Public Health England

Protecting and improving the nation's health

Minutes

Title of meeting	Public Health England Board	
Date	Friday 26 June 2015	
Venue	PHE Headquarters 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
	Poppy Jaman	Non-executive member
	Paul Lincoln	Associate non-executive member
	Sir Derek Myers	Non-executive member
	Duncan Selbie	Chief Executive
In attendance	Lis Birrane	Director of Communications, PHE
	Michael Brodie	Finance and Commercial Director, PHE
	Karen Carr	Public Involvement Co-ordinator, PHE
	Paul Cosford	Director for Health Protection and Medical Director, PHE
	Barry Creamer	PHE People's Panel
	Jennifer Crockford	PHE People's Panel
	Andrew Dougal	Chair, Public Health Agency, Northern Ireland
	Tina Endericks	Deputy Director, Global Health Security, PHE
	Andrew Furber	President, Association of Directors of Public Health
	Roger Gibb	PHE People's Panel
	Anthony Kessel	Director of International Public Health, PHE
	Victor Knight	Board Secretary, PHE
	Sue Johnson	PHE People's Panel
	Paul Johnstone	Regional Director, North, PHE
	Graham Jukes	Chief Executive, Chartered Institute of Environmental Health
	Gemma Lien	Head of Global Health Strategy, PHE
	Iain Mallet	Head of Public Involvement, PHE
	Claire Moore	PHE People's Panel
	Virginia Murray	Consultant, Disaster Risk Reduction, PHE
	Simon Reeve	Head of Public Health Strategy, Department of Health
	Fiona Scorer	PHE People's Panel
	Rachel Scott	Corporate Secretary, PHE
	Alex Sienkiewicz	Director of Corporate Affairs, PHE
	Jonathan Tritter	Aston University
	Tony Vickers-Byrne	Director of Human Resources, PHE
	Margareta Wahlström	United Nations representative on Disaster Risk Reduction (by teleconference)
	John Watson	Deputy Chief Medical Officer, Department of Health
Apologies	Richard Parish	Non-executive member
	Quentin Sandifer	Observer for Wales
	Lesley Wilkie	Observer for Scotland

There were six members of the public present.

1. Announcements, apologies, declarations of interest

15/093 Apologies for absence were received from Richard Parish, Quentin Sandifer and Lesley Wilkie.

15/094 No interests were declared in relation to items on the agenda.

2. Disaster Risk Reduction

15/095 Professor Murray presented PHE's international work and support to the United Nations *Sendai Framework for Disaster Risk Reduction 2015-2030* ("the framework"). Further work was needed internationally to improve preparedness for disasters and their public health impact. PHE had been instrumental in strengthening the role of science and health in the framework, which had been adopted in March 2015, presenting a number of opportunities, for example:

a) strengthening PHE's relationships with cross-government partners through leadership at local, national and international level;

b) promoting PHE's expertise in development and sharing knowledge with national and international partners; and

c) linking the work to the sustainable development goals.

15/096 Margareta Wahlström, the United Nations Special Representative for Disaster Risk Reduction, advised the Board that:

a) PHE's work on ensuring that science and health were included in the framework had been invaluable. She paid particular tribute to Professor Murray's personal leadership of this agenda;

b) the framework covered the period 2015 to 2030 and was aligned with sustainable development goals. The international profile of this needed to be increased;

c) the framework had been adopted at the Third UN World Conference on Disaster Reduction, which had attracted over 6,500 delegates from across government, academe and business;

d) the framework represented a shift from the traditional approach of managing the disaster event itself to managing the risks thereof. This involved working with a large number of local communities, strengthening governance arrangements and continuing to enhance competence. It recognised that there needed to be a focus on people and health and therefore incorporated learning from the recent pandemics, as well as the impact and destabilising effects of such outbreaks. This would support the development of national risk management;

e) a critical part of the framework was the use of stakeholder groups, defined for this purpose as being all those other than national governments. This was important for implementation, particularly in building sustainable partnerships, and strengthening outreach to health communities;

f) further work was required to expand the global partnership, which would be a key focus of the forthcoming conference in Geneva. This would explore research and how those areas without the scientific capability could be better supported;

g) the next steps following the adoption of the framework included the re-design of monitoring mechanisms. It was envisaged that this would take up to two

years to complete and was essential to improve the available data on disaster; and

h) in order to comply with the commitments outlined in the framework by 2017, there would need to be developed baselines for the new monitoring system, and, by 2020, countries and governments must have produced risk-informed plans. This would require a great deal of partnership working. All partners would be invited to outline how they would like to be monitored.

