Public Health England

Minutes

Title of meeting	Public Health England Advisory Board	
Date	Wednesday 25 September 2013	
Venue	Conference Room, PHE Headquarters, London	
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 (until min ref 13/081)
External Panel	Valerie Beral	Professor of Epidemiology, Oxford University (from min ref 13/058)
	Catherine Law	Professor of Public Health and Epidemiology, University College London (UCL) Institute of Child Health and Programme Director, National Institute for Health Research (NIHR) Public Health Research
	Christine McGuire	Research and Development Directorate, Department of Health
	Sharon Peacock	Sanger Institute, Cambridge University
	Timothy Walker	formerly Director General of the Health and Safety Executive
	Ursula Wells	Research and Development Directorate, Department of Health
In attendance	Tim Baxter	PHE Sponsor, Department of Health
	Michael Brodie	Finance and Commercial Director
	Paul Cosford	Director for Health Protection and Medical Director (from min ref 13/069 to min ref 13/081)
	Kevin Fenton	Director of Health and Wellbeing (from min ref 13/061 to min ref 13/089)
	Richard Gleave	Chief Operating Officer (from min ref 13/069 to min ref 13/081)
	Sian Griffiths	Director, School of Public Health, The Chinese University of Hong Kong
	Victor Knight	Board Secretary (minutes)
	Gemma Lien	Legal Corporate Secretary (minutes)
	Bren McInerney	Member of the public
	John Newton	Chief Knowledge Officer (until min ref 13/099)
	Juliette Roche	Member of the public (until min ref 13/081)
	Alex Sienkiewicz	Chief of Staff
	Dean Sowman	Member of the public (until min ref 13/081)
	David Walker	Deputy Chief Medical Officer, Department of health
	John Watson	Deputy Chief Medical Officer, Department of Health

1. Panel discussion: PHE Research Strategy - Part 1

13/054 The Chairman welcomed the external panel, which had been convened to provide PHE with a diverse range of knowledge and experience on public health research and test and challenge PHE's emerging approach to public health research. This would encompass both communicable and non-communicable diseases. The PHE Science Hub programme offered an opportunity for stronger partnerships between scientific bodies.

13/055 PHE had inherited a substantial health protection research capability from the former Health Protection Agency (HPA), which had produced 640 peer reviewed articles in 2012/13, and had 250 grant funded staff. In addition, the HPA had generated substantial intellectual property in the range of tens of millions of pounds each year and has directly contributed to substantial wealth creation in UK industry. PHE had also inherited research capability and research-valuable assets from other sender bodies, such as the National Treatment Agency and the Cancer Registries.

13/056 While PHE benefitted from a track record of excellence in science across the range of its operations, there was potential to do more. There were unmet needs for high quality science and research in many areas of public health. The creation of PHE meant there were many new opportunities to develop productive partnerships with other organisations with a common interest in public health science and research and to align academic activity more closely with delivery. Academic links needed to be strengthened.

13/057 It was hoped, for example, that the creation of PHE would deliver more work in the following areas:

a) evidence-based support for implementation of policies;
b) research on complex systems and models;
c) evaluation of research and randomised trials;
d) skills in 'big data' access and use;
e) genomics; and
f) antimicrobial resistance.

13/058 The external panel members were invited to contribute to the discussion. It was suggested that PHE could add value at the commissioning stage of research by being clear about its ultimate purpose. PHE could have a role in:

a) fostering better links with academics, public health practitioners and civil society;
b) providing career opportunities for researchers, including developing junior researchers and maintaining stable funding streams;
c) facilitating research through supporting infrastructure such as registries, monitoring, surveillance systems, and intermittent surveys;
d) quality assurance, curation, and making information and materials available;
e) research on behaviours and cultures; and
f) raising the profile of mental health research.

13/059 The panel expressed a concern that research might be difficult to commission in areas where gaps in knowledge were greatest, particularly for small organisations that could not afford research to test interventions from within their own budgets. The majority of funding went to large institutions which were accustomed to do

research.

13/060 There were two key funding streams from the Department of Health :

a) the Policy Research Programme, a national research funding programme within the Department of Health's Research and Development Directorate; and
b) the National Institute for Health Research (NIHR), which commissioned research for practice at the front line in the NHS, public health and social care.

13/061 The NIHR had introduced the Health Technology Disease Assessment Panel and the Public Health Research Programme, the Health Services and Delivery Research Programme, and Biomedical Research Centres and Units. NIHR also funded the School for Public Health Research.

13/062 In the health protection field, the Policy Research Units had funded research into radiation, mobile phones, vaccines, emergency preparedness, and modelling. Some PHE researchers received these funds. The Policy Research Units had provided a blueprint for what Health Protection Research Units (HPRUs) would look like.

