Public Health England

Protecting and improving the nation's health

**Enclosure PHE/15/11**

# Minutes

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| **Title of meeting** | Public Health England Board | |
| **Date** | Wednesday 28 January 2015 | |
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| **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 |
| | Poppy Jaman | Non-executive member |
| | Paul Lincoln | Associate non-executive member |
| | Sir Derek Myers | Non-executive member |
| | Richard Parish | Non-executive member |
| | Duncan Selbie | Chief Executive |
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| **In attendance** | Janet Atherton | President, Association of Directors of Public Health |
| | Viv Bennett | Director of Nursing and Midwifery, PHE |
| | Lesley Boswell | National Clinical Director for Rural and Remote Care, NHS England – external panel member for rural health discussion |
| | Jan Burn | Kingfisher Treasure Seekers |
| | Michael Brodie | Finance and Commercial Director, PHE |
| | Lis Birrane | Director of Communications, PHE |
| | Paul Cosford | Director for Health Protection and Medical Director, PHE |
| | Kevin Fenton | Director of Health and Wellbeing, PHE |
| | Tony Hill | Director of Public Health, Lincolnshire County Council |
| | Graham Jukes | Chief Executive, Chartered Institute of Environmental Health |
| | Bernie Hannigan | Research and Development, PHE |
| | Anthony Kessel | Director of International Public Health, PHE |
| | Victor Knight | Board Secretary, PHE |
| | Dr Tessa Lindfield | Director of Public Health, Suffolk County Council – external panel member for rural health discussion |
| | Jonathan Marron | Director of Strategy, PHE |
| | Cllr Cecilia Motley | Chair, LGA Rural Services Network - external panel member for rural health discussion |
| | Bren McInerny | Kingfisher Treasure Seekers |
| | Sheila Mitchell | Director of Marketing, PHE |
| | Christine McCartney | Director of Microbiology, PHE |
| | Dan Metcalfe | Deputy Director, Planning and Product Development PHE |
| | John Newton | Chief Knowledge Officer, PHE |
| | Gina Radford | Deputy Chief Medical Officer, Department of Health |
| | Simon Reeve | Head of Public Health Policy and Strategy Unit, Department of Health |
| | Rachel Scott | Corporate Secretary, PHE |
| | Alex Sienkiewicz | Chief of Staff, PHE |
| | Rashmi Shukla | Regional Director, Midlands and East of England, PHE |
| | Rod Thomson | Director of Public Health, Shropshire County Council |
| | Katie Tucker | Kingfisher Treasure Seekers |

## 1. Announcements, apologies, declarations of interest

15/001 There were no apologies for absence.

15/002 No interests were declared in relation to items on the agenda.

## 2. Panel discussion: Rural health

15/003 The Regional Director – Midlands and East of England advised that the paper built on discussions between PHE Centre Directors and Directors of Public Health on the challenges faced locally to improve health and reduce inequalities.

15/004 The external panel members shared their perspectives and suggestions on rural health as a national and local public health issue:

a) NHS England was working with local health and care systems in taking forward the Five Year Forward View, for example, with GPs and local communities in considering and designing new service models. There was an opportunity for greater collaboration between NHS England and PHE on rural health issues, for example, identifying potential gaps in delivery with respect to access, choice and distance;

b) the average age in rural areas was increasing at a faster rate than in urban areas. Whilst the rural ageing population arguably enjoyed better health and life expectancy than in urban areas, there were issues with respect to depression, strokes and falls, which were forecast to increase at a faster rate;

c) it was often assumed that rural populations were more active than their urban counterparts. However, driving was the most common form of travel, accounting for 90% of all journeys, more out of necessity than choice given the comparatively limited provision of public transport. There was scope for PHE to assist local authorities in their efforts to increase levels of daily physical activity in rural areas;

d) workplace health and wellbeing was an important public health issue and an opportunity for early intervention yet business in rural areas tended to be small in size, which made access to appropriate services more challenging;

e) rural populations tended to be characterised by low wage economies and less secure employment patterns, particularly in agriculture;

f) the alignment of public health and local government and the opportunities for collaboration on health and wellbeing was widely welcomed. There was, however, some concern at the challenge of maintaining a full suite of services to large rural areas in a tough local government funding environment. It would be important for local government and its partners to work together to address this challenge;

g) the changing demographics in rural areas presented their own challenges. At the same time as the population was ageing, birth rates were falling. This might increase future demand on services caring for the elderly as younger family members moved away to secure employment and/or housing opportunities in urban areas, not least because of the relative lack of affordable housing. There was scope for local government, PHE and others to work together to address the issue of empty housing stock; and

h) fuel poverty was a particular issue and tended to be more common among the elderly. Many health problems were attributable to the quality of rural housing, either because they were unheated, damp or relied on fuels other than mains gas. PHE and its partners could work together to strengthen the "green deal" to further incentivise landlords to undertake remedial work to damp and/or uninsulated properties.