15/097 To support this work, PHE was invited to establish a focal point and continue to contribute to the development of the health and science elements of the framework. Professor Murray's contribution was recognised and the Board congratulated her on her Award for Global Leadership in Emergency Public Health from the World Association for Disaster and Emergency Medicine at its World Congress in April 2015.

15/098 Adding health to the framework had been a substantial contribution. The UN would be taking this forward at its annual scientific conference in September 2015 in Geneva, which would set the future pace of the work, fill any known gaps in the knowledge and adopt trends to be continued.

15/099 The Board welcomed the briefing and endorsed the future direction of travel. A detailed update would be provided at a future meeting.

3. Public Involvement

15/100 The PHE People's Panel was an important part of its work and the commitment of the volunteers in the People's Panel was exemplary. PHE had developed its processes to ensure that the contributions of the People's Panel were both listened to and acted upon.

15/101 The impact of the People's Panel had been significant, and membership currently stood at 1,300. There were three levels of engagement available to members of the People's Panel:

a) Level One: members invited to complete surveys/questionnaires
b) Level Two: as at level one, but members also invited to attend workshops. Currently about 230-250 members;
c) Level Three: as at level two, but members also invited to join working groups and committees. Currently about 20 people, some individuals joining multiple committees.

15/102 The aspirations of the People's Panel included:

a) ensuring that it evaluated, challenged and improved the public information which PHE provided;
b) involvement in research: many bids for research required evidence of public involvement to be included as part of the application process;
c) ensuring representative composition of PHE panels involving members of the public;
d) supporting PHE's objectives, for example, developing the public narrative on prevention.

15/103 Specific examples of work undertaken by the People's Panel included contributing to the cohort study evaluating the impacts of flooding on mental health on people affected and focus groups on PHE's response to the outbreak of Ebola, particularly on screening at ports.

15/104 Further work would take place to establish the effectiveness and impact of the interventions, and clear metrics would be developed for public involvement.

15/105 Fiona Scorer, a member of the Panel, provided reflections on her involvement. This had included work on improving communications regarding on vaccination and antiviral use during the flu season, and work with the National Infection Service.

15/106 A further update would be provided to the Board following the publication of Ipsos MORI's public opinion survey for PHE in November. This would also lead to the development of PHE's Public Involvement Strategy which would be produced in early 2016.

15/107 The mechanisms for involving the People's Panel in PHE's work were discussed. At present this was done on an ad hoc basis, and it was recognised that a more systematic approach was required particularly in dealing with requests for support and being mindful of the capacity of the public involvement team. The mechanism for reimbursing people for their time would be reviewed in the context of HMRC rules and that involvement was purely voluntary.

15/108 It was suggested that local authorities might find it useful to have access to, and engagement with, the Panel and this would be further explored.

15/109 The Board welcomed the ongoing contribution of the Panel to PHE's work and endorsed the future direction of travel. Further updates on the work would be presented at a future Board meeting.

4. The future for public health in Sierra Leone

15/110 The outbreak of Ebola had had a devastating impact on the health system within Sierra Leone and was still ongoing, with a current weekly case incidence in West Africa of 20 per week. It was estimated that approximately 10% of all doctors within Sierra Leone had succumbed to Ebola.

15/111 As part of PHE's response to the outbreak it had established three laboratories in Sierra Leone: Makeni, Port Loko and Kerry Town. The Chief Executive and other PHE staff had met the Sierra Leone Minister for Health and Chief Medical Officer while at the World Health Assembly and reiterated PHE's long term commitment to Sierra Leone in rebuilding its public health system.

