Public Health England

PHE Board Minutes

Title of meeting	Public Health England Board, meeting held in public	
Date	Monday 3 February 2014	
Present	David Heymann	Chair of PHE
	George Griffin	Non-executive member (by teleconference until min ref PHE/14/066)
	Sian Griffiths	Associate non-executive member
	Martin Hindle	Non-executive member
	Paul Lincoln	Associate non-executive member
	Duncan Selbie	Chief Executive (until min ref PHE/14/066)
External Panel	Deborah Arnott	Chief Executive, Action on Smoking and Health (until min ref PHE/14/066)
	Alison Cox	Head of Tobacco Policy, Cancer Research UK (until min ref PHE/14/066)
	Gerard Hastings	Professor, Institute for Social Marketing, Stirling University (until min ref PHE/14/066)
	Ailsa Rutter	Director, Fresh North East (until min ref PHE/14/066)
In attendance	Tim Baxter	PHE Sponsor Unit, Department of Health (until min ref PHE/14/066)
	Joanne Bosanquet	Deputy Director of Nursing and Midwifery (from min ref PHE/14/036 until min ref PHE/14/066)
	Michael Brodie	Finance and Commercial Director (from min ref PHE/14/067)
	Paul Cosford	Director for Health Protection and Medical Director (from min ref PHE/14/036 until min ref PHE/14/066)
	Martin Dockrell	PHE Tobacco Lead
	Kevin Fenton	Director of Health and Wellbeing (until min ref PHE/14/066)
	Richard Gleave	Chief Operating Officer (from min ref PHE/14/036 until min ref PHE/14/048)
	Graham Jukes	Chief Executive, Chartered Institute of Environmental Health (until min ref PHE/14/066)
	Ayesha Khan	Member of the public
	Shakira Mokhtar	Member of the public
	Victor Knight	Board Secretary
	Gemma Lien	Legal Corporate Secretary (minutes)
	Jonathan Marron	Director of Strategy (until min ref PHE/14/066)
	Eugene Milne	PHE Director of Adults and Older Adults (until min ref PHE/14/066)
	Heather Morley	Head of Corporate Secretariat (minutes) (from min ref PHE/14/036)
	John Newton	Chief Knowledge Officer (from min ref PHE/14/036 until min ref PHE/14/066)
	Rosanna O'Connor	Director, Alcohol and Drugs, Public Health England (until min ref PHE/14/066)
	Elaine Rashbrook	Population and Behavioural Health, Public Health

		England (until min ref PHE/14/066)
	Neeraj Shah	Member of the public
	Alex Sienkiewicz	Chief of Staff
	Quentin Sandifer	Observer for Wales
	David Walker	Deputy Chief Medical Officer (until min ref PHE/14/066)
	John Watson	Deputy Chief Medical Officer (until min ref PHE/14/066)
	Lesley Wilkie	Observer for Scotland
	Sarah Williams	Member of the public
Apologies	Derek Myers	Non-executive member
	Richard Parish	Non-executive member

Announcements, apologies, declarations of interest

14/001 The Chair welcomed everyone to the meeting.

14/002 The Chair introduced Professor Sian Griffiths, the new associate non-executive member of the Board, the Chief Executive of the Chartered Institute of Environmental Health, the Observer from Wales, and the Deputy Chief Medical Officers.

14/003 The Board **AGREED** the appointment of Dr Lesley Wilkie as the Observer from Scotland.

14/004 Apologies had been received from non-executive Board members Derek Myers and Richard Parish.

14/005 The following declarations of interest were made:

a) Martin Hindle declared an interest as a non-executive member of the Medicines and Healthcare Products Regulatory Agency (MHRA) and as the independent chair of the East Midlands Academic Health Science Network; and
b) Paul Lincoln declared an interest as Chief Executive of the UK Health Forum which supported various anti-smoking campaigns.

14/006 PHE had provided a submission to the independent review into standardised packaging of tobacco products being led by Sir Cyril Chantler, which was expected to report in March 2014. Therefore, Board discussion on this aspect of tobacco would take place at a later date.

Panel discussion: Tobacco

14/007 The Director of Health and Wellbeing introduced the expert panel and his colleagues working on tobacco control in the Health and Wellbeing Directorate.

