Public Health England

Minutes

Title of meeting	Public Health England Board, meeting held in public	
Date	Wednesday 27 November 2013	
Present	David Heymann	Chair of PHE
	George Griffin	Non-executive member
	Martin Hindle	Non-executive member
	Paul Lincoln	Associate non-executive member
	Derek Myers	Non-executive member
	Richard Parish	Non-executive member
	Duncan Selbie	Chief Executive
External Panel	Lord Crisp	
	Janet Darbyshire	
	Carolyn Miller	
In attendance	Tim Baxter	PHE Sponsor Unit, Department of Health
	Michael Brodie	Finance and Commercial Director
	Paul Cosford	Director for Health Protection and Medical Director
	Tina Endericks	Global Health, Public Health England
	Kevin Fenton	Director of Health and Wellbeing
	Richard Gleave	Chief Operating Officer
	Irene Gonsalvez	Parliamentary Affairs
	Sian Griffiths	Director, School of Public Health, The Chinese University of Hong Kong
	Jenny Harries	Regional Director, South of England
	Anthony Kessel	Director of Public Health Strategy
	Victor Knight	Board Secretary (minutes)
	Gemma Lien	Legal Corporate Secretary (minutes)
	Annette Luker	Global Health, Public Health England
	Brian McCloskey	Director of Global Health
	Brigid McConville	Director, White Ribbon Alliance
	John Newton	Chief Knowledge Officer
	Mark Salter	Global Health, Public Health England
	Alex Sienkiewicz	Chief of Staff
	Quentin Sandifer	Observer for Wales

1. Announcements, apologies and declarations of interest

13/119 The Board approved the appointment of Dr Quentin Sandifer as the Observer for Wales and welcomed him to the meeting.

13/120 Apologies had been received from Derek Myers.

13/121 Martin Hindle declared an interest as a non-executive member of the

Medicines and Healthcare Products Regulatory Agency (MHRA) in relation to the Science Hub programme.

2. Update from the National Executive

Chief Knowledge Officer

13/122 The Chief Knowledge Officer reported on the integration of public health 'knowledge and intelligence' functions into PHE. At the local level this was to support local authorities and the NHS. New national intelligence networks, based on the model for cancer, were being developed for cardiovascular, child and maternal, and mental health. The PHE knowledge strategy was out for consultation and had been well received. PHE was working on a new version of the global burden of disease, updates to the Public Health Outcomes Framework and Longer Lives, the local authority health profiles which were valued by local authority members, the cancer e-Atlas, and, in partnership with the NHS, Commissioning for Value packs for every Clinical Commissioning Group on their populations.

13/123 The PHE web presence incorporated some 140 legacy websites. The PHE data and knowledge gateway would provide easier access to this data. The digital strategy would ensure a more prominent presence. The Directorate had strengths in handling large data projects, notably the national cancer registry, and was committed to developing a national register for congenital anomalies for public health and research purposes. Formal approval under Section 251 of the NHS Act 2006 was awaited to allow receipt of confidential data based on the results of the NHS information governance toolkit. Some 21 health protection research unit bids had been submitted with results expected imminently.

13/124 The PHE research strategy was developing, and incorporated the contributions made by the Board at its previous meeting. The Chief Knowledge Officer would present this to the Academy of Medical Sciences later in the week.

Health and Wellbeing

13/125 The Health Select Committee had provided an opportunity to consider PHE's vision and its role and ambition in obesity and tobacco control, NHS Health Checks, and the Public Health Responsibility Deal. PHE supported the Responsibility Deal as one of a range of interventions to drive change and would continue to work with the Department of Health to evaluate the evidence base for the approach.

13/126 HIV testing week was underway leading up to World AIDS Day on 1 December 2013. The latest statistics showed a slight reduction in the level of undiagnosed HIV cases, but the highest number ever was recorded for HIV cases amongst men who have sex with men. The first Twitter chat had taken place that day on HIV testing.

13/127 29,000 people continued to recover from drug addiction in 2012/13, however the number of people in treatment was falling. The population in treatment was ageing and often had a number of complex health issues in addition to addiction. This was challenging to sustaining performance.

13/128 A review of local assets and best approaches to obesity was underway with local authorities. New prevention and control initiatives were in hand for blood pressure, the second greatest cause of premature mortality in England. A health improvement forum had been set up by PHE to build capacity across

the system. The first meeting of the physical activity caucus would take place in January 2014.

13/129 The Director of Health and Wellbeing had presented at the 2013 Global Health Forum, attended by more than 200 international leaders in non-communicable disease and global health. There was great interest among global peers for increased PHE involvement in the prevention and control of non-communicable diseases, global health promotion networks and in bringing together national practitioners to share best practice.

Health Protection

13/130 The Director of Health Protection reported that two members of staff were in the Philippines as part of the global response to the recent typhoon there.

