The magazine of the
UK Faculty of Public Health
www.fph.org.uk

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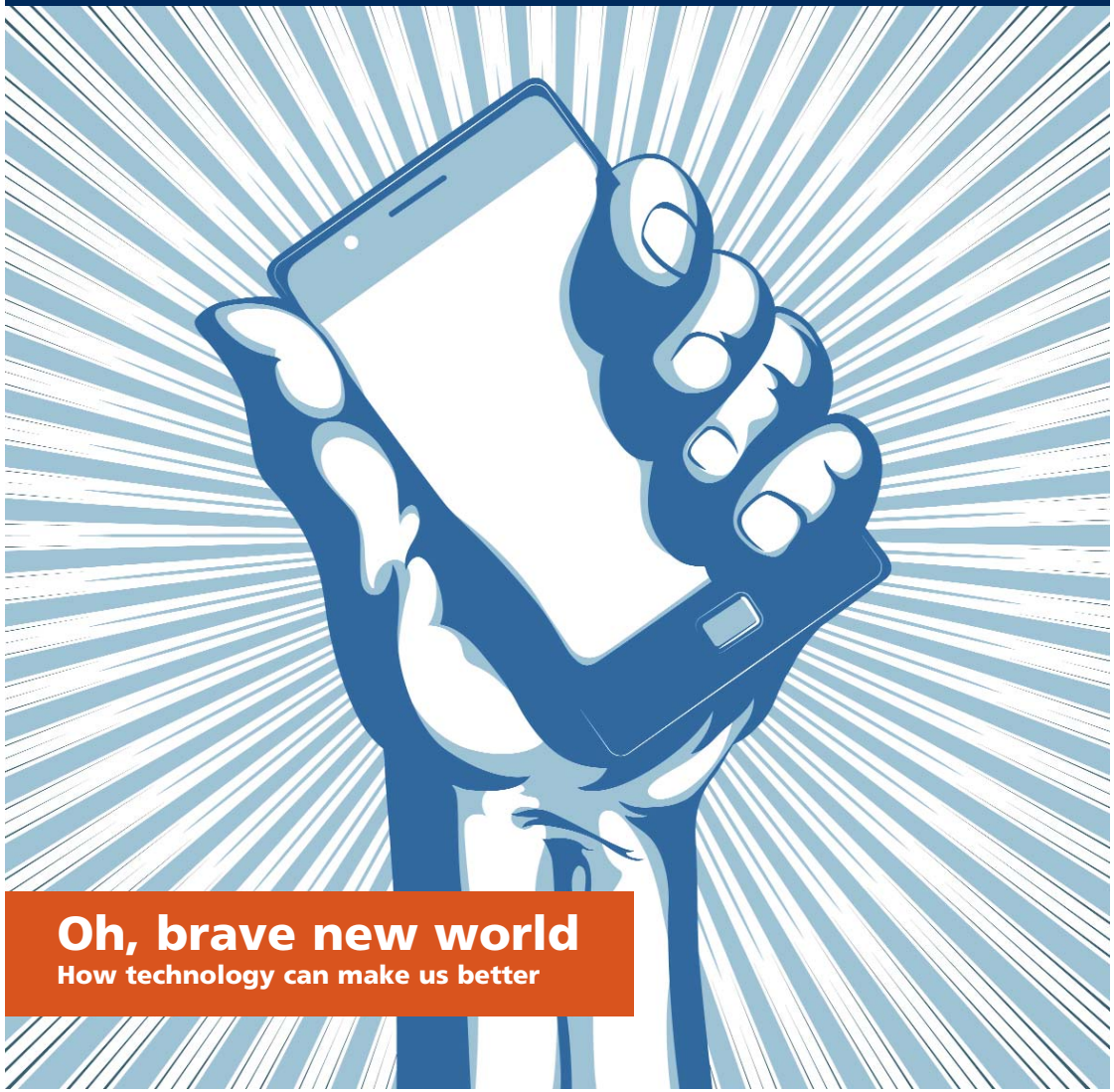
In this issue



# Public Health Today



## Oh, brave new world

**How technology can make us better**

**Public Health Today**
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## Contents





# Welcome

THE special theme of this edition for *Public Health Today* focuses on the pros and cons of technology, including social media – something I have been all too acutely aware of these past few months. A momentary lack of caution and judgement on my part has brought these benefits and risks into sharp focus. I responded inappropriately to a barrage of provocative and abusive, mostly anonymous, tweets attacking myself and my family. This followed my media defence of FPH's position on e-cigarettes.

I, of course, completely regret what happened and have sincerely apologised for my mistake. The support I have received from FPH's Board, officers, staff and members throughout this experience has been remarkable, and I am most grateful to them all.

Among the new technologies available to us, social media can be a great force for good – and ill – as this edition of *Public Health Today* debates. We all know that platforms such as Facebook and Twitter can be incredibly useful in galvanising opinion and action to tackle threats to public health and wellbeing. But, as my experience with social media shows only too clearly, they also have to be handled with care.

Social media is a tool that allows us to communicate on a global scale with people we might never meet but who nevertheless share a common purpose. This 'common purpose' is clearly demonstrated through our manifesto, *Start Well, Live Better* – a copy of which should be enclosed with this edition of *Public Health Today**. Produced after extensive consultation and discussion with members, it sets a bold challenge to all political parties to produce a strong and compelling plan for public health. It focuses on four key areas: investment in early years and children and young people's health and wellbeing; health-promoting legislation; a fairer and more

equitable society; and national action on climate change. A bold and ambitious agenda, you'll agree, but one that, as a public health family, we are more than capable of meeting head on. Through the Public Health Summit in October, we've already begun the conversation on how we might achieve this. FPH, working in partnership with the Association of Directors of Public Health, led the way in bringing together the UK's leading public health organisations to discuss how we actually do it.

I am totally committed to putting FPH on a firm footing for the future; working with you, the team at St Andrews Place and the wider public health family to realise the hugely ambitious and challenging vision set out in *Start Well, Live Better*. We need to harness our sense of common purpose, get smarter at using the amazing technologies available to us and the collective power of our growing global networks to slay the modern giants that threaten public health.

**John Ashton**

** Please email policy@fph.org.uk or call 020 3696 1452 if you haven't received a copy of FPH's Manifesto, 'Start Well, Live Better'. A more in-depth report can also be downloaded from www.fph.org.uk*



# Start Well, Live Better – a 12-point plan for public health

**FPH launches its manifesto ahead of the 2015 General Election**

Over the summer the Faculty of Public Health (FPH) asked its members what they thought were the priorities for any UK government – current and future – serious about improving people's health and wellbeing and about giving children the best possible chance of a healthy and happy life.

*Start Well, Live Better* is the culmination of that consultation. It sets out 12 key actions on child health, obesity, climate change, mental health, physical activity and healthy living. It is, of course, by no means a definitive list of everything that needs to change in public health policy, but it's an important and practical start, focused on those measures where there is good evidence that they will have a positive impact on health. The 12 actions included in *Start Well, Live Better* are those FPH has long advocated and will, if implemented, be hugely significant steps towards FPH's vision of 'better health for all'.

Following the Scottish referendum on independence, and with the close of the party conference season, all eyes are turned towards the General Election in 2015. Now, more than ever, we need to continue to advocate for the actions set out in *Start Well, Live Better:* standardised packaging, minimum unit pricing, children and young people to get that critically important good start in life, and collective action to tackle major global problems such as climate change.

But, as a small faculty, FPH can't do it alone. It needs its members' support. Share the manifesto with your MP and your local councillors, particularly those responsible for health and wellbeing. Share it with the people who you think can create positive change and lasting improvements in our own and our children's health and in our communities. Let's work together to realise our vision of 'better health for all'.

Tell us what you think. If you've supported any of the issues in the manifesto, or if you think there is something in particular FPH can do to realise the vision set out in *Start Well, Live Better,* let us know – email policy@fph.org.uk

You can find the FPH manifesto, *Start Well, Live Better* at http://bit.ly/1wWJ8g2

**UK government commended over action on Ebola virus**

The Ebola outbreak in West Africa is destroying communities and livelihoods, overwhelming weak health infrastructures, putting education systems at a standstill and raising the spectre of hunger and famine. Its scale may compromise effective containment and management.

FPH commends the UK government for action taken so far to support relief efforts, but much more is needed from the UK and internationally. Public Health England is providing up-to-date guidance for professionals (http://bit.ly/1pKLzNW) and the public (http://bit.ly/1B0SaJ1), and stresses that the risk to the UK remains low.

In response to the crisis, FPH has published a policy statement (http://bit.ly/1uhzymG). For further information, please contact markweiss@fph.org.uk

**Lindsey Stewart**
*Head of Health Policy & Advocacy*


# News in brief

**HIV evolving 'into milder form'**
HIV is evolving to become less deadly and less infectious, according to a major scientific study. The team at the University of Oxford has shown that the virus is being "watered down" as it adapts to our immune systems. Some virologists suggest the virus may eventually become "almost harmless" as it continues to evolve.

