Public Health England

Minutes

Title of meeting	Public Health England Advisory Board	
Date	Monday 22 July 2013	
Venue	Conference Room, PHE Headquarters, London	
Present	David Heymann	Chairman
	George Griffin	Non-executive member
	Martin Hindle	Non-executive member
	Paul Lincoln	Associate non-executive member
	Derek Myers	Non-executive member
	Richard Parish	Non-executive member
	Duncan Selbie	Chief Executive
External speakers	Philip James	International Association for the Study of Obesity
	Klim McPherson	Oxford University
	Charlie Powell	Sustain
	John Wass	Oxford University / Churchill Hospital
In attendance	Tim Baxter	PHE Sponsor, Department of Health
	Lis Birrane	Director of Communications
	Jamie Blackshaw	Nutrition Advice, Health and Wellbeing Directorate
	Michael Brodie	Finance and Commercial Director
	Kevin Fenton	Director of Health and Wellbeing
	Rufus Greenbaum	Member of the public
	Anthony Kessel	Director of Public Health Strategy and Research and Development
	Victor Knight	Board Secretary (minutes)
	Gemma Lien	Corporate Secretary, Legal (minutes)
	Jonathan Marron	Director of Strategy
	Heather Morley	Head of Corporate Secretariat
	Alex Sienkiewicz	Chief of Staff
	Alison Tedstone	Nutrition Advice, Health and Wellbeing Directorate
	Sally Warren	Director of Programmes

1. Public Health Priority – Panel discussion : Obesity (Enclosure PHE/13/01)

13/001 The Director of Health and Wellbeing opened the discussion and welcomed the panel members. PHE was at the beginning of a journey in terms of thinking through its strategy for obesity and healthy weight management and it was therefore an ideal time to seek input and challenge from the Advisory Board ("the Board"). It was important for the strategy to be fit for purpose today but at the same time it needed to enable PHE to be ready for the challenges that would undoubtedly arise in the future. The ability to be nimble, reflective and responsive would be crucial to delivery of the strategy.

13/002 By way of background, adult men in England were more overweight than women, although there was an increasing prevalence in younger women. The prevalence of obesity doubled in children between the beginning and the end

of primary school.

13/003 According to data from the National Child Measurement Programme, one in five children aged 4-5 years and one in three children aged 10-11 years was overweight or obese. Obesity was correlated strongly with deprivation and was highest in the most deprived areas.

13/004 PHE needed to create a step change in how stakeholders and the population as a whole worked together to make our environment, places, lifestyles and diets healthier and do this in a way that reduced the gap between the most and the least deprived. Tackling obesity was a complex issue involving many players across multiple sectors. PHE would work with partners to rebalance approaches and influence policy at national level.

13/005 PHE's obesity programme comprised a multidisciplinary team who would lead new conversations at national level and drive forward a shift in approach. They would advise and support local authorities, for example, by building on the Change4Life campaigns and through local toolkits. PHE would analyse and assimilate the evidence base to support and enable them to leverage and maximise a whole system approach.

13/006 The programme's focus was on tackling overweight and obesity across the life stages and to contribute towards the delivery of PHE's enduring priority to help people live longer and more healthy lives. It would report to two of PHE's corporate programme boards: 'reducing preventable deaths across the wider population' (CP1) and 'giving children and young people the best start in life' (CP4).

13/007 A PHE Obesity Network would be established to act as a learning and engagement platform to inform and support obesity activity across the health and care system, the membership of which would be drawn from across PHE and its stakeholders.

13/008 The measure by which PHE would judge success was a sustained downward trend in the level of excess weight in children by 2020, together with a downward trend in the level of excess weight averaged across all adults.

13/009 The panel members reflected on the factors that contributed to obesity as well as to the Foresight report[1]. Weight gain was a response of the human body to its environment. Levels of obesity had increased since the early 1980s as a result of lifestyles becoming more sedentary, with less manual labour jobs and greater use of technology.

13/010 Government intervention had resulted in a 15% reduction in the obesity rate in France between 1998 and 2007. There were useful lessons that could be learned from this experience, including on the importance of engaging local government, schools and wider communities.

