with nitrogen dioxide limits achieved well before the present 2030 target. This would require public consultation.

e) Londoners had been polled as part of the preparations for the London Health Commission and responded favourably when asked about action on air pollution. Further work would be needed to look at city wide deaths: the highest cause of deaths in London was smoking, but pollution was a contributory factor.

f) There were big opportunities in using urban design to address air pollution, particularly in London, which could be used to demonstrate a healthy town effect. Forums such as the Green Infrastructure Planning Group already looked at green assets and space which is available in London. However this depended on good land management and demonstrated the importance of using collective assets and advocacy.

15/068 The Board discussed the issues that had been raised by the panel with a particular focus on the actions which PHE could take to address air pollution and poor air quality. It would be important to ensure that the impact of air pollution in rural areas was not overlooked, particularly in agricultural areas with the impact of highways and traffic. There were co-benefits to the public's health of addressing air pollution, for example the impacts of diabetes and smoking were made worse with cardiovascular and respiratory illness which could be attributed to poor air quality.

15/069 Both public and professional awareness needed to increase, including what denoted a pollutant and how best this could be explained to the public. Clarity was also needed on what could and could not be influenced.

15/070 PHE was contributing relevant work to the developing the evidence base and the science, including through the Global Burden of Disease model. There was an opportunity to bring together the resources of PHE from across the Chief Knowledge Officer (CKO) Directorate and the outcome and exposure data prepared by the Centre for Radiation, Chemical and Environmental Hazards (CRCE). PHE was already providing mortality data and had developed a programme focusing on two main workstreams. The first was to raise awareness of air pollution issues in the healthcare and public health sector through sustained engagement with local authorities and wider stakeholders. The second was 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.

15/071 The wider government contribution also needed to be considered as well as work with partners across the devolved administrations. Further work was needed on developing the narrative, particularly as each locality would have different priorities and variations. Pollution had been the concern of environmental health officers but Directors of Public Health should also take an interest. The recent Board to Board meeting with NHS England highlighted the opportunities to take air quality into account in the delivery of the *Five Year Forward View*.

15/072 Air Pollution and air quality related to many of PHE's priorities. The Chief Executive invited Professor Kelly to write following the meeting to outline the three critical issues which PHE would then endeavour to follow up and act upon. Action: Secretariat

3. Minutes of the meeting held on 27 February 2015

15/073 The minutes (enclosure PHE/15/17) were agreed as an accurate record of the previous meeting.

4. Matters arising

15/074 The matters arising from previous meetings (enclosure PHE/15/18) were noted.

15/075 On behalf of the Board Rosie Glazebrook would lead the follow-up work on obesity following the discussion at the meeting in July 2013. An update on progress would be provided to a future meeting. Action: Kevin Fenton/ Rosie Glazebrook

5. Update from National Executive

15/076 The Chief Nurse advised the Board that:

a) the public health nursing leadership function had successfully transferred from DH to PHE. Senior nurses from the Directorate were now being linked with Regions and Centres to support national to local working.

b) '*Sound Foundations'* had been established to ensure that robust systems were in place to implement agreed audit recommendations following quality improvement and assurance reviews.

c) The Chief Nurse Directorate was contributing to the work on healthcare public health, and in particular developing a tool for personalised care and population health.

15/077 The Director - London advised the Board that:

a) her team was focussing on ambitions for the population's health, particularly following the recommendations from the London Health Commission to which she had contributed as the Mayor's statutory adviser on public health.

b) *Transforming London's Health and Care Together* had been published and set out the steps which would be taken across London to implement the *Five Year Forward View* and *Better Health for London*. 13 transformation boards had been established, of which she chaired the Prevention Board.

15/078 The Director for Health Protection and Medical Director advised the Board that:

a) PHE continued to contribute to the international response to Ebola outbreak in West Africa. The number of cases in Guinea and Sierra Leone had reduced during the previous weeks and Liberia had been declared free of Ebola. PHE was also contributing to the longer-term rebuilding of public health infrastructure in Sierra Leone. Paul Johnstone, Director - North was on secondment to the WHO and was working on this with Sierra Leone's chief medical officers and ministers.

b) A small outbreak of measles had been reported in a school in Devon. Local health protection staff were working to ensure that the outbreak was controlled, and were also reviewing MMR vaccine uptake rates..

c) The TB data discussed with the Board in May 2014 were being updated with the latest data.

d) Planning was under way for the flu season 2015, including appropriate circumstances for the use of antivirals and ensuring the maximum uptake for the vaccinations.

e) The organisational structure of PHE's Centre for Radiation, Chemicals and Environmental Hazards had been updated as part of Securing Our Future and would be subject to an external review in the Autumn of 2015.