**Funds pledged for eating disorders**
Deputy Prime Minister Nick Clegg has pledged an extra £150m of funding to help children with eating disorders. The aim is to invest in preventive therapy to cut the need for hospital treatment. The money, earmarked in this year's Autumn Statement, comes after figures show that admissions for eating disorders among young people have been rising in England.

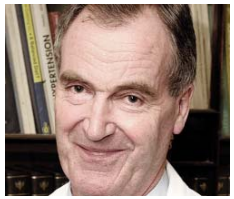
**'No link' between tough penalties and drug use**
There is "no obvious" link between tough laws and levels of illegal drug use, a Home Office report has found. Liberal Democrat Home Office minister Norman Baker said the report, comparing the UK with other countries, should end "mindless rhetoric" on drugs policy.

**Air pollution 'causing health crisis'**
New schools, care homes and hospitals should be built far away from major roads because of the dangers of air pollution, a report by MPs has said. The Environmental Audit Committee argued that air pollution was a "public health crisis" causing nearly as many deaths as smoking.

**Flu vaccine 'given to too few toddlers'**
Fewer than one third of two to four-year-olds are getting the flu vaccine nasal spray, the latest figures show. The uptake is down on the same point last year, the first time children were routinely immunised against flu. Public Health England said that young children were "super-spreaders" of flu.

**Obesity 'costing same as war'**
The worldwide cost of obesity is about the same as armed conflict or smoking and greater than both alcoholism and climate change, research has suggested. The McKinsey Global Institute said it cost £1.3tn, or 2.8% of annual economic activity. About 30% of the world's population were overweight or obese, the researchers added. They said measures that relied less on individual responsibility should be used to tackle the problem.

INTERVIEW



Graham MacGregor is Professor of Cardiovascular Medicine at the Wolfson Institute of Preventive Medicine, Barts and the London Hospitals (Honorary Consultant Physician). He set up Consensus Action on Salt and Health (CASH) in 1996 and World Action on Salt and Health (WASH) in 2005. He is also chairman of Blood Pressure UK.

# 'Change the food environment'

## It's easier than changing habits, says MacGregor

**How did you come to focus your research interest on salt?**
During my training as a nephrologist I was interested in the relationship between the kidney's control of sodium and how it maintained sodium balance. We were fortunate to have a metabolic ward which allowed us to carry out careful balance studies in which we were looking at the effect of blocking the renin-angiotensin system on different salt intakes. This led me to realise the overriding importance of salt in regulating blood pressure. I was surprised at this time that blood pressure pundits such as Sir George Pickering felt there wasn't much evidence that salt affected blood pressure. In view of this, I set up a double-blind study in the late 1970s which clearly showed that a modest reduction in salt intake caused relatively large falls in blood pressure. This put salt reduction as a means of reducing blood pressure on the map.

**And your shift into advocacy?**
Even then I was aware of opposition from the food industry to reducing salt intake. I was on the COMA [Committee on Medical Aspects of Foods] report in the late 1990s, which provided expert advice on how to change diet to prevent cardiovascular disease. One of the many recommendations it made in 1994 was to reduce salt.

This was initially endorsed by the Conservative government, but the food industry started to campaign about the 'nanny state'. The Chief Medical Officer then announced that the recommendation would not be implemented. It was then revealed in the *British Medical Journal* (*BMJ*) that several food companies had threatened to withdraw funding from the Conservative Party. It was alleged by the *BMJ* that someone from Downing Street had ordered the Department of Health to rescind the specific recommendation to reduce salt.

This made several members of COMA so incensed that we decided to set up an action group called CASH [Consensus Action on Salt and Health]. I was coerced into running this and hadn't much clue what to do. But over time we learned how to write press releases and work with the media. We were successful in changing the Department of Health policy on salt and then, through working closely with the public health minister and the Food Standards Agency, the UK salt reduction policy was started which then went on to lead the world in reducing salt.

**Why do you think CASH has been so successful?**
If I am going to do something, I want it to be successful. I have always been quite driven but also had very good people working with me who deserve great credit, and at the same time, a group of all the experts in the UK on salt were very supportive.

**What triggered your interest in sugar and public health?**
Like salt, sugar can also easily be reduced slowly so that the public don't notice. Having seen the success of the gradual reformation of salt, particularly in the UK, I thought: Surely we can do something about obesity and type-2 diabetes? We tried to persuade health and obesity experts to do it, but none of them were interested. At the same time we realised that sugar wasn't itself that toxic, unlike salt, but it was a completely unnecessary source of calories that gave no feeling of satiation. So we decided to set up an action group on sugar to reduce calorie intake and and caries. Given our previous experience we developed a very clear plan of how to reduce calorie intake through the reformulation of sugar and fat. We now have the more difficult task of persuading the UK government to take action.

Unfortunately, the Food Standards Agency is no longer involved due to Lansley's mad Responsibility Deal which has added to the difficulties of getting anything done in UK public health. We may have to focus on other countries to get sugar reformulation going. We are trying to maximise pressure on Jeremy Hunt [Secretary of State for Health] before the general election.

> **None of the organisations I have set up have committees, which are often a way of venting hot air. Nothing gets done and they often miss the bigger picture**

**What else could be done to improve our diet in Britain?**
Besides salt and sugar we need to reduce the huge amounts of fat which are another source of calories, particularly saturated fat. Palm oil is one of the worst – it is incredibly cheap and stuffed in all sorts of products. We would like to see an increase in fruit and vegetable consumption, but it is much more difficult to persuade people to change their habits than to change the food environment, particularly by incremental reformulation.

At the moment, obesity is one of the sixth or seventh causes of death worldwide, but it's rapidly increasing. Once you have it, there's very little you can do besides having a surgical operation on the stomach. I remember how trying to get obese people who attended a blood pressure unit to lose weight was a nightmare. Ten years later, they would have put it back on. The only successful public health policy would be to prevent obesity and thereby the development of type-2 diabetes.

**What are you most proud of in your career?**
The first paper we published in the *Lancet* on salt – but the excitement soon dies!

You must learn to delegate responsibility; you can't do everything yourself. I have had very good people advising and helping me with both the salt and sugar work, and also in our research.

**Is there anything that keeps you awake at night?**
I've been very lucky in my career and fortunate in not having to worry about things.

When I was younger, I saw very little of my children when I was training in nephrology, and I do resent that now.

**Is there anything you do to relax?**
I like to do something that takes me away from all the politics. I love getting stuck into a garden design or project, like getting the chainsaw out and clearing trees. The one thing I hate is committees. None of the organisations I have set up have committees, which are often a way of venting hot air. Nothing gets done, and they often miss the bigger picture. In public health we need to do things that are practical and will work. Gradual reformulation of food does work and will lead to major public health improvements.

**Interview by Liz Skinner**

# The future's byte

The potential impact of technology on public health is enormous – and we need to be cautious, says Alan Maryon-Davis

AS GEORGE W Bush once confidently predicted: "The future will be better tomorrow." It's a comforting thought, promising tangible improvement on today's future, to say nothing of yesterday's. What George W had in mind, no-one knows – perhaps not a lot. But there's just a chance he might have been contemplating the potential impacts of emerging technologies on the practice of public health across the globe. If so, it would have been an example of his amazing prescience. Because in many ways the future has arrived, and it's really quite exciting.

Take for example the phenomenal rise of social media. What an incredible power for good – or evil – and what a tool to promote and protect the health of the people. Think of all the interest groups and networks on platforms such as Facebook, LinkedIn and ResearchGate. Think of all the instant sharing of news, updates and opinions thronging the Twittersphere. Think of all the potential uses of sites such as YouTube or Dropbox for sharing videos, presentations, lectures, training notes and a lot else besides. And consider the miracle that is Google with its unimaginable ability to dig out more-or-less anything, anywhere, in a split nanosecond. We take this for granted now – but what an incredible facility it has been to public health.

> **Consider the miracle that is Google with its unimaginable ability to dig out more-or-less anything, anywhere, in a split nanosecond**

In this issue of *Public Health Today* we delve into the future here and now for technology and public health. We consider the use of Big Data for dynamic epidemiology in rapidly changing scenarios, see an example of touch-screen technology for patient information, have a glimpse of crowdsourcing being used to propagate mental health messages and discuss the increasing role of telehealth and telecare in the management of people with long-term conditions. There's a piece on prize-winning phone apps for health and wellbeing, another on confidentiality and sharing patient data, and a third on social media in training. We also see how solar power is transforming lives in Africa and India.

But George W's unbounded optimism may need to be tempered with the 'yes-buts' of harsh reality. New technology has its downsides and dangers – indiscriminate data-mining, social-media trolling, cybercrime and cyberterrorism. We have a piece on intrusive commercial marketing – the alcohol industry's manipulation of social media. And our debate focuses on the pros and cons of a technology that may turn out to have a huge impact on public health – genomics, the joys and the pitfalls.

So, as well as embracing these techno-wonders, we have to be on our guard and make sure the benefits for public health outweigh the risks. Because, as George W famously put it: "If we don't succeed, we run the risk of failure."