13/131 The Office of National Statistics had published winter deaths data for England and Wales on the previous day, showing a higher rate at 19% above the other three seasons than comparable countries in Europe. The UK had a cold weather plan and an influenza vaccination programme, but problems of housing and keeping the elderly and frail warm remained. A 'Keep Warm' booklet had been published with helpful advice.

13/132 In healthcare associated infections, carbapenemase resistance was increasing, especially in north-west England and London, which PHE was handling as a level 3 health protection incident. For C*lostridium difficile* (*C.difficile*) PHE was working with the NHS and others on the next steps needed now that major outbreaks were under control. Current testing regimes might no longer be appropriate due to the different epidemiological pattern emerging.

13/133 Childhood influenza vaccination offered a 40% reduction in hospitalisation across all age groups, but involved vaccinating 9.5 million children annually in a six week period. Various pilots, including self-administration by a nasal spray, were being carried out. It would be some three years before the programme was fully implemented.

13/134 Just under 95% of 10 to 16 year-olds had now received MMR vaccinations. A tuberculosis strategy was in preparation, not least because cases were on the increase compared to other developed countries.

13/135 PHE was discussing with the Advertising Standards Authority a complaint made to them by a member of the public about the wording used by PHE as part of an awareness raising campaign for the Human Papilloma virus (HPV) vaccine. PHE considered the wording to be appropriate and based on scientific evidence and the matter would therefore be adjudicated on by the ASA Council.

Operations

13/136 Regional and Centre staff were working with many of the programmes described by the other Directors.

13/137 The Cabinet Office would conduct a gateway review of the PHE Science Hub programme in December. Board members had received a letter regarding the Department of Health's decision to withdraw the National Institute for Biological Standards and Control (NIBSC) from the programme. This was part of a separate review of NIBSC which had become part of the Medicines and

Healthcare Products Regulatory Agency (MHRA).

13/138 Working with the local public health system and the NHS, PHE Centres had prepared prospectuses which covered issues such as influenza, accidents and falls, and community healthcare associated infections. These were available at www.gov.uk/phe. Guidance for local authorities had been published for appointing Directors of Public Health and supporting guidance on appointments of consultants in public health. Regional events had taken place on school nursing, networks for tobacco control and for HIV and sexual health.

Nursing and Midwifery

13/139 The Board noted the paper from the Director of Nursing and Midwifery.

13/140 The newly appointed Observer for Wales reported that Ministerial approval had been given to a review of the health improvement function in Wales. A presentation on the measles outbreak in south west Wales had been made to the annual meeting of the American Public Health Association and identified a number of areas with wider national significance. *C. difficile* still had a high profile in Wales for public health. Seasonal flu vaccination showed a 68% uptake which had been fairly consistent for seven years but had not broken through the 70% level. Other public health issues which PHE was lending its support on were the public health issues concerning shale gas extraction and radon in schools. The Observer for Wales welcomed the opportunity to exchange and build on shared learning.

3. PHE Global Health Strategy

Introduction

13/141 The Director of Public Health Strategy sought Board and expert panel input in the development of PHE's global health strategy. The UK cross-government *'Health is Global'* strategy, updated in 2011, covered global health security, international development, and trade for better health. It provided a mandate for global health work, as did the WHO International Health Regulations (2005), for which PHE was the designated UK National Focal Point. PHE had a role to play in public health capacity building.

13/142 PHE's global health strategy would encompass a broad range of global health work. The Board paper (enclosure PHE/13/16) highlighted five key questions in relation to the development of the strategy. It was supported by background information on legacy and existing international work in PHE, including the acute response to international outbreaks, extreme events and humanitarian relief, and other work such as long term secondments, laboratory twinning, WHO collaborating centres and research.

13/143 PHE had begun a consultation process for the development of the global health strategy, which included meeting Directors of Public Health in the New Year.

Illustrative presentations

13/144 Three illustrations were given by invited guests on aspects of global health.

13/145 China's strategy demonstrated four aspects: aid; global health security, for example, SARS and monitoring of rural communities; health knowledge at a community and wider level – including people exchange and research; and global governance, for example, through the World Trade Organization. Shared learning was to be found in pollution control, disaster response,

community approaches to non-communicable diseases - such as hypertension through increased exercise. PHE should participate in the post Millennium Goals 2015 discussion on non-communicable diseases, for example, in mental health.

13/146 Global health was an integral part of PHE's role, not an addition. The underlying aim was to contribute to the delivery of greater equity in health and wellbeing for people across the world, recognising the interdependence of states in delivering this. It was not a form of neo-colonialism; it was as much about learning from what worked well in health systems in other parts of the world as it was sharing UK knowledge and expertise with other countries.

