Public Health England

Protecting and improving the nation's health

Enclosure PHE/16/31

Minutes

Title of meeting	Public Health England Board	
Date	Wednesday 27 April 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	Viv Bennett	Chief Nurse
	Michael Brodie	Finance and Commercial Director, PHE
	Paul Cosford	Director for Health Protection and Medical Director, PHE
	Eustace DeSousa	National Lead - Children, Young People and Families, PHE
	Martin Dockrell	Tobacco Control Programme Lead, PHE
	Kevin Fenton	Director, Health and Wellbeing, PHE
	Andrew Furber	President, Association of Directors of Public Health
	Richard Gleave	Deputy Chief Executive, PHE
	Graham Jukes	Adviser on Environmental Health
	Clive Henn	Senior Alcohol Advisor, PHE
	Anthony Kessel	Director of Global Public Health, PHE
	Tom Mullarkey	Royal Society for the Prevention of Accidents
	John Newton	Chief Knowledge Officer, PHE
	Vasanthini Nagarajah	Secretariat Assistant, PHE
	Rosanna O'Connor	Director of Drugs, Alcohol and Tobacco, PHE
	Quentin Sandifer	Observer, Wales
	Rachel Scott	Board Secretary, PHE
	Alex Sienkiewicz	Director of Corporate Affairs, PHE
	Errol Taylor	Royal Society for the Prevention of Accidents

There were four members of the public present.

1. Announcements, apologies, declarations of interest

16/087 No interests were declared in relation to items on the agenda.

2. Tobacco Update

16/088 The Board was updated on PHE's tobacco control work since the time of their previous panel session in February 2014. PHE had made good progress across a variety of areas, not least publication of the evidence review on e-cigarettes last summer. PHE's tobacco control programme incorporated world-leading social marketing programmes, national surveillance and was working to reduce health inequalities caused by tobacco. This included work on smoking in mental health settings and during pregnancy.

16/089 PHE provided tools and data to local authorities to support local tobacco control initiatives as well as setting out the evidence to inform national policies. The official data related to smoking was published from a variety of sources, including the independent Smoking Toolkit Study. The data indicated that, overall, smoking prevalence continued to decline although the national figure masked some significant regional variations, for example, in the north east.

16/090 There had been significant success in meeting the ambitions set out in the national tobacco control plan, which focussed on reducing smoking prevalence in adults, young people and during pregnancy. The key challenge to be addressed in the r plan, due to be published in the summer, was to better engage the NHS in smoking cessation, particularly in supporting those in the healthcare system, including those with long term conditions, pregnancy and mental health. It was hoped that these interventions would help reduce the burden on the NHS, for example, targeting smokers prior to surgery was highly likely to result in improved outcomes and potential reductions in post-surgical infection.

16/091 Following the evidence review into e-cigarettes, PHE had worked with partners across the system to develop an evidence-based consensus. The team continued to work across the system to further develop this.

16/092 The Board watchlist prepared following the 2014 discussion was reviewed. In addition to the reduction in smoking prevalence and the e-cigarette evidence review, other highlights were:

a) the introduction of new legislation, including smoke-free cars and plain packaging;
b) PHE's contribution to the Government's refreshed Tobacco Control Plan, which was due to be published shortly; and
c) focusing on effective and affordable interventions.

16/093 The Board welcomed the progress made and made the following points in discussion:

a) the financial environment for local authorities should be carefully reviewed, in particular, the impact of the reductions to the local public health grant and the measures being taken locally to encourage smoking cessation. While the reduced prevalence rates were encouraging there were no grounds for complacency;

b) there could be greater emphasis on the steps being taken to ensure that people, particularly children, didn't start smoking in the first place;

c) clear guidelines should be developed for working with those in mental health settings, through working in partnership with the voluntary sector to ensure there was appropriate engagement and that interventions were evaluated and the results widely shared;

d) work should take place to fully understand the rates of smoking and the impact of tobacco control measures in diaspora groups, particularly among the eastern European community; and

e) existing initiatives such as *Making Every Contact Count* should be used to full effect when developing smoking cessation programmes.

16/094 There was a clear model for tobacco control in local authorities with a wide range of approaches. The *NHS Five Year Forward View*, Sustainable Transformation Plans and the focus on place-based approaches offered further opportunities to support local action.

