Public Health England

Enclosure PHE/14/25

PHE Board Minutes

Title of meeting	Public Health England Board, meeting held in public	
Date	Wednesday 30 April 2014	
Location	Skipton House, 80 London Road, London SE1 6LH	
Present	David Heymann	Chairman of PHE Board
	Rosie Glazebrook	Non-executive member
	George Griffin	Non-executive member
	Sian Griffiths	Associate non-executive member
	Martin Hindle	Non-executive member
	Poppy Jaman	Non-executive member
	Paul Lincoln	Associate non-executive member
	Derek Myers	Non-executive member
	Richard Parish	Non-executive member
In attendance	Charles Alessi	Senior Adviser on Primary Care, PHE
	Janet Atherton	President, Association of Directors of Public Health
	Viv Bennett	Director of Nursing and Midwifery, PHE
	Paul Cosford	Director for Health Protection and Medical Director, PHE
	Kevin Fenton	Director of Health and Wellbeing, PHE
	Richard Gleave	Deputy Chief Executive and Chief Operating Officer, PHE
	Ann Hoskins	National Lead, Children Young People and Families, PHE
	Victor Knight	Board Secretary, PHE
	Gemma Lien	Corporate Secretary, PHE
	John Newton	Chief Knowledge Officer
	Alex Sienkiewicz	Chief of Staff, PHE
	Kathryn Tyson	Department of Health
	Sotiris Valdoulakis	Group Leader, Air Pollution and Climate Change, PHE
	David Walker	Deputy Chief Medical Officer, Department of Health
	John Watson	Deputy Chief Medical Officer, Department of Health
	Lesley Wilkie	Observer for Scotland
	Two members of the public attended.	
Apologies	Quentin Sandifer	Observer for Wales
	Duncan Selbie	Chief Executive

1. Announcements, apologies, declarations of interest

14/122 The Chair welcomed Janet Atherton, President of the Association of Directors of Public Health (ADPH), to the meeting.

14/123 At the invitation of the Department for International Development, the Chief Executive was in Pakistan with members of PHE's international team to discuss with their government how PHE could assist in building their public health capability and in co-designing a national disease surveillance system.

14/124 There were no declarations of interest.

2. Public health theme: Personalisation of health care

14/125 Dr Alessi, senior advisor to PHE on primary care, advised the Board that

personalisation meant adopting a salutogenic approach to healthcare, focusing on people as individuals and not as carriers of a disease or targets for medical intervention. The biomedical aspects of healthcare were part of a solution rather than a solution in their own right. Emerging financial pressures on healthcare systems and the twentieth century focus on delivering evidence-based medicine made this more challenging. Patients often became disengaged, failing to adhere to treatment regimes and believed that public health messages were addressed to people other than themselves.

14/126 Advances in information and communication technology reduced individual reliance on medical professionals. This could empower individuals and improve awareness of the consequences of personal actions, bringing about behavioural change on a scale that the public health system had been seeking for some time. Small personal initiatives in self-care could generate substantial benefits to individual health and the cost of the health system. PHE had an important role to play in supporting and educating the public on their health and wellbeing as well as in working with partners in the health and care system.

14/127 The message of holistic medicine was not new, but while individual professionals might excel, the system as a whole had not been as successful as it could have been. Metrics that had been developed to measure performance at a system level could drive healthcare provision in different directions, and a medicine-focused approach detracted from personal responsibility.

14/128 The Board discussed whether there was a risk of personalisation increasing inequalities in light of evidence of differential uptake of educational initiatives. Dr Alessi reported on work that had recently been carried out on personalisation with a male cohort in a lower socio-economic group, which suggested that it very much depended on delivery of the healthcare message in a way that meant something to the individual and in a sensitive way. Personalisation had the potential to solve, rather than exacerbate health inequalities.

14/129 The Board agreed the necessity to focus on prevention and early intervention, not least because of the forecast increase in the number of the population with co-morbidities over the next ten years from 1.9 to 2.9 million. The healthcare system had been very successful in the previous century in prolonging life; the next challenge was to prolong life without misery. The relationship between personalisation and 'personalised medicine' and genomics was clarified. Where people knew the individual genetic factors influencing their life expectancy they could adopt compensating behaviours.

3. Public health theme: Commissioning effective public health services for children 0-5 years (the Healthy Child Programme – HCP)

14/130 The Director of Nursing and Midwifery and the National Lead for Children Young People and Families briefed the Board on the transfer of commissioning responsibilities for public health (HCP) for children 0-5 to local authorities, which would take place in October 2015. There were a number of key elements, the most significant of which were health visiting services and the Family Nurse Partnership programme.

14/131 Commissioning for public health (HCP) for children and young people 5 to 19 year olds had been transferred to local government in April 2013. NHS England retained responsibility for screening and immunisation whilst general medical services and CCGs commissioned services for sick children.