13/147 Examples were given from Japan where the population was known for its long, healthy life expectancy, with much lower levels of obesity and a different system of social insurance. PHE had been invited to take part in the first UK-Japan academic public health conference, which had arisen from a link through a former student at a UK university. There was little formal recognition of health inequalities in Japan, or of the harm versus benefit aspects of screening programmes, but strong workforce health efforts existed. The need to reduce costs in the health system demanded cost effective pathway design and offered income generating opportunities within a moral and value-driven state.

13/148 A further illustration was the experience of child and maternal health in developing countries. Childbirth was still the biggest cause of death of young women in some developing countries. There was a shortage of trained health workers and a reputation of maternity clinics in Africa for poor treatment of mothers. Both were strong factors in perpetuating childbirth in risky domestic settings. Midwives were both a cause of poor care and the agents for change. Training in respectful maternity care had led to a charter of seven maternity rights being developed across Asia and Africa. When applied in England it had produced substantial reductions in complaints in maternity units.

PHE Global Health Strategy - Panel discussion:

13/149 Expert panel members made the following comments on the development of a PHE global health strategy:

Aims

13/150 The aim should be to build global capacity in public health. It would be important to articulate what this looked like and to ensure that it added value, rather than just filling gaps in local health systems.

13/151 Global health was about 'countries co-development' not 'international development'. Influence depended on the part which PHE played. PHE had great expertise, and should ask itself what it could give and learn.

13/152 There was a very strong case for developing a global health strategy. PHE's role was inescapably global, for example, half of London's population had been born abroad. It was not an addition, but was part of PHE's wider strategy. The emphasis was on equity and equality with other citizens. More than horizon scanning was needed: it was valuable to have an existing relationship with other countries when incidents arose, with staff trained and ready to work internationally.

13/153 Diaspora populations in England benefitted from global sharing of health knowledge – for example, mental health from Ghana, diabetes from Pakistan,

multi-drug-resistant tuberculosis from Sierra Leone. The All Party Parliamentary publication “Improving Health at Home and Abroad” illustrated the benefits of overseas health volunteering.

13/154 For all nations the role of public health was unarguable: the benefit was not only in health but also in economics as improved nutrition and better sanitation were estimated to account for half of world’s GDP growth over recent centuries.

13/155 PHE should 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.

13/156 Secondment of staff was a powerful way of playing a strong role internationally; it served to invigorate those taking part and their teams on their return. It also helped to leverage resources, but should be part-time if resources were not to be lost to PHE.

13/157 PHE should keep in touch with areas which were innovating fast. For example, India was experimenting with new business models and technologies.

13/158 The UK government publication *'Health is Global'* contained very good principles and identified, but did not address, non-communicable diseases. These diseases 'not caused by infectious agents', were communicated through economic and other vectors and still needed to be addressed if developing nations were to avoid the experiences of the developed world. They included obesity as well as malnutrition.

13/159 There would be increased interest in salt reduction and food labelling. The global export of tobacco and alcohol products and over-processed foods posed new cross-border risks to public health.

Principles and values

13/160 Principles and values to underpin the strategy were discussed. A principle commended was to share and not to impose. There should also be a two-way flow of information and learning. For example, developing countries had provided important research data for such issues as tuberculosis and HIV.

13/161 PHE should consider humanitarian demands, which were likely to increase – both from natural and conflict-related causes. PHE should be ready to intervene and to influence. This was part of being a good world citizen. There was value in goodwill and goodness, not just in costed benefits.

13/162 Prior to becoming part of PHE, the Health Protection Agency had followed a policy of only going where it was invited. This was a good principle but sometimes it was appropriate for the UK to take risks and to push forward without waiting for an invitation.

Objectives and outcomes

13/163 PHE should seek achievements for partner countries. It was important to engage and work at the local and regional levels in other countries, and to encourage other governments to do so, rather than being confined to national and supra-national engagement.

Prioritisation

13/164 PHE should look for the gaps and let other countries fill them where they had the skills. For example, neighbouring countries could be encouraged to assist in a region where they would be more acceptable than the UK. Training and skills should be enhanced: not just of PHE staff but also those of partners, and at local and regional levels.

13/165 There were many global initiatives, with numerous new players including philanthropists and corporations.

13/166 PHE should focus on adding value and on what partners and clients said they wanted and in many cases would pay for.

13/167 In practical management of global public health activity there needed to be prioritisation both within and across, for example, different cancers. PHE should identify those areas in which the UK had a lead or strength to contribute. UK participation in global health committees and conferences needed to provide good value for money. Activities should be regularly reviewed, and, where appropriate, discontinued. It would be necessary to publicise how work was prioritised and why projects were declined.

Resources

13/168 The economics of global health activity were important. At one extreme, countries shied away from financial issues in humanitarian work. More neutrally, academic collaboration followed a barter exchange principle. However, there was a feasible model to finance roles in global health through joint ventures based on chargeable services providing plain benefit to the recipient.