16/095 The Board **NOTED** the update and the watchlist would be updated to reflect the points raised.

3. Alcohol Update

16/096 An update on PHE's alcohol work was provided following the panel discussion in March 2014. It was estimated that 25% of adults were regularly drinking more than the revised CMO guidelines of 14 units per week. The evidence review commissioned by Ministers in the 2015/16 annual remit letter would be published in the autumn, setting out evidence-based options to reduce the public health impact of alcohol.

16/097 It was estimated that over 20,000 deaths a year were alcohol related and it was important to consider the broader impact of this. While there was a promising reduction in consumption at a population level, the Household Survey for England suggested that, at the individual level, reduced consumption was more likely in those already drinking at lower levels. PHE's focus was therefore on developing the evidence base and its advice to government would set out policy options on harm reduction.

16/098 PHE was working closely with local partners, including supporting Directors of Public Health in their work on licensing and commissioning and ensuring timely access to alcohol treatment. Discussions continued on introducing a health objective with respect to licensing decisions, which was but one potential measure in a place-based systems approach.

16/099 The following points were raised during the Board's discussion:

a) One measure of success or otherwise was the trend in alcohol-related hospital admissions, although it was recognised that this did not take into account those who had not yet started drinking and the measures being taken to avoid heavy uptake;

b) there were common themes across the interventions required for drugs, alcohol and tobacco reduction;

c) further work should take place to highlight the macro-economic consequences of excessive alcohol consumption, including the costs to the NHS, the wider emergency services and the business sector;

d) it would be important to ensure that there was traction when the evidence review was published and that marketing campaigns suitably aligned in terms of public messaging;

e) health inequalities were an important consideration, in particular, the treatment provided to homeless and other under-served communities;

f) binge drinking and the impact of associated violence should be taken into account as the impact on bystanders and family members could be significant; and

g) in the same way that it had developed clear messages to the public on smoking and eating, PHE should develop clear messages on alcohol.

16/100 The Board **NOTED** the update and agreed that the watchlist should be updated to reflect the points raised.

4. Accident Prevention: Royal Society for the Prevention of Accidents

16/101 The Royal Society for the Prevention of Accidents (RoSPA) provided an overview of their work. Unintentional injuries accounted for approximately 2% of all deaths in the UK and also caused a significant proportion of years of life lost in the working age population.

16/102 RoSPA's work focused on introducing measures to prevent accidents that caused injuries leading to A&E attendances, serious injuries leading to hospital admissions and deaths. It was proposed that an Accident Prevention Strategy Advisory Group should be established, as well as to further engage local authorities in accident prevention. The Board noted that PHE's Best Start in Life programme already included a measure on the prevention of accidents in under-5s.

16/103 The Board raised the following points:

a) it was important to be clear on the definition of accidents as they could be very broad and interconnected, for example, accidents related to medication;

b) in developing accident prevention interventions, broad factors should be considered alongside behavioural factors, particularly when focusing on children; and

c) a sensible and common sense approach should be adopted and circumstances should be as safe as necessary, rather than as safe as possible.

16/104 It was recognised that funding was an important issue but opportunities for effective interventions should be sought from within current resource. As part of supporting the further development of this work, PHE would:

a) explore establishing a surveillance system for accidents; and

b) work with RoSPA in framing suitable research question(s) to test the real life hypothesis of accident prevention reducing demand on A&E, best placing them to compete for research funding, for example, through NIHR.

5. Global Health Update

16/105 The Chair of the Global Health Committee advised the Board that:

a) PHE's global health work had been reflected appropriately in the recently published strategic plan;

b) work was underway to implement the recommendations of the review of PHE's global public health work. Anthony Kessel had been appointed interim Director of Global Public Health and was working with teams across PHE to develop an operating model for PHE's global health work;

c) the Chief Executive had recently returned from a visit to India and Pakistan, in the case of the former, to further develop ongoing and planned commercial relationships on communicable diseases and to scope possible collaboration on non-communicable diseases. In Pakistan, he had introduced PHE's newly appointed public health team there, Anne Wilson (based in Islamabad) and John Forde (based in Lahore), to key government and wider stakeholders as well as reaffirming PHE's commitment to support Pakistan in their work in complying with the International Health Regulations;

d) PHE had an ongoing commitment to Sierra Leone to support the strengthening of their public health laboratory diagnostic capacity and wider emergency preparedness and response capability. It was envisaged that these laboratories would eventually extend into wider clinical diagnostics, as well as having a public health role. The work included establishing three regional laboratories in Makeni, Bo and Freetown.