13/011 The planning system could be used to help tackle obesity, for example, by ensuring availability of green space in urban areas and that fast food outlets were not in close proximity to schools.

13/012 Food consumption was a function of price, availability and marketing. The

[1] http://www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesities/reports-and-publications

price elasticity of various food components was known, as was the impact of price increases in reducing consumption.

13/013 The food marketing industry was considered to be a powerful force, one of whose targets was children. It was suggested that PHE could make recommendations to government on how to tackle unhealthy food marketing. The Advertising Standards Authority should be engaged to ensure that they fully appreciated the issues associated with food marketing to children.

13/014 The panel suggested that PHE could develop a clear strategy on junk food and consider how to discourage consumption of sugary soft drinks. A recent study involving 16 to 18 year olds had found that a 20p levy on sugary drinks was likely to result in a dramatic reduction in consumption.

13/015 The panel considered there to be a fragmented approach to obesity within the public health system, for example, some initiatives were commissioned by Clinical Commissioning Groups and some by local authorities. There was no overarching coordination between health visitors, schools and general practitioners, some of whom were apparently reluctant to address patients' weight issues. There was a great opportunity for PHE to ensure better co-ordination and, at a national level, to work better across sectors. The panel encouraged PHE to aim high with the goal being that England should be the first country in the world to successfully tackle the problem of obesity.

13/016 The Chairman thanked the panel for their contribution and invited members to comment.

13/017 Education would be critical in tackling obesity effectively. Martin Hindle, in his capacity as Chairman of the East Midlands Academic Health Science Network, offered to pilot a PHE-led project on obesity across its membership, which was drawn from the health, industry and academic sectors.

13/018 The impact of nutrition and obesity during pregnancy on the weight of children was highlighted. Birth weight could be addressed through education and ante-natal training. There was scope for improved education and awareness on the importance of nutrition through its inclusion in medical and nursing schools' curricula. When presenting advice to government on potential policy interventions, it would be important to be able to clearly demonstrate the cost/benefit and wider benefit to the health and care system. It was suggested that initiatives delivered by local government were likely to be implemented at a faster rate than those developed and implemented at a national level.

13/019 The panel strongly supported the approach to working with other government departments and the voluntary and community sector. It was suggested that there was a clear link to sustainable development and modelling of food health subsidies and incentives should be undertaken. The public sector was in a strong position to exercise its collective purchasing power to change patterns of diet and consumption, particularly in the NHS and local government.

13/020 The panel responded to a number the points raised during the discussion:

a) the soft drink tax in France was considered to have been a success and was supported by three quarters of the population. Approximately half of the revenue raised had been invested in the health sector;

b) a mother's weight before and during pregnancy was known to be a key factor in determining birth weight. It was, however, important to recognise that one of the most commonly used standards for singletons (ie. not twins, triplets etc) was derived from a series of births to women in Aberdeen between 1948 and 1964. This had been a historically deprived environment with corresponding levels of malnutrition with the result that the weight gain encouraged during pregnancy based on this data was likely to be much greater than it would be today;

c) it was important to bear in mind that although a Body Mass Index of 25 was used as a cut-off point for defining what was overweight, the increase in BMI from 20 to 25 should also be a cause for concern;

d) local and national initiatives should be joined up. It would be important not to rely on education alone in tackling the problem;

e) the public sector was the largest purchaser of food. This could therefore be an area of great importance for PHE to focus on;

f) it was not clear what the role of the Food Standards Agency (FSA) was with respect to obesity and how PHE and the FSA would work together on this. The Chief Executive advised that the two organisations were already working closely together; and

g) whilst macro nutrition was important to consider, the micro level would also be an important factor in tackling wider health issues, for example, vitamin D levels.

13/021 The Chairman and Chief Executive warmly thanked the panel for their contributions.

2. Introduction, apologies, declarations of interest

13/022 There were no apologies.

13/023 Paul Lincoln advised that the UK Health Forum, of which he was Chief Executive, was a member of the Smokefree Action Coalition and the Alcohol Health Alliance.

13/024 Richard Parish advised he was the outgoing Chief Executive of the Royal Society for Public Health.