14/008 There was a great deal of evidence on the harmful health effects of tobacco use. However, there were new and emerging products to the market for which new evidence on health effects was required. Regional tobacco control networks had also been challenged by economic austerity and changes to the public health system. PHE aimed to provide national leadership for tobacco control.

14/009 Since 1998, tobacco control efforts in the UK had resulted in in a reduction in the number of children smoking from 11% to 4% (in England), and in adults from 28% to 20% (in Great Britain). Whilst the UK was one of the

world leader's on tobacco control, tobacco consumption still contributed to a high burden of disease and reduced life expectancy.

14/010 There was a risk that the need to deliver significant costs savings in local authorities could undermine tobacco control efforts if public health experts were not fully involved in policy making decisions. The National Institute for Health and Care Excellence (NICE) recognised the public health benefit of smoking cessation services, but these were not mandatory. There had been a reduction in the number of regional tobacco control officers in England.

14/011 Action on Smoking and Health (ASH) had produced the CLeaR standard which could be used to implement evidence based local action.

14/012 Feedback from the local level to ASH was that PHE was seen as too passive on the issue of tobacco control and there was an appetite for a more proactive approach and response. PHE should focus on providing a national leadership role and needed to act with pace to realign its resources to address this.

14/013 ASH considered that PHE should focus on providing evidence-based support and should encourage Directors of Public Health at the local level. The UK still had over 9 million smokers; It was estimated the government spent £2.7billion each year on health-related issues caused by tobacco use.

14/014 ASH recognised that whilst efforts to help people stop smoking should remain a priority, many people either did not wish to stop smoking or found it very hard to do so. Better access to nicotine substitution products, which should be properly regulated to ensure product safety, would assist. There was as yet little evidence about the potential for harm from electronic cigarettes (e-cigarettes), especially in comparison to harm from smoking.

14/015 ASH's messages on e-cigarettes were that they were less harmful than smoking tobacco; they should only be promoted to existing smokers; regulation was necessary and should be promoted; there should be prohibition on promoting e-cigarettes to non-smokers and particularly to the young; there should be consistency with NICE guidance on harm reduction, which supported the use of licensed nicotine products as an aid to cutting down or quitting smoking and as a substitute for smoking; and there should be surveillance of the market so that any normalisation of e-cigarette use would be apparent.

14/016 PHE needed a clear position on this issue and to provide system leadership.

14/017 Cancer Research UK had commissioned an Endgame Report, which contained case studies of six leading tobacco control jurisdictions, an analysis of the current UK context derived from interviews with leading tobacco control academics and advocates, and provided strategic considerations and a set of mid-term and long-term recommendations.

14/018 The 'endgame' strategy for tobacco included the need to set bold targets for achieving a tobacco free future and was valuable for future tobacco control planning in the UK.

14/019 Endgame thinking had generated a number of academic papers and conferences and had proved attractive to governments wanting to make a bold health policy commitment. The question was whether England should match the ambitious targets set for becoming tobacco free in Ireland (2025) and Scotland (2034). The WHO European Regional Office was also considering a target of a tobacco free region by 2040.

14/020 However, such a target would require commitment, accountability, careful planning and modelling. Different types of strategies would need to be employed, for example reducing the nicotine content of tobacco products, reducing the number and concentration of retail outlets and setting limits on the volume of tobacco that could be imported and sold.

14/021 A key recommendation of the report was that in order to enable the UK to make significant progress, there would need to be a policy environment more receptive to step changes in tobacco control. To achieve this it would be necessary to shift the narrative and to address the influence of the tobacco industry, in light of Article 5.3 of the WHO Framework Convention on Tobacco Control. It would also be critical to take a clear position with regard to the use of e-cigarettes. Finding a way forward with harm reduction that maximised the opportunity, minimised the risks and maintained the community broad consensus would be crucial to success.

14/022 Endgame thinking was not just about new policy lever ideas and modelling on how to change the prevalence trends graph. Its value lay in delivering effective change in how to communicate and build support for an end to the tobacco epidemic as well as making bold commitments to achieve it.

14/023 A regional perspective on tobacco control could be seen in the Fresh North East organisation, established in 2005 as the UK's first dedicated regional tobacco control office when the North East had had the highest smoking rates in England. The office had enjoyed success and, over the first five years, smoking rates had declined in the North East at twice the national rate.