14/132 The Healthy Child Programme was a universal programme for child and family public health. Local Authority commissioning would bring opportunities for integration with early years, early intervention social care and education. In this

complex commissioning environment, Health and Wellbeing Boards had a key role in co-ordinating across local authorities and clinical commissioning groups to ensure best outcomes for local children.

14/133 The 0-5 HCP was led and largely provided through health visitors and their teams. The government had committed to increase the number of health visitors by 4,200 to 12,292 by the end of the current Parliament and to transform services. This was a huge workforce growth, which included a 500% increase in health visitor training. The timing of the transition was designed to enable sufficient time for growth in workforce and for services' ambition to embed in local areas. The family nursing partnership initiative, a licensed programme from the USA, would increase to 16,000 places by 2015, and focussed on early intervention with teenage mothers to lead to better public health outcomes for them and their children.

14/134 The Director of Nursing and Midwifery, in her Department of Health capacity, and Chief Executive of the Society of Local Authority Chief Executives (SOLACE) co-chaired an oversight group to lead the cross sector work on transition. The SRO was Jon Rouse, Director General for communities and local government at the Department of Health. The PHE lead director was Paul Johnstone, Regional Director for the North of England, working with Ann Hoskins, National Lead for Children Young People and Families.

14/135 The Board noted the significant increase to the health visiting workforce and sought assurance on the implications for supervision of a cadre of inexperienced health visitors, as well as on whether any pressures in local authority social services departments would mean that they would become more involved in child protection issues. It was acknowledged that the increase would lead to a larger, younger and less experienced profession as a whole and the support that would be provided to them was therefore being developed. The majority of effort at present was coming from current health visiting professionals, for which they should be acknowledged and thanked. The overall service model had been redesigned to provide four levels of service: community asset building, a universal programme (HCP universal), early intervention/brief intervention and support, and complex long-term interventions, which included support for families with children and young people with long term condition disability and in safeguarding.

14/136 The Board considered the early years to be key in addressing health inequalities in the longer term, suggesting that the evidence base should be aligned to the NIHR with calls for research on this topic. It was agreed that updating the evidence base would be helpful. The National Lead of Children, Young People and Families advised that this had already been commissioned and would be available in June.

14/137 The Board sought clarity on PHE's responsibilities in oversight and quality assurance during and following the commissioning transfer of 0-5 years from the NHS to local government in 2015.

14/138 During transition, PHE' role was to work with local government and NHS England to ensure readiness for the transfer of commissioning responsibilities for 0-5 child health services, in particular supporting the assurance process and guidance on information requirements. During and post transition, PHE's responsibility was to take a life course approach to its work programmes, for example, support work to give children and young people the healthiest possible start and build their resilience as they grew older, focussing on outcomes and benchmarking. The Public Health Outcomes Framework contained a placeholder for children aged 2 and a half, and PHE would have an ongoing role

with respect to the development and interpretation of the evidence base, as well as in developing the health visiting workforce.

14/139 The 5 to 19 year old transfer provided useful learning for the 0 to 5 transfer. The 0-5 transition involved an eighteen month period of aligned/joint commissioning to enable stability and sustainability. Some areas were already aligning future commissioning intentions, whereas for others this was new. It was important to build relationships and transfer contracts and business processes in advance of October 2015 and part of PHE's role locally was to promote joined-up working in advance of the formal transfer of commissioning responsibility.

14/140 The Board congratulated the team on their work to date and asked if prenatal development was included in the programme's remit in light of the evidence that development at this stage was an important contributory factor to longer term health and wellbeing. PHE considered midwives to be very much part of the wider public health workforce and would therefore be working with NHS England in the commissioning of maternity services. One of the six national success areas was the transition to parenthood and included increasing antenatal contact for parents expecting their first child or for subsequent children where there had previously been difficulties. There would be increased emphasis on the importance of early bonding, emotional resilience and mental health.

14/141 The Board considered the challenge in communicating the changes to the public, noting that there were opportunities for incorporation into established social marketing campaigns such as Start for Life.

4. Public health theme: Health burden of air pollution

14/142 The Director for Health Protection and Medical Director and PHE's lead for Air Pollution briefed the Board on the health burden of air pollution. The recent air pollution episode in London had attracted significant media attention because of its potential impact on people with pre-existing respiratory and cardiac conditions and those in vulnerable groups, including children. However, air pollution, and in particular, fine particles, had a long-term effect which the Committee on the Medical Effects of Air Pollutants (COMEAP) had estimated as causing the equivalent of 29,000 deaths a year in the UK.

14/143 Whilst there were some sources of short-term high levels of air pollution that could not be influenced, for example, sand particles from the Sahara, there were many that could be, in particular, those arising from road transport at a local level. There were multiple potential co-benefits of air pollution control, including through encouraging increased physical activity by provision of more green space and cycling.