3. Chief Executive update

13/025 The Chief Executive advised that:

a) PHE was a signatory to NHS England's "Call to Action", which focussed on the provision of healthcare to the sick and ill;

b) PHE planned to develop a Health Plan for England, the scope and timing of which would be agreed with Ministers;

c) the Framework Agreement, which defined the relationship between PHE and the Department of Health, had been shared with HM Treasury and was expected to be published in September. The document enshrined PHE's right to publish without fear or favour and to speak the truth to government from the evidence whenever the occasion demanded. The Board was pleased that this right had been made clear

in the Framework Agreement and emphasised the need for evidence published by PHE to withstand robust scrutiny; and

d) neither standardised packaging nor minimum unit pricing would be taken forward for the moment by government. With tobacco and alcohol being among the nation's top killers this was, however, hopefully a case of not now, rather than never. Both the Prime Minister and the Secretary of State had made clear that they were open to further evidence emerging. It was important to remember that nine out of ten smokers begin as children and helping them make better choices was a child protection as well as a public health concern. Likewise, there was strong evidence that doing all we could to reduce the ready availability of cheap, higher strength alcohol helped the youngest and the heaviest drinkers most. It would be important to keep abreast of development with respect to EU rules on packaging and to develop a timeline for public health action with advice from the Director of Health and Wellbeing and the Chief Knowledge Officer. The Board considered that England should be ahead of other nations in these matters and asked the Chief Executive to make this known to Ministers.

4. Delivering on our priorities (Enclosures PHE/13/02, PHE/13/03 and PHE/13/04)

13/026 The Board was pleased that the document (PHE/13/02) had been published in the first month of PHE's existence and the clear direction of travel that it signalled. Going forward, it was suggested that disaster management and sustainability in relation to weather events were worth highlighting, as well as the public health impact of incidents like 9/11.

13/027 The Director of Programmes summarised the governance arrangements that had been established to ensure delivery of PHE's priorities. Corporate programme boards had been established, which included stakeholders such as local government where appropriate in order to ensure feedback on implementation from a local perspective. The Director of Programmes would receive a monthly report on each programme and would then report to the National Executive on key issues and risks.

13/028 The Board would receive quarterly reports, the output of which would be shared with the Department of Health as part of the quarterly accountability meetings with them.

13/029 The Board was satisfied with the arrangements that had been put in place and asked that they be supported by a resource plan.

13/030 Once the corporate programme boards were fully up and running in the coming months they would generate quantitative information for inclusion in reports to the National Executive and the Board.

13/031 There was discussion about the ways in which non-executives could be engaged in addition to considering the quarterly reports. It was suggested that there should be a biannual engagement between the Board and National Executive and that non-executives could focus on a particular programme to provide informed support and challenge.

13/032 The Director of Strategy introduced the proposed PHE scorecard, which sought to capture at a high level how the public health system was delivering and how PHE was performing, including on financial stability and whether the needs of stakeholders were being met.

13/033 The Board was satisfied with the overall style and approach and suggested that:

a) the public's perspective itself should be more obviously highlighted amongst the stakeholders;

b) there should be more emphasis on trends in performance; and

c) on financial performance, assurance should be provided on how the local government specific grant was being used.

5. Non-executive engagement

13/034 The Director of Communications proposed ways in which non-executives could be best engaged with the organisation, which would include receipt of the weekly Directors' Brief. They were welcome to contact the Communications team to raise and discuss any points of clarification. There were a number of events that non-executives could attend if they so wished and they could perhaps partner a PHE Centre to understand issues faced by frontline staff and raise the profile of the Board. The Director of Communications would send out a note after the meeting and coordinate with the Board Secretary. The Chief Executive was keen that non-executives were visible and to this end there should be a routine invitation to staff events through the Secretary so that they were engaged to the extent they wished.

6. Global health

13/035 The aim of PHE's global health work, which built on that carried out by the former Health Protection Agency, was to:

a) support lower and middle-income countries;

b) fulfil its duties under the International Health Regulations 2005; and

c) continue to develop relationships with the 'BRIC' countries (Brazil, Russia, China and India) and Commonwealth countries.

