Public Health England

Protecting and improving the nation's health

Enclosure PHE/16/38

Minutes

Title of meeting	Public Health England Board	
Date	Wednesday 25 May 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
	Richard Parish	Non-executive member
	Duncan Selbie	Chief Executive
In attendance	Bola Akinwale	Scientific Lead - Health Equity, PHE
	Sarah Anderson	Head of National TB Office, PHE
	Claire Bambra	Durham University
	Viv Bennett	Chief Nurse
	Chris Bentley	Sheffield Hallam University
	Peter Bradley	Deputy Director, Chief Knowledge Officer Directorate, PHE
	Michael Brodie	Finance and Commercial Director, PHE
	Kim Collins	Tailored Review Team, Department of Health
	Ann Marie Connolly	Deputy Director, Health Equity and Impact, PHE
	Paul Cosford	Director for Health Protection and Medical Director, PHE
	Emily Dibble	Tailored Review Team, Department of Health
	Andrew Furber	President, Association of Directors of Public Health
	Richard Gleave	Deputy Chief Executive, PHE
	Graham Jukes	Adviser on Environmental Health
	Gemma Lien	Head of Global Health Strategy, PHE
	Cathy Morgan	Deputy Director, Planning, Performance and Accountability, PHE
	Vasanthini Nagarajah	Secretariat Assistant, PHE
	Trusha Patel	Tailored Review Team, Department of Health
	Simon Reeve	Department of Health
	Martin Reeves	Coventry City Council
	Rachel Scott	Board Secretary, PHE
	Alex Sienkiewicz	Director of Corporate Affairs, PHE
	Tony Vickers-Byrne	Director of Human Resources, PHE
	John Watson	Deputy Chief Medical Officer, Department of Health
	Mike Yates	Head of Governance, PHE

There were four members of the public present.

Announcements, apologies, declarations of interest

16/120 No interests were declared in relation to items on the agenda.

PHE Diversity and Staff Inclusion Awards

16/121 The Director of Human Resources and Poppy Jaman provided an update on the first PHE Staff Inclusion and Diversity Awards which had taken place at the House of

Lords on 11 July. They celebrated the commitment and achievements of PHE staff in promoting and ensuring inclusion and valuing diversity which would have a direct positive impact on the health and wellbeing of all PHE staff.

16/122 It was hoped that similar awards would take place in future, and PHE would work with the Civil Service, NHS and civil society to achieve the ambition of extending the awards beyond PHE.

16/123 Separately, it was proposed to develop a Science and Research award to recognise the expertise and achievements of PHE's scientific staff.

Health Inequalities: Support for action to reduce inequalities in England.

16/124 The Deputy Director, Health Equity and Impact introduced the panel session on the support for action to reduce health inequalities in England.

16/125 The *Global Burden of Disease* report published in September 2015 had highlighted the number of healthy years of life lost as well as the causes along with the comparisons with the upper and lower quartiles. Across England there was a gap in health life expectancy between the highest and lowest quartile of 19 years for men and 20.2 years for women.

16/126 PHE had a well-developed programme of work in this area, and also had a legal duty to reduce health inequalities. Progress was tracked through specific indicators in the Public Health Outcomes Framework and PHE had recently published a *Health Inequalities Framework for Action*. Further work would take place to identify how PHE's role could further support reduction in health inequalities as well as identifying the best of emerging practice.

16/127 The expert panel made the following observations:

a) there had been changes at national level to measure the reduction of health inequalities. Governments had in the past set targets to reduce inequalities, making a percentage change at population level and reducing health inequalities was regarded a national task;

b) health inequalities had a substantial impact on delivery of local health and care services; the most significant impact could be seen in the number of emergency admissions, which were substantially higher for those in the lowest quartile;

c) it was important that people connected with the services in their local area, otherwise the impact of any changes would be limited. The components of unmet need were outlined: the under-recognition of illness by individuals and those around them; where individuals were identified as ill but treatment was not accessible and there were barriers to uptake; inadequacies in quality of in-service provision; and insufficient resource for recovery or ongoing self-management. This could have a substantial impact on local services and should be broadened across the health system to ensure a place based approach.

d) Stockton on Tees had one of the largest gaps in health inequalities in the country. The Leverhulme Trust had conducted a household study of the health and determinants of health of people living in the 20 most and least deprived areas in order to understand the underlying causes of the inequalities. Initial results found that people living in the more deprived areas were more likely to have a health condition and almost twice as likely to have multiple health conditions.