13/063 There were 12 priority areas in which PHE and academic partners would collaborate in HPRUs. This was an opportunity to focus on suitable subjects needed in PHE's delivery but would need shaping, for example, to deliver on the government's recently published antimicrobial resistance strategy. It would also require a shift from a project-based to a strategic approach.

13/064 PHE should also seek research fellowships. A Research and Development Committee had been established by the Department of Health to provide oversight of activities across the research and development landscape, of which the Chief Knowledge Officer was a member. There was increased dialogue and collaboration with universities and HPRUs were one method for achieving this.

13/065 Commissioning research was different to conducting it; it was important to formulate good questions. While peer review was necessary for scientific evaluation, it could lead to conservatism and reinforced the “pecking order” of science. Research questions usually required multidisciplinary work and universities were not always structured in a way to facilitate this.

13/066 Career prospects were a concern for scientists. Young scientists would often not enter an area of study unless it offered a clear future. The stability or otherwise of funding had a particular impact on “soft” sciences such as psychosocial and behavioural research, where it was difficult to find resource and capacity.

13/067 Advisory Board members commented on the panel contributions and noted:

a) the importance of training researchers;
b) the need to invest in bioinformatics and the handling of 'big data';
c) the importance of linking with major charities because of their scale and role in UK research funding, as well as local government;
d) the need to redress the balance of research in non-communicable diseases and to move from a focus on individual diseases to an integrated approach encompassing wider health concerns; and
e) there was a 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.

13/068 The Chair noted that the recommendations of the panel would be summarised for the Advisory Board in order that their implementation could be monitored and reported to future meetings.

2. Update from National Executive members

Health and Wellbeing

13/069 The Director of Health and Wellbeing reported that work was underway on a Health and Wellbeing Framework for England. PHE was working with the National Institute for Health and Care Excellence (NICE) and others on its unique interventions.

13/070 The oral health survey, the first since 2008, showed tooth decay ranging from 21% to 34.8% in five-year-olds. This would inform PHE's oral health strategy, which would be published in 2014.

13/071 The NHS Health Checks programme had shown a 47.9% uptake compared to 47.5% in the same quarter in 2012/13, suggesting stability in delivery through the transition of the programme from the NHS to local government.

13/072 Several social marketing campaigns had been undertaken, including:

a) Change4Life, in which all local authorities and over 900,000 individuals were participants;
b) Smart Restart, a major new Change4Life campaign that aimed to help 140,000 families introduce healthy changes to their school-time routines following the summer holiday period; and
c) Stoptober, a campaign to encourage smokers to quit smoking for 28 days in October with widespread peer and technical support.

13/073 The campaign focus of the Be Clear on Cancer, which would be launched in February 2014, was breast cancer.

13/074 The Director of Health and Wellbeing had planned a series of visits to all PHE Centres and would meet the Directors of Public Health in each locality. A health improvement PHE staff event would take place on 30 September 2013.

Health Protection

13/075 The Director of Health Protection reported that there had been three Level 3 incidents requiring national co-ordination in recent months:

a) Phase 1 of the measles, mumps and rubella (MMR) catch up vaccination programme was complete. Phase 2 was planned , focussing on low coverage population groups. Measles cases in the 10 to 16 year old age group had fallen significantly since the beginning of the campaign.
b) Work was underway to try to trace everyone who may have had contact with a care worker infected with hepatitis C with 35 years activity. PHE was co-ordinating with all three devolved administrations on the matter.
c) The heat wave plan had been invoked, after being launched earlier in the year. The plan raised public and professional awareness of the potential dangers to health of a severe heatwave and described actions to be taken.

13/076 An outbreak of *E. coli* 0157 in watercress had not been escalated to Level 3 as a result of close and timely co-operation with the Food Standards Agency and the retailer.

13/077 International work continued supporting those dealing with Syrian refugees and in relation to Middle East respiratory syndrome coronavirus (MERS-CoV) in Saudi Arabia. PHE was also working with the British Overseas Territories in the implementation of the International Health Regulations 2005.

13/078 Other current health protection areas of work included the seasonal flu vaccine pilot, new vaccines introduced for shingles and rotavirus, and the 100,000 genomes project. A review of the structure of the Health Protection directorate would take place in the autumn.

Operations

13/079 The Chief Operating Officer described his Directorates role in the oversight of the new public health delivery system. The model was based on professional leadership and the Centres were the ‘front door’ for PHE-delivered services. Four Regional Directors provided oversight, support and challenge to the Centres.

13/080 There were two main strands of work within the Operations directorate:

a) engagement - bringing people together and explaining how the new system worked; and
b) facilitating the achievement of particular goals within the health system.

13/081 The Chair thanked the Directors for their reports. It was noted that the Director of Nursing would also provide a report at the next meeting.

3. Panel discussion: PHE Research Strategy – Part 2

13/082 The external panel resumed their contributions on the research strategy.