14/024 The 'vision' for tobacco control varied greatly between different local authorities. Some were interested in the emerging discussions around the endgame for tobacco and had a strong commitment towards reducing smoking rates and narrowing health inequalities. This contrasted with other local authorities that had struggled to see where their role fitted in relation to the local, regional, national and international aspects of tobacco control, and that no longer considered tobacco control a priority. PHE leadership was needed in this area to continue to reinforce the role that tobacco control would need to continue to play for many years ahead, to tackle health inequalities and to work towards the endgame for tobacco.

14/025 PHE also needed to reinforce the evidence base on the impact of tobacco use on health inequalities and the gap in life expectancy. Tobacco control was beginning to be viewed in some local authorities as not as important as addressing the "causes of the causes" of ill health and social factors such as employment and poverty. A clear specific focus on tobacco cessation support, proactive regulatory services, implementation of NICE guidance across the NHS and good amplification of national media campaigns was necessary.

14/026 Funding for the remaining regional tobacco programmes remained unstable, which made it difficult to plan and sometimes hampered innovation. Support from PHE was needed on this issue. Regional programmes that could provide significant benefits to PHE could:

a) provide expertise across all aspects of tobacco control;
b) allow local commissioners to benefit from economies of scale,
c) provide leadership, vision and strategy;
d) foster a continued social movement around smoking; and
e) lead on advocacy.

14/027 NICE had modelled a level of tobacco control between the local and national at £0.40 per head. In London this would mean spending £3.3 million to have a regional tobacco control office generating savings of some £6 million.

14/028 Concerns were raised over e-cigarette marketing. The key drivers of success in tobacco control were policy measures, such as smoke-free places and taxation, and the de-normalisation of smoking. It was clear that marketing had a huge influence over social norms.

14/029 A key message was on inequalities as nicotine addiction cost money and impacted most on disadvantaged communities. It was important not to disempower smokers who hoped to overcome their addiction through use of e-cigarettes. Health promotion had a straightforward message: that how people lived their lives directly affected their health and life expectancy.

14/030 The external panel considered that the tobacco industry had already begun to use the marketing of nicotine containing products to promote its core business of tobacco. Nicotine was too easily accepted in e-cigarettes. The advertising of e-cigarettes was just like tobacco cigarettes with packaging and lifestyle images. It was important to bear in mind that adults very rarely took up smoking and that the majority of smokers started when they were children.

14/031 The panel recommended that PHE should focus on de-normalising smoking, lead the push against the tobacco industry and ensure that smokers were empowered to quit.

14/032 The Chair made a summary of the expert panel's comments. They considered that PHE had been too passive in its approach to tobacco control and it needed to rethink its strategy in supporting the work of local authorities and implementing NICE guidance. The endgame for tobacco needed to be addressed and smokers needed to be empowered to quit.

14/033 Board members commented on the public health benefit of tobacco control. In particular, the link between tobacco use and health inequalities was of great concern. PHE should focus on those areas where it would have the greatest impact. It was also noted that regional activities could bring good results.

14/034 PHE needed to harness the evidence base and ensure that local tobacco control resources and levers had not been lost in the transition of the public health system. It was noted that there was cross-party support for tobacco control and that PHE should build on the momentum. A UK approach would bring the greatest impact, and help to address undue influence from the tobacco industry, in accordance with Article 5.3 of the

WHO Framework Convention on Tobacco Control. Educating children about the dangers of smoking was crucial.

14/035 The Observer for Scotland highlighted the importance of strong leadership and raised concerns that the use of e-cigarettes, which risked renormalising smoking in public places. The 2014 Commonwealth Games in Scotland would be e-cigarette free. Following successful resolution of tobacco industry legal challenges, the Scottish Government had implemented a ban on self-service tobacco vending machines and a tobacco display ban in shops.

14/036 The Observer for Wales reported that Public Health Wales had published a position statement on e-cigarettes. This statement did not yet represent Welsh Government Policy but had been produced to provide consistent professional advice to the public and to Public Health Wales' partners and service users.

