DEPARTMENTAL BOARD
Boardroom, Richmond House, London

Thursday 29 September 2016, 1:30pm – 4:00pm

DRAFT MINUTES

Present:

Chris Wormald	Permanent Secretary (chair)
David Williams	Director General – Finance and Group Operations
Charlie Massey	Director General – Acute Care and Workforce
Tamara Finkelstein	Director General – Community Care
Chris Whitty	Chief Scientific Adviser
Peter Sands	Lead Non-Executive Board Member
Gerry Murphy	Non-Executive Board Member

In attendance:

Naomi Abigail	Head of System Oversight, Planning and Legislation
Cariad Hazard	Senior Private Secretary to the Permanent Secretary
Name Redacted	Assistant Secretary to the Departmental Board

Apologies:

Jeremy Hunt	Secretary of State for Health
Philip Dunne	Minister of State for Health
Lord David Prior	Parliamentary Under Secretary of State for NHS Productivity
David Mowat	Parliamentary Under Secretary of State for Community Health and Care
Nicola Blackwood	Parliamentary Under Secretary of State for Public Health and Innovation
Sally Davies	Chief Medical Officer
Chris Pilling	Non-Executive Board Member

Welcome and introductions

1. Chris Wormald opened the meeting, noting apologies from members. There was no ministerial attendance due to the House of Commons summer recess and the upcoming party conference season. Since the last meeting of the Board, Theresa May had been invited by the Queen to form a government, and the following junior ministers had subsequently been appointed to the Department:

    - Philip Dunne MP, Minister of State for Health
    - David Mowat MP, Parliamentary Under Secretary of State for Community Health and Care
    - Nicola Blackwood MP, Parliamentary Under Secretary of State for Public Health and Innovation

2. This was Charlie Massey's last Board meeting. He would be leaving the Department on the 31 October to take up post as the Chief Executive of the

General Medical Council. Chris Wormald led members in thanking him for the leadership and commitment he had given to the Department since May 2012.

Board Effectiveness

3. Peter Sands began by explaining that this year's Board Effectiveness Evaluation had been a light touch one in accordance with Cabinet Office guidelines. The results showed a decrease in the confidence of the board when compared to the previous year and an ongoing trend of reduction in ministerial attendance since 2010. The trend in reducing ministerial engagement was also reflected in cross-Whitehall results. Though there was no definitive cause for the further erosion in perceived effectiveness, the loss of Catherine Bell, the interregnum between permanent secretaries, the general election, and the junior doctors' contract had all no doubt played their part.

4. It was noted that across Whitehall there was enormous diversity in models of departmental boards, which resulted in a level of ambiguity of purpose. Some had strong ministerial involvement, with the Secretary of State chairing, whilst others had much less ministerial involvement. In some cases the appointment of a new secretary of state had resulted in increased confidence and effectiveness of the board, whilst in others it had had the opposite effect. The ambiguity surrounding the purpose of Departmental Board needed to be resolved for it to operate effectively.

5. Peter went on to explain that, following the Board Effectiveness Evaluation results, he had spoken with Chris Wormald to agree the basis of a submission to the Secretary of State outlining a range of options for the future of the Board. The submission refocused the Board on the Department, rather than the system; aligning its purpose more strongly to the strategic leadership of the Department, realising the benefit of NED challenge on specific issues, rather than ill-defined and wide-raging areas, and ensuring that new NEDs had the relevant range of skills.

6. Bringing his presentation to a close, Peter advised that he had spoken to Chris Pilling who had expressed his support for the content of the submission. Finally, he explained that this was the Board's opportunity to shape the final content of the submission before Chris Wormald sent it to the Secretary of State.

7. In discussion, the Board made the following points:

   - Members noted the past and future potential value of the Board. Following the Health and Care Act[1], it had been instrumental in ensuring strategic cohesion between the Department and its newly formed ALBs. The Board had also provided valuable guidance on DH 2020.

   - There was agreement that the Board should be the forum for conversations that could not or did not happen anywhere else within the Department, and provide the challenge and perspectives that could only be added by NEDs.

[1] 2012 c. 7

Members agreed that the Board should concentrate on the three themes outlined in the submission: performance, risk and horizon scanning. It was, however, important this was not a prescriptive list; the Board needed to retain the flexibility to provide guidance on other matters such as elections, exiting the European Union and stewardship of the health and care system.