13/169 The international image of the NHS was not to be underestimated: other countries wished to copy aspects of it, particularly the primary care system.

13/170 'Jigsaw' and 'patchwork' funding were ways to get others to join in where a single donor could not be identified. It would be important to engage the pharmaceutical sector early.

Future

13/171 There would come a time when global health was not managed as part of international development but would be a routine component of international relations, led by Ministries for foreign affairs.

13/172 The impact of climate change was primarily a global public health issue.

13/173 Middle income countries were becoming more developed and losing eligibility for aid, but many of the poorest people still lived in these countries.

Other

13/174 PHE should engage with the National Institute for Health and Care Excellence on global issues.

13/175 In events such as the Philippines typhoon there was a need for international co-operation both in the acute phase and afterwards.

13/176 Every Board meeting should include a local representative of public health. Board Secretary

13/177 PHE should follow the Department for International Development's (DfID) change to technical partnership in India from 2015.

13/178 The Chief Executive affirmed that global health was core to what PHE did and that the best possible use would be made of the panel's observations.

13/179 The Secretariat would prepare a watch list of the panel's recommendations to which PHE would hold itself accountable.

4. Minutes of the meeting held on 25 September 2013

13/180 The minutes of 25 September 2013 were agreed.

5. Matters arising from the last meeting

13/181 The comments and recommendations from previous expert panel discussions on public health priorities had been tabulated into a 'watch list' for consideration by the executive, and for future reference by the Board.

13/182 The table of actions and matters arising from the meeting of 25 September 2013 was **NOTED**.

6. Chief Executive update

13/183 The Chief Executive and members of the National Executive had given oral evidence to the Health Select Committee the previous week on PHE's role and priorities. Its constructive challenge would help to shape PHE's thinking going forward. The Chief Executive welcomed the Board's offer of becoming more fully involved in the process by which PHE decided on its future priorities and in horizon scanning for upcoming issues such as e-cigarettes and fuel poverty.

13/184 PHE had opportunities on every stage, not just in global health. A local government voice would be valued at Board meetings, perhaps provided by the Association of Directors of Public Health.

7. Finance report

13/185 The operating surplus for the six months to 30 September 2013 was £14.5 million, primarily due to initial delays in appointing the budgeted establishment. The full year forecast was to break-even. The Department of Health had recently confirmed a budget allocation of £3.526 billion for PHE. This excluded funding for three specific items: the Science Hub programme, academic appointments, and the cost of pension bulk transfers, which the Department of Health had agreed to underwrite if required.

13/186 A mid-year review showed under-spending on cancer screening of £12 million, due to savings in the delivery approach. PHE had agreed with the Department to retain part of the saving to apply to other public health aspects of cancer, leaving the overall full year spending on target for £3.526 billion at this stage of the year.

13/187 At the half year, capital spending was slipping against the £50 million general budget for the full year so PHE would accelerate some approved 2014/15 schemes which would have been incurred anyway. However there was a likelihood that some estate rationalisation programmes of particular locations might slip, in which case some capital funds would be returned to the Department. Specific capital spending plans for drug and alcohol schemes, water fluoridation and vaccines were on target at this stage.

13/188 The Board confirmed that the operating budget forecast outturn was neutral, with no significant issues forecast for the year end. It was noted that whilst the Health Protection directorate was showing a year to date overspend, this position was likely to be recovered by year end. The Board **NOTED** the report.

8. Establishing a Global Health Committee

13/189 PHE had no single programme board within PHE's corporate programmes covering global health but it was an aspect of many of them. A Board committee was proposed to engage with representatives of key partners and provide guidance as necessary on global health matters. The Board **AGREED** to the proposal. Terms of Reference would be drawn up for consideration.

Board Secretary/ Director of Health Protection

9. Minutes of Reporting Committees

13/190 **Meeting of the Audit and Risk Committee held on 21 November 2013**
The draft minutes were being prepared. Two expert independent members had been appointed to strengthen the committee and had contributed significantly to the meeting. The Chief Executive had given an overview of the organisation. Internal and external auditors had reported on their work and progress in developing an overall assurance framework. The executive, and the committee, were of the view that, where areas of weakness had been noted in the reviews completed to date, they would be appropriately mitigated.

10. Audit and Risk Committee Terms of Reference

13/191 The Board noted the Audit and Risk Committee terms of reference which had been revised to include the specific newly appointed independent members, and to allow George Griffin to stand down from the Committee. The terms of reference were **AGREED**, with the addition of a sentence to allow the valid conduct of meetings by teleconference.

11. Board forward calendar

13/192 The topics for the three coming meetings were agreed as tobacco, alcohol and antimicrobial resistance.

12/13. Questions from the public / Any other business

13/193 There were no questions from the public, and no other business.

Victor Knight
Board Secretary
November 2013