14/037 The position statement advised that:

a) smokers who wished to quit or reduce their smoking, should be advised to access one of the free NHS services providing scientifically proven support including a range of tested nicotine replacement products;
b) the promotion of e-cigarettes or electronic nicotine delivery systems should be strictly limited to smokers only. It should not promote the concept of safe smoking and should only be used as a way to cut down and quit. Whether any marketing should be allowed at all required urgent review;
c) their use should be prohibited in workplaces, educational and public places to ensure their use did not undermine smoking prevention and cessation by reinforcing and normalising smoking;
d) electronic nicotine delivery systems should not be available to people under 18. Anything that might increase their appeal to children should be avoided, for example, flavouring or packaging;
e) promotion should not appeal to non-smokers, in particular children and young people. This could include product appearance and the use of plain packaging in order not to attract people into using it. There should be no flavoured products;
f) research was needed to increase the understanding of electronic nicotine delivery systems with particular regard to their safety, effectiveness, role in normalising smoking behaviour and role as a gateway to nicotine addiction and smoking, particularly in children.

14/038 It was noted that there was a lack of a singular message in the public health system on the use of e-cigarettes. A clear, simple message needed to be communicated to the public and implemented into policy effectively. There was a great need to gather an evidence base on the role of electronic nicotine delivery systems in normalising smoking behaviour.

14/039 The Chief Executive of the Chartered Institute of Environmental Health highlighted the importance of smoking cessation support services. His organisation and members had been intimately involved in controlling smoking in public places and was now aware of the lack of a single, overarching, message. It was very important that this was simple and enforced. Whatever was decided on the cigarettes had to be clear, simple and enforceable in practice and there should be agreement on de-normalisation.

14/040 The Director of Health and Wellbeing noted the need to invest in tobacco control capacity both in PHE and in the public health system. PHE would provide national leadership and support the strengthening and development of regional tobacco control networks. The Health and Wellbeing Framework being developed by PHE provided a good opportunity to promote tobacco control, and would help inform a future endgame strategy for tobacco.

14/041 Where there was any uncertainty, including on the evidence, PHE needed to be honest about this. PHE had commissioned updates of evidence reviews and would continue to monitor the development of evidence in this field, and to closely follow international developments in research. It would also look to commission research in those areas where there was not yet an evidence base.

14/042 PHE was convening a symposium on e-cigarettes in April 2014. This would comprise diverse experts to explore issues around e-cigarette use, promotion, safety and regulation and would help to inform actions for PHE to prioritise in the short and medium term.

14/043 The panel observations would be listed for PHE to consider further.

Update from National Executive
Report from the Chief Operating Officer

14/044 The Chief Operating Officer thanked Martin Hindle for his contribution to the Science Hub programme.

14/045 A Programme Assurance Review had been carried out to terms of reference agreed between PHE and the Department of Health. This bespoke review had concluded that the vision for the Science Hub had been developed and could be articulated clearly by the programme leadership. PHE had been advised to make clear the links to government policy objectives and to the delivery of tangible benefits. Further work was being carried out to communicate across other government departments at a more senior level.

14/046 The Board member on the programme board confirmed that PHE was taking a disciplined and structured approach to the programme. This was appropriate to a potential investment of up to £500m of public money. Timescales were tight because the target date for a decision on the Outline Business Case was December 2014.

14/047 The amber rating from the Review was appropriate for a programme on track to be delivered on time, but with some issues to be addressed to ensure delivery. Ratings from previous reviews had also been amber.

14/048 The Chief Operating Officer would arrange a meeting to brief the most recently appointed member of the Board, Professor Griffiths. **Chief Operating Officer**

Report from the Deputy Director of Nursing

14/049 The Deputy Director of Nursing reported on behalf of the Director of Nursing. The Directorate was a small one, providing professional leadership to the 320 nurses employed across PHE and embedded in NHS England Area Teams. The aim was to raise the profile of public health nursing and midwifery, maximise the potential and measure the impact of the nursing and midwifery contribution to improving and

protecting the public's health. This included: providing national strategic leadership in public health nursing and midwifery; providing professional leadership for nurses in public health roles, including public health practitioners and other nurses working in public health roles outside the NHS as well as supporting and developing PHE employed nurses to participate in PHE at strategic as well as operational levels as part of PHE's workforce development commitments.