15/112 PHE's Director -North had recently returned from a month-long WHO secondment to Sierra Leone. By way of context, the population of Sierra Leone was 6 million with a life expectancy of 46 years (and a healthy life expectancy of 39). Ebola had proved very difficult to eradicate in the slum areas and the national economy had collapsed as a result of the outbreak. Sierra Leone's GDP had declined by a reported 23%.

15/113 Sierra Leone had requested assistance both immediately and in the longer term: Immediately for emergency planning, strengthening infection surveillance, and support for infection prevention and control; and for the longer term for establishing a research institute in Sierra Leone, addressing the wider determinants of health, and establishing a school for public health.

15/114 The Board agreed that PHE should establish a country office in Sierra Leone, the funding and technical arrangements for which would be worked through at pace. It would be essential for PHE to work in partnership with other organisations across the area and much of what was proposed was embedded in PHE's published *Global Health Strategy*.

15/115 The critical role of environmental health officers was discussed, particularly in relation to water and sanitation. A series of Memorandums of Understanding had been in

place to support this, but further work was required to enact institutional change. This would be further explored, particularly taking into account the impact of gastro-intestinal infections which were present, and this would be taken further in partnership with the Chief Executive of the Chartered Institute of Environmental Health.

Paul Johnstone

15/116 Training was essential to support development of a new system. This included not only the training of doctors, but also nurse practitioners, technicians and environmental health officers. This was important to enact a long-term commitment and change. Public health development should therefore be linked to the more general development agenda. For example, as a result of the outbreak schools in Sierra Leone had been closed for 10 months, with an adverse impact on children's education that would take time to address.

15/117 Consideration should also be given to streamlining processes in the UK, to enable NHS staff who wished to support the response to be able to travel to Sierra Leone. It was hoped the development of a response force for these types of emergencies would address such issues.

15/118 The Board gave its full support to the proposals.

5. Global Health Security Agenda (GHSA)

15/119 The Deputy Director, Global Health Security updated Board members on the outcome of the UK recently completed pilot assessment. The GHSA aimed to promote global health security and encourage compliance with International Health Regulations (IHRs). The GHSA was US-led and had been driven forward as part of the international response to Ebola.

15/120 The work compromised of eleven action packages which co-ordinated international action to improve prevention, detection and responses to global health threats. An assessment toolkit was developed against these targets and was piloted across a range of countries, including the UK.

15/121 The pilot was to evaluate the GHSA assessment tool using the information provided by the UK and applying the tool to make proposals to improve it. It would also be used to describe the functions and structures within the UK and identify best practice to share with other GHSA countries.

15/122 The GHSA had a number of action packages which covered a diverse number of areas, including, amongst others, antimicrobial resistance, immunisation and workforce deployment. As part of the assessment process a detailed report was produced providing evidence against each of the packages, outlining progress against set criteria of targets and measures. This was then given to the review team who evaluated and challenged the information outlined in the report. This included a review of best practice and identifying gaps in PHE's systems.

15/123 The review team and host country provided many suggestions for strengthening the assessment tool. The UK scored well across the action packages, demonstrating strong systems, and a culture of continual assessment and improvement. The overall findings in respect to the UK were:

a) there were particular strengths in in UK coordination and response, in particular, the link between government and non-governmental organisations;
b) there was a good approach to "One Health"
c) there were well-practiced systems between real outbreaks and simulation exercises;
d) the level of political interest in such issues was high;
e) the contribution to the international response to Ebola was an excellent example of UK capability;

f) use of behavioural science were recognised and increasingly effectively applied in the UK.

15/124 The GHSA Steering Group meeting would review the results formally in June, following which it would be finalised and made publicly available, and the actions in the report would be reviewed to address areas identified for improvement.

15/125 The Board welcomed the initial findings of the GHSA assessment and were keen that opportunities to share this work across the public health system were actively explored.

6. Minutes of the meeting held on 22 May 2015

15/126 The minutes (enclosure PHE/15/24) were agreed as an accurate record of the previous meeting.

7. Matters arising

15/127 The matters arising from previous meetings (enclosure PHE/15/25) were noted.

