Jill MacGuire was a specialist in elderly care. In her old age she became a recipient of it. Here her daughter, **Frances MacGuire** (pictured left with Jill) tells the story of her mother's sudden decline and the ensuing struggles to meet her health needs

LIKE glacial retreat, my mother's dementia started slowly and was barely perceptible. The day she waited in the wrong restaurant to celebrate my brother's 50th. The frequent times she ran out of petrol. It was when the police called me at work that I finally accepted things were wrong. She'd been found in a pub, dazed and confused with her two dogs. She'd abandoned her car, the tank dry and had no money on her.

Then a fall, a broken leg and our lives went into freefall. Surgery and a short hospital admission saw her discharged home alone with a Zimmer frame but with no social support. She'd refused it. I begged the relevant services and eventually secured an emergency support package consisting of three half-hour visits a day to prepare meals. It was still down to me to ensure the fridge and cupboards were full. I lived six hours away with two young children and a demanding job.

Over the next couple of weeks she deteriorated. A proud, strong, independent woman, she hated having carers. I uncovered serious debts, unpaid fines and her house was about to be re-possessed. She left her home of 20 years for the last time when my brother took her to hospital because the ambulance never turned up.

She had vascular dementia, hepatic encephalopathy and her diabetes was off the scale. High blood pressure too. She'd been very overweight in middle age. The medics call it complex health needs. I call it a living nightmare. She was desperately

Professor Jillian MacGuire PhD RGN, Paris 1959

miserable in hospital and told us to put her head in a bucket.

I trudged back and forth, juggling work and family, getting more and more exhausted, dispirited and disenchanted with the healthcare system. Eventually the consultant agreed to my repeated requests to move my mother to a nursing home near me. I asked him how long he thought she had. He gave her one to two years. Two months later she was dead, six weeks after my father. She'd had three further hospital admissions and then slipped into a coma. I will never forget her last smile. It took 10 days for her to die, and it was anything but peaceful.

Jill MacGuire was the first Professor of Nursing for Wales, a nurse and a ward sister specialising in elderly care. She was smart, sassy, irreverent, kind, loving and generous. She was also hopeless with money and hard to help. At her funeral, the church was packed.

Age wearied her though she was only 76. Dementia diminished her. Liver disease destroyed her. It felt as if the healthcare system – which she'd trained and worked in, led and lived for – abandoned her. The manner of her death (not death itself), coupled with battling the system, broke my heart, body and spirit.

Do I wish I'd looked after my mum myself? Yes. Did I have the skills? I doubt it. A tidal wave of dementia is about to hit our ageing population. We are not prepared.

Frances MacGuire
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Information

ISSN – 2043-6580

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If you have an idea for an article please submit a 50-word proposal and suggested authors to news@fph.org.uk. The subjects of the special features for 2016 are: Sustainability (Spring), Sport and physical activity (Summer), Arts and humanities (Autumn), What has public health ever done for us? (Winter).

The magazine of the
UK Faculty of Public Health
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Winter 2016

In this issue

Public Health Today

Effectiveness, efficiency, equity
Why healthcare public health is blossoming

Public Health Today
The magazine of the
UK Faculty of Public Health
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Winter 2016

Contents

Welcome

THESE are tough times for public health. There appears to be a systematic attack on the determinants of health and disease but in the wrong direction. Beveridge's five giant evils appear to be on the march again and we are not in a good position to tackle them. Let's take each of them in turn:
Want. Until recently we have been more concerned about relative than absolute poverty, but the combination of low pay and zero-hours contracts is impacting even on young graduates.
Ignorance. The confused and confusing state of the nation's schools is being compounded by insufficient school places in areas with high birth rates and a revival of the arguments about grammar schools and the fair distribution of educational resources.
Idleness. Approaches to the health of the workforce and the relationship between employment and health have become very confused as a result of recent policies for 'fit notes' and pressures being put on those with long-term disability to return to work.
Squalor. Homelessness and overcrowding have become widespread. Cut budgets have reduced the ability of local government to respond and deal adequately even with the basic aspiration of good environmental health standards and enforcement.
Disease. The NHS is in crisis financially and staff morale is at an all-time low. Public health budgets are under attack and public health teams are being cut back.

On the positive side, Simon Stevens' *Five Year Forward View* has attracted widespread support, not least for its insistence that public health and prevention should be at the heart of the plan to save and reinvigorate the NHS.

So how has the Faculty of Public Health (FPH) risen to the challenge? Over the past few months our team in St Andrews Place has been working tirelessly with the Academy of Medical Royal Colleges (AoMRC) to bring together an unprecedented group of organisations that are opposed to the cuts to local authority budgets and who co-signed a letter to the Chancellor of the Exchequer about our concerns. As well as AoMRC members, FPH was supported by the Association of Directors of Public Health, the British Dental Association, the Chartered Institute of Environmental Health, London Councils, the Local Government Association, the Royal College of Nurses, SOLACE and the UK Health Forum. Dr Arif Rajpura, director of public health in Blackpool,

was interviewed for national BBC TV, radio and online news; it is thanks to him and his team that the vital work carried out by public health specialists was given national media attention.

In mid October, when the Health Select Committee demanded that Public Health England's report *Sugar reduction: from evidence into action* be made available for the committee's deliberations on obesity, FPH was able to lend its authoritative voice to what proved to be successful public health advocacy. It is important that members and fellows keep the pressure on to ensure that the obesity strategy that sees the light of day in 2016 should not be a rehash of the failed Responsibility Deal.

On substantial issues such as these FPH's voice must be heard and used to best effect. Our legitimacy to engage with such matters is clear from our mission, part of which stipulates that FPH should be an authoritative body for the purposes of consultation and advocacy in matters of educational or public interest concerning public health. Like any charity, it is entirely correct for FPH to engage in political matters relating to its mission, without becoming party political.

Chief executive David Allen and I had a most productive visit to World Health Organization Copenhagen and meetings with Programme Manager, Governance for Health, Monika Kosinska, Regional Director for Europe Zsuzsanna Jakab and other members of staff. We anticipate developing a strong collaboration with this most important partner.

On the office front we have two new additions to the team: Femi Biyibi, Policy Officer, and Keith Gilbey, Business Development Consultant. These will help us broaden and increase our resource base and develop the active participation of members and fellows through the Special Interest Groups.

John Ashton

CSR: rock solid evidence is being ignored

THE Government's Comprehensive Spending Review (CSR) has confirmed, in the wake of the £200m cut to the local authority public health grant, further real-terms cuts each year to 2020/21, amounting to approximately 20% of the grant.

Statutory public health functions may change after 2017, with serious implications for health and public health services provided by local authorities, such as already fragmented sexual health services and fulfilment of children 0-5 years responsibility.

The CSR signals the grant's replacement with a retained business-rate model. Eventual redistribution may hurt deprived local authorities striving to address wider health inequalities. If the grant is not ring-fenced, Public Health England's ability to influence outcomes will be tested.

The Faculty of Public Health (FPH) has made strong representations to the Government that the CSR represents poor value for money. FPH continues to advocate for more, not less, investment in public health – which the Government has committed to through its support of the *Five Year Forward View.*

The impact of welfare reform on child health

THE All-Party Parliamentary Group (APPG) on Health in All Policies (http://bit.ly/1P8R579) was set up to explore the effects of all national policy on the health of the populations of the UK – particularly on health inequalities between different population groups.

Supported by FPH, the APPG has launched an inquiry into child poverty and health and wellbeing (including inequalities), focused on the impact of the Welfare Reform Bill (http://bit.ly/1UU4i8o). In addition to making provisions related to the Secretary of State for Work and Pensions' duty to report on progress towards achieving full employment, the bill proposes changes to child poverty reporting and repeals most of the Child Poverty Act 2010.

The APPG welcomes evidence on the relationship between child poverty and health, including inequalities, the impact of the welfare reforms on levels of child poverty (and inequalities), children's health and wellbeing (including mental health and wellbeing), and the future life chances of children. It will publish its findings in February 2016. Learn more at bit.ly/1ThrxqK

MPs call for urgent action on child obesity

THE House of Commons Health Select Committee, chaired by Dr Sarah Wollaston MP, has made clear that the scale and consequences of childhood obesity demand bold, urgent, government action (http://bit.ly/1Tg4lsJ). FPH has welcomed the committee's report and its thorough, evidence-based approach to improving child health.

One third of children leaving primary school are overweight or obese. The calories children consume and exercise they get are affected by various factors including family, schools, access to safe

outdoor space and food advertising. That is why all aspects of the strategy need to be implemented if we are to tackle childhood obesity and reduce the ill health, financial costs and misery it causes.

The report offers a stark warning to food and beverage companies: do the right thing now, voluntarily, or mandatory approaches will be rapidly introduced. FPH welcomes the report's call for a duty on sugary drinks. Read FPH's written evidence to the Health Committee at http://bit.ly/21cynmU.

Mark Weiss
Senior Policy Officer
Faculty of Public Health

News in brief

Free sugar app checks products
Parents are being urged to sign up for a free app that tells them the sugar content of food and drink. The 'sugar smart app' from Public Health England works by scanning barcodes and revealing total sugar in cubes or grams.