14/144 The Department for Environment, Food and Rural Affairs (DEFRA) had lead responsibility for air quality in government. Local authorities monitored and reviewed air quality on a regular basis and were required to prepare air quality management plans if they exceeded set levels. PHE provided the secretariat to a relevant expert committee, COMEAP, the Committee on the Medical Effects of Air Pollutants, and provided the evidence base and advice for influencing local authorities. There was an opportunity which was not being fully grasped to address air pollution through Directors of Public Health and Health and Wellbeing Boards, using the evidence from COMEAP on the evidence on the impact of air pollution on public health and facilitating the implementation of evidence based interventions at a local level, nationally and internationally.

14/145 The President of ADPH shared her concern that proposed changes to monitoring could lead to a reduction in monitoring at a local level in the event

that is was not a statutory requirement. She advised that Directors of Public Health would welcome more evidence on interventions at a local level, for example, on active transport policies. PHE strongly agreed the need for there to be continuity of monitoring data and it was important for the system to be in good shape. PHE would share its views with DEFRA's Air Quality Group.

14/146 The Board noted that in Hong Kong there was a real time indicator on the effects of air pollution and asked whether the costs of the excess mortality due to air pollution were known in England. It was clarified that DEFRA carried out a cost-benefit of the impact of air pollution; PHE's approach was to firstly raise awareness of the issue, followed by advice on interventions to tackle the public health impact at a local and national level. PHE was seeking to model the impact of air pollution on morbidity outcomes, with a particular focus on cardiovascular morbidity. The Met Office now provided five day forecasts of air quality, which provided better public awareness, and PHE was providing public health advice for the general public and vulnerable groups, including children, where forecasts suggested levels of air pollution that exceeded the norm.

14/147 The 2009 COMEAP report on impact of air pollution had made an assessment at a national level. PHE's report of earlier in the month; *Estimating Local Mortality Burdens associated with Particulate Air Pollution* set out the impact at a local level and was supported by spatial data. Maps at local authority level however disguised more local high spots as traffic related pollution, in particular from heavy diesel traffic, varied with distance from roads. The Health Protection Research Unit was looking at air pollution at local level and how it varied within cities.

14/148 The Board agreed that the next step for PHE was to consider how to provide knowledge and practical tools to help Directors of Public Health and their local government colleagues to prepare air quality and transport plans, as well as monitoring the situation nationally and advocating for appropriate national policies. PHE had an important role to play in ensuring that data was collected and used to map the problem accurately at a local level, as the recent PHE report showed. This could be presented alongside other work prepared by the Chief Knowledge Officer's and Health Wellbeing Directorates on the burden of disease and wider aspects of the environment and health. The impact of air pollution had not been considered as a public health priority in its own right but the case for it being so was becoming stronger given the headline figures on mortality attributed to it. It would be important to recognise the additional benefits of tackling air quality at a local level as well as dealing with it as a health burden in its own right.

14/149 The Board agreed that it would revisit the issue in six months' time in conjunction with the public health impact of climate change.

5. Update from Observers

14/150 The Observer for Scotland reported that Health Protection Scotland had produced a briefing for Health Boards and local authorities to help them interpret the published PHE data for the UK. Scotland had a lower target for particulate air pollution than the rest of the UK and emphasised reduction in emission from vehicle traffic. Know and Respond Scotland provided a targeted alert service for members of the public on air quality, including through text messages.

14/151 Early years interventions were a priority in combatting inequalities. The Early Years Framework aimed to make Scotland the best place to work and grow up. 'Getting it right for every child' (GIRFEC) was a universal approach adopted across all services for children and young people. Single outcome agreements

for local areas were based on a logical model of interventions based on evidence. There was no commissioning in Scotland but an equally complex map of relationships existed between providers.

6. Update from the National Executive

14/152 On behalf of the Chief Executive, the Deputy Chief Executive and Chief Operating Officer reported that Sally Warren, Director of Programmes, was leaving PHE at the end of May in order to take up a new role at the Care Quality Commission. The Board thanked her for her contribution to PHE's first year and wished her well.

14/153 The Government's response to the Health Select Committee report into PHE was likely to be published after the purdah period for the forthcoming local and European elections.

Deputy Chief Executive and Chief Operating Officer

14/154 PHE was playing a key role in the East of England's modernised pathology service. The Pathology Partnership, which would be launched on 1 May, involved 125 laboratory staff from hospitals in Ipswich, Colchester, East and North Herts and West Suffolk joining the PHE microbiology team. PHE warmly welcomed their arrival, which would augment the already formidable expertise of this specialist service.