13/036 PHE's activity took the form of projects, secondments and missions, recent examples of which included South America, India, Taiwan and Vietnam.

13/037 The mass gatherings surveillance tool that had been developed by PHE had been used at Glastonbury and the pilgrimage to Mecca. In South Africa the National Institute for Communicable Diseases had received a secondment leading to 30 exchanges of staff and a nationwide survey of tuberculosis. Other engagements had included a World Health Organisation mission in Sierra Leone concerning a cholera outbreak, a recent chemical incident in Hungary and coronavirus in Qatar.

13/038 PHE was assisting 13 UK overseas territories and Crown dependencies which were not yet compliant with International Health Regulations by supporting them in providing a surveillance and response capability. Kenya, Uganda and the International Association of Public Health Institutes (IANPHI) had invited PHE assistance and there were emerging links with the International Rescue Committee in the United States of America.

13/039 The importance of non-communicable diseases was emphasised, recognising the decision of the United Nations General Assembly to convene a high level meeting on non-communicable diseases in 2011.

13/040 The Department of Health had provided funding to support the global work over the past years and discussions were now underway on its renewal.
The Board noted the overview and suggested that UK-based non-governmental organisations could provide useful advice and support. It considered there to be significant value in these global experiences and learning from the public health issues faced elsewhere.

7. Development of the Corporate Risk Register

13/041 The Chief of Staff reported on the development of the PHE risk register, a process which would be supported by George Selim, Emeritus Professor of Internal Auditing in the Faculty of Management at Cass Business School.

13/042 The Board **NOTED** the developments.

8. Finance report

13/043 The Finance and Commercial Director advised that:

a) full year net expenditure was £3,560.1m;

b) the forecast outturn incorporated a £10m non-recurrent development budget to enable PHE to deliver public health outcomes through greater collaboration and innovation;

c) product and service sales were shown in summary, and were expected to be on budget by the end of the financial year; and

d) together with the Director of Strategy, he would be undertaking a review of PHE's commercial activities with a view to identifying areas of opportunity and improvement.

13/044 The Board **NOTED** the finance report.

9. Minutes of Reporting Committees

13/045 The Chair of the Audit Committee introduced the minutes of its first meeting. These included the completion of the Annual Report and Accounts 2012/13 for the Health Protection Agency and the National Treatment Agency for Substance Misuse.

13/046 The Board **ENDORSED** the minutes, subject to their approval by the Audit and Risk Committee at its next meeting.

10. Advisory Board appointments

13/047 The Board **AGREED** the following appointments:

a) George Griffin and Martin Hindle to be additional members of the Audit and Risk Committee;

b) Martin Hindle to be a member of the Programme Board of the PHE Science Hub; and

c) Martin Hindle to chair the annual meeting of the Pay Committee.

11. Governance documents

13/048 The Board **AGREED** its Terms of Reference and the adoption of the *Code of Conduct for Board Members of Public Bodies*, which had been published by the Cabinet Office in June 2011.

13/049 The Chair informed the meeting that nominations for an observer from each of the Devolved Administrations had been invited from their Chief Medical Officers.

12. Information items

13/050 The Secretary presented the schedule and topics proposed for future meetings, including the change of date of the first meeting of 2014 to 3 February. An additional meeting would be held in October 2013 subject to availability of members.

13/051 The acceleration of genetic science should be covered at a future meeting, the timing of which would be agreed with the Chief Operating Officer. **Board Secretary**

13. Questions from the public

13/052 Mr Greenbaum had submitted a question in advance asking whether PHE had any plans for active programmes to promote "preventative health" but, having observed earlier discussions at the meeting, considered that this was being addressed. Mr Greenbaum then referred to four questions he had put to the Scientific Advisory Committee on Nutrition (SACN) in February 2010. While not criticising SACN, he was concerned that its remit was the assessment of nutritional risks but not the management of those risks. Mr Greenbaum invited PHE to consider and act upon his suggestions and provided four books on the matter to the Board. The matter would be referred to the Director of Health and Wellbeing. **Director of Health and Wellbeing**

14. Any other business

13/053 None. The next meeting would be held on 25 September 2013 at 10am.

Victor Knight
Board Secretary
July 2013