Public Health England

Protecting and improving the nation's health

Enclosure PHE/16/16

Minutes

Title of meeting	Public Health England Board	
Date	Wednesday 24 February 2016	
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	Julian Abel	Consultant in Palliative Care, Weston Area NHS Health Trust
	Nuzhat Ali	Lead Older Adults, Health and Wellbeing, PHE
	Viv Bennett	Chief Nurse, PHE
	Antonia Bunnin	Director of Hospice Support and Development, Hospice UK
	Michael Brodie	Finance and Commercial Director, PHE
	Paul Cosford	Director for Health Protection and Medical Director, PHE
	Derrick Crook	Director, National Infection Service, PHE
	Stephanie Crowe	Ipsos MORI
	Kevin Fenton	Director, Health and Wellbeing, PHE
	Richard Gleave	Deputy Chief Executive, PHE
	Claire Henry	Chief Executive, The National Council for Palliative Care & Dying Matters
	Allann Kellehear	Academic Director of DHEZ Health and Wellbeing Centre and 50th Anniversary Professor (End-of-Life Care), University of Bradford
	Cathy Morgan	Deputy Director, Performance Planning and Strategy, PHE
	Vasanthini Nagarajah	Secretariat Assistant, PHE
	John Newton	Chief Knowledge Officer, PHE
	Bill Noble	Medical Director, Marie Curie
	Anna Quigley	Ipsos MORI
	Elaine Rashbrook	National Lead for Older People, PHE
	Heather Richardson	Chief Executive, St Christopher's Hospice
	Rachel Scott	Board Secretary, PHE
	Alex Sienkiewicz	Director of Corporate Affairs, PHE
	Amy Sinclair	Partnerships and Policy Manager, PHE
	Tony Walter	Honorary Professor of Death Studies, University of Bath,
	Julia Verne	Head of Clinical Epidemiology, Public Health England
Apologies	Richard Parish	Non-executive member
	Quentin Sandifer	Observer, Wales

There were six members of the public present.

UNCONFIRMED MINUTES

1. Announcements, apologies, declarations of interest

16/035 Apologies for absence were received from Richard Parish and Quentin Sandifer

16/036 No interests were declared in relation to items on the agenda.

2. Public Health Approaches to End of Life Care

16/037 The Director of Health and Wellbeing introduced the panel session on public health approaches to end of life care (enclosure PHE/16/08). Approximately 460,000 people died in England every year, and the potential annual health and social impacts affected millions of people.

16/038 The expert panel made the following observations:

a) the main national quality indicator for end of life care had historically been based on place of death. Although an increasing number of people were dying other than in an acute care setting, further community support was required to take greater account of personal needs and preferences. The palliative care and hospice movement had historically focused on people suffering from cancer and had been highly successful in this but there had been less focus on those living with other terminal illnesses;

b) there were many health and social impacts associated with end of life care including on physical and mental health of people and their carers, as well as those caused by inequalities in health, wellbeing and social capital. There needed to be greater focus on people at the end of their lives who did not enjoy a support network of family and friends. Many of these wider social issues could be better managed through public health interventions;

c) end of life care affected a wide range of people, including the dying, their family and friends, neighbours, colleagues and employers and volunteers and professionals, particularly in palliative care settings. It should be viewed as a civic movement where assets in the local community were a valuable source of support, including schools and local media;

d) it was estimated that approximately 30% of people were not pain-free at the end of life, which increased to over 40% for those dying in the community. A number of practical measures needed to be explored to reduce these levels;

e) “Dying Matters” week allowed engagement across a number of individuals and organisations, including integration with existing groups and networks. It covered a number of themes and increased social media activity. A portal had also been developed to allow members of the public to find out about services in their area using a post code look up facility;

f) further work was needed to look at the opportunities strategically and recognise resources available in the community. The Dying Well Charter could support this;

g) independent evaluation was required for the National End of Life care intelligence and PHE was supporting its development;

h) there were a number of opportunities provided by the *Five Year Forward View* and the forthcoming publication of NHS Sustainability and Transformation Plans, which would enable health and social care systems to work together better. This could be linked to the work of external partnerships including Mental Health First Aid and Dementia Friends;

i) people should be better enabled to die in the setting of their choice and encouraged to talk more openly about their preference. Networks should be built from the start and there were many examples of this being implemented in local areas, including community development for the frail and elderly in Frome and the establishment of a living well group in Cornwall, which supported people as they became frail and elderly rather than solely at or near the point of dying. Investment in community development could enable a more place-based approach;

j) further evaluation was needed to fully understand the skills of those working in end of life care. This evaluation should be built in from the outset.