Bacteria that resist 'last antibiotic' found in UK
Bacteria that resist the most common antibiotic of last resort, colistin, have been discovered in the UK. Scientists warned the world was on the cusp of a post-antibiotic era when such resistance was discovered in China in November.

Cancer is more lifestyle than bad luck, says study
Cancer is largely a result of environmental factors rather than bad luck, a study in the journal *Nature* suggests. It used four approaches to conclude that only 10-30% of cancers were caused by the way the body naturally functions.

One in three young Chinese men will die from smoking, study says
A third of all men currently under the age of 20 in China will die prematurely if they do not give up smoking, a study has found. The research, published in the *Lancet*, says two-thirds of men in China now start to smoke before 20. Around half of those will die from the habit, it concludes.

UK end-of-life care 'best in world'
End-of-life care in the UK has been ranked as the best in the world. The study of 80 countries said that thanks to the NHS and the hospice movement, the care provided was "second to none". Australia and New Zealand were ranked second and third respectively.

Footballers' teeth in bad shape
Professional footballers have worryingly poor teeth, say dentists from the International Centre for Evidence-Based Oral Health at University College London. Their study of 187 players at eight clubs in England and Wales, showed nearly 40% had cavities, compared with 30% of people of a similar age in the general population. Regularly consuming sugary and acidic food and drink is one possible explanation.

INTERVIEW

Colonel David Ross is Defence Consultant Advisor Public Health and Parkes Professor of Preventive Medicine at the Army Medical Directorate. He has led Medical Force Protection Audits in Afghanistan and provided public health support to the Ministry of Defence's response to Ebola. He explained to Liz Skinner how the army delivers public health

'Our approach is cradle-to-grave'

Mental health support is vital, says Ross

An army corporal at the Kerry Town Ebola treatment centre, Sierra Leone

How did you come to join the Royal Army Medical Corps and public health?
Luck, rather than judgement. I was at Barts medical school and had quite a few colleagues who had relatives in the medical services. At that time, I played a lot of sport and enjoyed the outdoor life so the armed forces seemed a good fit. I went to the first Gulf War where I enjoyed the comradeship of working in a team, and it was my first insight into working in an austere environment. When I came back, I started general medical training and moved into paediatrics. My masters in community paediatrics was perhaps my first insight into public health medicine, and from there I changed tack and later qualified as a public health consultant.

What does a typical month look like for you?
That's the appeal of public health: there isn't a typical month. Similar things re-occur, but I have so many different roles. At the strategic level, I could find myself briefing senior officers and officials on disease-prevention strategies – clearly I was involved in the Ebola response. My other role as Parkes Professor means I champion a lot of research. Perhaps one of my proudest moments was leading on a survey of all new recruits into the armed forces for blood-borne viruses, which led to us being the first employer in the late 2000s to offer universal Hepatitis B vaccines. It's a real joy to help younger medical officers getting a peer publication. I'm also an examiner for the [FPH] Part B exam.

How is providing population healthcare to an army population different from providing it to a civilian one?
The key is understanding your population. Historically we have had largely a young population. We know it's much better to stop smoking the younger you are, and so we can tailor our programmes to our population. We've also had some initiatives around peer-led sexual health; sometimes it's better for the advice to come from someone of the same rank.

We have a responsibility to the husbands or wives of people who are deployed overseas. That can mean we need to access healthcare locally and that brings an important assurance and governance angle. I've been privileged over the years to look at child and maternal health services in many countries. Recently I've been doing quite a lot of work in Kenya with their armed forces and Ministry of Health, particularly in the area of sexual health education. It is important though to recognise that we assist, rather than turn their services into our models of care.

For health protection, we have a consultant on standby ready to deploy within 24 hours for six months. Often though, it's about assuring the health protection policies we have in place. When you rely on good handwashing to prevent the spread of disease but you have no running water, you have to observe the situation first hand to put the right measures in place.

We are taking a cradle-to-grave approach so that we can maintain our population's health while they are in the armed forces and working with our civilian colleagues once they leave.

How does being in the armed forces help, or hinder, public health?
There are more positives than negatives. The difficulty for both the military and civilian population is that a lot of people don't understand what public health is. I have one advantage because I am able to tackle public health initiatives on a more discrete population.

I'm also very lucky that we have good relationships with our civilian colleagues, particularly Public Health England. For instance, in planning for the flu pandemic without the support of HPA [the Health Protection Agency] at that time, and me sitting on the pandemic flu planning team, I don't think we would have been in as good as place as we were. We offer a uniqueness within our training programme because our specialist trainees spend an equal amount of time in the military and in civilian attachments. That exposes them to military and civilian public health, which leads to cross-fertilisation of initiatives.

> **We have some good public health experience of managing Ebola, and it would be all too easy to lose that. We cannot rest on our laurels**

If there was an outbreak of Ebola in Chile this week, what might the army do differently?
I think that's a very difficult question to answer, because the armed forces and our civilian partners are still learning the lessons. There is no doubt that the practice of the clinicians who responded was exemplary. The global lesson is that we could have responded more quickly. If the example you give is of the first two or three cases, it would be important to get in early and understand what was happening with that population. We must maintain the legacy from our recent experience; we have some good public health experience of managing Ebola, and it would be all too easy to lose that. We cannot rest on our laurels.

Which have been your proudest moments so far?
Being appointed Parkes Professor is my proudest moment. I was the first generation in my family to become a doctor. Another one was becoming a Queen's Honorary Physician two years ago. Being part of a huge team that works for the royal family and providing medical support at important occasions is a real privilege.

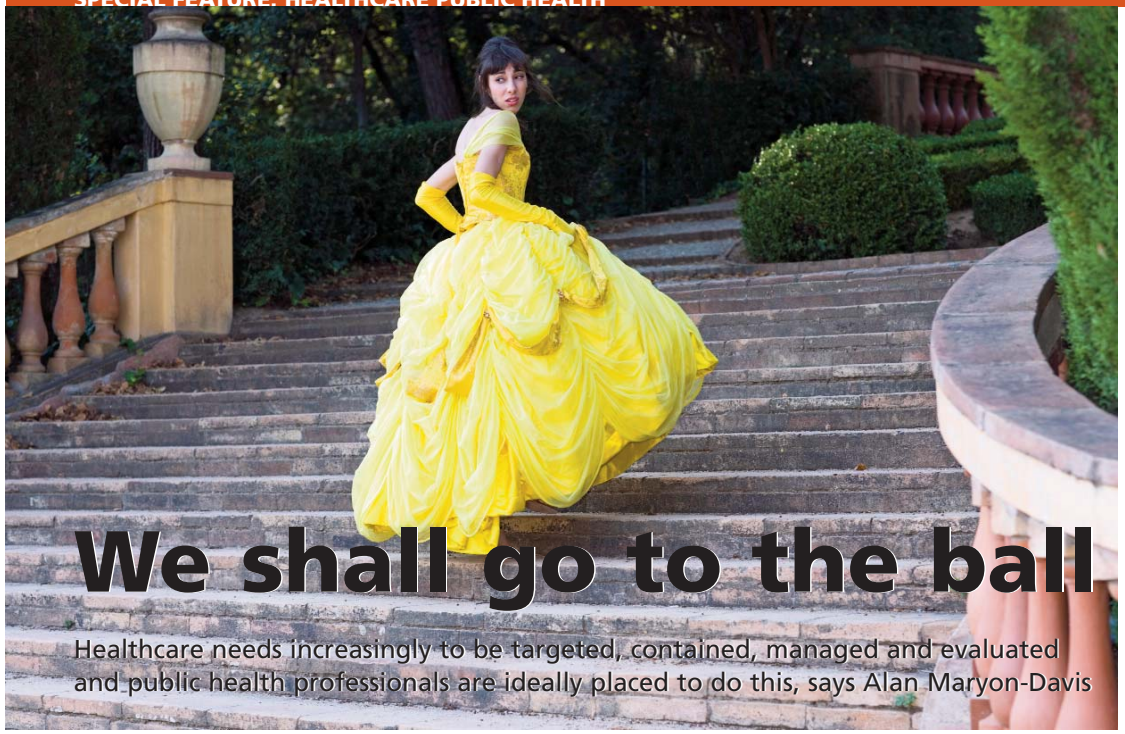
Which is your biggest frustration?
An evidence base is so important but people are all too quick to change policy based on emotion rather than hard evidence. The controversy over MMR has had untold consequences.

Is there anything that keeps you awake at night?
I was kept awake a lot during the Ebola crisis, worrying about our people on the ground. I particularly worry about the mental health legacy for healthcare workers who respond to a crisis. Once they have returned to their own work environment, it's crucially important that their employer provides appropriate support. We have recognised within the military that mental health is really important. Although we have been relatively successful in recent years in de-stigmatising mental illness, it is still a risk for people working in risky professions.

What also concerns me is what I will do when I leave the army in five years time. I think it will be important to keep working past 60 so I can give something back. Finally, what the future holds for my children. I've been privileged to have one career: my children's prospects are very different.