- Members agreed that the effectiveness of the Board was linked to ministerial engagement, as much as it was to executive and non-executive engagement. It was thought that the balance between executive, non-executive and mistrial members was important, though there was a level of ambivalence amongst executive members at the proposed reduction in their membership. Some suggested it may be appropriate for them to attend the Board for the discussions on performance, risk and horizon scanning – especially where there had not been a similar discussion by the Executive Committee.

- Members were concerned by the Secretary of State's continuing lack of engagement with the Board. Chris Wormald explained to members that ministerial attendance at the Department for Education's Departmental Board had been compulsory and enforced by the Secretary of State. He also advised that the Ministerial Code requires Secretaries of State to chair their Departmental Boards. On the proposal that the Secretary of State nominate a junior minster to chair in his absence, members noted that both David Prior and Philip Dunne had appropriate board-level experience.

- Turning finally to the recruitment of new NEDs, there was agreement that it would be necessary to be precise about the skills and experience the Department needed, as well as being clear about the Department's role as steward of the system. Members noted that the culture of the Department was 'consensual', whereas external challenge could be 'fierce, narrow and partisan'. The NED contribution was vital to preparing for the latter. The conversation focussed on the need for digital skills – particularly in relation to data sharing and the Department's relationship with its ALBs. It was also noted that commercial skills would also be important, though it was suggested that this be framed in terms of contact management skills.

8. Bringing the discussion to a close, Chris Wormald confirmed he would amend the submission to take into account the comments made by the Board.

9. **Action: Chris Wormald to amend the submission to the Secretary of State to reflect the comments from the Board.**

Horizon scanning

10. Chris Whitty spoke to his slides. He explained that they outlined some probable trends in the next 20 years – particularly in relation to cardiovascular and cancer. There had been a phenomenal reduction in dementia in men, but not in women. The current understanding was that dementia in men was largely vascular, whilst in women it was largely neural. He explained that the demographics of cities will change: they will import younger people from, and export older people to, rural

and semi-rural areas. As it currently stood, stroke units had been located in areas where the prevalence of stroke would likely decrease.

11. He went on to explain that the UK is part of a global ecosystem affected by external factors. There was the possibility that drugs and devices may become a single market, as could nursing. The UK would soon move from being one of the oldest country in Europe to the youngest, with Germany likely to likely to be the oldest having 31% of its population aged over 65 by 2035. For every two years of life gained, only one of those will be healthy with the other subject to multiple and complex illnesses.

12. The following points were made in discussion:

- Members were concerned that rural and semi-rural general practices and hospitals were simply not prepared for this demographic shift. It was noted there would be a significant lead-time to make the changes necessary to accommodate the changing demographics. It was noted there were numerous linkages with cross-cutting issues, such as transport, urban planning, housing, education, technology, and nation and regional devolution.

- There was acknowledgement that perhaps, in the past, the Department had not been an 'intelligent customer'; it needed to know more about the longer-term and then ask the right questions of the system. It was thought important the difference between problems of today and problems of the future was differentiated. It was also important to differentiate between questions the Department should ask the system, and areas where the Department should make policy.

- The workforce implications were noted as a significant issue. The Board touched briefly on the matter of immigration, noting the problems the aging and aged population of Japan had presented in terms of geriatric care. It was suggested that difficult decisions needed to be made around immigration, similar to those made by Germany. It was noted by members that the General Medical Council did not yet appear to have thought about the future of the workforce.

- There was concern that the Department's current technology agenda was not relevant to this challenge. There appeared to be the need for the management of multiple complex illnesses, rather than there being cures.

13. Bringing the discussion to a close, Chris Wormald confirmed the next horizon scanning session would be on rural-urban, followed by healthy lifespans. Executive members should attend and, where appropriate, relevant academics should be invited to contribute.

Risk

14. Helen Shirley-Quirk, Director of Health Protection and Emergency Response, and Rebecca Sugden, Private Secretary to the Chief Medical Officer, attended for this item.

High Level Risk Register

15. David Williams presented the High Level Risk Register (HLRR) and heatmap to the Board. He explained that the Board's future horizon scanning session should be used to ensure risks entered onto the HLRR are correctly balanced between the long and short-term. It was important the HLRR identified individual ALB risks; particularly those replicated by multiple ALBs and the system more widely. There was a need for the Department to obtain assurance from ALBs that their risks were being identified and, where appropriate, mitigated. He proposed that some mitigations on the HLRR could read more like current plans, rather than a contingent response.