14/050 Key areas of the current work programme included contributing to the development of PHE's assurance framework, leadership of Corporate Programme 4 and producing standardised job descriptions for public health nurses. Preparations were underway for the introduction of nurse revalidation from 2015. Relationships had been established with Health Education England, NHS England, NICE and academic colleagues.

14/051 The Public Health Nursing Award had attracted a number of applicants in its first year. The second PHE nursing conference would take place on 1 July, following an oversubscribed conference in 2013. Consideration was being given to drawing on secondees to supplement the Directorate's resources.

14/052 It was **AGREED** to brief the Board at a future date on the transfer from NHS England to local government from 2015 of responsibility for commissioning of public health services for children aged 0-5 years. **Deputy Director of Nursing & Midwifery**

Report from the Director for Health Protection and Medical Officer

14/053 The Director of Health Protection and Medical Officer highlighted some recent activities. PHE had played a significant role in responding to the threat to health from flooding in the Somerset Levels, alongside Directors of Public Health and other partners in the emergency response system. PHE had been providing support to COBR and to the Department of Health on prevention against infectious disease. Local government, local and national teams from PHE, and the Department of Health had worked well together and the emergency public health system was effective.

14/054 Much of the influenza season had now passed without surges in the number of cases in England. Higher levels were being experienced in the United States, and levels were now increasing in England to an extent which had triggered, on PHE advice, the Chief Medical Officer to authorise the use of antivirals in certain groups. Vaccination rates in eligible groups were about the same as in recent years, leading some to express a wish to do better in the future, but it had been noted that vaccination rates in England were the second highest in the world. Seven pilots were underway in primary schools as part of the process of implementing childhood vaccination. The aim was to vaccinate all children up to the age of 16 years, within a few years.

14/055 The National Sustainable Development Strategy had been launched jointly by PHE, local government and NHS England. A copy of the Strategy would be circulated to the Board. **Director of Health Protection**

14/056 The Board would be briefed at a future meeting on the work being undertaken to ensure total clarity on roles and funding in the new public health system for health protection. **Director of Health Protection/ Chief Operating Officer**

Report from the Chief Knowledge Officer

14/057 The Chief Knowledge Officer reported on the successful integration of several disparate and teams from sender bodies into a well performing national team. Further consolidation would be taking place shortly.

14/058 The draft PHE Knowledge and Intelligence Strategy had been well received in consultation, and would now be implemented. The priority was to provide the knowledge required to support local government in the execution of their duty to improve the health of the public in their respective areas.

14/059 The number of datasets was being extended. In recognition of the benefits of creating a single cancer registry, PHE had now been asked to develop a new register of rare diseases.

14/060 The Directorate continued to build partnerships, including with the Care Quality Commission, NHS England, NICE, the MHRA and the Office of National Statistics. Work was underway in conjunction with the Director of Health and Wellbeing to achieve a more strategic focus on end of life, pharmacy and diagnostic services from the Directorate's large flow of outputs.

14/061 An update of Public Health Outcomes Framework data would be published the following day, providing a complete view of the health of the population. There was potential to make much more of the Public Health Outcomes Framework in the coming year. The work plan also reflected areas of particular interest to the Secretary of State, together with the statutory obligations PHE exercised on his behalf in relation to fluoridation.

Report from the Director of Health and Wellbeing

14/062 The Director of Health and Wellbeing reported that three health marketing campaigns had been launched since the beginning of the year, the latest on breast cancer screening for older women, which was led by the Regional Director London.

14/063 It was important for PHE's campaigns to be subject to academic evaluation in order to build a base of evidence. Evaluations of the "Stoptober" and "Be clear on cancer" campaigns were underway. An internal estimate on the impact of the latter suggested that it had led to 700 earlier diagnoses and 300 earlier cases of surgery.

14/064 In relation to lifestyle programmes, a caucus had been formed on physical activity, and a framework for tackling obesity in 2014/15 was being developed. There would be an integrated business plan across PHE, learning from the experiences of local authorities. A tool was being produced to support local government. Obesity and physical activity would be areas of major investment in coming years.

14/065 Key activities in the field of sexual health and HIV included the development of a National Service Framework for health services provided to men who have sex with men, and producing standards for the commissioning of services by the end of March, to be rolled out in the course of 2014/15.

