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

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In this issue

Public Health Today

A year is a long time in health

Twelve months on from transition

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Contents

Welcome

IT GIVES me particular pleasure to welcome delegates to this year's conference in Manchester as I was regional director of public health in the North West for many years. Perhaps nowhere is one more conscious of standing on the shoulders of giants than in this region. William Henry Duncan was the country's first full-time medical officer of health in Liverpool (appointed in 1847) and Manchester boy Edwin Chadwick made his mark at national level as the first director of the Board of Health. *The Times* declared that it would sooner take its chance with cholera than be "bullied into health" by Chadwick. We should take the opportunity to celebrate the work of Manchester and the other WHO Healthy Cities across the North West for making local government once again a key partner with civic society. I would also like to thank the leader of Manchester City Council for the hospitality being shown to our conference.

In extending our conference again to two days, we have been rewarded by the numbers of delegates registering. We trust that the programme does justice to this enthusiasm. As well as taking stock of our programme of FPH renewal in such areas as the FPH strategy, the curriculum review, governance arrangements and global health, in addressing the theme of 'Glocal Health – Making a World of Difference' we have grounded the meeting in practical opportunities for our Members and Fellows to make a difference, working together through Special Interest Groups (SIGs) and Communities of Practice, and in partnership with our St Andrews Place team.

There is also a strong political theme with sessions on developing our own manifesto for the main parties to respond to in election year and contributions from politicians of different political persuasions. Shadow health secretary Andy Burnham is making a plenary appearance, and we are recognising Tessa Jowell, the country's first Public Health Minister, with the award of Honorary Fellowship. We also welcome major international figures in public health in Georges Benjamin, Executive Director of the American Public Health Association, and Jim Chauvin, Immediate Past-President at World Federation of Public Health Associations, both of whom are to become Honorary Fellows.

This year's conference features, for the first time, a public health film festival with the leadership and support of the Oxford Film Festival Team and our colleagues, Pam Luna and Gary Black

from the USA.

It is becoming clear that the future of our efforts in global health will be best served by members with a particular world regional interest, organising themselves into SIGs as is beginning to happen with Africa and Europe. Furthermore, the growing interest in having more public health input into clinical work gives us the opportunity to develop not only a SIG/Community of Practice for population healthcare but also to respond to requests from other colleges for partners who can bring public health to their tables. One such request is from the Royal College of Obstetricians and Gynaecologists. Our membership survey has enabled us to identify how many of our Members and Fellows have dual-membership with other medical colleges and other public health related organisations. We need to build on this and use the information to facilitate SIGs which can build bridges.

The theme of this issue of *Public Health Today* is '12 months on from transition'. Different opinions are to be found on where we are on our new journey in England and perspectives are also sought from Scotland, Wales and Northern Ireland. The mission of public health is never complete. It is always challenging. Whatever structures we are gifted we have to make sense of but at the same time it is important that we use our influence to try and optimise the arrangements to achieve our goals. FPH is committed to being part of these debates.

I would like to take this opportunity to thank our staff in London for their enormous contribution over the past 12 months. Their numbers are not large and there is much to do. Often they can be invisible. It is important that we acknowledge them and the leadership that David Allen is showing after only a few months in post.

John Ashton

Life-saving research put at risk by HSCIC data-access delays

Data access blocked; vital statistics cut

The Health and Social Care Information Centre (HSCIC) has responded to allegations of misuse of data by deciding not to consider any new applications for data access, pending a review. There have also been delays in providing data to existing HSCIC customers. The combined effect impedes public health analysts and researchers and puts at risk publicly-funded, time-sensitive research that could lengthen lives and prevent disability.

The Faculty of Public Health (FPH) has urged the health secretary to ensure that HSCIC consider already-approved applicants separately and to start processing their applications as soon as possible. FPH has also suggested that, wherever capacity difficulties are holding up the processing of applications, HSCIC should consider delegating its responsibilities for releasing data for research purposes to the UK Data Service.