**Alan Maryon-Davis**
*Editor in Chief*





# How teenage Fahma's simple ask became a global phenomenon

WHEN 17-year-old Fahma Mohamed started a petition calling for Education Secretary Michael Gove to write to schools about female genital mutilation (FGM), she had no idea the impact it would have. In less than three weeks 200,000 people signed her petition, and she was invited to meet Mr Gove, who then agreed to her request. Now, with the support of United Nations Secretary-General Ban Ki-moon, the campaign has gone global.

Fahma's petition was successful because she told her story of being a teenager who had seen first hand the impact of FGM. Backed by the *Guardian* newspaper and featured on change.org, her story was shared, and the public supported her. Fahma asked for something simple – just a letter to schools. It was a simple request, easy for Mr Gove to say yes to, but it brought FGM to a new audience and gave the campaign to end it huge momentum.

Many successful change.org petitions share these two features: a personal story of someone affected by the issue and a simple ask. People relate to individuals and a simple ask makes winning a possibility. People believe that their signature matters.

> **It can be a great way to engage with thousands of people and explain decisions**

Phill Wills' campaign to bring his son Josh home featured both of these. Phill's son Josh, a 13-year-old with serious autism, was being kept in a unit in Birmingham 500 miles from his family in Cornwall. Phill's petition just asked to "bring Josh home". Within one day of starting the petition, 10,000 people backed him, and the chief executive of his local NHS agreed to meet. From that point forward everything changed, and a person-centred plan was introduced for Josh. The family were listened to. Four months later – with a campaign backed by 240,000 signers – Josh is coming home.

Since the success of Phill's petition, more families in similar situations have started petitions. They are working together, supporting each other through their campaigns. People are realising the power that they have to call for change, and the internet is helping them connect with people across the country who want to support them.

PETITION: Fahma Mohamed

Patients and families should always be at the heart of any decision-making in the health service. But, as Josh's story shows, sometimes they become lost in the system. Petitions help give power back to the families, to gather support and get their voices heard.

As more patients and families start to use these tools, health and healthcare professionals will need to be ready to respond. Responses can be directly to the families or sent to everyone that has signed the petition on change.org. It can be a great way to engage with thousands of people and explain decisions. Fahma and Phill's petitions both had happy endings because officials engaged with them and listened to their concerns. Then they worked together to find a solution.

Dialogue will be the key to the success of petitions. If petitions help patients highlight concerns, raise ideas and establish a better dialogue with decision-makers in the health service, they will have a positive impact on services. Public health may be about populations, but the narrative approach of individual stories can lead to a ripple effect that changes the lives of many.

**Katherine Sladden**
*Senior Campaigner*
*change.org*

# Don't wait for class – teach it on Facebook

THE undergraduate medical curriculum is a crowded place. Producing safe, skilled and professional doctors is a complex task, and public health topics are often squeezed. Across the UK, a number of medical schools are using social media to increase student engagement with these topics.

Social media gets information to students outside normal teaching hours; you can discuss a recent outbreak or report when you find it, rather than wait for a lecture or lose the opportunity altogether. A platform such as Twitter allows the sharing of relevant media, questions after lectures and specific teaching activities using hashtags (a way to identify Tweets on a specific topic). Such conversations can be summarised later using a platform such as Storify (eg. storify.com/DundeePublicH/fluscenario-week-1). Twitter feeds can also be embedded in teaching web pages.

Twitter is a public space. This encourages interdisciplinary teaching, such as the #O157 hashtag used by Dundee medical school and Nottingham and Bristol veterinary schools. Public access is also a disadvantage: while most of the Twitter community make positive contributions, there is a possibility for misunderstanding or even abuse. The tutor needs to consider these risks and plan accordingly or move to a closed-group format such as Facebook or Google+.

Also of value to educators are 'curation' tools. Scoop.it can be used to collate subjects and can be embedded in web pages. Rather than a static reading list, the Scoop.it feed updates with relevant articles. Other similar platforms include Pinterest and Padlet. If you want to know more about medical education and social media, try #FOAMed (Free Open Access Medical education) on Twitter, or the website http://lifeinthefastlane.com/foam/

Interestingly, our experience is that very few students view social media as an educational tool, especially Twitter. Often they have absorbed the messages about the risks of public exposure and digital professionalism and concluded that it is safer to avoid it altogether. It's important to demonstrate the added value of the format to students. It's a powerful tool but needs engagement from tutors and students for greatest effect.

**Eleanor Hothersall**
*Consultant in Public Health Medicine*
*University of Dundee and NHS Tayside*

DEBATE: Is genomics a game-changer for public health? Hilary Burton says it would be if we recognised its power, while Hilary Rose cautions against believing the hype

## A vital tool in prevention and healthcare

GENOMICS is a game-changer in modern medicine, but it seems that only public health, with its insistence on looking at populations rather than individuals, has failed to recognise its power.

Public health has traditionally focused on major risk factors for disease and the prevention and management of common chronic diseases. It has included external environmental factors and used a 'one size fits all' approach. Genomic science, together with the increasing ability and demand of individuals to take more control of their own health, will inevitably move care towards a more personalised approach. As noted by Simon Stevens in the recent *NHS Five Year Forward View*, we face an increasing gap between the needs of an ageing and increasingly unfit population and the resources available to pay for healthcare. Genomics and other technologies will be an essential element of the 'transformational' solution. What role should public health play in this solution?

Genetic variation is a vital factor in disease risk, and prevention programmes should be tailored accordingly. For inherited conditions, such as familial hypercholesterolaemia, systematic identification and treatment of affected family members must be put in place.

**YES**

There is potential for preconception, antenatal, newborn or even adult screening. Focusing preventive interventions, such as cancer screening, on individuals whose genetic makeup makes them more susceptible to disease is likely to be cost-effective whilst minimising harm.

Genomics is now a fundamental feature of medical diagnosis and healthcare. The molecular signature of a tumour provides information about prognosis and guides treatment choice, while cell-free cancer DNA biomarkers in the bloodstream may soon provide early warning of recurrence. For rare disorders (which are thought to affect almost one fifth of the population), sequencing technologies will increasingly enable early, rapid and accurate diagnosis. Pathogen genomics is expected to become essential in evaluating antimicrobial resistance and treatment choices, controlling hospital and community outbreaks, and identification and monitoring of emerging infections.

Genomics helps get things right first time for each individual. This is good for healthcare systems and will be demanded by the public. Public health people must use their knowledge and experience on population need to promote preventive and healthcare systems that institutionalise the provision of effective, efficient and high quality care for their populations. This will be their essential role in the 21st century and genomics will be a vital ingredient.

**Hilary Burton**
*Director*
*PHG Foundation*

## It tells us little about the real challenges

THE 1989 editorial in *Science*, welcoming the Human Genome Project (HGP), was a spectacular essay in hype – promising treatments for depression, Alzheimer's, schizophrenia and heart disease, and, therefore, solutions to problems of homelessness. With gene therapy, new drugs and personalised medicine, the whole nature of medical care would be transformed.

Twenty five years later the language has calmed down, but the optimism of genomics remains. Given enough sequences and big enough data analyses, multiple genes will be identified and tailor-made drugs will arrive. But so far, with the exception of specialised cancer treatments, there have been remarkably few new drugs to deal with the major killers.

By contrast, leading scientists have argued that 'molecularisation', with weak theory, has generated the equivalent of a list of telephone numbers but no names – a list of parts but no Ikea guide to put them together. Some have turned to epigenetics as offering an analysis of gene/environment interaction and epistasis as gene/gene interaction during development. Hype has been replaced by more modest claims for health.

Meanwhile, the public health challenges of the 1990s remain,

**NO**

but with the addition of a horrifying epidemic of class-related obesity and diabetes. What can genomics say about the intensifying precarity of everyday life, leading so many to reach for the cheap comfort food of saturated fat, salt and sugar?

In the 1980s, when public health was faced with alarming figures for heart-related morbidity and mortality, the World Health Organization Europe launched a health promotion programme to adapt lifestyle to one more appropriate to a post-industrial economy. But the pressure was not just on individuals – it was also on governments and the food industry to reduce fat content and label food clearly so that consumers could easily see what they were buying. It was to "make the healthy choices the easy choices".

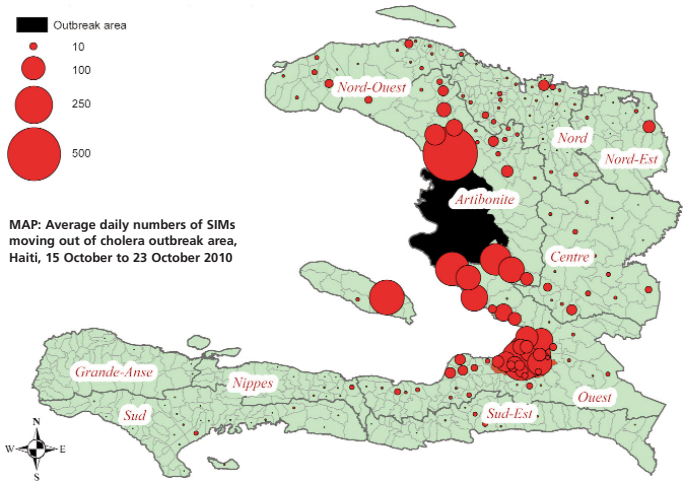
Today's policy is to 'statinise' the nation whilst bariatric surgery is offered as a stopgap measure to save individual lives. We need good public health research and public policy to reverse the obesity epidemic.