14/155 Regional and Centre Directors were engaging with local public health system partners on the development of PHE's Health and Wellbeing Framework and on what sector-led improvement in public health should look like. In the case of the latter, this might best be led by the LGA and ADPH in the context of providing assurance on demonstrating that a robust system was in place and delivering on what needed to be done. The National Audit Office was in the early stages of planning a value for money review on the new public health system and PHE had held initial discussions with them on the form that this work would take and its contribution.

Director of Nursing and Midwifery

14/156 Social media was being used to connect 500,000 nurses and midwives to the PHE team. This was linked to NHS Change Day with blogs from key contributors. The second annual public health nursing and midwifery conference would be held in Birmingham on 1 July, which the non-executives were invited to attend. Director of Nursing and Midwifery

Director for Health Protection and Medical Director

14/157 PHE had launched a collaborative tuberculosis strategy for consultation, which aimed to bring together best practice in clinical care, social support and public health to strengthen TB control.

14/158 Pandemic flu was a national risk for the UK and PHE was responsible for much of the planning of a national response to it. A major cross-government exercise would be held later in the year, which PHE was designing, running and participating in.

14/159 PHE was working with NHS England on a specific developing carbapenamase resistance that had been identified through its surveillance systems in order to mitigate the risk of an outbreak, which had already happened elsewhere in Europe.

14/160 The heatwave plan for England would be republished shortly.

Chief Knowledge Officer

14/161 21 formal publications had been issued since the time of the last Board meeting, including on the health effects of water fluoridation, which was a statutory responsibility, forward planning models for teenage pregnancy and the economic impact of obesity.

14/162 The systemic anti-cancer database, SACT, would help evaluate the effectiveness of the £1.2 billion spent annually on cancer by the NHS on anti-cancer therapy.

14/163 The research and academic strategy would be submitted to the National Executive for approval on 6 May and covered the points raised by the panel and Board at an earlier meeting.

14/164 The Health and Social Care Information Centre had suspended new releases of record level data pending the outcome of a review of their policies and procedures. This had had an adverse impact on several of PHE's projects and programmes, including on rapid response surveillance activities and monitoring of vaccine safety. PHE was seeking to understand the HSCIC's position and had made clear the impact on PHE's ability to carry out key public health duties.

14/165 The National Drug Treatment Management System, which had previously been run by the National Treatment Agency for Substance Misuse, was an end-to-end information system on all treatment for addictions, including alcohol. The data was used for commissioning services, which made up approximately one-third of the local government public health grant, as well as more widely across government. It continued to be very effective and the Board thanked the staff in the NDTMS team for their work.

Director of Health and Wellbeing

14/166 The three year PHE health marketing strategy 2014-2017 was nearing completion. It aligned with PHE's priorities and supported health and wellbeing across the life course in areas of the highest need and impact. Detail on the campaigns for 2014/15 would be shared with the Board by correspondence. — Director of Health and Wellbeing/ Board Secretary

14/167 Digital health tools were a growth area for PHE. The concept was one of personalisation and using technology to help people take on behavioural change when they were ready to do so. The couch to 5K app had proved particularly popular and the alcohol health check, which had been piloted with staff, was targeted directly at consumers.

14/168 The Directorate was undergoing a systematic review with partners and staff after its first year of existence to align resources to demands including the areas of addictions, health equity and strengthening the science base.

14/169 Board members were invited to attend two forthcoming symposia, one on harm reduction and E-cigarettes and the other on the research agenda for the health checks programme.

14/170 The Board asked how health apps were assessed and it was confirmed that they were evidence-based and fully integrated with campaigns. The Chair asked for a paper on all aspects of campaigns to be prepared for consideration at a future meeting. — Director of Health and Wellbeing

7. Minutes of the meeting held on 26 March 2014

14/171 The minutes of the last meeting (Enclosure PHE/14/20) were agreed subject to a

minor amendment to the section relating to the establishment of PHE's Global Health Committee and to the attendance list.

8. Matters arising

14/172 The recommendations on research had been incorporated into the new strategy and the implementation of those on global health would be overseen up by the Global Health Committee once established.

9. Annual report of the Audit and Risk Committee

14/173 The Board noted the report (Enclosure PHE/14/22).

10. Information items

Forward calendar (Enclosure PHE/14/23)

14/174 Public health topics to be covered at future meetings should include health inequalities, health checks, and multi-morbidities. Climate change would be suitable to bring back in about 6 months with an update on air pollution. Board Secretary

14/175 It was suggested that PHE's relationships with local authorities be the theme of a future meeting. The President of ADPH kindly offered to assist with this agenda item, which the Board accepted. Board Secretary

11. Questions from the public

14/176 A member of the public shared their pleasure at seeing the work set out in the item on 0-5 years commissioning as well as the accessibility of the presentation for the partially sighted.

12. Any other business

14/177 There was no other business. The meeting closed 13:30

Victor Knight
Board Secretary
May 2014