Meanwhile, the Office for National Statistics (ONS) announced that a set of key health inequalities analyses will no longer be produced, after a 2013 ONS consultation over cost savings on statistical product (http://bit.ly/1iPDukj).

The cuts could have serious implications for the Secretary of State's legal duty to pay due regard to reducing inequalities in public health, as well as the impact of the NHS in reducing inequalities.

The ONS analyses are essential benchmarks for the measurement of health inequalities and inform future research. The results are critical to shaping, monitoring and evaluating policy to reduce inequalities; they form the basis for needs assessment and resource allocation. Several government measures rely on them, including the 2012 alcohol strategy and a 2013 initiative on avoidable premature death.

FPH President John Ashton has written to the health secretary about both issues; see the letters at http://bit.ly/1lhLoXY and http://bit.ly/1ifDw55

Teaching children about health and relationships

The Commons Education Select Committee is running an inquiry into Personal, Health, Social and Economic Education (PHSE) and Sex and Relationship Education (SRE) in schools. In a written response, FPH recommends that PHSE and SRE in schools should be a statutory provision, and that this must include mental and emotional wellbeing and social development skills.

FPH advocates evidence-based programmes that:

- improve academic outcomes
- have a whole-school approach, considering staff/student relationships as well as peer relationships
- help develop skills in emotional intelligence, positive relationships and conflict resolution and address children's self-awareness, self-esteem and bullying.

FPH's evidence is at http://bit.ly/1o4UJpP

FPH responds to the National Health Screening inquiry

The Commons Science and Technology Select Committee is hearing an inquiry into the scientific merits of national health screening programmes – including the evidence behind calls for screening to be extended to cover prostate and lung cancer.

Responding to the consultation, FPH is calling for the National Screening Committee's independence from the Government and NHS to be protected and maintained. FPH also argues that randomised controlled trials, which form the evidence base for new screening programmes, should include economic assessment and modelling as standard. FPH's evidence in full: http://bit.ly/UnRVqM

Regulating e-cigarettes

Electronic cigarettes come under a range of consumer legislation. FPH has argued that extra safeguards are needed to make them as effective as possible as cessation aids, deliver nicotine as safely as possible and ensure they are manufactured to a consistent quality. FPH has also called for advertising and promotion of e-cigarettes to non-smokers to be prevented, especially to children. Simon Capewell spoke for FPH on BBC Radio 2's Jeremy Vine show in late May, and FPH responded to a Committee of Advertising Practice consultation on the marketing of e-cigarettes (http://bit.ly/1o6rdfP).

Mark Weiss
Senior Policy Officer
Faculty of Public Health

News in brief

Skin cancer rates 'surge since 1970s'

The incidence of the most serious skin cancer in Great Britain is now five times higher than it was in the 1970s, figures show. Cancer Research UK statistics show that more than 13,000 people develop malignant melanoma each year, compared with around 1,800 in the mid-1970s. It says the rise is partly due to the rising popularity of package holidays. Sunbed use has also fuelled the increase, the charity said.

UK cities becoming mosquito-friendly

Changes to UK urban areas are providing habitats for mosquitoes, including species known to spread malaria and West Nile virus, a study suggests. Warmer ambient temperatures and more water containers in gardens are bringing mosquitoes into closer contact with people, say scientists. The team says more of the insects breeding in urban areas increases the chances of a potential outbreak. The findings appear in Plos One at http://tinyurl.com/nqtu6gg

UKPHR achieves AVR accreditation

UK Public Health Register's (UKPHR) voluntary register of public health specialists and practitioners has been accredited by the Professional Standards Authority for Health and Social Care under the Accredited Voluntary Registers (AVR) scheme. Employers now have the option of seeking practitioners on a register that has been vetted and approved.

E-cigarettes face curb in public places

Wales could be the first area of the UK to ban the use of electronic cigarettes in enclosed public places. Ministers say they are responding to concern that the devices normalise smoking and undermine the smoking ban.

World now 80% polio free

The World Health Organization has declared its South East Asia region polio-free, so 80% of the world is now officially free of the disease. The certification comes after India officially recorded three years without a new case of polio.