15/079 The Chief Knowledge Officer advised the Board that:

a) PHE and the Health and Social Care Information Centre (HSCIC) had recently agreed a Memorandum of Understanding to formalise the basis on which data flowed between the two organisations for public health purposes. This would be reviewed in October 2015.

b) PHE's information governance toolkit score had increased to 66%. This was a significant achievement and further work was underway to embed level 2 compliance across all domains.

c) PHE was contributing to the National Cancer Taskforce, which was due to be published in July.

d) The Global Burden of Disease work had been included in discussions which had taken place at the World Health Assembly in Geneva.

e) The most recent British Medical Journal awards had been announced. It was proposed that PHE could sponsor a public health category in future years to ensure that public health was appropriately represented. Action: Director Corporate Affairs

15/080 The Director for Health and Wellbeing advised the Board that:

a) The Scientific Advisory Committee on Nutrition (SACN) was finalising report *Carbohydrates and Health*. PHE was working on the evidence for the sugar recommendations.

b) PHE was supporting the Secretary of State's public health priorities, including both diabetes prevention and obesity. There was an emerging cross government focus on obesity and childhood obesity prevention would also be a specific piece of work.

c) Work was taking place on developing clinical preventive services, specifically exploring where clinicians could improve treatment and prevention of:
   i. Reducing alcohol harm.
   ii. Managing undiagnosed hypertension.
   iii. Reducing falls, fragility and fractures. and
   iv. Reducing smoking, in particular smoking in pregnancy

6. Update from the Chief Executive

15/081 The Chief Executive advised the Board that:

a) the Board to Board meeting of earlier in the week with NHS England had reinforced the shared commitment between the organisations on the importance of prevention and how this would be taken forward in partnership, including through PHE's chairmanship of the NHS Prevention Board.

b) the National Infection Service would go live on 1 June. Professor Derrick Crook had joined PHE from Oxford University as its Director and the detailed design work which would bring together PHE's epidemiologists, microbiologists, bio-informaticians, laboratory scientists and others in creating a world-leading "end to end" infections service had started.

c) The Secretary of State for Health had reconfirmed approval of the PHE Science Hub OBC, which had since been shared with HM Treasury and Cabinet Office.

7. Updates from Observers

15/082 The Observer for Wales advised the Board that:

a) The Government of Wales Bill was expected to be included in the forthcoming Queen's Speech.

b) Public Health Wales had published a report showing that over a quarter (26%) of four-to-five year olds in Wales had a body mass index indicating they are overweight or obese (against 23% in England) and a strong relationship between levels of unhealthy weight and deprivation.

c) 550 clients of a tattoo and piercing studio in Newport in South Wales had been invited to attend precautionary health checks including testing for Hepatitis B and C and HIV. Public Health Wales was concerned about the need for tighter regulation of the tattooing and piercing industry.

8. Global Health Update

15/083 The Director of International Public Health advised the Board that:

a) PHE had submitted its application to become a member of the Global Health Cluster. The Cluster comprised of over 40 international humanitarian health

organisations, including US CDC, DfID and Save the Children. Under the leadership of WHO it aimed to optimise health outcomes before, during and after crises.

b) PHE was working with DfID to provide disease surveillance support and development in Pakistan.

c) PHE staff had joined the UK delegation to the World Health Assembly in Geneva, which had taken place in the previous week. A series of constructive, public health focussed meetings had taken place.

d) A future model of working for global health was being developed including exploring those programmes which could be externally funded.

e) Other international programmes continued, including work with the Fleming fund on AMR, and with the International Association of Public Health Institutes (IANPHI).

f) PHE's Global Health Strategy: *Health is Global* would be reviewed and an updated iteration would be presented at a future Board meeting.

15/084 The Board **NOTED** the update on PHE's global health activities.

9. Finance Report

15/085 The Finance and Commercial Director presented the finance update for the full year 2014/15 (enclosure PHE/15/19).

15/086 PHE had delivered financial break-even in 2015/16 as well as its capital programme, which had a particular focus on accommodation and investment in IT infrastructure. Collaborative work was underway across the organisation to ensure investment in PHE priorities.

15/087 The Board **NOTED** the finance report and congratulated the team for its work in 2014/15.

10. Information Items

15/088 The Board noted the following information items:

a) Audit and Risk Committee minutes of 26 February 2015 (enclosure PHE/15/20)
b) Board forward calendar (enclosure PHE/15/21)

11. Any other business / Questions from the public

15/089 An update on PHE's research strategy was provided. Arrangements for publication of strategy would be put in place following the end of the pre-election period.

15/090 An update on rural health would be provided at the June Board meeting.

15/091 There were no questions from the public.

15/092 The meeting closed at 2.15pm.

Rachel Scott
Corporate Secretary
June 2015