15/128 The theme of obesity would feature on the Board's September agenda. A detailed review of all outstanding watch-lists would take place ahead of the next meeting, and Board members assigned to lead and work with national directors on their follow up and implementation. **Victor Knight**

8. Updates from Directors

15/129 The Director of Health Protection and Medical Director advised the Board that:

a) MERS Coronavirus in South Korea: PHE teams were providing support and there had been good progress in reducing its incidence. The key issue related to the outbreak was the chain of transmission. Brian McCloskey, Director of Global Health Security was working in South Korea on the evaluation of the response systems. Consideration had been given as to whether screening should be introduced at points of entry, following the recent cases in Thailand. This was being monitored carefully on an ongoing basis.

b) preparations were well underway for the winter flu season, including preparing for the vaccination campaign.

c) a cohort study of the impact of flooding on mental health was now underway, involving approximately 2,000 people. This was an excellent example of linking service delivery at the local level and health protection work.

15/130 The Director - North advised the Board that, as part of the changes being taken forward under the *Securing our Future* programme, the new PHE Centres would "go live" on 1 July, aligning PHE's presence with that recognised by local government.

15/131 The Director of Human Resources advised the Board that:

a) PHE's Head of Diversity and Staff Inclusion would review in the whole PHE's diversity and staff inclusion system, and ensure that there was best practice across the whole public health system.

b) Lauren Finnegan, Poppy Jaman and Tony Vickers-Byrne had met Lord Patel of Bradford to plan PHE's first Diversity Awards, which would to be hosted at the House of Lords in June 2016. This would have a particular focus on the impact of diversity on health.

c) PHE was supporting the Faculty of Public Health in developing principles for inclusion in an open and transparent way. It was proposed to share this

approach across the FPH members and represented an excellent opportunity for PHE to establish itself as a leader in the system in this area.

9. Update from Northern Ireland

15/132 The Chair, Public Health Agency, Northern Ireland, advised the Board that:

a) he was taking the opportunity to visit organisations across the health system since taking up post on 1 June 2015.

b) a visit of PHE's Directors to Northern Ireland was being arranged and details would be confirmed outside of the meeting.

10. Update from the Chief Executive

15/133 The Chief Executive discussed with the Board the recent £200m reduction to the public health grant, which in no way should be interpreted as being a step away from the shared commitment across the health and care sector to prevention. PHE would be exploiting the opportunity afforded by the *NHS Five Year Forward View* to reduce growth in NHS activity and to save money but also, crucially, to close the gaps between the poorest and the most wealthy. PHE would be looking to accelerate this by supporting devolution wherever the energy and commitment to it existed, and where it could be shown that by working in different ways they can close the gaps faster than could be done today.

15/134 There had been a recent adjournment debate on the PHE Science Hub, the Hansard transcript of which was shared with the Board. The OBC was with HM Treasury and Cabinet Office and PHE continued to work with them and colleagues in DH in progressing this.

11. Finance Report

15/135 The Finance and Commercial Director presented the finance update (enclosure PHE/15/26). The Board noted that:

a) the Annual Report and Accounts had been audited by the National Audit Office and an unqualified audit opinion was expected.
b) there had been a small underspend at the end of month 2, which was as expected as a result of the *Securing our Future* programme. PHE continued to forecast year-end financial break-even and full delivery of its capital programme, which included

15/136 The Board **NOTED** the finance report.

12. Information Items

15/137 The Board noted the following information items:

a) Minutes of the Global Health Committee meeting held on 26 January 2015 (enclosure PHE/15/27)
b) Minutes of the Global Health Committee meeting held on 20 April 2015 (enclosure PHE/15/28)
c) Board forward calendar (enclosure PHE/15/29)

13. Any other business / Questions from the public

15/138 Electronic Cigarettes: PHE had been active in reviewing the evidence both in the UK and abroad and planned to publish the results of this review in the summer. Work with key partners, such as MHRA, would be important.

15/139 The following updates were provided on the work of the Kingfisher Treasure Seekers:

a) Kingfisher had agreed that the e-bug literature would be developed further

with the support of the Deputy Chief Medical Officer.

b) The Kingfisher building would be formally opening on 17 July 2015.

15/140 The meeting closed at 1.45pm

Rachel Scott
Corporate Secretary
June 2015