16. Opening to discussion, Chris Wormald asked the NEDs in particular for their observations and suggestions.

- Gerry Murphy expressed the need for the Department to be disciplined in terms of when risks were entered onto the HLRR and when they were removed. The complexities of the system could make it difficult for the Department to identify where work done by one ALB may have an effect on another, with the interdependencies between NHS England and NHS Improvement being a particularly strong example. There was a need for the Department to ensure that mitigations were having the intended effect upon the whole system. The balance between 'strategic' and 'operational' risks was weighted too far in favour of the strategic – a ratio of 9:4. David Williams advised the Board that the HLRR would be referred back to the Audit and Risk Committee on this point.

- Peter Sands thought that the potential for overload in the system was massively underrated. There was a temptation to look at negative trends, at the expense of continued focus on risks with a level or improving trend. Brexit had created new risks, particularly in relation to workforce. On Risk 9 (Obesity), he was concerned that there may not be the political momentum to achieve the Department's previous objectives. He thought the risk could be more meaningfully presented in terms of overall demand for NHS services, of which obesity plays a part – a cumulative rising demand of 4% per annum.

17. Subject to the changes discussed, members agreed the HLRR. They also welcomed the opportunity to consider the HLRR at every Board meeting, and agreed the next deep dive should be on Risk 5 (Leadership (Health & Care System Risk)). It was suggested Ed Smith should be invited to attend to share his insights into cross-system leadership.

18. Action: Risk 9 (Obesity) to be reframed in terms of cumulative rising demand of 4% per annum.

19. Action: The next deep dive to be on Risk 5 (Leadership (Health & Care System Risk).

20. Action: The HLRR to be referred back to ARC for consideration of the point raised by the Board.

Infectious diseases deep dive

21. Helen Shirley-Quirk began by explaining that the Department was the lead government department for infectious diseases and pandemics. There were three known reservoirs of infectious diseases and pandemics: endemic diseases in hot or poor countries, emerging diseases with a high ability to spread, and a deliberate terror attack using a known or unknown biological agent. Whilst relevant to the Department, the latter would not form part of the deep dive.

22. The import of an infectious disease into the UK, though relatively rare, gives rise to the risk of infection of healthcare workers and the general population. This is particularly acute where spread could be rapid, or where there was no known treatment – H5N1, H7N9, and MERS-CoV being contemporaneous examples, with the latter having already been imported into the UK. Early diagnosis by clinicians is essential in preventing spread.

23. The human response to the risk may sometimes be disproportionate, and can drive in two opposing ways. People may overestimate the risk and restrict travel, which would lead to a detrimental impact on the UK's economy. People may also underestimate the risk, which may lead to increased transmission.

24. The Department had been planning for a major outbreak or pandemic for many years, and the UK is recognised as one of the most prepared counties in the world: for example it had invested more in anti-viral stockpiles than most other countries. The Department is taking part in Exercise Cygnus, which would take place between 18 and 20 October 2016 and be modelled on a pandemic scenario. It had been cancelled twice: once because of Ebola outbreak and once because of the junior doctors' walkouts.

25. It was more likely than not that even a moderate pandemic would overrun the system. At the extreme, there would be significant issues if it became necessary to track or quarantine thousands of people. A decision to fund high-end quarantine facilities had already been deferred by ministers.

26. All decisions in response to an outbreak or pandemic would need to be made by the Department, as a department of state, though ALBs would have their role to play. There were, however, concerns about how resilient the somewhat fragmented system would be – especially in light of previous or future funding cuts.

27. Helen Shirley-Quirk concluded by explaining that the question is not necessarily about how much money was spent on tangible assets, such as building new hospitals or stockpiling medicines, rather it was about how much planning the Department and the system should undertake.

28. In discussion, the following points were made:

- Chris Whitty explained that, on average, there is usually one major global infectious disease outbreak per decade; for example, HIV in the 1980s, Ebola in the 1990s, SARS in the 2000s, and Ebola again in the 2010s. Any

infectious disease outbreak would likely be respiratory. He explained that the UK had significant strengths: the world-class academic sector was free to access, and PHE, falling only just behind the USA's Centre for Disease Control and Prevention (CDC), was recognised as the preeminent authority in Europe.

- Members expressed concerns that the basic data a minster would need to make a timely decision may not be available. It was important it was clear which ALB was responsible for providing what data and, where possible, data was provided in real-time. Members noted that during the 2009-10 H1N1 influenza pandemic, individual parts of the system had plans but they were not linked together. For example, ambulances would have continued to take critically ill patients to overrun hospitals. Recent discussions with NHS England – who are ultimately responsible for delivery – in preparation for the proposed five-day junior doctors' strike revealed the tipping point appeared to arrive very quickly.