Have we got our biomedical research priorities wrong? When, a quarter of a century after the launch of the HGP, US President Barack Obama boasts that every dollar spent on genomics has generated 144 dollars in wealth, he unwittingly points to a shift in emphasis from health to wealth creation.

**Hilary Rose**
*Emerita Professor of Social Policy*
*Bradford University*








**MAP: Average daily numbers of SIMs moving out of cholera outbreak area, Haiti, 15 October to 23 October 2010**

# Big Data, big change

Mobile phones are now used by large numbers of people in every part of the world, and phone data is telling us how to fight epidemics, says Linus Bengtsson

ON AVERAGE, 30 million people are displaced every year by natural disasters. During large crises there is a severe lack of basic information on the locations of affected people. This prevents relief organisations from delivering the right amounts of supplies to the right places, even when sufficient resources are available.

Relief coordinators currently rely on eyewitness accounts, manual headcounts, registers of people in camps or satellite images of shelters. These approaches are either subject to heavy bias or too slow to provide robust decision support in rapidly changing conditions.

Organisations such as Flowminder, a Stockholm-based, not-for-profit organisation, can help to improve public health outcomes by analysing anonymised mobile-phone location data to understand where displaced people are and where they are moving to. This application of mobile operator data was pioneered by Flowminder after the Haiti earthquake.

Mobile phones now cover a large proportion of the population in most countries of the world. Increasing evidence shows that mobile operator data can provide important information on the spread of infectious diseases. Such data is crucial for efforts to eliminate malaria, for example, by enabling interventions to target the right populations. Methods developed by Flowminder are now used in routine work to support malaria elimination efforts in Namibia.

Flowminder also worked on the cholera epidemic in Haiti by providing near real-time analyses of population movements. The preliminary results look promising, indicating that the spread of cholera followed the movements of mobile phones well. The hope is that mobile data can also be used to predict the spread of other infectious diseases such as measles and influenza.

> **Mobile-phone data gives a better chance of knowing where cases may appear**

Flowminder's recent work has focused on supporting the Ebola response in West Africa. The researchers have analysed mobile phone and survey data from West Africa to build models of how people have moved during the crisis. However, while anonymous data from mobile operators can provide a supportive role, it can only be *part* of the solution to the epidemic.

You can be prevented from doing successful contact-tracing because the necessary resources are not available or people are unwilling to share such information. Mobile-phone data gives a better chance of knowing where cases may appear and allows for increased vigilance and surveillance. However, the data has its limits: it cannot track infectious people and for ethical reasons Flowminder researchers do not track individuals.

Much of what Flowminder does is focused on health problems in low- and middle-income countries, but many issues also apply to high-income countries such as the UK, where mobile operator data can be used to better understand population mobility and social networks of communities. Flowminder member Andy Tatem of Southampton University has shown how mobile data can be used to create dynamic population maps to better plan healthcare and social services. In low- and middle-income countries these analyses are even more valuable since other data sources are of such poor quality.

Some applications of Big Data in public health will no doubt prove to be very important, but the field is still very new and for most applications there is a lack of rigorous studies. More robust research is needed before we can realise the technique's full public health potential.

*Adapted from an interview with* **Linus Bengtsson**, *founder of Flowminder*

# What do we do with all the information?

IT IS becoming increasingly apparent that variations in our DNA, for the most part, are not sufficient to allow us to predict who will get a clinical problem nor when. So for the big killers (cardiovascular disease, diabetes) the advice to keep trim and carry on eating right remains the most applicable.

As we shift from testing for genetically-caused conditions through biochemical markers and go straight to the human instruction manual, a series of questions arises. What do we do with all the information generated? Do we give the person only the result they were tested for? Or do we give it all to them and let them deal with the uncertainty? Current advice is to only test a child for something that will affect them when they are old enough to understand and manage it themselves. So who will keep the 'other' results: the state, general practitioner (GP) or parents?

There is little doubt that the knowledge that one carries a recessive gene for a serious genetic disease is useful. What individuals do with that information varies. Should the NHS use resources on this? Is this something for an individual to pursue or should we run formal screening programmes for schoolchildren? Should we require individuals who have the test to tell their genetic relatives? Will self-testing, uploading results onto your phone and sending them direct to your medical records render much call/recall activity obsolete? Those who are IT-enabled can organise their own screening tests, repeat tests and follow up appointments. How can we ameliorate the inevitable inequities?

Other less fashionable technologies offer opportunities to change the way screening is carried out. The ability of computers to speak to one another without massive central systems and to push information to phones means that selection of a screening cohort can become much more complex. Currently, age and sex are pretty much the limits in determining who to invite. However, diabetic eye screening is showing us a more targeted approach by inviting people with diabetes from GP lists. The information is transferred electronically from GP records to call/recall systems.

> **Diabetic eye screening is showing us a more targeted approach by inviting people with diabetes from GP lists**

We know that family history, age, weight, age at menarche and menopause all shift one's risk of breast cancer. It's possible that this information could be gathered electronically from GPs if (it's a big if) the information is collected and stored in the patient's record. Perhaps patients could use their phones to add data to their records to make sure that such information is available to the electronic creepy crawly gathering the cohort. Whatever happens it will be fun!

**Anne Mackie**
*Director of Programmes*
*UK National Screening Committee*

# Remote care – from confusion to integration

TELEHEALTH and telecare are often portrayed as discrete classes of technology, but they are actually applications whose function depends on the service provided through them.

For telehealth, we are supporting people in the management of long-term conditions, such as heart failure, with technologies varying from light-touch app-based self-management systems to full-blown patient management platforms. These systems allow patients and clinical teams to collaborate. As such, telehealth is primarily monitored by healthcare professionals and usually falls under the long-term-condition-management pathways of primary care. It does not typically provide emergency or out-of-hours crisis response.

Telecare is mainly concerned with keeping people safe in their homes through the use of remotely monitored technologies, and so falls under the broader remit of assistive-living technologies. Care needs are often complex, and telecare is usually deployed as part of a broader package of assistive and care support, with a range of technologies and services being deployed.

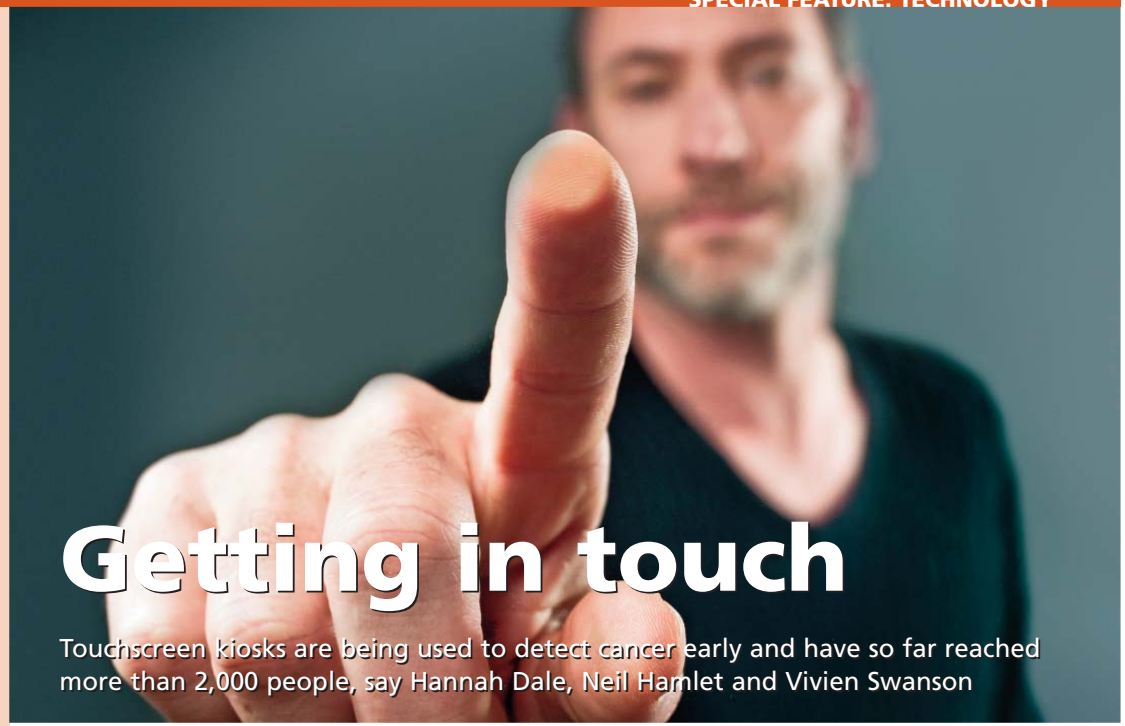
These technologies can be grouped in a number of ways, such as security (bogus-caller buttons, video entry systems), safety (falls detectors, pull cords and pendant alarms) and health and activity monitoring. The broader context of assistive technology could also include memory aids (auto lighting, reminders), leisure, social and communication (big-button TV remotes and phones) and carer support (key safes). Services tend to be monitored by housing or social care staff, but relatives may also provide a physical response. Telecare is usually 24/7 and provides assistance, emergency or crisis response.