What helps you switch off?
Getting away from my work environment. I try to make myself swim two to three times a week. I'm an avid armchair sports fan. I've been very lucky to travel a lot; I try to get to Jamaica regularly to visit my step-mother. I love sitting and watching the world go by; I sometimes think I would have liked to have studied anthropology!

Interview by Liz Skinner



We shall go to the ball

Healthcare needs increasingly to be targeted, contained, managed and evaluated and public health professionals are ideally placed to do this, says Alan Maryon-Davis

IF YOU think of healthcare public health as the Cinderella among our three domains, you must be living in panto-land. Health protection may be the backbone of our specialty and health improvement the voice, or maybe even the heart, but healthcare public health is surely the guts.

Healthcare chomps through massive chunks of the UK's GDP like the hungriest of hungry caterpillars. It has to be targeted, contained, managed and evaluated. Since the birth of the NHS, public health gurus have sought to examine health services through a population lens. In 1972, epidemiologist Archie Cochrane scored an international hit with his seminal monograph, *Effectiveness and Efficiency: Random Reflections on Health Services*. He rocketed to stardom in the public health world and was promptly elected as our faculty's very first president.

Effectiveness, efficiency, efficacy, equity, cost-effectiveness, availability, accessibility, appropriateness, acceptability – such words may trip lightly off our lips to spice our conversation and amuse our friends, but in reality they are the very bread and butter of healthcare public health. Understanding these parameters and getting the trade-offs right is, or should be, a crucial part of getting best value for money out of the NHS and giving it the best chance of survival.

> **Healthcare chomps through massive chunks of GDP like the hungriest of hungry caterpillars**

The expanding healthcare role for public health, and the need to ensure better coordination around health protection, led to its transplantation from local authorities into the NHS in 1974. Now, with the public health function in England back where it came from, what is the impact of the split from the NHS on healthcare public health? Are the levers as strong as they were? Are NHS commissioners making full use of public health skills and the population perspective?

These are some of the questions we ask in this healthcare-themed issue of *Public Health Today*. What exactly is healthcare public health? What is the difference between 'quality' and 'value'? How can we reconcile a patient-centred approach with a whole-population perspective? Where and how does social care fit in?

As ever, we take a view from many angles. We have a piece pondering 'value-based' public health, another on quality standards from NICE, and an outline of the Royal College of Physicians' Future Hospital programme. We look at the work of FPH's Health Services Committee. We have contributions on varying aspects of healthcare in France, Cuba and South Africa. Our 'debate' gives us different views on the question of how to tackle the prevailing culture of overprescribing, including an outline of the multi-agency Choosing Wisely campaign, and we have a brace of articles on what is almost certainly the most worrying global consequence of this misguided practice: antimicrobial resistance.

Healthcare public health is not just alive and kicking, it's playing an increasingly pivotal role. OK, no glass slipper quite yet – but certainly no Cinderella.

Alan Maryon-Davis
Editor in Chief

What do we actually mean by 'healthcare public health'?

AS THE third arm of public health practice, alongside health improvement and health protection, healthcare public health (HCPH) is integral to health service delivery and planning. Sir Muir Gray described it as aiming to "maximise value and equity". The Faculty of Public Health's Health Services Committee is currently working to help define HCPH.

In England, HCPH is integral to addressing prevention and quality gaps in supporting delivery of the NHS Five Year Forward View. Through advising on cost-effective practice and prevention, HCPH helps to plug financial gaps, reduce health inequity and maximise population health and wellbeing.

Healthcare services within the UK have a significant reach and contact with the population, with a workforce of around 1.2 million in acute and community health trusts alone. HCPH supports planning and delivery across the whole integrated pathway, championing what works with the other two public health practice domains to support primary, secondary and tertiary prevention and early diagnosis. By working in partnership with those providing health and care services, HCPH can make a real impact by supporting the scaling up of effective services, helping to reduce unwarranted variation and encouraging consideration of prevention and earlier intervention within care pathways. Public Health England's (PHE's) remit for HCPH, tasked by the Secretary of State for Health, includes activities to:

- Promote evidence of return on investment, including for public health interventions
- Provide analysis of future demand to help shape healthcare services
- Provide advice to NHS England on securing healthcare services to achieve the greatest impact for the population's health.

HCPH helps bring a crucial population focus to the commissioning and planning of NHS services and is described by Jenny Harries, PHE Regional Director for the South, as "planning for quality, accessible healthcare services proportionate to the population need".

PHE has adopted an inclusive distributed model of leadership for HCPH involving a national team led by Dr Raymond Jankowski and a network of HCPH leads within PHE regional offices and centres that includes deputy directors of HCPH, HCPH consultants and specialised commissioning consultants.

> **Healthcare public health helps bring a crucial population focus to the commissioning and planning of NHS services**

In addition, a new PHE centres network has a focus on HCPH, supporting nationwide implementation of priorities, with two lead centre directors, Sue Ibbotson and Debra Lapthorne, and a network of HCPH leads. HCPH activity is also undertaken by public health dental and health and justice leads and by screening, immunisation and specialised commissioning leads embedded within NHS England.

PHE centres provide leadership and support for HCPH capacity – and capability – building within the local health and care system. And HCPH also includes important multi-agency programmes of allied health professionals, such as community pharmacists, to support a functional model of primary care based on World Health Organization principles.

HCPH activity may include analysing whether services can meet current and projected demand, whether interventions are clinically and cost effective, whether equity and unwarranted variation will be addressed and whether services meet requirements for quality, safety and patient experience. Local authorities also have, as part of their public health statutory functions, a responsibility for providing HCPH advice to clinical commissioning groups to support the core offer.

Mandy Harling
National Healthcare Public Health Team
Thara Raj
Public Health Strategy Division
Public Health England

Working to keep healthcare a valued domain

HEALTHCARE public health (HCPH) is a precious and often overlooked part of our practice. The Faculty of Public Health's (FPH's) Health Services Committee (HSC) provides leadership and support to ensure it remains a core and valued element of what we bring to health and social care.

The HSC exists to "act as a source of advice and expertise on all public health aspects of health services". We provide input on policy and technical advice to FPH, respond to requests for information, promote HCPH issues associated with training and continuing professional development and link with other stakeholders such as Public Health England.

The HSC is currently working on HCPH capacity and capability, seeking feedback from the FPH Registrars Committee, directors of public health and training programme directors. The experiences of these colleagues will help develop a better understanding of emerging trends and concerns. We are also helping the Royal College of Physicians (RCP) develop health improvement and public health narrative in their specialty prospectus.

Many readers will be familiar with the Provider Public Health Network of public health professionals working in NHS provider units. FPH is very supportive of this, and the HSC is looking at ways of harnessing the skills of that network.

FPH is very much engaged in the work of the Academy of Medical Royal Colleges (AoMRC). As a core member, our President sits on the academy council, providing a vital link to mainstream NHS healthcare business and promoting HCPH at a strategic level.

Sustainability is being championed through a service delivery workstream, and there is a direct link with members who work in NHS provider organisations. We are currently exploring with the RCP how good examples of public health strategies of NHS trusts can inform their Future Hospitals Programme.

The AoMRC's Choosing Wisely programme is an example of how HCPH can show its worth in health policy. We are also represented on the AoMRC Quality Improvement Group which is promoting the embedding of quality-improvement training in all medical disciplines.

Chris Packham
Chair
FPH Health Services Committee

DEBATE: How can we prevent over-prescribing? Sue Bailey says a fundamental change in culture is required and Katherine Murphy argues that patients need to be better informed

We must change to meet new complex needs

OVER-medicalisation and over-prescribing have reached a peak in the UK and the ensuing debate is now at the forefront of health policy. This is, in part, an inevitable consequence of the financial pressures on the NHS as it struggles to meet the needs of an ageing, multi-morbid, increasingly diverse population with complex needs.

There is a recognition that we need to change the way we practise medicine to meet contemporary challenges. Prevention, patient-centred care and population-based approaches to delivering high quality services is a vision clearly outlined in the Government's *Five Year Forward View*. This approach would put patients at its heart and help to address unnecessary interventions and treatments.

To achieve this will take more than tinkering with policies at the periphery; it needs a fundamental change in culture and behaviour. That is why the Academy of Medical Royal Colleges has launched Choosing Wisely, a campaign made up of a range of Royal Colleges, patients' organisations, NHS England, NICE and many more. The aim of the campaign is to change the way doctors and their patients communicate about their treatments or procedures and discuss whether these are truly necessary, free from harm and supported by evidence. As part of the campaign, the Royal Colleges have developed lists of interventions or procedures which they believe are of questionable value and should be discussed carefully by doctors and their patients.

> **We need to move away from a culture of "more is better" to offering optimal care for every patient**

By changing the parameters of the conversations patients have with doctors and encouraging shared decision-making, Choosing Wisely seeks to avoid unnecessary procedures and drugs. As we know, all medicines have side effects, so reducing unnecessary treatments should lead to less pain and emotional distress. We need to move away from a culture of 'more is better' to offering optimal care for every patient.

Cultural shift is not easy to achieve and will inevitably take time; Choosing Wisely is just the beginning of this journey. But all healthcare professionals have a responsibility to help create a sustainable healthcare system that puts patients at its centre, reduces waste and costs and reduces potential harm to patients. Choosing Wisely promotes and encourages a conversation and debate that we should all be having, with the objective to improve patient care and clinical outcomes for all.