13/083 It was noted that to reduce life expectancy by ten years required ten cigarettes a day, or one bottle of vodka a day, or to be morbidly obese with a body mass index of 40. That was to say that, quantitatively, smoking was a very significant public health challenge and the cause for 20% of excess mortality. In planning research, effort should therefore be proportionate to the burden of different factors.

13/084 Reference was made to a recent report from South Africa, where a question had been introduced on death certificates regarding the individual’s smoking habits five years prior to death. This simple measure provided substantial data on inequalities, change over time, and better statistical appreciation of smoking in relation to other causes of death. Its adoption in other countries had been recommended.

13/085 Some responsibility for health screening had moved to PHE. Screening programmes presented benefits and harms that needed to be balanced just as they did for vaccination.

13/086 The Sanger Institute sought funding every five years from the Wellcome Trust, which provided about 85% of its funding. The organisation thought very hard about its strategy which was tough, rigorous but healthy for science. There were over thirty members of the Faculty, each with their own teams. These were guided by the strategy and worked independently but strong links were in place across the different teams.

13/087 Two key aspects of the Sanger Institute were stressed: its role in expert teaching worldwide, and the fact that it shared its data freely. Two recent examples of research publications were cited: the first on the Middle East respiratory syndrome coronavirus transfer mechanism which had been shown to be much more complex than originally thought, and the second on challenging the proposition that

antimicrobial resistance was exacerbated from overuse of antimicrobials in animals.

13/088 As the 100,000 genomes project progressed, personalised medicine would become a reality. PHE would play a key role in this and was expected to focus on tuberculosis, hepatitis C and HIV. Eventually the consequence of every defect in the human gene would be known and catalogued. Health problems including cancer, malaria, diabetes, obesity and other infectious diseases were partly genetically determined.

13/089 Over the coming decade, microbial sequencing was expected to be applied to a wide range of pathogens, for example *Salmonella*. It was envisaged that PHE might maintain a 'National Grid' equivalent for microbial sequencing in hospitals. The adoption of technologies for interpreting large amounts of sequence data would be needed, and growth expectations would need to be managed carefully.

13/090 The following suggestions and recommendations were made:

a) PHE needed to be outward facing, engage with others without conditions, and supress any tendency to compete internally;
b) the need to generate income in relation to sequencing could be reduced at first as restrictions on data sharing were created by protecting intellectual property;
c) PHE should focus on applied and translational research leaving the basic science to others;
d) more effort was needed to ensure scientists behaved in a cohesive way;
e) adequate investment and sustainable funding was needed. An infrastructure to support not just the next five years, but over a much longer timescale;
f) PHE could form a strong partnership with the Sanger Institute based on a comprehensive research strategy. Proximity was an advantage and colocation at the PHE Science Hub at Harlow might help. In the meantime, a PHE presence on the Sanger site with PHE staff would be a practical early step.

13/091 The Sanger Institute did not provide fee-for-service sequencing, but perhaps this could be revisited for public health.

13/092 The Chair thanked the panellists and a Board discussion followed highlighting the following issues:

a) Department of Health funding mechanisms;
b) behavioural research;
c) the need to carefully support scientists' careers;
d) the value of informal intelligence;
e) the need to include the impact of economic and social determinants in research;
f) combined intervention measures (including legislation and fiscal measures);
g) the value of joint appointments;
h) the need to clearly define priorities in research design;
i) the importance of linking academic approaches and practice;
j) the need to build capability as well as capacity through training;
k) failures in public health initiatives merited more evaluation studies than the successes; and
l) the usefulness of horizon scanning and timely commissioning.

13/093 A cost benefit assessment of a partnership between PHE and the Sanger Institute

could be undertaken.

13/094 PHE should strive to publish more public health information which may stimulate research proposals. It should also look for international research opportunities. It was noted there was a number of international collaborators willing to work with PHE. However, funding was an issue.

13/095 There was more work to be done in the area of surveillance. It was hoped that PHE might play an advocacy role in facilitating access to data especially across the system.

13/096 Working with the NIHR School of Public Health could create opportunities and benefits and the PHE research strategy should build on this.

13/097 In summing up the Chair noted that:

a) links with the Sanger Institute could be strengthened, for example through staff secondments;
b) there should stronger and more formalised collaboration with the Department of Health in the area of strategic research;
c) more effort was needed to develop and strengthen research opportunities globally;
d) simple interventions were effective - for example, smoking data on death certificates could yield significant benefits;
e) non-communicable diseases should be more embedded in health protection research;
f) links with research-based charities and non-governmental organisations would be beneficial;
g) behavioural research should be better explored; and
h) sustainable funding mechanisms needed to be identified.

13/098 The Board Secretary would draw up a list of recommendations and circulate it so that Advisory Board members could track the progress made. **Victor Knight**

4. Announcements, apologies, declarations of interest

13/099 Martin Hindle declared an interest as a Board member of the Medicines and Healthcare products Regulatory Agency and as the Independent Chair of the East Midlands Academic Health Science Network.