14/066 A number of organisational changes and new appointments were also reported.

Minutes of the previous meeting

14/067 The minutes of the meeting held on 27 November 2013 (enclosure PHE/14/03) were **AGREED** to be an accurate record.

Matters arising

14/068 The Board **NOTED** the action list and watch lists from previous meetings of the Board (enclosure PHE/14/04). It was **AGREED** to add timescales for the completion of actions to the action list. **Board Secretary**

14/069 The Board was keen that the watch lists would be fully used by the PHE executive. The matter would be discussed at a meeting between the PHE Board and National Executive to be arranged in coming weeks. **Board Secretary**

Report from the Chief Executive

14/070 The Chief of Staff made an oral report on two matters on behalf of the Chief Executive.

14/071 A complaint made by a member of the public to the Advertising Standards Authority with respect to PHE's leaflet promoting the HPV vaccine had been considered by the ASA's Council. The complaint was not upheld. PHE and the ASA were developing a constructive working relationship in light of PHE's wide range of marketing activities designed to inform the public of key public health issues.

Finance Report

14/072 The Finance and Commercial Director introduced a report on the financial position to the end of December. There was a net underspend of £14.3 million, which was a strong position from which to be moving into the fourth quarter, and the forecast outturn at the year-end was a minor underspend of £3.8m (0.1% of the net expenditure budget).

14/073 The variance of £1.1 million on local authority grants was the result of recognition of one correction been made in the allocations which PHE would absorb from its own resources. The systems for PHE to make the payments to local authorities were working satisfactorily. The vaccines programme, the cost of which was underwritten by the Department of Health, was on track. The favourable variance on total net operating expenditure at the year-end was expected to be £4.9m.

14/074 PHE had returned £6m of its capital allocation to the Department of Health because it could no longer be used in 2013/14 as a result of delays in relocation to buildings, particularly in London and Leeds. The capital budget was substantially underspent to date but additional scrutiny of capital projects had been introduced and it was expected that the capital programme would be delivered by the end of the year.

14/075 Formal notification of PHE's financial allocation for 2014/15 had not been received from the Department of Health. PHE was working to an informal assumption for the purposes of budget-setting and business planning, and renegotiations were in progress.

14/076 The Finance and Commercial Director **AGREED** to send information about the impact on programmes to non-executive board member Martin Hindle. **Finance & Commercial Director**

14/077 The finance report (enclosure PHE/14/05) was **NOTED**.

Reporting Committees

14/078 The PHE Board **ENDORSED** the unconfirmed minutes of the meeting of the Audit and Risk Committee held on 21 November 2013 (enclosure PHE/14/06), subject to their adoption at the next meeting of the Audit and Risk Committee.

PHE Board Forward Calendar

14/079 The forward calendar (enclosure PHE/14/07) was **NOTED** and suggestions for topics from April onwards were invited.

14/080 It was suggested that a discussion of antimicrobial resistance be held at the earliest opportunity to fit in with the timescales of other initiatives. It should have a clear focus, such as new and emerging threats, stewardship and research.

14/081 It was also suggested that the Board should consider the focus within topics selected for Board discussion; for example, the focus for antimicrobial resistance might be the Chief Medical Officer's report, educating clinicians and global developments. The key question was what could be done now that infections were increasingly resistant to the drugs available. The topic was welcomed by other Board members. The linked issues of healthcare-associated infections and patient safety would also be of interest, as well as alcohol.

14/082 The PHE Board would also welcome a discussion of the relationship between PHE and NHS England. The two organisations had a major role to play in ensuring better productivity in improving the public's health. It was suggested that a Board-to-Board meeting might usefully build on the Chair-to-Chair and Executive-to-Executive meetings already held.

Questions from members of the public

14/083 Some members of the public attending commented that they had found it a good meeting and intended to continue to attend in the future. In response to a query about the mechanism for ensuring actions were followed up, it was explained that it had been agreed earlier that a substantial meeting would be arranged between the National Executive and the PHE Board to further enhance the interaction between them. There was a commitment to reporting the outcome of this meeting in public.

Any other business

14/084 No further business was raised and the meeting closed at 1.50pm.

Victor Knight
Board Secretary
February 2014