16/039 A discussion with the Board followed on the points raised by the expert panel and the following points were raised:

a) end of life care should be embedded in workforce planning to ensure appropriately skilled staff were available, with suitable career paths and development open to them;

b) the impact on carers and volunteers should be better understood, for example, the mental and physical impacts;

c) the clinical effects of grief should be better understood and PHE's health improvement role in this explored further;

d) the place of death indicator should be considered carefully as some people classified as dying at home were care home residents, in other words, they were not living in their own homes when they died. Moving people between care homes should be carefully monitored, in particular, the negative impact this might have on quality of end of life care.

16/040 The Board thanked the expert panel for their contributions and the points raised from the discussion would be incorporated into the PHE watchlist and progress reviewed at a future meeting.

3. Minutes of the meeting held on 27 January 2016

16/041 The minutes (enclosure PHE/16/09) were agreed as an accurate record of the previous meeting subject to explicitly noting the Board's thanks to Professor Newton and Professor Hannigan for their work in preparing the Research discussion.

4. Matters arising

16/042 The matters arising from previous meetings (enclosure PHE/16/10) were noted.

5. Ipsos MORI: Stakeholder Opinion Survey Results

16/043 The Deputy Chief Executive introduced the results of the PHE's stakeholder opinion survey. This was an important source of data on how PHE was perceived by key partners and identified areas for further improvement.

16/044 Anna Quigley, Associate Director at Ipsos MORI, presented the key findings:

a) PHE remained highly valued by its stakeholders as the go-to organisation for public health expertise and advice;
b) PHE was seen as particularly unique and strong in health protection but still in development in health improvement;
c) working relationships remained positive, with three-quarters of respondents stating that their relationship with PHE was good;
d) PHE was seen as willing to work in partnership with its stakeholders, with 85% of respondents stating that that PHE worked with stakeholders to a great

extent or to some extent;

e) there were mixed views on changes to PHE's relationships with its stakeholders. The majority of respondents however felt that the changes, mainly the reduction in the number of Centres and aligning them with the geographical areas recognised by local government, were for the better;
f) advocacy levels remained high - half of respondents stated that they would speak positively about PHE. This was similar to the previous year's results and compared well with other public sector organisations;
g) PHE needed to do more to understand the priorities of stakeholder organisations and provide support to external work; and
h) local relationships were working well although there was a perceived disconnect between local and national teams.

16/045 The Board discussed the results and the following points were made:

a) in future surveys, it would be helpful to fully understand the contextual information behind the survey. Ipsos MORI confirmed that, as a matter of course, results were compared to the previous year's survey as well as to similar organisations, enabling trends to be identified and acted on year-on-year;
b) the views of Directors of Public Health should be highlighted given that they formed one of the most important stakeholder groupings for PHE;
c) further work was needed on how PHE could best communicate its priorities to partners;
d) stakeholders' views on PHE's independence should be kept under close review. There were several examples in the past year where PHE had spoken and published to the evidence, for example, on e-cigarettes;
e) as PHE concluded *Securing our Future*, its organisational change programme, it would be important to ensure that personal relationships at a local level continued to be developed.

16/046 The Board thanked Ipsos MORI for the presentation and **NOTED** the results

6. Global Health Update

16/047 A significant number of staff across PHE were engaged in global health work either as part of their routine duties or specific programmes of work, including deployments in response to public health emergencies. For example:

a) PHE's ongoing presence in Sierra Leone. The Chief Executive had recently visited Sierra Leone and formally opened PHE's laboratory in Makeni, a key component of rebuilding public health capacity in the country. PHE would also help with the strengthening of district laboratories and training of local staff;

b) supporting Pakistan at both national and provincial level in complying with the WHO international health regulations;

c) an emerging relationship with China at national, provincial and local level. Further to the recently agreed MoU with the Chinese Centre for Diseases Control, PHE would jointly host a workshop in Beijing in May with sessions on sugar and salt, climate change, HIV and global health development;

d) contributing to global health security. PHE continued to support WHO missions in response to MERS-CoV and was providing expert advice to the Brazilian Ministry of Health and International Olympic Committee in preparation for the 2016 Olympic Games. PHE was also working to establish the UK Rapid Support Force, a joint partnership with an academic partner underpinned by Organisational Development Assistance (ODA) funding for five years;

e) disaster risk reduction. PHE was chair of the organising committee of the recent United Nations Office for Disaster Risk Reduction (UNISDR) conference on the implementation of the Sendai Framework for disaster risk reduction.