Dr. Barry Evans was retiring from PHE following a long and distinguished career, most recently acting as Head of Mission in Sierra Leone. The Board thanked him for his significant contribution both to the Ebola response and public health more generally over many years;

e) PHE continued to contribute to the international response to Zika, building on existing relationships with the Caribbean Public Health Agency (CARPHA) and the International Association of National Public Health Institutes (IANPHI);

f) As part of its MoU with the Chinese CDC, PHE was running a workshop in May in Beijing on health security and emerging infections, nutrition (sugar and salt reduction), climate change and HIV; and

g) the joint Rapid Support Team with the London School of Hygiene and Tropical Medicine was expected to go live the following month.

6. Minutes of the meeting held on 23 March 2016

16/106 The minutes (enclosure PHE/16/24) were agreed as an accurate record of the previous meeting.

7. Matters arising

16/107 The matters arising from previous meetings (enclosure PHE/16/25) were noted.

8. Updates from Directors

16/108 The Director for Health Protection and Medical Director advised that:

a) Local AMR action plans had been developed and work was underway to ensure that they were embedded across the country;

b) The response to the Zika outbreak continued, in particular, PHE was monitoring the international epidemiology; and

c) PHE continued to work with local partners on reducing the impact of air pollution on health.

16/109 The Director for Health and Wellbeing advised that:

a) The new Eatwell Plate had been launched, having been updated in light of the recent SACN review on carbohydrates;

b) Work continued on sugar reduction following the Chancellor's announcement in the 2016 Budget to introduce a levy on sugar sweetened beverages; and

c) New data regarding salt consumption had recently been published. There had been an 11% reduction in salt consumption since 2005/06 when the salt reduction programme commenced. The average daily amount of salt consumed was currently 8g and further work was needed to reduce this to the recommended limit of 6g per day.

16/110 The Chief Knowledge Officer advised that:

a) PHE would be submitting a Level 2 compliant Information Governance toolkit assessment to the Health and Social Care Information Centre; and

b) it was expected that the Caldicott review would be published in the summer. PHE continued work closely with partners on the issue of type 2 opt-outs and how to ensure that key public health surveillance systems were not adversely affected.

16/111 The Chief Nurse advised that:

a) PHE was contributing to the development of the *All our Health "call for action for health professionals";* and

b) The national Nursing Strategy was being developed, with PHE taking a particular lead on prevention.

9. Observer Update

16/112 The observer, Wales advised the Board that:

a) The *Health and Wellbeing for Future Generations Act* in Wales had come into force on 1 April 2016. The act legislated for sustainable development and a update on its implementation would be provided at a future Board meeting; and

b) Dr Frank Atherton had been appointed as the new Chief Medical Officer for Wales.

Chief Executive's Update

16/113 The Chief Executive advised the Board that:

a) he had now met the Permanent Secretaries of ten of the main Government departments, most recently with DEFRA. This was part of PHE's cross-Government influencing strategy, working with national government and policy makers, to continue to win the argument for the priority of effective, evidence based interventions in the short and long term to improve the public's health, so that increased longevity was matched by improved quality of health throughout life and particularly in later years;

b) the recruitment exercise for the new Director of Communications was underway and would conclude by the end of May; and

c) PHE scientific staff had contributed to the Government's response to the recent Parliamentary debate on the public petition calling for the Meningitis B vaccine to be made available to older children.

10. Finance Report

16/114 The Finance and Commercial Director introduced the financial review to February 2016 (enclosure PHE/16/26). PHE continued to forecast a year-end financial break-even position and delivery of its capital programme. A year-end report would be presented to the Board at the May meeting.

16/115 The Board noted the update.

11. Science Hub update

16/116 It was reported that the programme remained on track and that the first in a series of public engagement events would take place in Harlow in early May.

Information items

16/117 The Board noted the following information papers:

a) Audit and Risk Committee Update (enclosure PHE/16/27)
b) Board forward calendar (enclosure PHE/16/28)

12. Any other business

16/118 Two members of the public emphasised the importance of health inequalities across all of PHE's work, with which the Board very much agreed.

16/119 There being no further business the meeting closed at 2.10pm.