NHS tells bodybuilder she must lose weight

A superfit bodybuilder was branded overweight and put on a strict diet by an NHS nurse, based on her body mass index (BMI). Personal trainer, Anita Albrecht, of east London, said she was told during a routine appointment she was "eating too much". She said her BMI came out at 29 – four points over the healthy range and one short of obese.

INTERVIEW

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Polly Toynbee is a columnist for *The Guardian* and is the newly elected President of the Community Practitioners & Health Visitors Association. She was formerly BBC social affairs editor, columnist and associate editor of *The Independent* and feature writer for *The Observer*. She was a member of the panel for the recent People's Inquiry into London's NHS

'I hope nobody ever does it again'

Put an end to reorganisations, says Toynbee

What was the most important finding from the independent inquiry into health in London?
The most important finding is that the NHS does need more money. There's no way round that. An Office of National Statistics report found that the UK is the second lowest spender on health in the G7.

We weren't in a position to say whether particular reconfigurations are good or bad or will make savings as there is no template. I'd argue that a blanket approach doesn't work: each case has to be looked at very carefully. We ended up with a series of principles of what should be considered every time someone is thinking of a reconfiguration.

Often the idea that you should stick together two indebted organisations and somehow miraculously produce something that isn't indebted isn't necessarily the case. An efficiency saving in one place might not be in another.

How do you think we can translate the findings of the inquiry across the UK?
Whether it's health service managers or NHS England, people have to be very sensitive to local situations. For instance, you might say that if you put all trauma units into a few highly specialised centres with consultants available 24 hours a day covering every specialty, you will get a certain percentage increase in survival rates. But if the vast majority of people going through A&E are never going to need that level of expertise, you may find a lot of people with a lower level of need are massively inconvenienced or put at risk. If it's frail old people taken miles from home with no-one to visit them, you have to factor that in. A few percentage points on survival for highly specialised conditions isn't the only way to look at things.

Is this the same across the UK, or is this a particular problem for London?
I'm sure it must be the same, although we need a UK-wide measuring system [for NHS funding] that everyone agrees on, and then you can make comparisons. It's a very good thing that we have nations making very different choices about how to run their health services. We have a real-life control trial for different ways of doing things.

What motivates you?
I wrote a book back in 1975 about the Royal London Hospital. I spent a lot of time in different departments watching managers, departments and professions at work. It is fascinating studying an institution. In those days, much more than now, each consultant ran their own fiefdom and managers were much weaker. That has got better: managers are more powerful and that is a good thing.

There have been so many reorganisations since then. Every government reorganises about every five years. There is no perfect way to manage the NHS. Every time a new Health Secretary or government comes in, they take a look at this great machine and say, "Oh! I could do it all much better", as if it were a kind of green field site, never thinking about the incredible disruption that each [reorganisation] causes.

If you think about the 18-month's worth of managerial time lost and people having to reapply for their jobs and make new relationships, the amount of productivity that gets lost in reorganisations is phenomenal.

Imagine if Andrew Lansley had said: "I'm going to follow the patient through from seeing a GP to getting diagnosed, see where all the obstacles are and work out how to iron out all of those things." You could make a big difference. This approach doesn't make a big splash because very often it's about small things: how people are treated, how they answer the phone, how much accessibility and accountability there is.

Politicians always want to put their thumbprint on a big, structural change. I hope nobody ever does it again. I hope the Lansley [restructure] makes every politician stand back and say:

> **"Every time a new Health Secretary or government comes in, they take a look at this great machine and say, "Oh! I could do it much better"**

"We've done that to destruction; we won't do that any more. We'll just think about how patients feel, are treated in their beds and are treated in the community." It always gets forgotten because we can't see it, but 90% of medicine happens in the community.

What's your view of public health?
I'm really pleased and honoured to have been made President of the Community Practitioners' and Health Visitors' Association. I'm going to have good time learning about their work. All I do is to observe what they do and promote it.