Current services tend to be stand-alone. But the overwhelming need for service integration coupled with more flexible technology and 'bring-your-own-device' policies seems set to integrate services at a much more intimate community level. Public health plays a major part in these developments, driving direct engagement with individuals and communities, benefiting each for the benefit of all.

**Jonathan Thorpe**
*Telehealth Project Manager*
*University of Hull*
**Mike Burton**
*Independent telecare consultant*







# Getting in touch

Touchscreen kiosks are being used to detect cancer early and have so far reached more than 2,000 people, say Hannah Dale, Neil Hamlet and Vivien Swanson

HEALTH psychologists are specialists in applying psychological principles to understanding and improving health and wellbeing. Expertise focuses on understanding the psychological influences on and consequences of health and illness, and using this to develop individual-level to population-level interventions. These aim to improve lifestyle, self-management and emotional adjustment to health conditions and treatments through working with individuals, groups, communities and populations, along with staff, systems and policy.

Health psychology and public health have long been considered complementary disciplines with overlaps in aims and competencies. Work focuses on interventions with the general population, patients and staff, involving teaching, research and evaluation, service improvement and policy. In particular, health psychology can contribute to key areas such as the integration of health and social care in Scotland and, more generally, to reducing inequalities.

Health psychologists bring added value to public health teams through a greater understanding of the psychological processes involved in health promotion, disease prevention and care management. This expertise was put to good use in developing a local Detect Cancer Early campaign using interactive digital technology.

The initiative was led by the NHS Fife Public Health Department partnered with health psychology and a third-sector technology organisation. Interactive Bluetooth-enabled touchscreen kiosks were loaded with messages concerning the early detection of bowel, breast and lung cancer. The messages were framed in ways consistent with psychological evidence and theory, with close attention being given to the wording to ensure they were accessible, in particular by using plain English and short sentences. The touchscreen kiosks were located in prominent places in hospitals, pharmacies, leisure centres and workplaces.

> **Health psychology can contribute to key areas such as the integration of health and social care in Scotland and, more generally, to reducing inequalities**

In the first six months, the screens reached more than 2,000 people, of which 29% were from the 20% most deprived areas. People concerned about possible symptoms of cancer were directed to seek advice from their GP, cancer support organisations and, in appropriate cases, local bowel and breast cancer screening programmes. Fortunately, there were no major teething problems with the technology. A colleague from the third sector organisation leading on the technical aspects of the project had already undertaken a number of similar projects in the NHS, including developing technology to enable Bluetooth downloads. A pre-post evaluation exploring attitudes and intention around screening and help-seeking for symptoms is underway.

**Hannah Dale**
*Health Psychologist*
*NHS Fife and NHS Grampian*
**Neil Hamlet**
*Public Health Consultant*
*NHS Fife*
**Vivien Swanson**
*Senior Lecturer in Psychology*
*University of Stirling*

*http://www.bps.org.uk/networks-and-communities/member-networks/division-health-psychology*

# A bit of light relief

Bringing sustainable energy to large populations in low-income countries requires serious planning, investment and policy shift, says Andy Beckingham

PLACE IN THE SUN: Solar panels on the African savannah

LOOK across the skyline in Indian cities and you see thousands of rooftop solar drums which heat water for middle-class homes. The poor often don't even have rooftops. Solar-powered photovoltaic (PV) lights also largely remain out of reach for poor families, so thousands of children still do homework by oil lamp, which carries fire risk.

In Indian and African urban slums, lack of education reduces immunisation uptake. But in remote villages, even if a woman gets her infant to the health centre, there may be no electricity that day. How do you ensure that vaccines stay cold when the fridge is off? Direct-drive solar refrigerators are now being sponsored for villages by non-governmental organisations (NGOs) and some governments. Unlike standard fridges, they store energy for cooling and can maintain temperatures for 10 days without sunshine.

In rural Africa it's not uncommon for women to die from obstetric complications when the electricity goes off during an operation. The World Health Organization says that in sub-Saharan Africa, one in four health facilities in 11 countries lack electricity. Many that are connected have an unreliable supply, and fewer than 30% of these have a back-up generator that works. Many night-time births take place in near-darkness. During Caesarean section, suction and cautery machines may stop working and operations have to continue by torchlight. One alternative is the NGO-sponsored 'solar suitcase' – a portable kit containing a PV panel, battery charger and LED lights. Now some governments are waking up to the health-improvement possibilities of solar power. In Sierra Leone, 36% of health facilities use solar energy alongside other electricity sources. More public health centres use solar PV than use diesel generators.

> **It's not uncommon for women to die from obstetric complications when the power goes off**

Some poor communities are sharing their solar skills in amazing ways, not leaving it to governments. Barefoot College in Rajasthan, north-west India, works to improve the lives of the rural poor by addressing their need for water, electricity, health, education and income. They train poor women from Africa, Asia and Latin America as solar engineers to bring solar lighting to remote inaccessible villages off the energy grid. Recently four women travelled there from Chile's Atacama desert to learn how to install and repair solar lighting. Barefoot has since enabled 450,000 people in remote villages to benefit from solar lighting.

Deafness is a barrier to education and participation for impoverished people in Africa, and when the batteries die their hearing aids become useless. Now a school for hearing-impaired children in Botswana is getting around this problem by using solar-powered battery-charging.

Bringing sustainable energy to large populations in low-income countries requires serious planning, needs analysis, government policy shift and a lot of investment by NGOs and activists in grassroots innovation – otherwise it can widen inequalities. China is mass-producing solar devices, and Brazilian scientists have developed thin flexible plastic panels with PV cells printed on them, to replace the heavy and costly silicon solar panels.

But many governments still show a lack interest in sustainable power policies that could improve population health. Health impact assessments need to feature more heavily in national energy policies across the developing world.

**Andy Beckingham**
*Consultant in Public Health*
*UK and Hyderabad, India*





# Mobile apps can get us all moving again

PUBLIC Health England (PHE) recently announced the three winners of its Health X competition – an initiative designed to encourage people to move more and eat more healthily through the use of free motivational mobile phone apps.

Recognising that mobile phones have become one of the most widely adopted technologies in human history, we have explored the impact that their use can make to health and wellbeing and have been keen to work with app developers to increase the potential for helping people to make changes to their lifestyle.

The accessibility, affordability and interactivity of mobile technology opens up new possibilities in this area and the response to this competition has confirmed that this is an area of rich potential.

Almost 150 early-stage technology businesses put forward entries and were judged by a panel of industry experts, including representatives from PHE, the *Daily Telegraph* newspaper, Entrepreneur First, Health Box, Delta Partners and Tech City.

The winning bids were:

- **Fee Fi Fo Fit:** an intervention product designed to promote positive changes in young people using a game-based reward system. The judges felt that it was "beautifully simple" and were impressed by how it targeted children and families.
- **Foodswitch:** a smartphone app that provides consumers with nutritional information to help them make healthier choices when shopping. The judges felt it had the potential to "change every shopping basket in the country" and create mindfulness in the consumer.
- **Youniverse:** a 28-day exercise and diet planner which generates daily meal plans, shopping lists and exercise ideas. The judges felt this app could "create something really exciting".

> **The accessibility, affordability and interactivity of mobile technology opens up new possibilities**

The successful companies will receive a package of support from PHE, across key campaign brands such as Change4Life. This includes marketing and exposure through the scale and reach of the PHE marketing network, the Change4Life On Demand Portal and the NHS Choices website.

The first prototypes are due be released early in 2015 and will be available to download free on demand.

The winners will also receive mentoring and support in design and product development and assistance in how to expand their business strategy.

We have been delighted by the response to our inaugural Health X competition. The calibre of entries and innovation that we have seen in such a short time encourages us to think that by collaborating in this way we can find new and innovative tools to help people live healthier lives.

**Kevin Fenton**
*National Director or Health and Wellbeing*
*Public Health England*

BEAUTIFULLY SIMPLE: Chris Morland and son James, eight, use the Fee Fi Fo Fit app

# Drink marketing thrives in world of social media

MARKETING has long played a key role in drinking cultures. In the 1920s, the 'Guinness is Good For You' poster campaign established the enduring popular belief that Irish stout is, somehow, healthier than other beers made with identical ingredients. Today, the landscape of alcohol marketing has been transformed by digital technologies. Across the sector, advertising spend has shifted from billboards, television and radio onto social media. There, alcohol brands can weave their way into the fabric of everyday online experience. Through 'liking' and 'following', brands can establish a persistent presence in consumers' social exchanges.

Alcohol Research UK is funding three projects looking at this issue. One explores how young people use alcohol in the construction of their online identities. Being seen to drink the right things in the right places plays a key role in establishing social capital online. A second looks at how 'real-world' marketing interacts with social media – how the links are made between screen and bottle. The third assesses whether advertising regulations can deal with the ephemeral world of online alcohol marketing. Can a regulatory regime designed to oversee TV, radio and the press cope with the protean world of social media? If not, what are the alternatives if we want to keep an eye on how alcohol is marketed to the public?

