Public Health England

Protecting and improving the nation's health

Minutes

Title of meeting	Public Health England Board	
Date	Friday 27 February 2015	
Venue	PHE Headquarters (Skipton House) London	
Present	David Heymann	Chair
	Rosie Glazebrook	Non-executive member
	George Griffin	Non-executive member
	Sian Griffiths	Associate non-executive member
	Martin Hindle	Non-executive member
	Paul Lincoln	Associate non-executive member
	Richard Parish	Non-executive member
	Duncan Selbie	Chief Executive
In attendance	Janet Atherton	President, Association of Directors of Public Health
	Viv Bennett	Chief Nurse, PHE
	Neil Bentley	Microbiology, PHE
	Michael Brodie	Finance and Commercial Director, PHE
	Chris Bull	Local Government Adviser, PHE
	Paul Cosford	Director for Health Protection and Medical Director, PHE
	Jenny George	National Audit Office
	Richard Gleave	Deputy Chief Executive, PHE
	Jenny Harries	Regional Director - South, PHE
	Graham Jukes	Chief Executive, Chartered Institute of Environmental Health
	Anthony Kessel	Director of International Public Health, PHE
	Victor Knight	Board Secretary, PHE
	Christine McCartney	Director of Microbiology, PHE
	Cllr Jonathan McShane	Cabinet Member for Health, Social Care and Culture, London Borough of Hackney
	Anita Marsland	Local Government Adviser, PHE
	John Newton	Chief Knowledge Officer, PHE
	Paul Ogden	Health Adviser, Local Government Association
	Quentin Sandifer	Observer for Wales
	Rachel Scott	Corporate Secretary, PHE
	Alex Sienkiewicz	Chief of Staff, PHE
	Lesley Wilkie	Observer for Scotland
	Robert White	National Audit Office
Apologies	Poppy Jaman	Non-executive member
	Sir Derek Myers	Non-executive member

There were seven members of the public present.

1. Announcements, apologies, declarations of interest

15/039 Apologies for absence were received from Poppy Jaman and Sir Derek Myers.

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

2 Panel discussion: Local Authority Engagement

15/040 The Deputy Chief Executive introduced the panel members and summarised the presentations, which focussed on two linked themes: the experience of leaders in local government in exercising their new duty to improve health and the National Audit Office (NAO) and Public Accounts Committee's recommendations following their review of PHE's public health grant to local authorities.

15/041 The expert panel members advised the Board that:

a) the transfer of public health to local government had provided a number of opportunities which had not been present in the previous system. These included political leadership for public health, which allowed for matters to be progressed with greater pace; the sense of accountability to the local community; strong relationships between local political leaders and local partners such as voluntary groups, the police and others; greater opportunities to tackle the wider determinants of health; and a sharper focus on commissioning key services;

b) PHE and local government had worked closely together on developing and implementing a sector-led improvement approach, including the establishment of networks to support this. Appropriate processes were in place for dealing with poor performance and the sector-led improvement programme was therefore focussed on those areas where good work was taking place. There was, however, a desire to widen its focus;

c) the importance of the public health workforce in local authorities was widely recognised. Directors of Public Health were the leaders of the local public health system and, as such, needed well qualified teams to support them. Free and flexible movement of staff across the system should be ensured to encourage professional development and PHE was committed to delivering this;

d) although it had taken place at a time of significant financial pressure, the focus in 2013/14 had been on ensuring the successful transition to the new public health system, which had been achieved. The focus was now on working with Directors of Public Health to establish how local government could better design and deliver effective public health services according to the needs of their local populations;

e) local authorities commissioned services in an innovative and rigorous way, which had resulted in improved levels of scrutiny and equity of access to public health interventions. Local authorities provided a critical edge to public health commissioning and brought long-standing expertise in the areas of contract negotiation and management.

f) funding constraints meant that local authorities adopted novel approaches in the way that services were delivered and found different ways of executing public health interventions, for example:

i. in the London Borough of Hackney, joint work with local Clinical Commissioning Groups to establish a federation for all public health practices in the area;

ii. the establishment of a fund to allow groups to review interventions and innovations for intergenerational groups for smoking cessation in Chinese communities; and

iii. providing enhanced NHS Health Checks, with effective links to drugs and

alcohol programmes;

g) the Local Government Association (LGA) supported local authorities in delivering their functions, for example, through leadership programmes and a wide range of publications for public health staff. The LGA also provided a health and wellbeing peer-review process, which involved support from elsewhere in the system to help find the best solutions to fit the area in question;

h) the focus on integration and prevention meant that local authorities were linking together to improve approaches to reducing ill-health and its causes;

i) there was great enthusiasm for improving public heath following the transition. The new PHE's Centres being mapped across to the nine local authority regions provided further opportunities for integration;

j) accountability to the local electorate was right, although there were corresponding challenges from fitting in with election cycles and the risk of short termism. The focus should be on ensuring that the public received accurate and objective advice on public health, and a system appropriately strengthened to manage political change; and

k) relationships with the NHS required further development to achieve optimal service delivery and improved engagement. This was underway, for example, as part of the work on the Better Care Fund.