Sue Bailey
President
Academy of Medical Royal Colleges

Patients must feel able to ask questions

OVER-prescription of medication – or not taking it once dispensed – are both issues at the heart of patient safety. The Patients Association has two particular areas of concern where we feel significant improvements can be made.

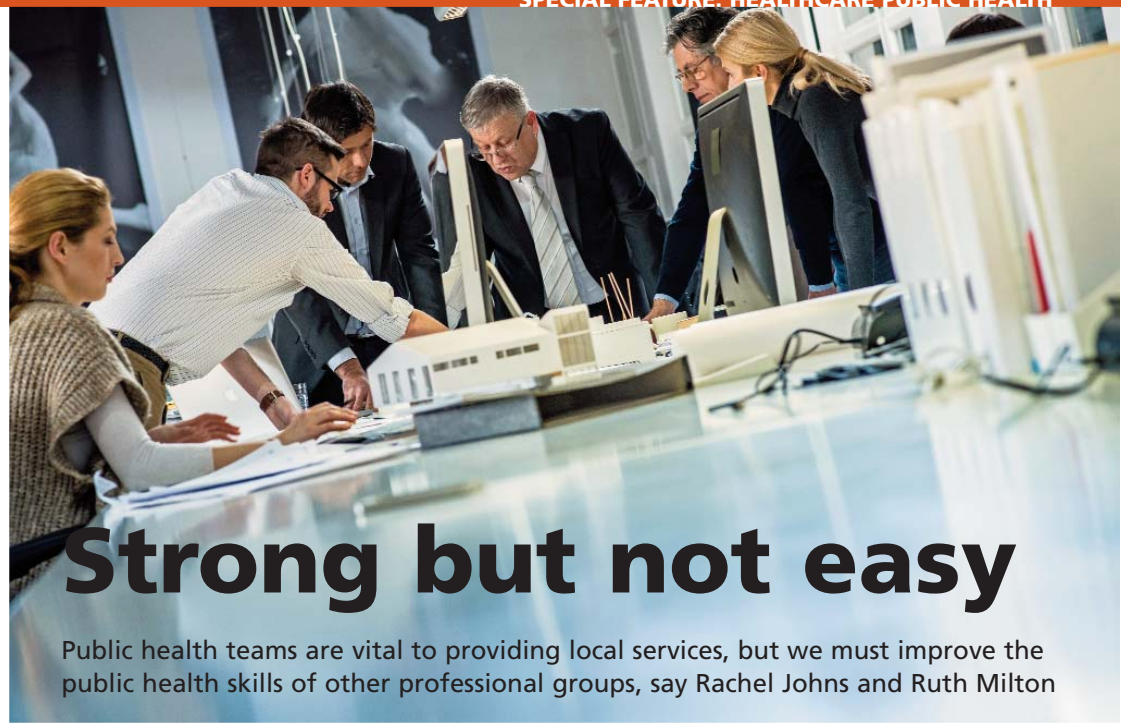
Firstly, the over-prescription of antibiotics. A culture has been created whereby GPs feel patients put them under pressure to prescribe antibiotics even when they know they will be ineffective. This is wasteful and potentially harmful. Antibiotic use has become so commonplace that patients all too often have an expectation that their doctor will prescribe them.

With the recently formed All-Party Parliamentary Group (APPG) on Patient Safety, the Patients Association commissioned four white papers on infection prevention. One of the APPG's primary concerns was the overuse of antibiotics causing an increase in antimicrobial resistance. This is making it increasingly difficult for healthcare professionals to treat patients with effective antibiotics, for whom they are important or even vital, and for drug companies to develop, test and market new antibiotics. A change in prescribing culture would not only save a great number of lives but also a significant amount of money. This could be achieved by increasing knowledge and understanding of antimicrobial resistance amongst the general public.

> **When a patient is asked to start taking a new medication and sees the list of potential side effects, this can be very troubling and off-putting**

The second issue is the non-use of prescribed medication. For example, when a patient is asked to start taking a new medication and sees the list of potential side effects, this can be very troubling and off-putting. Patients then decide not to take their medication, meaning it not only goes to waste but its non-use may cause avoidable harm. Some people simply do not like taking pills or a particular form of medication and, rather than discuss this with their doctor, they collect and then do not take them. A hoard of out-of-date medicines is not only dangerous for patients, but also a significant waste of public money. Patients must be helped to feel confident that they can speak to their doctor or pharmacist about their prescription. The best way to address this issue is for health professionals to involve and engage patients in discussions about the risks and benefits of any treatment before it is prescribed.

Katherine Murphy
Chief Executive
Patients Association



Strong but not easy

Public health teams are vital to providing local services, but we must improve the public health skills of other professional groups, say Rachel Johns and Ruth Milton

AFTER a period of transition, the new public health and NHS arrangements are strong at local and national levels. Public health staff in local authorities (LAs) and in Public Health England (PHE) support NHS commissioners in Clinical Commissioning Groups (CCGs) and NHS England respectively, with an increasing number of public health trained professionals working within the NHS itself.

That's not to say it's easy. In true public health style we can (and do) spend time defining exactly what healthcare public health is. In its broadest sense it covers all input to the commissioning and provision of services at a population (and sometimes individual) level. This includes needs assessment, planning, prioritising, commissioning, governance, evaluation and reconfiguration.

The challenge however, is not what's in the definition; it's that the capacity and skills available may mean that local areas are not able to consistently offer the same spectrum of services as their neighbours.

Skilled local public health teams are essential to support commissioning within local authorities and in the NHS, but there are also opportunities to further develop the public health skills of other professional groups such as commissioning GPs.

Capacity itself is a challenge. In LAs, support for CCGs is one of many responsibilities of the public health team which, alongside all other council services, is under scrutiny to maximise value-for-money. Tight finances and small teams often put pressure on partnerships but can also create the environment for innovation. PHE is looking at ways to strengthen capacity by using the skills of all who face the NHS, including health and wellbeing and health protection colleagues. Across the public health system we're all aware of the need to ensure that future practitioners have the chance to train in healthcare public health.

> **The new agreement for local authorities to access Hospital Episode Statistics data is very welcome**

The public health responsibilities of LAs provide opportunities for local politicians to become increasingly well informed about evidence-based approaches, evaluation of outcomes and the subsequent benefits to their citizens. The new commissioning responsibilities often require local authorities, CCGs and NHS England to coordinate the commissioning of different parts of a single care pathway.

Public health teams in LAs and PHE do and must continue to work together to make sure that advice and support is consistent and enables such collaborative commissioning. The co-commissioning agenda provides further opportunities for us to break out of organisational silos and maximise health gain most efficiently across our populations.

Public health intelligence and our reliance on the evidence base have become increasingly important as local health- and social-care systems seek to prioritise and maximise cost-effectiveness. Working with NHS England and the National Institute for Health and Care Excellence, PHE aims to support local decision-making by providing high quality analysis. But it's the local implementation within a complex, nuanced system that turns this advice into change on the ground. On a practical level the new agreement for LAs to access Hospital Episode Statistics data is very welcome.

Despite the challenges, strong professional relationships will continue to ensure that public health contributes significantly to the development of value-for-money healthcare which improves health outcomes.

Rachel Johns
Deputy Regional Director
Public Health England
Ruth Milton
Director of Public Health
Hampshire County Council

The five-year strategy for fighting superbugs

THE scale of the antimicrobial resistance (AMR) issue and its implicaitons for public health were outlined by Dame Sally Davies, Chief Medical Officer for England, in her 2013 annual report. She called for urgent action at a national and international level to slow down and prevent the spread of AMR through a broad strategy spanning people, animals, agriculture and the wider environment.

Implementation of the UK five-year AMR strategy is being coordinated by the Department of Health, Public Health England and the Department for Environment, Food and Rural Affairs. An inter-departmental steering group comprising senior representatives from government departments, agencies, the NHS and the devolved administrations is responsible for driving delivery.

An implementation plan was published in the first annual progress report on the UK strategy in December 2014. Many of the actions set out in the plan address the whole of the UK but the devolved administrations have produced their own plans tailored to reflect local issues and priorities.

In Scotland, the Scottish Antimicrobial Resistance and Healthcare Associated Infection (SARHAI) Strategy Group was established to provide leadership across the healthcare associated infection (HAI) and AMR landscape. A new 2016-17 to 2020-21 AMR/HAI Scottish strategy is currently being developed, overseen by SARHAI. An expert group Controlling Antimicrobial Resistance in Scotland (CARS) has also been set up to oversee Scotland's AMR strategy and support delivery of the UK AMR strategy.

In Northern Ireland, the Strategic Antimicrobial Resistance and Healthcare Associated Infection group is responsible for maintaining a strategic overview of AMR and HAI and implementation of the Strategy for Tackling Antimicrobial Resistance action plan, ensuring actions are aligned with the UK five-year AMR strategy.

In Wales, a delivery plan for NHS Wales and its partners is being developed, outlining Wales's contribution to the UK AMR strategy.