Social media moves quickly, and marketing is one of the few sectors able to keep up. However, research of this kind is essential if public health is to understand how cultural attitudes to alcohol will be shaped by industry activities in the future.

**James Nicholls**
*Director of Research and Policy Development*
*Alcohol Research UK*

# Public mental health has been a late adopter

WE ARE in the middle of the third industrial revolution. Digital technology has been changing our lives for more than 60 years. The internet is connecting devices with each other. The web has made it possible for people to find information and services easily. The ever-dropping price of mobile technology has liberated these functions from being fixed in a particular time and place. Public health, and public mental health in particular, has been slow to react to these changes.

When people think about digital technology they often think about information-conveying websites. Digital technology is as likely to be about tools (or apps) and communication as about reading and watching. Digital technology allows us to deliver solutions to problems at scale, but in ways that, if we develop them correctly, are easily personalisable and reactive to individuals' needs.

I'm currently involved in two projects that use digital technologies in ways that benefit public mental health. The first, A Day in the Life, is a crowdsourcing project asking people who experience mental health difficulties to share four days in their life by writing a blog on four dates across the year. These are published on the site with content analysis being carried out to identify themes across the total number of uploaded days. Funded by Public Health England, Social Spider launched this project in November 2014.

To date more than 1,200 people in the UK have signed up, with more than 360

> **This volume and spread of experiences would have been impossible in the pre-digital age**

people living with a mental health difficulty uploading an account of 7 November. We have more than 180,000 words of personal experience to analyse. This volume and spread of experiences would have been impossible in the pre-digital age. Qualitative wellbeing studies often involve far fewer people at greater expense.

The second project is Doc Ready, a web-based application that helps young people get ready to make their first mental-health-related GP visit. The tool helps young people take the right problems to their GP and prepare what they wish to talk about. Doc Ready is an example of digital tools designed to increase effectiveness of existing services. Both projects are starting points for thinking about ways in which digital technology might deliver public mental health benefits. In the past five years, organisations such as Mind Tech and mHealthHabitat have been exploring ways in which digital technology can be harnessed by health institutions and have been attempting to broaden both thinking and development of such products and services.

In her report on public mental health, England's Chief Medical Officer, Sally Davies, quoted the World Health Organization's 2005 *Promoting Mental*


*Health: Concepts, Emerging Evidence, Practice* summary report: "Within a public health framework, the activities that can improve health include the promotion of health, the prevention of illness and disability, and the treatment and rehabilitation of those affected." These three areas will not be new to public health professionals, but the potential for digital technology to act upon them in the pursuit of mental health and a reduction in mental illness may be.

The best way to understand the potential of these changes is to be curious about them. Public mental health needs digital pioneers and digital champions if it is not to miss the benefits of a revolution already well underway.

**Mark Brown**
*Development Director*
*Social Spider CIC*

*A Day in the Life:*
*https://dayinthelifemh.org.uk/*
*Doc Ready:*
*http://www.docready.org*

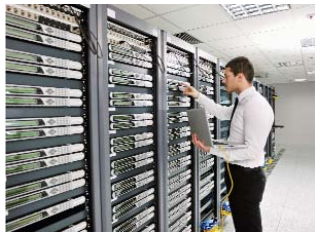
# Use of local data requires close scrutiny

THE value of health-related data and its application for uses other than its primary purpose is well recognised. The impact of these actions and processes have yet to be fully realised. Broadly speaking, the public wants to know who has access to its data, who will be using it, and how it will be used. On the basis of recent MORI polls, where assurances on these were provided, the public were more likely to consent to data sharing. While supportive of the use of personal data for the public good, such as for health and research purposes, there was considerable opposition to sharing data for commercial purposes.

Health-related personal data, data sharing and data linkage is an evolving area. There are system-wide issues relating to the collection, use, sharing and linkage of large national health-related data which have recently been embodied by, and attributed to, NHS England's care.data programme and its implementation.

Nevertheless, public health professionals should welcome the ongoing activity towards providing assurance on security and uses of health data, and pro-actively seek active engagement and participation in these developments. There is a particular need for scrutiny of how data is being used and shared locally. The Faculty of Public Health (FPH) needs to review arrangements for public health practice through feedback from its membership. FPH should actively engage in and be seen as a key player in the ongoing developments of the care.data programme, alongside other organisations such as the Royal College of General Practitioners and the British Medical Association.

**Parul Desai**
*Consultant in Public Health and Ophthalmology*
*Moorfields Eye Hospital*







# How to ensure you have an exciting career

WE SPEND a large portion of our time at work and our professional decisions have major impacts on our lives, but, if you are anything like me, your career will be formed more from reacting to circumstances than adhering to any grand design. I think this is a particular issue in public health as people not only enter the profession from a variety of backgrounds but also follow a diverse range of paths once in public health, often with changing roles within changing organisations. *Working in Public Health* is a fabulous new resource for addressing these issues, taking a more proactive approach and orientating yourself through your public health career.

The main focus of the book is on professionals starting off their public health careers in the UK, but people will find it useful regardless of the stage of their careers or the country they work in. The book is structured into three main sections:

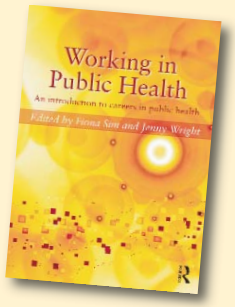
- Functions (eg. academic public health)
- Settings (eg. local authorities)
- Career paths (eg. public health training scheme).

Additionally, it has an introductory chapter which gives a very clear overview of the public health discipline, and a concluding chapter which gives practical advice on the next steps in the career development process.

I thought the book was both interesting and inspiring, and I am sure readers new to the discipline will be energised about joining the profession. I certainly felt motivated reading the case studies which detail the difference to population health that leaders in the profession have made. The book is also comprehensive, concisely covering the broad range of public health roles in just under 200 pages.

Personally I would have liked the balance of the book to be tipped more in favour of a detailed overview of the different functions (as per the health intelligence chapter) rather than extended case studies looking at a few specific roles (as per the health improvement chapter). However, I am sure others will prefer the way detailed case studies add colour, bringing the structures of the profession to life.

In conclusion, this book will inspire people to join public health and also maximise the talents of those already in




the profession by enabling them to find their ideal role.

**Paul Fisher**

**Working in Public Health: An introduction to careers in public health**
Edited by Fiona Sim and Jenny Wright

Published by Routledge
ISBN 9780415624558
RRP: £23.99

# The insanity of world-wide inequalities

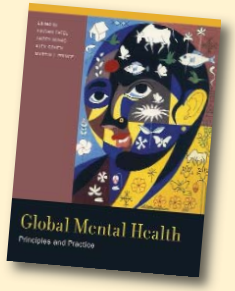
WORKING in Hyderabad urban slums while reading this book, I watched a man climb into a rubbish skip and poke through reeking food remnants looking for things to re-sell so that he could buy that day's meagre meal. The book's powerful grounding of mental health inequalities in economic determinants made perfect sense. How can anyone have good mental health in such dreadful circumstances? "When people are uncertain where the next meal will come from, when their crops fail and they have no savings, human security contracts. People eat less and some starve. They pull their children out of school… Reducing mental illness… requires strengthening of human rights protections and development of mental health systems that ensure equitable access to skilled treatment, housing and employment."

The book covers social determinants, economic inequalities and vulnerable groups, and sets out the key factors of each, trends, policy impacts over time and epidemiology; all are extensively referenced from a huge range of countries. This is a guidebook, informing the reader about all the issues you need to understand in order to work effectively in this field. There are no prescriptions; instead a huge breadth of material spans prevention, treatment, policy and programme implementation, but all of it, crucially, is grounded in grassroots-level explanations of cultures, contexts and the way diverse populations think about mental health and illness.

So where the hell do you start to influence mental health in seriously resource-poor countries? Patel *et al* base their recommendations on the building of research, epidemiology, advocacy, capacity-building, community learning about mental health, stakeholder involvement and scaling-up mental health services.

Public health professionals will find much of what they need to grasp the sheer scale of the issues and action needed, including frameworks for primary prevention of mental disorders across the lifespan. There are chapters on women's mental health – still horribly neglected in many low-income countries – on suicide, and on the stigmatising and subsequent 'invisibility' of mental health. There's a chapter on needs and prevalence in various countries; there are sections on co-morbidity, epidemiology, social capital interventions and large systems development.

This is a book that lends itself to public




health action. It's a great alternative to the decades that focused on classification and diagnosis, thus keeping mental health thinking focused on 'medical treatments' instead of prevention.

**Andy Beckingham**

**Global Mental Health: Principles and practice**
Edited by Vikram Patel, Harry Minas, Alex Cohen and Martin J Prince

Published by Oxford University Press
ISBN 9780199920181
RRP: £38.99

## From the CEO

IT HAS been another busy but fascinating few months as I complete my first year at FPH. Recent events have certainly tested our resilience but have ultimately demonstrated the strength of support from the public health community. Technology has played both a key and tangential role in much of our work. Repercussions arising from the episode on social media have been a distraction from our core business, but we have had considerable support from members and partners in our handling of difficult issues.