15/042 The NAO briefed the Board on their recent report into PHE's public health grant to local authorities and the recent PAC hearing. Their report focused on three main themes: local authority spending and outcomes, governance and accountability arrangements for the spend and PHE's support to local authorities. A number of recommendations for PHE had been made by both the NAO and PAC, which the Board welcomed, noting that work on several of them was already underway. Progress would be monitored by the PHE Audit and Risk Committee.

15/043 The Board welcomed the NAO and PAC's overall assessment that PHE had made a good start to its work with the local public health system. The Board noted that the NAO had not been able to reach a value for money conclusion on the use of the grant at this early stage of the new public health system and that this was therefore something that would be revisited by them in the future.

15/044 The Chief Knowledge Officer assured the Board on the support provided to local authorities by PHE's local Knowledge and Intelligence Teams (KITs). Whilst responsiveness was an issue, it was important to recognise that a significant amount of knowledge and intelligence resource had been transferred to local government. The KITs were not able to respond to each and every request for support, rather they were prioritised according to their relevance to public health outcomes and the needs of needs of local authorities. PHE would continue to work on providing support to local authorities to enable them to develop their own capacity in using tools developed by PHE, which had also enabled the NAO to undertake the analysis used in their review.

15/045 The Chief Executive thanked the NAO team for their report, which was both timely and would greatly influence the next stage of PHE's development.

3. Minutes of the meeting held on 28 January 2015

15/046 The minutes (enclosure PHE/15/11) were agreed as an accurate record of the previous meeting.

4. Matters arising

15/047 The matters arising from previous meetings (enclosure PHE/15/12) were noted.

15/048 The process for reviewing progress on the “watch list” would be considered by the Board at its next awayday session.

5. Update from National Executive

15/049 The Director for Health Protection and Medical Director advised the Board that:

a) there was a continuing increase in Meningococcal Group W (MenW) disease across all age groups in England. PHE was monitoring the situation closely, not least since MenW carried a greater risk of fatality than the more common Meningococcal B;

b) PHE continued to make a significant contribution to the national and international response to Ebola, including on supporting and monitoring returning workers from the affected region. The number of cases in West Africa was declining but significant work remained to reduce the cases to zero. The broader issues of improving the co-ordination of international response and deploying expert staff quickly to any future outbreak of infectious disease of whatever type would be considered as part of a lessons learned process;

c) the number of flu cases remained low. Work was underway with medical practice journals regarding the debate on prescribing antivirals for use in flu. PHE’s position remained that the evidence fully supported their use of antivirals where clinically appropriate, particularly in care of the elderly settings, and this advice would continue to be clearly communicated;

d) the Joint Committee on Vaccines and Immunisation (JCVI) had previously recommended that the vaccine to prevent Meningococcal B infection (MenB) should be introduced, and that the government should seek to implement this subject to agreement of a cost-effective price.

15/050 The Deputy Chief Executive advised the Board that:

a) the *Securing our Future* programme was well underway. The work focused on three elements:

i. new organisational structures. Organograms had been developed for the organisation, and consultations were underway with affected staff. Staff side colleagues had been involved throughout;

ii. delivery of the required efficiency savings; and

iii. improving ways of working and developing PHE’s values and behaviours, which was being progressed through a staff engagement process led by PHE’s Registrar.

15/051 The Chief Nurse advised the Board that:

a) work continued on ensuring the smooth transfer in October of commissioning of services for 0-5 year olds from the NHS to local government. The Department of Health would make final allocations based on the lift and shift principle with a minimum floor. Additional commissioning costs had been funded by the Department of Health. The Advisory Committee on Resource Allocations (ACRA) would be consulting on factors to be taken into consideration in the PH grant equity formula to recognize 0-5 commissioning;

b) public health nursing leadership would transfer from the Department of Health to PHE from 1 April 2015;

c) the framework for personalised care and population health, which had been launched in November 2014, was a helpful tool for public health professionals. It was currently being developed into a digital format;

d) the Health Check Conference 2015 had taken place earlier in the week. There had been very informative and constructive discussions with a focus on prevention;

e) a number of hospital visits had taken place, and there were examples of excellent healthcare public and health promotion activity taking place across the country, for example, on dementia support and nutrition; and

f) it was expected that the target an additional 4,000 health visitors would be delivered in the coming months.