Early wins have included:

- A world-class ESPAUR (English surveillance programme for antimicrobial utilisation and resistance)
- Clinical Commissioning Groups have been implementing toolkits such as TARGET and 'Start Smart – Then Focus' to optimise prescribing as part of an NHS England Quality Premium
- AMR is in the Prevention and Control of Infections: Code of Practice (2015)
- 25,000 individuals across the UK are Antibiotic Guardians
- A range of guidance by the National Institute for Health and Care Excellence to support effective and cost-effective interventions.

At the end of the five-year period (2018) an evaluation report will assess effectiveness, identify further priorities for action and make additional recommendations.

Thara Raj
Locum Consultant in Public Health
Public Health England

We have a key role in the war against AMR

MANY of those working in public health seem to be wary of getting involved in antimicrobial resistance (AMR). It is seen as the province of microbiologists, perhaps because there has been a strong focus on prescribing practice for bacterial infections. Those in public health do not usually see themselves as having much to contribute.

However, AMR is much more than this. The World Health Organization definition includes viruses, fungi and parasites. The role of good infection-control practice in preventing the spread of resistance is often overlooked. Hospital infection control teams may struggle with collection and analysis of data. Public health has many practical skills in surveillance and epidemiology that could be much better used to help them.

Resistance of malaria parasites is a worldwide problem: should this not be a commissioning issue? The drug supply pipeline for HIV is keeping up with the development of resistance, but this may not last. There is a major role for public health in continuing to promote measures to limit spread and advising commissioners on appropriate services for those infected and at risk.

It has been estimated that only three antibiotics currently in development are likely to be active against the most resistant bacteria being treated today. We need innovative solutions, including better management of clinical trials to facilitate drug development. We also need mechanisms to encourage local providers to take part in clinical trials.

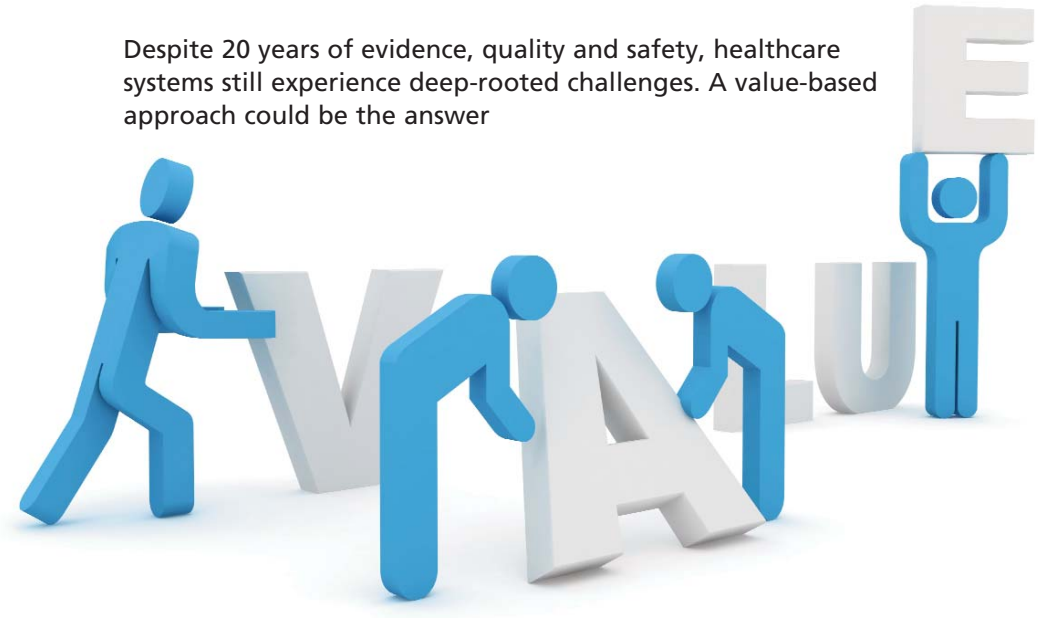
At a local level AMR should be part of the commissioning quality agenda. There is a tendency for acute trusts and primary care providers to each see the other as the source of all resistance problems. Healthcare public health has much to do in breaking down these cultural barriers.

Commissioners should be encouraged to ensure contracts include access to infection control expertise for all healthcare providers, not just acute trusts. Infection control in a care home is much more challenging than in hospital, yet very often this aspect of controlling resistance is ignored.

AMR is not a niche for microbiologists. We need to make it everyone's business, especially healthcare public health.

Sally Millership
Consultant in Communicable Disease Control
Public Health England

Despite 20 years of evidence, quality and safety, healthcare systems still experience deep-rooted challenges. A value-based approach could be the answer



AFTER at least two decades of evidence-based decision-making and an explicit focus on quality and safety, most healthcare systems still face five fundamental problems:

- Massive unknown and unwarranted variation in healthcare provision that cannot be explained by variation in severity of patient illness or patient preferences
- Patient harm from over-diagnosis and over-treatment, even when the quality of healthcare is otherwise high
- Inequity from underuse of available high-value healthcare services by some groups
- Waste in healthcare, which is anything that does not improve outcomes for patients
- Failure to prevent diseases that public health and healthcare are capable of preventing.

As we all know, solving these problems takes more than the injection of extra money, new medical technology or structural reorganisation. We need a new solution: value-based healthcare.

The term 'value,' unlike over-diagnosis and evidence-based medicine, already has centuries of use across the world and has therefore acquired many meanings. Therefore, the use of the term in healthcare needs careful definition, particularly because it has different meanings in the plural and the singular. 'Values', the plural, has a moral and ethical implication, for example "our organisation's values are equity and honesty". In the singular, the meaning is economic, for example "bringing my own lunch to work rather than buying at the canteen is good value".

There are three aspects of value relevant to healthcare and health services:

Personal value: to ensure that each individual patient's values are used as a basis for decision-making in a way that will optimise what is important to him or her.

> **Decisions on allocative value could be made when dividing resources between systems such as early years care or elderly care**

Technical value: to ensure resources are used optimally by focusing on outcomes most important to both patients and populations, and to consider how these outcomes may best be achieved by interventions relative to the resources spent on those interventions.

Allocative value: determined by the distribution of finite resources across different competing groups of need. Allocative value can occur at different levels, such as when resources are allocated nationally between health, defence or education; or between people with mental health problems or people with cancer. Locally, decisions on allocative value could be made when dividing resources between systems such as early years care or elderly care, or within systems such as the prevention of heart attacks or the treatment of valve abnormalities when considering budgets for a cardiovascular service.

NHS England's Right Care Programme, set up five years ago, has been developing and sharing a range of tools to help those responsible for designing and commissioning healthcare to embed a value-based approach into health systems and services. For more information visit: http://www.rightcare.nhs.uk/

Stella Botchway
Anant Jani
Muir Gray
Phil D'Silva
Value Based Healthcare Programme
Nuffield Department of Primary Health Care Sciences
University of Oxford

Prevention and cure

The new health system in South Africa is based on the founding principles of the NHS and the idea of health promotion rather than reaction, says Shan Naidoo

A BRAVE new direction has been taken by South Africa for its health system following the publication of the government's green paper on national health insurance (NHI) in 2011. This move to embrace universal health coverage was informed by our post-apartheid constitution in which access to healthcare is regarded as a fundamental human right for all South Africans.

The NHI policy was guided by the following social justice principles:

- Right of access enshrined in the Bill of Rights
- Social solidarity – financial risk protection for the entire population
- Effectiveness through evidence-based interventions
- Appropriateness through fit-for-purpose health service delivery models
- Equity – ensuring universal coverage with care according to need
- Affordability – services procured at reasonable cost recognising that health is a public good and not a tradable commodity
- Efficiency, ensured by creating new administrative structures that avoid duplication across national, provincial and district spheres of governance.

In his green paper, the Minister of Health, Aaron Motsoaledi, acknowledged the need to move away from a 'hospi-centric' curative model of healthcare and proposed a "re-engineered primary healthcare system" which aims to encourage a more responsive patient-centred health service promoting health rather than the current primarily passive one reacting to disease. This approach is based largely on the Brazilian experience modelled on family health teams in defined communities.

Since the green paper was published, 11 pilot sites and an Office for Health Standards to ensure quality have been established. The pilot sites have been evaluated and further modified to improve the intended roll-out to the rest of the country. However, in the Minister's 2015 budget speech he made only brief reference to the NHI, and, when asked to elaborate more, he promised that a white paper on its planned financing would be brought to parliament by the end of the current year.

> **Access to healthcare is regarded as a fundamental human right for all South Africans**

In my view the main challenges will be in sustainable implementation of the financing model and the involvement of the private sector in a much more structured way than currently described in the green paper. In essence, the objective of the NHI policy is to provide improved access to cost-effective, high-quality health services for all South Africans based on some of the founding principles of the UK's NHS. However, looking at the current dismantling of the NHS by successive Conservative-led governments, I worry that we in South Africa might find ourselves following a similar Thatcherite new public management approach that looks to the private sector for efficiency and cost effectiveness.

Investment in health, education, social services and housing is as much an investment in our current and future gross domestic product as it is a moral and social justice imperative. We have a national development plan that seeks to address the intersectoral developmental areas that drive the social determinants of health, many of which undermine economic growth. The NHI can enable universal health coverage for all South Africans, but only alongside a sustainable, affordable health system that emphasises health improvement and disease prevention as well as cure.