Our strategy consultation period has closed with more than 200 members completing our online survey, giving us a very useful insight into your views on FPH work over the coming five years. The ambition is considerable, and it remains to be seen if we can develop the member and staff capacity to deliver the programme as quickly as we would like. However, I am confident in the broad direction and welcome the mandate that your feedback provides.

FPH is developing an e-portfolio system to be launched in early 2015. As well as helping Registrars log their achievement of competences during training, the simpler system will help with preparations for the Annual Review of Competence Progression – and has sufficient future-proofing to allow adaptation for the new curriculum. Many thanks in particular to Richard Firth and all our 'e-portfolio champions' for their input into this project – another excellent example of how members can support FPH. Such innovations are not without their challenges. We are working hard to address these prior to launch and welcome feedback at educ@fph.org.uk

It was a great privilege to co-host a UK public health summit alongside the Association of Directors of Public Health in October. I was encouraged by the commitment given by presidents and CEOs from all the key public health agencies across the UK to developing a collaborative agenda. Bringing together such an illustrious group has given us a wonderful opportunity to put aside differences and deliver some quick wins in the run up to the general election.

Finally, as I return from the annual FPH Scotland conference, I am again enthused and encouraged by the passion and commitment of our members and partners. Minister for Public Health Michael Matheson MSP announced plans for a public health review in Scotland over the coming months. This must surely provide an opportunity for public health to demonstrate its strategic and practical importance. I am sure FPH will rise to the challenge and support our Scottish colleagues in their task.

**David Allen**

## Retirees meet to ask: what can we do next?

FACULTY of Public Health (FPH) staff returned to the office with concrete plans for improving retired membership following the second Retired Fellows Tea on 29 September. Twenty-five Fellows met in Liverpool's Athenaeum to talk about their experiences as public health retirees and what FPH could do to make their membership more relevant and engaging.

They heard from longstanding Fellow Sushma Acquilla on her life in senior public health and as a retiree. She explained that training and competencies had been the main focus of her work with FPH and how this had allowed her to benefit future registrars.

FPH CEO David Allen and Dan Seddon, FPH's local board member for the North West, then gave a brief rundown of FPH's plans for the next five years and how these were laid out in the upcoming FPH strategy.

Proposals to improve retired membership:

- A pack containing information on 'What next after retirement?' FPH is committed to updating this as needed so that all members retiring in the future will learn what they need to do professionally, how they can do these things and how they can continue to stay actively involved with FPH and public health in their local communities.
- Improve the Retired Fellows Tea so that next year it is more accessible and more effectively delivers the values of public health
- Take concerns over the current arrangements for continuing professional development and revalidation for retired members to the FPH Standards Committee for review and feedback to the General Medical Council and others
- Distance learning for trainees through the help of retired members
- Retired members providing leadership support and executive coaching to less experienced members
- Opportunities for IT training and updates on new technology for retired members
- Clearer ways for members to get involved with FPH communications and publications.

**Nick McKenzie**
*FPH Professional Standards Administrator*

### Vacancy for Chair of FPH International Committee

DEVELOPMENT of the Faculty of Public Health's (FPH) role in global health is a key element in its strategic plan for 2015-2019. The International Committee is currently developing a strategy to support this vision, focusing on building global public health capacity through education, training and standards, advocating for better health, developing partnership working and establishing world and regional special interest groups. It is an exciting time for global health within FPH.

We currently have a vacancy for a Chair of the International Committee and welcome applications from FPH Fellows with a passion for global health. A post description and person specification is are available at http://tinyurl.com/l7mfk3e but, if you require further details, please contact Caroline Wren at carolinewren@fph.org.uk or on 020 3696 1464.

Applications are invited in the form of a short CV and covering letter – making clear how you meet the requirements of the person specification. This post will be appointed: the deadline for applications is Friday **9 January 2015** and interviews are anticipated w/c 26 January 2015.





# In memoriam

**Roy Deans Weir FFCM**
**1927 – 2014**

Roy Weir led the Department of Social Medicine in Aberdeen from 1969 to 1990. He was an epidemiologist who believed in social medicine as integral to the public's health, and his focus was on improving healthcare as a means of improving outcomes for populations. He used the geographically circumscribed Grampian population to develop information systems based on patients not hospitals and found uses for these new data employing a single-patient identifier, the forerunner of the now-established Scottish CHI (Community Health Index) number.

With James Crooks in Materia Medica, they set up a Medicines Evaluation and Monitoring Unit (MEMO), funded by the World Health Organization, which still functions from Dundee. The Scottish Automated Thyroid Follow-up Register (SAFUR) followed and computerised medical records summaries, both based on patient pathways – now taken for granted but which broke new ground. In the late 1960s he questioned whether the NHS could afford all the new technology that was available and set up the first costing study in the UK that counted and costed the use of services by each hospital patient. In the 1970s he linked this to the question of whether such spend was value for money; this led to the Health Economics Research Unit, still a successful international research leader.

Roy was Senior Vice-Principal of Aberdeen University and Vice-Chairman of Grampian Health Board, both in the 1980s when the first cuts in public spending hit both sectors. His ability to think laterally and creatively was highly valued and effective in helping them to weather some of the storms and adapt to future stringencies. He retired early to become the Scottish Chief Scientist, a role that he found deeply frustrating at times, although the Chief Scientist Office was instrumental in encouraging high quality health services research throughout Scotland.

Roy was a quiet innovator, inspirational leader and teacher who led from behind. In 1952 he had a bronchial adenocarcinoma and pneumonectomy. He was active until shortly before his death when he succumbed to the slow erosion of his remaining lung.

His first wife, Margaret, died in 2005, and in 2007 he married Elizabeth Russell, his long-term colleague in the Department of Social Medicine.

**Elizabeth Russell**

**David Bookless FFPH**
**1920 – 2014**

David Bookless originally went to Edinburgh University to read physics, but in 1939 found himself in the North Atlantic on the Russian convoys, and later in north Africa, spending the final months of the war and its aftermath in bomb disposal.

After qualifying as a doctor in 1950, and doing short stints in general practice and hospital, he went to Fiji, returning to study at the London School of Hygiene and Tropical Medicine. In 1966, he gained a diploma in public health at John Hopkins University, Baltimore. He left Fiji in 1969 and, at the age of 51, became principal assistant senior medical officer at Leeds Regional Hospital Board.

Following the 1974 NHS reorganisation, David was appointed as the first Area Medical Officer of the newly-created Norfolk Area Health Authority with responsibilities covering healthcare planning, information systems and research. Contemporaries described him as a superb, highly respected professional with deep experience of public health; approachable, down-to-earth, finger firmly on the administrative pulse.

**Norman Nevin FFPH**
**1935 – 2014**

Born in Belfast, qualifying in medicine at Queens in 1957, Norman Nevin took a series of hospital jobs before turning to research in 1965, gaining a Medical Research Council Clinical Fellowship at the Clinical Genetics Research Unit at the Institute of Child Health in London.

In 1967 he returned to Belfast to set up the Medical Genetics Centre, later being appointed consultant head of the Northern Ireland Northern Regional Genetics Service and professor in human genetics. With some 300 peer-reviewed publications, he became a national and international expert in this emerging field, notably for his work on folic acid and spina bifida and for the identification of the gene for cystic fibrosis.

Norman served on many advisory committees, including the Government's Gene Therapy Advisory Committee which he chaired from 1996 to 2006, receiving an OBE for services to gene therapy research. He also held office in a clutch of charitable organisations. He was a deeply religious man and a strong advocate of the 'intelligent design' concept of the origin of nature, seeing no conflict with his thorough understanding of genetics.

## Deceased members

**The following members have also passed away:**

**Dr Edward Adams FFPH**
**Air Vice Marshal David Davies MFCM**
**Dr Dulcie Gooding FFPH**
**Mr Stephen Hewitt Hon MFPH**
**Prof Anthony McMichael FFPHM**
**Dr David Proudler MFPH**

# Faculty prizes – notice of deadlines 2015

**Please be aware of the Faculty of Public Health prizes for 2015 and ensure that all applications and nominations are submitted before the deadlines stated below.**

**Cochrane Prize**
- Awarded to an undergraduate student to support educational activity in public health. Applicants must be bona fide students at a higher education school in the UK at the time of the application.
- The application must provide clear statements of the aim(s) and/or expected benefits of the project, methods by which these will be achieved and the precise, intended use of the funds.
- The winner will receive a certificate and an award of up to £250.

**Deadline for entries: 1 February 2015**

**June and Sidney Crown Award**
- Open to all FPH members in good standing and under the age of 35 at the time of application. To support the cost of travel undertaken to gain experience or training outside the UK. Preference will be given to those working within the NHS.
- Applications should comprise a full CV and a travel plan specifying further experience or training to be gained, the place(s) to be visited and an outline of the expected benefits.
- The winner will receive a certificate and award of up to £150.