- Peter Sands explained that he thought not enough was being spent, either globally or nationally. He drew out comparisons between that spent on preparing for an outbreak or pandemic, and the amount spent terrorism prevention or the circa £17bn that has been spent to date on the financial crisis. He explained that the economic impacts of an infectious disease outbreak or pandemic could be significant for the UK. He drew out the comparison even further: the Zika virus had massively affected the tourist economies of South America, more so than it had affected people. There was a general reluctance by populations to believe government advice, especially when there were now so many alternative sources of information. He concluded by explaining that in the USA the military is deeply involved in planning for an outbreak or pandemic; in most part because the government sees bioterrorism as a real and credible threat to national security.

- There was no consensus on how much additional money the Department should spend – if any at all. All members agreed with the evident and inevitable economic impacts of an outbreak or a pandemic, but there was no certainty how this could be quantified and mitigated. It was suggested that the comparison to other national spends may be misleading. On one side it may be that some counties have taken the position that significant contingency planning is unlikely to materially influence what happens during an outbreak or a pandemic. On the other, it may be that there is a desire to undertake contingency planning but the necessary funds have not been secured from their respective governments.

- Members acknowledged that there were similarities between planning for winter, the junior doctors' walkouts and for an outbreak or a pandemic. There was, therefore, the opportunity to reuse the planning already undertaken, perhaps merging it with that undertaken by OGDs for terror attacks.

29. Bringing the discussion to a conclusion, Chris Wormald advised members that, if necessary, the Department would be able to lay emergency legislation under the

provisions of the Emergency Powers Act[2]. Some general legislation had already been drafted, whilst specific legislation would be drafted if required.

Performance: winter planning

30. Kathy Hall, Director of Hospital Productivity, Tristan Pedelty, Interim Deputy Director for Patient Access and from December Principal Private Secretary to the Secretary of State, and Martin Coates, Senior Delivery Advisor, attended for this item.

31. Kathy gave a brief verbal presentation. She outlined that performance for winter 2015-16 had been worse than for 2014-15, and that the system was entering winter 2016-17 in a much worse position than had been the case in 2015-16. The Department was undertaking six strands of work: three preparing for winter, and three for managing winter. The preparation strands had focussed on the A&E Improvement Plan, influenza, and capacity planning, whilst the managing winter strands will focus on communications from October onwards, and escalation, and social care, from December onwards.

32. In discussion, the following points were raised:

- Chris Whitty advised members that emerging data from the southern hemisphere estimated the efficacy of this years' influenza vaccine at around 50%. Though this was an improvement on last year, where the efficacy had been around 20%, it was not at a level that would be considered good – around 70%. Kathy explained to members that last year the weather and respiratory illness had been the two most significant caused of pressure on the system; this may also be the case this year.

- The Board were advised that the number of elective surgeries was consistent across the year. Members noted that, whilst cancelling elective surgeries it had been an option last winter, it had been too late to take action when it became clear the access standards would not be met. Members discussed whether an incentive could be offered toward an elective summer bias, but noted that there was scarce capacity in the system, even during the summer, for there to be an immediate switch.

- The NEDs were keen that there was a change in discourse, particularly in relation to the way the media portrayed the movement of winter monies from HM Treasury, though the Department to providers. This should be presented as the ordinary course of things; a sensible and proportionate response to winter pressures. Members were advised that the Department did not provide emergency funding last year – it had been a front-loaded payment. It was noted by members that there was an ongoing debate concerning who should hold winter monies: the Department, NHS England, CCGs or providers, specifically some of the larger – multi-billion pound – trusts.

[2] 1964 c. 38

- Members agreed that social care was a concern. There was a risk that some local authorities may attempt to sequestrate money from the care budget for other purposes. The Department was able to safeguard continuing service provision as it had the statutory power to request inspection by the Care Quality Commission. This power had never been exercised, and it was not known if there would be the political appetite for it in any event. Tamara Finkelstein advised members that there would be a meeting between the Department and the Department for Communities and Local Government next week where this would be discussed, as would the regular exchange of data.

33. Bringing the discussion to a close, Chris Wormald explained that it was important a tight grip was kept on the system; particularly on the multi-billion pound trusts who should be able to cope with the (relatively) small variation in demand over winter. He advised members that the Executive Committee would be reviewing the situation on a monthly basis until next year.

Any other business

34. No items were raised.