The study also suggested that health inequalities could be explained by environmental factors such as housing. Many also demonstrated other risk behaviours such as smoking and excessive alcohol consumption. There appeared to be a cluster effect when the various factors were considered together, for example, social isolation caused by a low income leading to a lack of exercise. The study suggested that both behavioural and environmental factors needed to be addressed.

e) Prevention and treatment issues needed to be fully considered when reducing health inequalities. This included engaging the non-traditional public health workforce, such as those who worked in the welfare system and adopting a whole person approach when helping people back into work.

f) Coventry was a designated Marmot city and had implemented a range of practical measures to address health inequalities, including:
   i. working with parents, carers and children to ensure that every child had the best start in life;
   ii. a “job shop” for people looking for work;
   iii. “Cycle Coventry”, a network of cycle pathways across the city and working with partners such as Halfords to encourage people to take up cycling;
   iv. working with energy companies to address fuel poverty;
   v. an air quality alliance

g) the devolution agenda provided opportunities for delivering change at scale.

h) tackling health inequalities and improving economic prosperity went hand in hand and local authorities were well placed to address both.

16/128 A discussion of the Board followed, with the following points raised:

a) there were many opportunities for PHE to contribute to the reduction of health inequalities, and the Board would continue to be an important source of advice and advocacy. Many of the themes it had to date, included health inequalities as part of the analysis, for example, rural health and best start;

b) the Academic Health Science Networks Clinical Council would examine the opportunities provided by the Sustainability and Transformation Plans (STPs);

c) the impact of early intervention in reducing health inequalities should be considered, particularly in educational settings, the evidence for which was compelling;

d) further work was required to understand how best to tailor interventions for those in the lowest quartile, together with a balanced approach that addressed both behavioural and environmental factors;

e) practical steps were required to address health inequalities and PHE would be able to provide support to local authorities in delivering these. A detailed narrative was also required, but measures were required to break cycles of deprivation;

f) working together with NHS England and NHS Improvement, PHE was providing the STP areas with a menu of interventions, setting out what they could do and what impact they could expect to see;

g) all possible levers for reducing health inequalities should be exploited, including employers and civil society. The role of the wider public health workforce should also be explored, as this was a valuable and as yet untapped resource;

h) further work should take place with Health and Wellbeing Boards, in particular, on practical steps that could be taken locally to reduce health inequalities.

16/129 The Board thanked the expert panel for their contributions. There was much more to do, but significant progress had been made in recent years, for example, on reducing teenage pregnancies and the evidence-based advice on e-cigarettes as means of reducing tobacco-related harm.

TB Update

16/130 An update was provided on progress since the time of the Board's previous panel discussion in May 2014.

16/131 In January 2015, PHE and NHS England had launched the *Collaborative Tuberculosis Strategy for England 2015-2020*. A National TB Programme had been established along with seven local TB Control Boards to oversee delivery of the strategy and the local actions that needed to be taken to reduce TB incidence.

16/132 The Board was briefed on early progress in each of the ten action areas:

a) *To improve access to services and early diagnosis*. Awareness work was underway, particularly with GPs and primary care services with the development of updated literature, videos and animation;
b) *Provide universal access to high quality diagnostics*. An audit of TB laboratory services in PHE would take place, and TB was recognised as a priority for the Whole Genome Sequencing technology for both PHE and NHS England;
c) *Improve treatment and care services*. A national TB service specification had been issued for use by TB Control Boards, CCGs and clinicians. TB control Boards were working closely with local stakeholders to improve treatment and care;
d) *Ensure comprehensive contact tracing*. This was included in the TB service specification and the NICE TB guidance also supported improved contact tracing;
e) *Improve BCG vaccination uptake*. PHE and NHS England were working together on this issue in light of the global vaccine shortage;
f) *Reduce drug-resistant TB*. PHE and NHS England were working on a needs assessment for the management of drug resistant TB patients;
g) *Tackle TB in underserved populations*. This was a major workstream for the programme and a toolkit would be developed to support TB Control Boards in better meeting the needs of underserved populations;
h) *Systematically implement new entrant latent TB screening*. A national programme to test and treat new migrants for latent TB infection had been a main focus for the national programme and TB Control Boards in 2015/16;
i) *Strengthen surveillance and monitoring*. TB Strategy Monitoring indicators could be viewed on PHE's Fingertips data tool which allowed efficient access to local and national TB data by TB Control Boards and CCG commissioners;
j) *Ensure appropriate workforce to deliver TB control*. A review of the TB nursing workforce had taken place and was due to be published in July 2015.

16/133 The following points were made in the subsequent Board discussion:

a) there had been good progress across a number of indicators. It was essential to maintain the momentum to ensure that progress continued;

b) it was recognised that the programme of work was operating in a resource constrained environment, however, it was important that it remained sustainable. PHE was contributing to this by applying evidence of what was working in a systematic way to drive improved outcomes;

c) it was key to ensure that people were getting into treatment earlier, and PHE had worked hard on raising awareness in primary care on how to identify and diagnose TB;

d) it was essential that the range of interventions highlighted in the strategy were implemented to ensure a sustained reduction in the number of cases;

e) it would be important to present the economic analysis and the perspective of different partners in delivery of the strategy, along with what the long term scenarios including how to manage a steady state and reaching the targets. Evaluation was embedded throughout the delivery the strategy.