I think public health coming into local authorities has caused anxieties in all directions, but in terms of wellbeing, it ought to be fruitful. In normal times, I would be hopeful, but it's difficult to be hopeful at the moment.

What do you feel have been your biggest triumphs?
The book I'm most proud of is called *Hard Work*. It was the most important thing I've done. I did a number of different jobs and wrote about how you can't get by on the minimum wage. It was about the working poor and benefits. I ended up with only three light bulbs in my flat and being incredibly careful with every penny. People shouldn't deceive themselves and think that they'd be such a super-duper manager of their money and that they could cope.

The majority of people who are poor are in work. Let's not have strivers versus skivers: two thirds of children living in poverty have parents who work. Work is paying less and less, and half of graduates are not in graduate jobs.

Would you say you've had any particular disappointments?
I have been unbelievably lucky. I have worked for editors and organisations I respect and admire that want to get to the truth of things.

Going to the BBC as the first Social Affairs Editor, setting up the department and hiring people was a very exciting time. Having to decide what to say to camera in a 20-second piece was a very good discipline. It was a relief to get back to newspapers after that and have the self-indulgence to be able to write at length!

How do you relax?
I've got four children and five grand-children, so every spare inch of time I spend with them.

I have a lovely time at the Brighton Festival where I am chair. We have a whole strand this year, which Tom Scanlon, the Director of Public Health in Brighton, has contributed to. Bring the Happy [a project at the festival] is about finding out what would change people's sense of wellbeing.

The Festival is a totally different world, and I love being part of it. It's hard work but it is a world apart from journalism, politics and social policy. I treasure that a lot.

Interview by Liz Skinner

The People's Inquiry report, London's NHS at the Crossroads, can be found at http://www.peoplesinquiry.org.uk/

Adapt or die

Embracing change has been a strength of public health professionals down the years – even in times of austerity, says Alan Maryon-Davis

"CHANGE is the law of life. And those who look only to the past or present are certain to miss the future." A core public health skill is to seize opportunities, and JFK's sage words serve to remind us that change is in our bloodstream. We are change junkies.

The transition in public health in England following the 2012 Act has been a massive shake-up and wake-up. Disruptive, invigorating, wasteful, energising, destabilising, exciting. Glass half-full and half-empty at the same time.

Everyone agrees the timing was dreadful. Again and again in this transition-themed issue of *Public Health Today* our contributors talk about the challenges of pursuing public health in an age of austerity and swingeing local authority cuts. But one person's 'raided' public health grant is another's stake in the wider determinants agenda.

Then there's the culture shock of moving from NHS to local government. Different drivers, different levers, different ways of working and, crucially, different interpretations of just how 'independent' the local public health voice can be. But then again, one person's political interference is another's healthy democratic accountability.

In the next few pages we have Martin McKee painting a rather gloomy picture of what he sees as patchy public health in a time of famine, counterbalanced by Jonathan McShane's upbeat appraisal of local government's strengths in health and wellbeing. Ed Jessop describes the Faculty of Public Health's work developing standards for public health in local authorities. The main findings of the recent BMA survey of public health professionals are chewed over by Mark Gamsu, and Beth Bennett-Britton contemplates the career prospects for Specialty Registrars entering the new landscape.

> **One person's political interference is another's healthy democratic accountability**

While England goes through its convulsions and contortions, Rosemary Fox and Paul Darragh consider how Wales and Northern Ireland are settling down after their own re-jiggings, and the anonymous 'Cross Borderer' speculates on what the huge question mark of independence might mean for public health in Scotland.

Controversy continues with Mark Bellis on the way evidence around reducing alcohol harm seems to be consistently sidelined by the Responsibility Deal-makers. And our Big Debate asks: Is evidence-based policy going out of fashion? Clare Bambra argues that it is being consistently ignored. Steve Pleasant says that evidence is just one of many factors in the mix.

In our Big Interview, columnist Polly Toynbee pleads for no more big structural changes to the NHS. And our Final Word is from Helene Raynsford, public health manager, ex Olympic rower and cancer survivor, who talks about what it takes to tackle changes forced upon us.