Shan Naidoo
Professor and Head of Department of Community Health
School of Public Health
University of the Witwatersrand

GPs and clinics are the bedrock in Cuba

ALTHOUGH Cuba's universal health coverage model has not been adopted by other countries, it has informed many in their search for healthcare systems based on primary healthcare.

Article 50 of the Cuban Constitution of 1976 says that everybody has the right to health protection and care. The state guarantees this right by:

- providing free medical and hospital care through a rural medical service network, polyclinics, hospitals and preventive and specialist treatment centres
- providing free dental care
- promoting health publicity campaigns, health education, regular medical examinations, general vaccinations and other measures to prevent disease outbreaks.

Article 4 of Cuba's Public Health Law adopted in 1983 sets out guiding principles for the organisation of the Cuban health system, defined as being free, unified, universal and internationalist. These include:

- high priority given to preventive measures and actions
- public health planning
- application of scientific and medical advances to healthcare
- active public participation in health activities and planning
- international cooperation in health, including provision of health services to other countries.

In 1960, Cuba had 3,000 doctors. A major effort had to be put into the development of human resources as well as the organisation of a single national public health system to provide universal access. Since then 142,910 doctors have graduated in Cuba; more 30,000 from 130 other countries.

By 1970, health services were available across the country, starting with the construction of rural medicinal services. By 1985, the Family Doctor and Nurse Plan had been initiated: each team was responsible for the health of 600 to 800 people (120-150 families), now close to 1,500 people. The team should have the competencies to resolve close to 80% of the main health problems of the assigned community. These doctors cluster around a local polyclinic, serving 20,000 to 40,000 inhabitants.

These teams are supported by 152 hospitals, 12 medical institutes and research centres. Added to this there are more than 300 maternity homes (pictured below) and 200 senior daycare facilities and senior centres.

In addition to physician specialists, polyclinics offer advanced laboratory testing, diagnostic procedures, dentistry and rehabilitation services. Patients requiring care beyond the scope of the family doctor are referred to a polyclinic which offers specialty care in a variety of areas.

Cuba has provided medical cooperation to more than 130 countries since 1960, always under the principle of solidarity, and whenever possible under a shared costs agreement. The collaboration has placed Cuban doctors and other health professionals in rural areas, in full respect for the cultures, religions and beliefs of the peoples and ethnic groups and national and local standards established by the authorities of the countries.

José Luis Di Fabio
Representative in Cuba 2011-2015
Pan American Health Organization/World Health Organization

French sanguine in face of dire cash prognosis

FRANCE came top of the World Health Organization's national healthcare performance table in 2000. While this result points to much that is good about the French system, it may have also been something of a poisoned chalice because it has often been used as a reason to keep the status quo. In the intervening 15 years many other health systems have been improved while France's has remained fairly static.

The distinguishing feature of the French system is that one state insurer pays the bulk of the costs (77%) and the rest is topped up by patients. Rather than providing services, as in the UK, the state focuses on reimbursing payments via the system of the 'carte vitale,' a kind of credit card carried by every citizen. For example, if you visit your GP, your carte vitale pays for 70% and you pay the rest, either out of your own pocket or through private health insurance. In 1970 just half the population had private health insurance. Now, as health costs have soared, the figure is around 90%.

The provision of healthcare is much more mixed than in the UK, with around a third of hospitals being for-profit, a fifth not-for-profit and the rest public. Choice is a significant feature of the system, with patients free to choose between the private and public sectors and free to refer themselves to a GP or a particular specialist. This 'medecine liberale' philosophy also protects the doctor's freedom to practise and prescribe.

In general, waiting times are short and outcomes good. However, poor coordination between primary, secondary and community care is a concern, exacerbating inefficiencies and driving up costs. France spends 11.7% of its GDP on health, the third highest in the developed world (the UK figure is 9.1%). There has been a recurrent deficit of several billion euros for some years. This is largely being ignored and could be storing up serious problems in the current harsh economic climate.

Meanwhile, public health policy is seeing some radical innovations, including safe injection centres (so-called 'shooting galleries'), legal action against student party organisers who encourage excessive drinking and clearer healthy-eating labels on food.

Richard Allen
FPH Productions Editor
French resident 2007-2010

NICE becomes standard-bearer for quality

QUALITY standards provide a new opportunity for the National Institute for Health and Care Excellence (NICE) to support the work of the public health community, Public Health England and local authorities.

First established in 2010, and embedded in the health and social care system through the Health and Social Care Act 2012, NICE quality standards cover a broad range of healthcare, public health and social care topics. Each standard contains prioritised statements designed to help measure quality and drive service improvement within a particular area of care. They are intended to sit alongside and complement NICE guidance and are developed in line with NICE principles of transparency, independent advice, patient and public involvement, expert input and an evidence base.

Quality standards are not mandatory, but are designed to provide a consistent framework for improvement to be used within a local priority-setting process.

To date we have published quality standards for the following public health topics:

- Hepatitis B
- Maternal and child nutrition
- Alcohol: preventing harmful alcohol use in the community
- Smoking: harm reduction
- Smoking: reducing tobacco use in the community
- Mental wellbeing of older people in care homes
- Physical activity: encouraging activity in all people in contact with the NHS (staff, patients and carers)
- Health and wellbeing of looked-after children and young people
- Smoking cessation: supporting people to stop smoking
- Drug use disorders.

Each quality standard contains around six to eight quality statements with a set of accompanying quality measures. Below is an example from the quality standard for smoking-harm reduction, which details a priority area for improvement and measures to show how improvements can be demonstrated and tracked over time by services, commissioners or public health communities.

Quality statement
People who are unwilling or not ready to stop smoking are offered a harm-reduction approach to smoking

Quality measures
Structure: Evidence of local arrangements and written protocols to ensure that people who are unwilling or not ready to stop smoking are offered a harm-reduction approach to smoking.
Process: Proportion of people identified as being unwilling or not ready to stop smoking who are offered a harm-reduction approach to smoking.
Outcome: Uptake of smoking harm-reduction approaches.

Quality standards can be used to plan and deliver services, demonstrate that high quality care is being provided and support investment and disinvestment decisions. They can also be used by teams to review local performance against the national public health outcomes indicators. For example, the 10 local authorities that form the Greater Manchester Public Health Network are using quality standards to inform strategies to improve performance in key areas. Also, in Stockport, the council

> **Quality standards are not mandatory, but are designed to provide a consistent framework for improvement**

and the clinical commissioning group are working together to consider every new NICE quality standard and ensure an integrated, evidence-based approach to the area's health and wellbeing strategy.

Stakeholders have the opportunity to get involved in developing quality standards by helping to identify which health and care topics should be covered and by commenting on draft standards including the quality statements and the accompanying measures. Forthcoming topics already scheduled for development and comment include:

- Antimicrobial stewardship
- Skin cancer
- Early years: promoting health and wellbeing
- Contraceptive services
- Older people: promoting mental wellbeing
- Prevention of dementia
- Community engagement
- Falls prevention
- Maternal health promotion
- Vaccine uptake in the general population
- Oral health promotion in the community.

Gillian Leng
Deputy Chief Executive
National Institute for Health and Care Excellence

Hospitals of the future need radical thinking

RADICAL thinking about how to provide patients with safe, high-quality, sustainable care was the recommendation of the Future Hospital Commission (FHC) report, 2013.

The Royal College of Physicians (RCP) established the Future Hospital Programme (FHP) to develop and implement this vision with a focus on driving real change in the way medical services are structured and delivered to meet the underlying principles of the FHC report. Central to the programme are the development sites – clinically-led projects focused on quality improvement and the delivery of integrated care for people across a health economy. The first four sites were launched in September 2014, with a common theme of providing care for frail elderly people. The recruitment process is currently underway for four additional sites to be launched in January 2016. The sites will develop:

- Plans for person-centred integrated health and care services in the community, supported by a multidisciplinary team including GPs and specialist physicians
- Partnerships between specialist physicians, primary and care providers and commissioners that ensure services reduce fragmentation and duplication
- More efficient and cost-effective healthcare models for people with long-term conditions or complex health needs.

The RCP supports development sites with expertise in quality improvement methodology and evaluation, facilitating relationships and networking to bring about sharing and cross-fertilisation of ideas and innovation. The lessons learned by each of the development sites will be collated and shared with other partners in the FHP and beyond, to spread good practice.

Lindsay Dytham
Future Hospital Programme Coordinator
Royal College of Physicians

How we can all help to mind the gap

MICHAEL Marmot is on a mission to eliminate the conditions that make people sick. He wants you and me to join him. We have a key role in shifting healthcare from fire-fighting to prevention. This will improve care and reduce workplace burn-out, whether it be in an under-resourced local authority, an under-skilled nursing home or a hospital ward that has lost its compassion.

Here you will find the holy trinity of doctors, anthropologists and statisticians exploring why people have different rates of illness depending on where they live.