16/048 The recommendations of the recent independent review of PHE's global health activity were now being implemented, including new management arrangements and structural changes designed to enhance PHE's contribution and support the Government's wider international priorities.

16/049 The Board discussed PHE's involvement in Europe-wide public health arrangements, including its work as a full partner of the European Centre for Disease Control and research income from the EU. The potential impacts of leaving the EU would be identified in advance of the EU referendum.

16/050 The Sustainable Development Goals and PHE's role in supporting their delivery would be considered at a future meeting of the Global Health Committee.

16/051 The Board **NOTED** the update.

7. Updates from Directors

16/052 The Director for Health Protection and Medical Director advised that:

a) PHE continued to contribute to the international response to the Zika virus. PHE's work focused on travel advice to UK citizens. PHE's Migrant and Travel Health team, along with the National Travel Health Network and Centre, were co-ordinating this. The possibility of sexual transmission of the virus was also being explored. PHE staff continued to monitor the vectors that transmitted the virus, noting that the mosquitoes did not survive in the UK.

b) he and the Director of Health and Wellbeing had taken part in a roundtable discussion hosted by the Royal College of Physicians and Royal College of Paediatrics and Child Health on the reduction of health harms due to air pollution. This sought to build on existing work to reduce health harms and build a coalition agreement of action which needed to be taken, particularly at a local/community level. The potential for PHE to undertake an evidence review would be explored as part of the development of the annual remit letter for 2016/17;

c) PHE's emergency and preparedness colleagues were contributing to the development of a number of government-wide exercises designed to test PHE and the wider system's response to emergency incidents.

16/053 The Director for Health and Wellbeing advised that:

a) the Diet and Obesity team continued to contribute to development of the Government's Childhood Obesity Strategy;

b) an evidence review validation event had taken place to consider PHE's Alcohol evidence review, which would be published later in the year;

c) a round table discussion had taken place with the Faculty for Homeless and Inclusion Health. PHE teams were working to improve the use of data to help address the challenges of homelessness and health.

16/054 The Director, National Infection Service advised the Board that:

a) work continued on development of the National Infection Service which was a

major change programme, which affected a large number of staff throughout PHE. There was a particular focus on ensuring that there were clear career pathways;

b) A paper on automated TB sequencing, a major infrastructure development, would be submitted to the Board for consideration at a future meeting. **Derrick Crook**

The Chief Knowledge Officer advised that:

16/055 a) PHE's report on recent trends in life expectancy at older ages had been well received and reinforced the high quality of PHE's evidence-based products;

b) CKO staff were working closely with the Caldicott review team on consent models for data use and sharing. A paper outlining PHE's work in this area and potential risks would be prepared for a future Board meeting; **John Newton**

c) a recent roundtable event had considered the Statistics Authority's review into health and social care statistics, which aimed to ensure there were clear examples of good practice and that the production of analysis in this area was fully aligned;

d) he had chaired the recent conference celebrating the 30th anniversary of the British Paediatric Surveillance Unit. The conference theme was *Rare Disease in Paediatrics* from birth to transition and centred on the patient journey from diagnosis through to end of life care.

8. Finance Update

16/056 The Finance and Commercial Director introduced the finance report to the period ended December 2015 (enclosure PHE/16/13). PHE continued to forecast financial break-even for 2015/16.

16/057 The budget for 2016/17 was being developed and would be shared with the Board in March.

16/058 The Board **NOTED** the update.

9. Any other business

16/059 A member of the public asked about PHE's position on coverage of the Meningitis B vaccine in light of recent media coverage.

16/060 Decisions on introducing vaccines rested with the Joint Committee on Vaccines and Immunisation (JCI) to whom PHE provided scientific support. The UK was the first country in the world to offer a vaccination programme for Meningitis B, focussing on children under the age of one. The advice was not expected to change although the prevalence of Meningitis in teenagers was being kept under careful review.

16/061 There being no further business the meeting closed at 2.40pm.