15/052 The Chief Knowledge Officer advised the Board that:

a) as part of the work on the *Securing our Future* programme, the resources of his Directorate were being realigned around its core functions, for example, in the areas of health economics and non-communicable disease surveillance;

b) he was PHE's representative on the National Cancer Taskforce. This was chaired by the Chief Executive of Cancer Research UK and aimed to produce a strategy which would be agreed by the next government. PHE was contributing to the sections on prevention and inequalities;

c) the Chief Executive was the Deputy Chair of the National Information Board that had been established as part of the work of implementing the *Five year Forward View* and he, the Chief Knowledge Officer, was the Deputy Chair of the NIB Working Group (both of which were chaired by Tim Kelsey of NHS England);

d) the next update on the Global Burden of Disease report had been submitted to the Lancet. This provided the analysis for England and looked at the data at both regional level and by quintiles of deprivation;

e) the report on *Life expectancy: recent trends in older ages* had been published. Life expectancy at older ages in England and elsewhere in Europe fell slightly from 2011 to 2012. Although this had not happened for a number of years, the overall trend was still positive and the change was small. PHE and the Office of National Statistics would continue to monitor this closely.

6. Updates from Observers

15/053 The Observer for Scotland advised the Board that:

a) following the case of a returning Scottish healthcare worker from Sierra Leone, a lessons learned and de-brief process was underway involving both the Chief Medical Officer and PHE;

b) there had not been the same related flu pressures in Scotland as there had been in England. The impact of vaccinating all pre-school and primary school age children in Scotland was due to be evaluated;

c) Scottish Ministers had commented on PHE's proposals for the future of CRCE, including its Glasgow office;

d) the Scottish Government welcomed the UK Parliament's decision to introduce regulations for standardised packaging for cigarettes;

e) a consultation was underway with regards to e-cigarettes. A number of proposals were being considered which included banning the selling of e-cigarettes to under-18s and proxy purchasing as well as on advertising;

f) from September 2015 a smoke free policy would be enforced on hospital premises throughout Scotland;

g) the review of public health in Scotland had encouraged a number of responses to it consultation, including from PHE and Public Health Wales; and

h) the health and social care service integration across Scotland had received royal assent and the new Integration Boards would come into being in April 2015.

15/054 The Observer for Wales advised the Board that the environmental health team based within Public Health Wales was providing a wide range of technical support and advice on a number of issues. These included the implications of nuclear power in Anglesey, the proposals for a tidal wave plant in South Wales and potential sites for shale gas extraction. These were areas of mutual interest with PHE and the relevant teams would collaborate.

7. Update from the Chief Executive

15/055 The Chief Executive advised the Board that:

a) the discussion earlier on in the meeting on local government and public health reinforced the importance of excellent relationships at local level; and

b) a Government decision on the PHE Science Hub would not be made until after the general election.

8. Global Health Update

15/056 The Chair of the Global Health Committee briefed the Board on the recent PHE visit to Hong Kong and China, the prime purpose of which was to identify common public health challenges and share and learn from each other. The meetings in Hong Kong had generated a number of actions, include a Memorandum of Understanding (MoU) with the Centre for Health Protection in Hong Kong, joint working on disaster response and preparedness and leadership training.

15/057 Further work was also planned with China, including a MoU with their Centre for Disease Control and international collaboration on strengthening public health systems in Sierra Leone.

9. Microbiology contribution to Ebola response

15/058 The Head of Specialist Microbiology Technical Services provided an overview of the support provided, including the three PHE-led laboratories in Sierra Leone: Kerry Town, Makeni, and Port Loko. PHE worked with international partners including DfID, Save the Children, International Medical Corps, and GOAL in establishing these sites as well as a large number of commercial suppliers. As of early February 2015 over 9,500 samples had been tested across the three laboratories. PHE was in the unique position of being able to offer broader public health support as well as the diagnostic facilities. Further support was provided from across PHE including procurement, training, management, clerical and IT resource.

15/059 PHE provided bespoke training to volunteers and had trained 192 staff. PHE's Rare and Imported Pathogen Laboratory service had provided extensive support both in the UK and in West Africa, and a 24/7 fever service which encompassed diagnostic activity and clinical advice.

15/060 Extensive diagnostic support was also provided following the two healthcare workers infected with Ebola who had been repatriated to the UK. The laboratories provided daily follow up on all samples until patients were discharged.

15/061 The Board discussed PHE's contribution to the outbreak and the need for ongoing international support to rebuild public health capacity and capability in Sierra Leone. The Board wished to place on record its sincere thanks and admiration for all PHE members of staff who had supported the UK's national and international response to Ebola.

10. Finance Report

15/062 The Finance and Commercial Director presented the finance update (enclosure PHE/15/14) and advised the Board that PHE continued to forecast a year-end financial breakeven position and would deliver its capital programme on budget.

11. Board forward calendar

15/063 The Board reviewed the forward calendar of business and agreed that it would not meet in March. A date for the Board development session would be established by correspondence.

12. Any other business / Questions from the public

15/064 There was no other business and no questions from the public.
The meeting closed at 3.25pm.

Rachel Scott
Corporate Secretary
March 2015