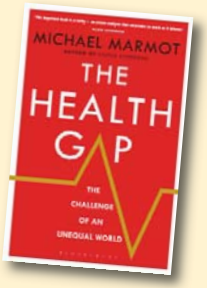
A habit of asking too many awkward questions took Marmot from medical wards to academia. Trained in medicine, not thinking, he treads a journey from a Sydney hospital through the glory days of Berkeley to the British corridors of power. The Whitehall Study comes to life, revealing a real phenomenon where a "higher rank leads to better health".

The important things in life are outlined: family, friendship, safe play places, good schools and food, public transport, warmth, a roof, green spaces, freedom from crime, interesting work, job security and looking after our elders. What's not to like? Yet the Americanisation of society has cut away at these over the past half century.

Back in the 1980s, when I studied microbiology, we learned that the great public health advances were not won through antibiotics and vaccines – though these have their place – but by sanitation, clean-air acts and better working conditions for the poor, particularly for women and children. Conventional wisdom is that over-indulgence in alcohol, tobacco and sugar are now eating away at our hard-won health gains. This fails to explain the bigger picture. A protective effect from social capital also exists, alongside a destructive effect from emotional abuse in the home or workplace.

The divide between rich and poor, within and between nations, creates steep gradients of inequality: from a life expectancy of 46 years in Sierra Leone to 84 in Japan. That health can improve quickly, however, is illustrated by Nepal where life expectancy increased by 20 years from 1980 to 2012.

The Health Gap showcases inspiring examples, particularly from low-income countries, of building fair societies which lead to better health. His book calls for a



radical change in the way we think about how health is shaped by society and how societal changes can improve health for all. Key is being in control of our lives – having agency – and living meaningful lives that we value.

Frances MacGuire

The Health Gap
Michael Marmot

Published by Bloomsbury
ISBN 978-1408857991
RRP: £20.00

The lonely planet guide to health systems

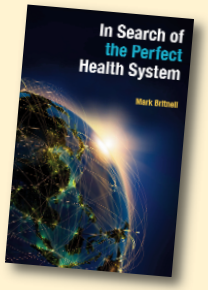
THIS fascinating book by the global head of healthcare at KPMG is an overview of the health systems of 25 countries around the world summarised into short chapters which can be read, claims the blurb, "in the time it takes to drink a cup of coffee".

Although written in five parts, there are really two aspects to the book. The first four parts cover the country profiles addressed geographically. Part five is a section on global challenges of common concern including universal healthcare, clinical quality and ageing populations.

As a whistle-stop tour of healthcare around the world, it succinctly addresses the key aspects of different systems with some historical and economic context, outlining what works and what doesn't, and includes personal reflections that bring the chapters to life. Certainly, for the countries whose health systems I know well, it covers the salient facts as well as further interesting aspects of the health system or the country as a whole. It does not pretend to be an in-depth academic analysis of every health system; it is a lighter read than this, Britnell describing the chapters as "reflections" on countries that are "both striking and familiar to me".

Perhaps the most interesting part of the book is the first chapter which picks the 'best bits' from different countries in order to create an imagined perfect health system. For example, the values and universal healthcare of the UK, the primary care of Israel, the community services of Brazil and the health promotion of the Nordic countries. This chapter emphasises that no health system is perfect and the importance of learning from other countries. It also demonstrates what works really well and where. There is certainly much learning that we should reflect on for our own health system. For this reason, this section might be better placed as the conclusion, tying the book together more successfully perhaps than the actual conclusion which highlights how health systems are restricted by their historical contexts. This final chapter also looks at "near-future trends that show great promise for tomorrow" which would have fitted better in an earlier section. It might also have been helpful to include a chapter or, at least, table that grouped health systems by theme, such as those which are universal, welfare-orientated, socialist or entrepreneurial.

Overall this is a very interesting book



covering a vast amount of ground for anyone with an interest in health systems. Best of all, its self-contained essays can be dipped into, if not over one cup of coffee, then at least over two.

Leonora Weil

In Search of the Perfect Health System
Mark Britnell

Published by Palgrave Macmillan
ISBN 978-1137496614
RRP: £19.99

From the CEO

IT'S difficult to keep up with all the work that the Faculty of Public Health (FPH) is involved in – even if, like me, you are in the fortunate position of having an overview of our activities. So, in this edition, I offer an in-year update on FPH central activity – including some work with which members may be less familiar.

We delivered our annual conference in June in Gateshead with 500 delegates attending. We launched our Special Interest Groups (SIGs) and now have 14 SIGs in place covering local and global issues. We launched an All-Party Parliamentary Group in Westminster on Health in All Policies. We have had regulator approval for the revised Specialty Training Curriculum and have developed our understanding and plans for practitioner membership and support. We received a positive quality assurance review of our continuing professional development scheme and introduced new awards for local public health teams in collaboration with partners. We continued to lead the development and shape of the UK Public Health Network (of national public health bodies), engaged in the People in Public Health cross-sector workgroup and continued to build effective partnerships across a range of our work. We increased our international engagement – supported by a new FPH Global Health Strategy – with a successful Department for International Development bid for capacity-building work in India, engagement events in India, Singapore, Milan and Copenhagen, and leadership of the Academy of Medical Royal Colleges' Global Health Group. We achieved a high level of media coverage (advertising value equivalency c£1.4m), started the redevelopment of our website and began a strategic review of the *Journal of Public Health*. We developed a new governance model for an incorporated FPH and received a strong mandate from our members in favour of the revised articles and regulations.

I thought it might also be useful for readers to get a sense of some of the 'in-week' work for the week I wrote this update: preparing for the Health Select Committee report on obesity, readying ourselves to launch our campaign to challenge the cuts to the public health budget in England, finalising our charity commission application for the new incorporated body, tweaking our proposals for the 2016 budget for the November board meeting, user-testing our customer relationship management system (to improve our IT and how we do our business), meeting the General Medical Council to develop the Part A examination, preparing a presentation for the American Public Health Association conference, and finally, meeting the publisher of the *Journal of Public Health* to discuss our contract. Of course, this only represents a fraction of the overall weekly work of the team here at FPH headquarters, which is working hard to deliver improvements to a wide variety of our services, but hopefully it offers a flavour, and perhaps highlights some areas of work that are new to you.

If you feel there is something missing from this update – or something you feel strongly that FPH should be doing – please do get in touch. The management team and I are keen to improve the ways that members can help deliver our ambitious and challenging strategy – and we are always open to ideas.

David Allen

News in brief

Equality and diversity
Members with an interest in equality and diversity are invited to help the Faculty of Public Health (FPH) review existing policies and practice and develop new policies across all aspects of our work.

If you would like to contribute to this equality and diversity working group, please get in touch through our membership officer at membership@fph.org.uk

Practitioner membership
FPH membership is now open to practitioners registered with the UK Public Health Register and those enrolled on a practitioner registration scheme.

As the professional home for public health we understand that many public health practitioners are undertaking more strategic work, and FPH members have chosen to expand our community and welcome our colleagues who deliver public health across the UK. Find out more and download the registration forms at http://www.fph.org.uk/fph_practitioners

Your 2015/16 annual CPD return

The end of the continuing professional development (CPD) year approaches and so is the time to submit your annual CPD return for 2015/16. This is the return which states how many CPD credits you will be claiming for the period 1 April 2015 to 31 March 2016. Your return is due to reach FPH no later than 30 April 2016.

Journal of Public Health
Coming up in the *Journal of Public Health* are, among many others, articles on:

- Improving the help and support provided to people who take new psychoactive substances ('legal highs')
- Factors associated with the uptake of seasonal influenza vaccination in adults
- Reducing social inequalities in obesity: complexity and power relationships

Find out more: jpubhealth.oxfordjournals.org

Resuscitation training in schools
FPH President John Ashton will be representing FPH at a conference on resuscitation training in schools on 26 February 2016 at the Royal College of Physicians, London. Creating a Generation of Lifesavers aims to bring together those interested in CPR and automated external defibrillator (AED) awareness in schools.

In memoriam

Hastings Carson FFCM
1923 – 2015

QUALIFYING in 1946 and after a spell in the Royal Army Medical Corps, Hastings Carson followed a career in local public health, becoming Medical Officer of Health (MoH) for St Marylebone Borough Council until 1965 when it was merged into the City of Westminster.

As Westminster's Deputy MoH, Hastings developed a close interest in communicable diseases, public hygiene and school health. In 1970 he was appointed MoH for the London Borough of Wandsworth where he remained until his retirement. During his tenure at Wandsworth he published a paper on the prevalence of TB in local schoolchildren, finding a rate almost double the national average, correlated closely with the borough's large Asian community.

Hastings was a keen proponent of multidisciplinary public health from the earliest days and was involved in the development of the Diploma in Public Health by the Royal Institute of Public Health & Hygiene. In the 1990s he was elected Chairman of the Royal Institute of Public Health, later becoming a Vice-President. He was also an invigilator of the Faculty of Public Health Part A exam for many years.

Hastings was a charming man with sparkling eyes and a cheerfully Pickwickian manner. Aside from public health, his greatest passion was cricket, and he was never happier than in the members' enclosure at Lords.

Walter Wigfield FFCM
1927-2015

WALTER Wigfield qualified at the Middlesex Hospital Medical School and did his National Service in the Royal Army Medical Corps, including a tour in Malaya which first fired his interest in public health.