15/005 The Board reflected on the challenge faced by health and care providers in providing services to rural populations, in particular, on recruiting and retaining talented medical professionals to their organisations. There was some evidence to suggest that they were reliant on a transient population of locum GPs and consultants and that posts in their organisations were seen as less attractive career options compared to their urban counterparts. This could be addressed through the design and delivery of Research and Development programmes in organisations serving rural areas, sharing of excellence across organisational and population boundaries and development of consultant-led services focussed on their health and care needs.

15/006 There was scope for PHE to develop a cross-government and system-wide look at rural health, its determinants, economics and analysis, as well as the challenge of informing ACRA's deliberations based on need and small area analysis. NIHR had recently announced a research call on rural health and this should be investigated further.

15/007 The possibility of rural proofing as a component of health impact assessments should be actively explored. There was an opportunity for PHE to explore how it could support and mobilise small and medium-sized enterprises in providing workplace health and wellbeing services.

15/008 The Chief Knowledge Officer summarised PHE's role as supporting people locally: a place-based approached delivered by local leadership. PHE produced health data at local level and shared this with widely its partners. Significant work was in hand to describe the population health need of small areas although PHE did not have a model that looked at the independent effect of rurality rather than a broader socio-economic lens. The data was, however, available, and it was suggested that the effect, if any, would be best considered by academic researchers, potentially with access to NIHR funding.

15/009 The Director of Health and Wellbeing advised that his team had been commissioned to consider health ageing and the possible adoption of a life-course based approach. PHE's approach to asset-based community development would be published shortly and he was keen to engage with the panel and the wider public health community about how rural issues might be identified and considered as part of this.

15/010 The Chief Executive thanked the Regional Director – Midlands and East of England and external panel members for raising awareness of the issue. The focus for PHE going forward would be on how it could add value to the significant work that was already underway in local government and elsewhere.

15/011 The Board agreed the Chairman's suggestion that the theme of rurality should be a key agenda item at the next meeting with NHE England's Board.

## 3. Presentation

15/012 The Board received a presentation on the work of Kingfisher Treasure Seekers, a social enterprise established to enhance the lives of disadvantaged and vulnerable adults and teenagers, including adults with learning difficulties and disabilities and marginalised and struggling individuals in Gloucestershire. Their approach was to work with the whole community and not segregate by age or need.

Supported by PHE, the organisation was seeking a social impact bond for its work to make it more sustainable.

15/013 The Board congratulated the team on their work and thanked them for their presentation.

**4. Minutes of the meeting held on 28 January 2015**

15/014 The minutes were agreed as an accurate record of the previous meeting, subject to a minor amendment noting Professor Griffin's apologies.

**5. Matters arising**

15/015 The matters arising from previous meetings (enclosure PHE/15/03) were noted.

**6. Update from National Executive**

15/016 The Chief Knowledge Officer advised the Board that:

a) alongside colleagues from the Department of Health and NHS England, he had given evidence to the recent Public Accounts Committee hearing on cancer. There had been a huge step forward in making cancer staging data available for the 345,000 registrations in 2013. PHE had recently accepted an invitation to be a member of the National Taskforce on Cancer, which was chaired by the Chief Executive of Cancer Research UK;

b) he and the Chief Executive had recently met the Chief Executive of the Health and Social Care Information Centre (HSCIC) to discuss system-wide data flows. Agreement had been reached on the legal basis on which patient identifiable data was shared with PHE in order for it to discharge statutory public health duties;

c) the staff consultation on the functional integration of the CKO, Health and Wellbeing and Strategy Directorates had been launched;

d) Peter Bradley had been appointed as Director of Knowledge and Information;

e) a positive meeting had been held with Scottish counterparts, with a particular focus on evidence systems and use of knowledge;

f) analytical work on the Global Burden of Disease was being taken a stage further, with data disaggregated for the first time by region and deprivation quintile; and

g) positive discussions had been held with WHO colleagues on non-communicable disease surveillance and how PHE could support them.