16/134 The Board noted the update and thanked the team for the progress which had been made.

Minutes of the meeting held on 27 April 2016

16/135 The minutes (enclosure PHE/16/31) were agreed as an accurate record of the previous meeting.

Matters arising

16/136 The matters arising from previous meetings (enclosure PHE/16/32) were noted.

Updates from Directors

16/137 The Chief Nurse advised that:

a) The latest edition of *Health Matters* focused on health in pregnancy and up to the age of 2 and was the first based on a life course approach. Many subscribers had indicated that the evidence was being used to inform decisions as well as providing examples of cross-working from across the system;

b) PHE had been approached by WHO Europe to become the first designated Collaborating Centre for Nursing, Midwifery Public Health and work was progressing well;

c) *Leading Change; Adding Value* the new national strategy for nursing had been published. It included commitments for population health, significantly increasing preventative practice and case studies on what could be achieved on the obesity challenge and AMR.

16/138 The Director for Health Protection and Medical Director advised that:

a) following the publication of the *Review on Antimicrobial Resistance* led by Lord O'Neill, PHE would led on the responsibility for implementation of the recommendations in the UK, in particular, on reducing inappropriate prescribing. PHE was well placed to lead this work, with world-leading expertise in the National Infection Service and WHO Collaborating Centre;

b) PHE continued to develop the evidence base on the health impact of air pollution, including further work on nitrogen oxide. This was an important part of PHE's work in ensuring sustainable health across the lifecourse;

c) PHE continued to monitor the spread of the Zika virus and provide cross-government support to the international response.

Chief Executive's Update

16/139 The Chief Executive advised the Board that:

a) Plain packaging of cigarettes would become mandatory following the recent High Court judgement rejecting the challenge from some of the tobacco companies;

b) at the request of Ministers, PHE had begun the technical work with industry necessary to implement the Childhood Obesity Strategy once published;

c) PHE would shortly be giving evidence to the Health Select Committee's inquiry into the impact of the post-2013 reforms on public health;

d) PHE's advice on health eating, including the Eatwell Guide, was based on the best scientific evidence. The Board reflected on the recent publication by the National Obesity Forum, which appeared to fall well short in this regard.

Capital Expenditure Report

16/140 The Finance and Commercial Director introduced the capital expenditure report which provided a summary of PHE's 2015/16 capital expenditure (enclosure PHE/16/33). PHE's Management Committee received monthly updates on the capital programme and each piece of work was underpinned by a thorough business case outlining the strategic case, economic, financial, commercial and management details.

16/141 The Board noted the update.

Global Health update

16/142 The Chair, Global Health Committee advised the Board that:

a) through the WHO Collaborating Centre for Mass Gatherings, PHE continued to provide support in advance of the Rio2016 Olympic Games. The main issue continued to be the response to the Zika virus outbreak;

b) PHE staff had taken part in a successful visit to Japan to share learning from the development of PHE's cold weather plan. Support was also in place for the Tokyo 2020 Olympics and it had been proposed to establish a seconded post to work with the Japanese government to support their preparations, building on the experience of staff who worked on London 2012 in the former HPA;

c) a number of PHE staff had taken part in a wide range of workshops with Chinese CDC. This had been supported by the FCO and had been successful in establishing strong working relationships between the two organisations;

d) The World Health Assembly currently taking place had a strong focus on AMR. In the discussions there had been several positive references to PHE's

work, particularly on plain packaging and obesity.

Science Hub update

16/143 It was reported that the programme remained on track and that the first in a series of public engagement events had taken place in Harlow in May.

Information items

16/144 The Board noted the following information updates:

a) Audit and Risk Committee Update
The next meeting on the Audit and Risk Committee would take place on 7 June.
b) Quality and Clinical Governance Committee (enclosure PHE/16/35)
Significant work was taking place to embed quality and clinical governance excellence across PHE, and discussions had taken place to align the information reporting to the Committee.

c) Board forward calendar (enclosure PHE/16/36)
Future topics for panel sessions were suggested, including PHE's environmental health strategy, drug treatment services, health protection and sexual health services. These items would be added to the Board's forward calendar.

Any other business

16/145 A member of the public emphasised the importance in working jointly with local voluntary organisations to ensure that they were not overburdened. To address issues such as TB it would be important to work collaboratively with civil society to ensure that any initiatives for local populations were as effective as possible.

16/146 There being no further business the meeting closed at 2.10pm.