5. Minutes of the meeting held on 22 July 2013

13/100 The following amendments were made to the 22 July 2013 meeting minutes (enclosure PHE/13/12):

a) the affiliation of Philip James would be reflected as the London School of Hygiene and Tropical Medicine, and the International Association for the Study of Obesity instead of the UK Health Forum;
b) in item 6 (global health), a reference to the discussion on non-communicable diseases would be made, including the recent United Nations high-level meeting on noncommunicable disease prevention and control.

13/101 Subject to the above amendments, the minutes of the meeting held on 22 July 2013 were **AGREED**.

6. Matters arising from the last meeting

13/102 A paper was tabled which contained the recommendations made by the panel on obesity at the previous meeting and the actions resulting from them. The proposal to pilot a PHE-led project on obesity in the East Midlands should remain on the action list. The Chief of Staff suggested that this should be published as part of future meeting papers. The title of the paper would be revised to standardise the format for future use. A separate paper would be produced for the recommendations of each panel. **Victor Knight**

13/103 It was noted that in minute reference 13/025d) (enclosure PHE/13/12) the Advisory Board had requested that its views on standardised tobacco packaging and minimum alcohol unit pricing should be conveyed to Ministers. This would be added to the recommendations/actions paper. Progress was being made on these issues in the Devolved Administrations. **Victor Knight**

7. Chief Executive update

13/104 The Chief Executive's update noted that the PHE annual conference had been impressive and European delegates had valued its pragmatic approach. There would be a follow up assessment on the conference. The Advisory Board expressed its thanks to the organising team.

13/105 The Health and Wellbeing Framework had been discussed at a meeting the previous week with the Department of Health Departmental Board. The Permanent Secretary considered that it might be made cross-sectoral. This would be considered at a forthcoming event.

8. Finance report

13/106 The Finance and Commercial Director presented his report for the four months ending 31 August 2013. He reminded the Board that PHE's budget was effectively split into three segments. Firstly, the payment of the local government specific grant for the first and second quarters, which he reported had been made on time and in full. The second segment was the approximately £425 million of vaccine payments and emergency preparedness payments. Neither of these two segments represented a financial risk as PHE was funded in full for the payments made. The third segment was PHE's own operating expenditure budget of around £475 million. At the end of the fourth month this was underspent by £9.3 million. He explained that the projected outturn for the year was prudently being forecast as breakeven.

13/107 The Finance and Commercial Director also presented PHE's capital position. He explained that funding for capital was provided on an annual basis and that the capital budget was over-programmed by about 10%, which given the experience from the predecessor bodies and across the sector, was a modest and manageable level.

13/108 The Advisory Board agreed that the level of detail provided in the report was correct and that further financial information should be provided on an exception basis only. The Finance and Commercial Director offered to explain the financial position in more detail to members of the Advisory Board upon request.

13/109 The finance report (enclosure PHE/13/13) was **NOTED**.

9. Minutes of Reporting Committees

13/110 Derek Myers, Chair of the Audit and Risk Committee, presented the unconfirmed minutes of the meeting held on 13 September 2013 (PHE/13/14). The Advisory Board **ENDORSED** the minutes, subject to their adoption by the next meeting of the Committee.

10. Information items

13/111 The forward calendar was **NOTED**.

13/112 It was **AGREED** that Advisory Board meetings should still aim to take place within three hours, with the option of extending the meeting by 30 minutes if required.

13/113 The Advisory Board considered themes for future meetings. A number of suggestions had already been raised including alcohol, tobacco, hypertension, physical inactivity and global health. Further suggestions provided were genomics, mental health, ageing, sexually transmitted infections and tuberculosis.

13/114 Social inequality would form a part of many of the health themes and might be considered as topic in itself. General Practitioners were increasingly concerned with multi-morbidity. An answer might be to adopt a life course approach as used by the United Nations on non-communicable diseases.

13/115 The possibility of holding an Advisory Board retreat on priority health topics was raised, to which the National Executive could be invited.

11. Questions from the public

13/116 A member of the public referred to the value of asking communities about their issues. He noted the multiple audiences for research. For his community, research often entailed 12 weeks of funding for a particular project, but there was no longevity. When requesting assistance in research projects it was important to ensure that expectations were carefully managed, and that they were realistic and open. Broken promises undermined the process, particularly when those affected were vulnerable people. He requested PHE to listen actively to communities and commended the life course approach.

12. Any other business

13/117 The advertisement for two more Advisory Board members was expected to be published at the beginning of October.

13/118 Further information would be provided to Advisory Board members by the Director of Communications regarding engaging with staff regionally. **Lis Birrane**

Victor Knight
Board Secretary
September 2013