15/017 The Director for Health Protection and Medical Director advised the Board that:

a) the number of cases of Ebola in West Africa was decreasing; in the past week there had been approximately 60 in Sierra Leone and single figures in Guinea and Liberia. It was important to not be complacent and to continue to focus on reducing the number of new cases to zero. Overall, there had been approximately 22,000 cases and 9,000 deaths since the outbreak began. PHE continued to support the UK response, for example, the Imported Fever Service had carried out 292 assessments since July 2014 of which two had been positive, and the active monitoring of returning workers.

4,000 people had been screened at ports of entry to date. PHE had worked successfully with health protection colleagues in Scotland to rapidly trace and contact all passengers on the same flight of the returning worker diagnosed with Ebola over Christmas. More generally, the cross-organisational effort continued to be extremely good; of the six Incident Directors working in rotas, only two were from his Directorate, the others being from CKO, Health and Wellbeing and Operations. Work was beginning on how to support cross-Government action in redeveloping the public health systems in the affected countries, with a particular focus on Sierra Leone, including on the legacy of the laboratories that had been established there by PHE;

b) PHE and NHS England had launched the joint TB Strategy the previous week. This was in response to the poor rates compared to elsewhere in western Europe, with no downward trend on the horizon. The implementation plan would be shared with the Board at a future meeting and regular progress reports would be made;

c) PHE's evidence-based guidance on anti-virals and their use in nursing homes had been challenged by the Cochrane Review and some GPs, with whom PHE was engaged in detailed discussions. PHE maintained that there was a strong case that they should be considered in certain circumstances, particularly in the vulnerable elderly in care homes, and was therefore working with NHS England and GPs and, as importantly, to separate evidence-based issues from contractual-related ones; and

d) a workshop would be held the following week with CIEH and ADPH on air pollution with a view to developing a practical programme of action across the country. A further update would be given at a future Board meeting.

15/018

The Director of Nursing and Midwifery advised the Board that:

a) PHE and DH would shortly be announcing the future arrangements for public health nursing from April 2015 onwards, which would be located in PHE under her leadership as Chief Nurse. DH would retain a role in providing policy advice; and

b) PHE was a pilot site for nurse revalidation, which would be introduced later in the year and be required every three years.

15/019

The Director of Health and Wellbeing advised the Board that:

a) the Government had recently announced that it backed the public health case for introduced standardised packaging of tobacco;

b) three major public health campaigns were underway in January: Dry January, Change4Life sugar swaps and smoke health harms;

c) building on recent research and pilot exercises, the newborn screening programme was being extended, benefitting an estimated 30 babies every years, identifying life-threatening conditions early and having a major impact on their care and prognosis;

d) the evidence on e-cigarettes continued to evolve and it was important to update policies and approach in real time. The first phase of a national conversation on the subject was taking place with colleagues from ADPH and the Faculty of Public Health; and

e) PHE was collaborating with colleagues from NHS England and the Local

Government Association on community based resilience and asset building, which would be launched at the latter's conference the following month.

## 7. Chief Executive's update

15/020 The Chief Executive advised the Board that:

a) further to the update in the previous item, the government's principal advisor on public health nursing would be based in PHE from April 2015;

b) PHE's staff continued to make a significant contribution to the Ebola response both nationally and internationally;

c) the launch of the TB strategy reflected the Board's previous consideration of TB as a key public health issue; similarly, the item later on the agenda on research did the same for that topic. The way in which the Board focussed on the key issues and spent its time was both effective and powerful, as was the engagement of expert panel members from other organisations to provide perspective and challenge;

d) PHE was leading on the prevention commitments in the Five Year Forward View. He would shortly be chairing the inaugural meeting of the NHS Prevention Board, which would focus on pre-diabetes and helping to get people back into work. This was a core part of the new health and care system showing how it could work together to make things happen;

e) the Outline Business Case for the PHE Science Hub was with Ministers for decision;

f) he had recently visited the Chinese Centre for Disease Control with Professor Griffiths. England and China were facing the same public health issues but at different scale, for example, it was estimated that 114 million people there had type 2 diabetes. They were keen to work with PHE and a Memorandum of Understanding was being developed on anti-microbial resistance, TB and diabetes; and

g) he and the Finance and Commercial Director had recently given evidence to Parliament's Public Accounts Committee on the local authority public health grant.