**Deadline for entries: 1 February 2015**

**Sian Griffiths International Award**
- The aim of the award is to promote the development of public health capacity by helping FPH members, working within the specialty, to gain international public health experience either while in training or as a part of continuing professional development. An emphasis is placed on work in middle- and low-income countries.
- Applications should comprise a full CV and a travel plan specifying the details of the proposed overseas placement or secondment, further experience or training to be gained, place(s) to be visited and an outline of the expected benefits.
- The prize will consist of a certificate and a cheque for up to a maximum of £500.

**Deadline for entries: 1 February 2015**

**McEwen Award**
- Awarded in March each year to the candidate with the highest score in the Part B MFPH (OSPHE) examination at their first attempt.
- All candidates must be recognised as SpR/SpT/StR members of FPH on the date of the application for the Part B MFPH (OSPHE) examination. Consideration is automatic (candidates need not apply).
- The winner will receive a medal and a cheque for £100.

**Ann Thomas Prize**
- Awarded in March each year, on the recommendation of the Welsh Affairs Committee of Public Health, to the Welsh candidate who attains the highest mark in the Part B MFPH (OSPHE) examination at their first attempt.
- Applicants must be recognised as SpR/SpT/StR members of the FPH on the date of the application for Part B MFPH (OSPHE) examination. Consideration is automatic (candidates need not apply).
- The prize will consist of a certificate and a cheque for £100.

**BACP Travelling Fellowship**
- Awarded biennially to assist FPH members in training to undertake educational travel, normally outside the UK.
- Applications should comprise a full CV and a travel plan specifying the detailed educational aims of the travel, the place(s) to be visited, with reasons for the choice, and an outline of the visit programme with expected benefits.
- The winner will receive a letter and cheque by post.

**Deadline for entries: 1 February 2015**

**Michael O'Brien Prize**
- Awarded to a candidate at each exam sitting for gaining the highest marks in the Part A MFPH Examination.
- All candidates who have passed the Part A MFPH Examination sitting the exam at the first attempt will be eligible for consideration. Consideration is automatic (candidates need not apply).
- The winner will receive a medal and a cheque for £100.

**Sir John Brotherston Prize**
- Awarded to the best essay or piece of research on a public health topic by a student or young graduate (for medical students this is prior to full registration).
- This must consist of original work compiled solely by the entrant and contain no more than 3,500 words.
- The winner will receive a certificate and a cheque for £100.

**Deadline for entries: 1 February 2015**

All awards, apart from the BACP Travelling Fellowship, will be presented at the FPH Annual Awards Ceremony at the Newcastle Civic Centre on 23 June 2015.

To view the regulations for these prizes, please go to the FPH website at http://www.fph.org.uk/faculty_prizes or contact the FPH Education and Training Department on 020 3696 1451 or at educ@fph.org.uk. Please read and follow the regulations closely and adhere to the closing date before applying for any prize.







# 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 2014

**Fellows**
Nisreen Alwan
Rebecca Cooper
Alisha Davies
Siobhan Farmer
Nigel Field
Ruth Harrell
Jason Horsley
Catherine Johnman
Punam Mangtani
Louise Marshall
Susan Matthews
Anthony McGinty
Anjana Sahu
Geeta Sharma
Sarah Theaker
Dean Wallace
Pui Yeung

**Members**
Gillian Armstrong
Mandy Clarkson
Susannah Cochrane
Philip Daniels
Joanne Darke
Christopher Johnson
Joseph McDonnell
Misha Moore
Rebecca Nunn
Kristina Poole
Nika Raphaely
Martin Seymour
Ruth Speare
Jessica Stokes

**Diplomate members**
Najwan Abu Al-Saad
Keith Allan
Peter Baker
Behrooz Behbod
Sally Cartwright
Andrea Clement
Ian Diley
Anna Donaldson
Gemma Dunn
James Elston
Louise Flanagan
Charlotte Flynn
Robert Marr
Rohan Mongru
Keith Quintyne
Sarah Rayfield
David Roberts
Anna Seale
Emily Smith
Sara Southall
Helen Tapson
Hayley Teshome Tesfaye
Taavi Tillman
Gerald Tompkins

**Specialty Registrar members**
Claire Beynon
Charlotte Booker
Ben Brown
Elizabeth Cross
Ioseff Llion Davies
Rebecca Devine
Elizabeth Elliott
Katie Ferguson
Andrew Fox
Sandra James
James Mallion
Ruth Mellor
Anjali Pai
Cassandra Powers
Kirsten Rennie
Molly Thomas-Meyer
Emily Tweed
Emmeline Watkins
Carol Wilson

# Elections

**FPH Vice President for Policy**
Three nominations have been received and a full membership ballot is currently underway. The closing date is noon on **5 January 2015**. If you have not received a ballot paper, please contact Caroline Wren at carolinewren@fph.org.uk/020 3696 1464.

**FPH Assistant Academic Registrar**
Nominations opened on 24 November 2014 and close on **12 January 2015**. All FPH Fellows in good standing are eligible to stand, but must be nominated by a member of the Board.

**FPH Local Board Members**
Nominations open on 12 January and close on **16 February 2015** for the election of Local Board Members for Yorkshire & the Humber region, Scotland and Northern Ireland. All FPH members in good standing, who are eligible to vote in the constituency in question, may stand for election.

Full nomination papers can be found in the FPH Online Members' Area at http://members.fph.org.uk or are available from Caroline Wren.

# New public health specialists

Congratulations to the following on achieving public health specialty registration:

**UK PUBLIC HEALTH REGISTER**

**Training and examination route**
Andrew Harkness
Katharine Hartley
Elizabeth Orton
Amy Potter

**Defined specialist portfolio route**
Linda Churm
Karen Saunders
Louise Woolway

**GENERAL MEDICAL COUNCIL REGISTER**

Nisreen Alwan
Daniel Carter
Elizabeth Crowe
Nigel Field
Felix Greaves
Lynne Hamilton
Marko Kerac
Merav Kliner

# FPH leading on WHO operation

THE World Health Organization Europe Action Plan (EAP) for Strengthening Public Health Services and Capacity is structured around 10 essential public health operations (EPHOs) which countries can use to create stronger public health services across the region. FPH is leading on EPHO 8 – "assuring sustainable organisational structures and financing" – and has already co-produced a public health brochure providing the economic case for prevention and examples of preventive interventions which can save money in both the long- and short-term. The next steps will look at the financing of public health and the organisation of preventive measures. The FPH group is bringing together relevant public health expertise to facilitate these two programmes of work.

The 10 EPHOs can be viewed at http://tinyurl.com/mvrq6uo

**Chris Boardman** was recently vilified for not wearing a helmet while demonstrating cycle safety for BBC TV. Here the Olympic cycling gold medalist (whose bike company makes helmets) explains why he believes the focus on helmets is the wrong one

PEOPLE get very passionate about helmet use – or the lack thereof – but most don't get to the next, critical step of asking themselves why? Why do I feel the need to wear a helmet and high-visibility clothing? What is it that scares me so much that I feel the need to wear what amounts to body armour?

People wear helmets and high vis as they feel it's all they can do to keep themselves safe. It shows just how far away Britain is from embracing cycling as a normal and convenient form of transport. In Utrecht in the Netherlands, helmet use is less than 0.5%, and there isn't a stitch of high vis in sight. They have an incredible safety record and some of the lowest casualty rates of anywhere in the world.

I'm willing to bet that even those who swear by helmets and high vis would feel comfortable discarding their body armour in such an environment. In Utrecht they have addressed the real dangers to cyclists.

"But that's over there and not here; we're different," people will say. "That's not the place we live in." Sadly, this is right. Yet still, advocating safety equipment for the vulnerable is not the answer. Countries that have tried to bring in compulsory helmet laws, such as Australia and New Zealand, have actually seen a 30-50% drop in the number of people cycling. When less than 2% of people in the UK cycle regularly, bringing in a law that would actually put more people off would be a serious step back.

If cycling looks and feels normal, more people will cycle. The more people cycle, the safer they are and the more lives will be saved from amongst the 37,000 who die each year from obesity-related illnesses.

> **I want cycling in the UK to be an everyday thing that people can do in everyday clothes, whether you are eight or 80 years old**

In contrast, there are approximately 116 cyclists killed in the UK each year. That's one per every 1,000 times around the planet. Cycling is statistically safer than gardening, and yet it doesn't feel like it when you're cycling next to a lorry or car that gets too close at a busy junction.

So I understand exactly why people feel so passionately about helmets or high vis. I understand why people wish to use them. But these actions seek to deal with an effect. I want to focus the debate on the cause and campaign for things that will really make cycling safe. That is why I won't promote high vis and helmets. I want cycling in the UK to be an everyday thing that people can do in everyday clothes, whether you are eight or 80 years old.

In February, British Cycling launched a 10-point action plan to get Britain Cycling. #ChooseCycling sets out what local and national government should be doing to get more people on bikes. We're at a crucial moment for cycling, and the run up to the 2015 general election presents us with an unmissable opportunity to get some substantial commitments on cycling. I sincerely hope we can win the argument and get one step closer to getting rush hour in towns and cities across Britain looking a bit more like that in Utrecht.

**Chris Boardman MBE**
*Director of Research and Development*
*Boardman Bikes*

*A version of this article was first published on the British Cycling website*


# Information

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