Back home he worked in preventive and community health in various parts of the country including Oxford, Middlesbrough and Coventry before eventually putting down roots in Eastbourne where he became a geriatric consultant and specialist in community medicine.

After he retired, Walter volunteered with the St John Ambulance, campaigned for improvements in public health (notably hearing loops in meeting places and wheelchair access in town centres) and did a great deal of outreach work in his local community.

Aidan Halligan Hon FFPH
1957 – 2015

GRADUATING from Trinity College Dublin in 1984, Aidan Halligan specialised in academic obstetrics and gynaecology at Leicester University and by 1997 had become the UK's youngest professor of foetal maternal medicine.

His great passion was patient safety and clinical audit, publishing prolifically on the subject, which led to his appointment in 1999 as Director of Clinical Governance for the NHS. In 2003 he was elevated to the post of deputy chief medical officer for England and, together with Liam Donaldson, helped the drive for consistent standards of patient safety and care across the NHS.

In 2007, as director of education at University College London Hospitals (UCLH), he set up a state-of-the-art learning centre with simulated theatre and wards equipped with CCTV to provide trainees with opportunities to observe and learn from human behaviour in various challenging situations. A visit to the A&E facilities in Camp Bastion Afghanistan inspired him to establish an NHS staff college in leadership development at UCLH based on the close teamwork focused around patient welfare that he had witnessed at Bastion.

Alongside all this, in 2010 Aidan and a colleague created an independent charity, Pathway, to improve the way the NHS cares for homeless people. There are now 10 Pathway teams across the country. In 2014 until his death in April he was the inspiring Director of Well North, a Public Health England initiative to improve the health of the underprivileged across the North of England.

Throughout his all-too-short life, Aidan was a man who not only cared about those less fortunate than himself but made sure he used his immense energies to do something practical to help them help themselves.

William Barton FFCM
1923 – 2015

BORN in Kisumu, Kenya, William Barton graduated from Edinburgh in 1945 and joined the British Overseas Colonial Service the following year as a medical officer for the Kenyan administration, serving in many of the colony's districts.

In 1956 he was transferred to Zanzibar as Assistant Director of Medical Services and later as Director, a post he held until the independence of Zanzibar and the other East African Colonies in 1963. During his tenure he was put in charge of the World Health Organization (WHO)/United Nations Children's Fund malaria eradication programme in Zanzibar.

Back in the UK, William was appointed Senior Lecturer in Tropical Hygiene at the London School of Hygiene and Tropical Medicine (LSHTM) and was seconded on two occasions in the mid-1960s as a consultant to the Foreign Office working on public health liaison in Afghanistan and Ankara.

In 1969 he was promoted Reader at LSHTM and given responsibility for structuring a new programme in 'public health administration for the developing situation' for the new Diploma in Tropical Public Health.

Between 1967 and 1971, William worked for WHO as the director of a training course on the administration of parasitic disease programmes at Makerere University, Kampala; and later as a consultant for the WHO Division of Public Health Administration on programmes in Indonesia and Thailand. In 1973, under WHO Director General Halfdan Mahler, William was appointed head of an evolving, whole-organisation, staff development and training programme which became an important component of the 1979 Health for All by the Year 2000 global strategy.

After retiring from WHO in 1983, William continued with health administration consultancies, including three years for the health minister of Dubai.

Deceased members

The following members have also passed away:

Sydney Baigel FFPH
Peter Burvill FFPH
Duncan Conacher OBE FFPH
Arun Datta-Sarma MFPH
Viola MacKay FFPH
Clifford Shaw FFPH

Using your specialist skills after you retire

A GROUP of 30 retired FPH Fellows met on the afternoon of 2 October 2015 at the Royal College of Physicians of London. Two previous FPH presidents as well as senior FPH members led energised and productive discussions on how members could use their specialist skills during retirement and engage with FPH and public health standards.

A second group of 20 senior FPH Fellows met on 2 November at the Royal College of Physicians of Edinburgh. This was the first time that FPH had hosted such an event with its Scottish members, and it provoked an equally engaging and passionate discussion.

Outlined below are some of the key actions that emerged from these afternoons and that we have started working on at the FPH offices and with members.

London meeting actions

Eileen Rubery offered to set up and lead a group of senior FPH members to conduct work relevant to retired public health specialists. This would include:

- Giving feedback to the NHS on their experience as users of their services
- Giving feedback to the General Medical Council on their experience with revalidation
- Putting together a member-led policy and working group on disability and equality access.

Anyone interested in helping Eileen set this group up should contact her at edr1001@cam.ac.uk

FPH Chief Executive, David Allen, will propose a dedicated Retired Members Group to the Governance Review Working Group as part of the new FPH committee and group structure.

Nick McKenzie, FPH Membership Officer, will set up an online group for retired members to discuss ideas, projects and events.

Faculty Local Affairs Committee (FLAC) information will also be included in the retired members' bulletins.

FPH will contact its known blind members and put them in touch with one another.

FPH will ensure that the new FPH database captures retired members' skills and experiences so that targeted groups can be approached for future work.

Edinburgh meeting actions

FPH will circulate more calls to action and ways in which retired members can contribute directly to its advocacy campaigns. Senior members have the time and experience to lobby their MPs well. These calls will include:

- A new FPH guide on how to contact your MP and advocate in your local area
- Asking members to sign national petitions.

FPH will make continuing professional development requirements clearer to retired members to improve the transition for public health specialists from work into retirement.

FPH will look into extending the current buddy scheme for new consultants to allow senior members to support local working members.

If you have any questions or feedback on any of these items, then please contact us at membership@fph.org.uk or call 020 3696 1483.

Nick McKenzie
FPH Membership Officer

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to FPH between September and November 2015

Fellows
Bayad Abdalrahman
Josip Car
Catherine Coyle
Bethan Davies
Helene Denness
Durka Dougall
Jane Fowles
Delphine Grynszpan
Farrah Hart
Rachel Isba
Jillian Johnston
Srinivasa Katikireddi
Ben Leaman
Bruce McKenzie
Gillian O'Neill
Elizabeth Orton
Vivienne Robbins
Louise Sigfrid
Sarah Smith
Jason Strelitz
Claire Turner
Fiona Watson
Kirsten Watters

Members
Adeola Agbebiyi
Keith Allan
Helen Armitage
Esther Aspinall
Mohamed Azhar
Sally Cartwright
Richard Firth
Claudia Langenberg
Anna Seale
Thomas Waite

Diplomate Members
Julia Bates
Bethan Bowden
Peder Clark
Timothy Crocker-Buque
Andrew Dalton
Ioseff Llion Davies
Jonathan Wai-Kin Fok
Simon Hailstone
Rachael Hornigold
Elizabeth Moore
Christos Mousoulis
Georgina Pearson
Charlotte Smith
Samantha Taplin
Emily Tweed
Emily Walmsley
Jenny Wares

Specialty Registrar Members
Claire Greszczuk
David Munday
Andrew Rideout
Sarah Wilkinson

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Bayad Abdalrahman
Liann Brookes-Smith
Jonathan Hobday
Johanna Jefferies
Abigail Knight
Ben Leaman
Lisa Peto
Vivienne Robbins

Defined specialist portfolio route
Kate Ezeoke-Griffiths
Cheryl George

GENERAL MEDICAL COUNCIL REGISTER

Dominique Allwood
Esther Aspinall
Ruchi Baxi
Stella Botchway
Dhanika Dabrera
Michelle Gillies

FPH elections

President
We are delighted to announce the election of Professor John Middleton as the new President of the Faculty of Public Health (FPH). He will take office from the close of the annual general meeting in June 2016 and serve for a term of three years.

John is the immediate past FPH Vice President for Policy, an office he held for five years. He is an Honorary Professor of Public Health at Wolverhampton University and former Director of Public Health in Sandwell.

We would like to record our sincere thanks to all the candidates who stood in this election. A full report of the election results can be found on the FPH online members' area or is available from Caroline Wren at carolinewren@fph.org.uk, tel. 020 3696 1464.

Academic Registrar
We are very pleased to announce the election unopposed of Brendan Mason as Academic Registrar. He will take up office from the annual general meeting in June 2016 and serve for a term of three years. Brendan is currently Assistant Academic Registrar and has a wide-ranging interest in medical education. He successfully led the recent FPH curriculum review which resulted in the approval of the new 2015 curriculum by both the General Medical Council and the UK Public Health Register.

Treasurer, Assistant Registrar and Assistant Academic Registrar
The results of the Treasurer, Assistant Registrar and Assistant Academic Registrar elections will be known by early to mid-February. The results will be announced in the monthly ebulletin and the next issue of *Public Health Today*. The successful candidates will all take up office from the annual general meeting in June 2016.

Local Board Members for the North West of England, East Midlands and West Midlands
Nominations opened on 8 January and close on 5 February 2016 for the election of Local Board Members for the North West of England, the East Midlands and the West Midlands. The posts are open to all FPH members in good standing. Nomination papers, including a post description, are available on the FPH online members' area or from carolinewren@fph.org.uk, tel. 020 3696 1464.