## 8. Updates from Observers

15/021 <u>The Observer for Wales</u> advised the Board that:

a) a refreshed three year strategy for Wales was being considered by the Board of Public Health Wales (PHW) at its meeting the following day, which, if accepted, would be submitted to the Welsh Assembly. Priorities included adopting and implementing a multi-agency systems approach and developing a new dialogue with primary care, who would be considered as a vehicle for public health interventions. Whilst this was not a new concept, PHW wished to revisit it and see if it could be developed within the Welsh context;

b) carbon monoxide poisoning was a key public health issue in Wales; a range of campaigns and projects had been established to raise public awareness, improve incident response, data collection and surveillance.

Work was underway with local authorities to incorporate the issue as a core

part of their public health activity; and

c) work was underway with clinical colleagues and Baroness Findlay of Llandaff on cardiopulmonary resuscitation (CPR).

## 9. PHE social marketing programme

15/022 The Director of Marketing outlined PHE's 2014-2017 marketing strategy and the work of her three teams covering commercial marketing, behavioural science and digital communication. As part of this, the Board was shown a film summarising PHE's recent campaign activity.

15/023 The Deputy Director, Planning and Product Development briefed the Board on developments on e-health. It was essential to have a mobile-optimised website for campaigns. Stoptober provided an evidence-based personal tool as well as feedback to PHE. With a smartphone App there was no proportionate scaling of cost as uptake grew.

15/024 The Director of Marketing advised that PHE did not yet have a commercial model for exploiting marketing assets and intellectual IP. The team was, however, working with Cabinet Office colleagues to determine whether there was a cross-government approach to monetising communication and marketing properties.

The Board discussed the evidence base for impact and benefit, the use of pre-testing and independent evaluation and requested a further agenda item in six months' time.

## 10. Research, development and innovation strategy

15/025 The draft strategy, which was out to consultation until early March 2015, built on the Board's consideration of the issue at its September 2013 meeting. The majority of the issues raised thereat had been incorporated in the consultation document.

15/026 In recognition of the fact that there was much to be learned from around the world on research and development, PHE would be establishing an International Advisory Board led by PHE's Chair.

15/027 Whilst PHE was fortunate to have excellence and world leadership in some areas, this was not always the case organisation-wide. Work was required to raise awareness across the organisation of the resources and opportunities available, and, where none existed, then in-house funding might need to be secured. It would also be important to make clear to academic and other partners what PHE wished to do and why it was required.

15/028 The Director of Nursing and Midwifery highlighted the need for PHE to support multi-disciplinary research, research from a number of academic disciplines and to look at how to build research capacity and capability in its workforce.

15/029 The Board was pleased to note the developing partnership with the NHS. More generally, there was a need to ensure continued investment beyond 2016 and asked the executive to consider what the Board could do to ensure that this happened.

15/030 The Board was keen to ensure that the strategy was sufficiently ambitious and suggested that there was more that could be done in this regard; PHE had a key role to play in advising on strategic research priorities and evaluating the evidence base, something which was not immediately apparent from the document as drafted.

15/031 The Board was also keen to see PHE's links with research charities further developed and strengthened, as well as active exploration of international funding through EU

and other research calls.

15/032 The Board agreed that a dedicated session on the strategy should be convened in the coming weeks with the Chief Knowledge Officer to discuss how it could best contribute to the finalisation of the strategy. The Chairman would also convene a meeting with key partners in the UK research community to consider how best to influence the priorities of funding bodies towards public health, prevention and early intervention.

**11. Finance Report**

15/033 The Finance and Commercial Director advised the Board that PHE continued to forecast a year-end breakeven position and would deliver its capital programme on budget.

**12. Minutes of the Global Health Committee of 2 October 2014**

15/034 The Board minutes of the Committee's October meeting (enclosure PHE/15/07) and Professor Griffith's verbal update on the previous week's meeting. Lord Crisp, co-Chair of the All Party Parliamentary Group on global health, had attended and had agreed to contribute to the Committee's work in the future.

**13. Minutes of the Audit and Risk Committee of 20 November 2014**

15/035 The Board noted the unconfirmed minutes (enclosure PHE/15/08) of the most recent Audit and Risk Committee.

**14. Board forward calendar**

15/036 The Board agreed that there would not be a public meeting in March, the timeslot for which would be used for a Board development session.

**15. Any other business / Questions from the public**

15/037 There was no other business and no questions from the public.

15/038 The meeting closed at 15:03.

**Victor Knight**
*Board Secretary*
February 2015