Ultimately it's all about adaptation. As Charles Darwin famously observed over 150 years ago: "It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change."

Alan Maryon-Davis
Editor in Chief

One thing is clear: it is one of the worst drafted laws ever

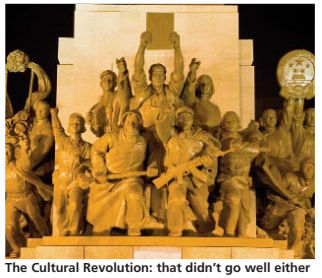
WHEN asked, in 1972, whether the French Revolution had been a success, the Chinese Premier Chou En Lai is reputed to have replied: "It's too soon to tell." I was tempted to take a similar approach when asked to reflect on the impact of the Health and Social Care Act on public health. But I suspect that we already know, and the answer is far from encouraging.

An obvious problem is deciding what the Act means. There is a growing consensus that it is one of the worst-drafted pieces of legislation ever. Nonetheless, many organisations are trying to find pragmatic ways to make sense of it. The Act is permissive, leaving considerable flexibility for interpretation. Those local authorities that believe in collective action to promote health can now make their visions a reality. Those who see health as a matter of individual responsibility can disinvest in public health, as some are already doing.

Those who can recall what happened when responsibility for public health last resided with local authorities remind us that provision was extremely uneven. There were some excellent public health departments, with inspirational leaders like Paddy Donaldson. Many others were abysmal. Yet at least local authorities had the powers and resources to promote health across a range of services.

> **Those councils who see health as a matter of individual responsibility can disinvest in public health**

In the following years they have lost many of these responsibilities. Successive governments have sought to transfer entire sectors out of local democratic control, aided and abetted by some of the more unhinged local politicians, such as those seeking to create an 'EasyCouncil' model, in which almost everything is an optional extra. This process has continued apace, with educational reforms that sometimes seem to echo Mao Tse Tung's wish to see "a thousand flowers bloom". Unfortunately, that cultural revolution



The Cultural Revolution: that didn't go well either

didn't work out well either.

The situation is compounded by the massive squeeze on local government budgets, which are starved of funding from a combination of centrally imposed cuts and demands that they freeze council taxes. Certain councils have responded imaginatively, such as those in inner London who have sought to relocate anyone in need of their services to other parts of the country, while transforming themselves into what is effectively a giant car parking operation. Those who persist in clutching at straws still hope that Health and Wellbeing Boards might provide a means of advancing public health, if anyone can work out what they are meant to do.

The challenges that the public health community faces are immense. The Government remains committed to austerity, despite the now compelling evidence that this has damaged economic growth. The misery and suffering that this has caused, especially in northern England, is enormous. Just as in the early 1980s, a cohort of school leavers faces years of precarious employment, on zero hours contracts and lacking any meaningful social safety net.

Despite adversity, there are examples of public health making a difference, for which we should be grateful. Those within these few beacons of hope can provide the seeds for what will one day be a reinvigorated public health community. But as we move forward perhaps we should all ask: how on earth did we ever let this happen?

Martin McKee
Professor of European Public Health
London School of Hygiene and Tropical Medicine

What does good public health look like?

HOW do we define public health for local authorities who have acquired the expertise of public health specialists but without, necessarily, an instruction manual on how to make the most of those skills?

The Faculty of Public (FPH) has been working on a document that sets out the tasks of public health at local level. Maggie Rae, Health Board member and Director of Public Health for Wiltshire, has masterminded an effort involving more than 30 FPH Fellows and all the major committees of FPH. Although written with the current situation in England in mind, we hope it will prove useful in all jurisdictions.

The functions of the local public health system have been presented within the three domains of public health practice: health protection, health improvement and health services. This has been presented alongside the underpinning functions of public health intelligence, academic public health and workforce development that are integral to each of the three domains. Public health requires effective action by many different organisations and players. The balance of responsibility will vary from place to place, but the essential functions which *must* be assured in every locality remain constant. It is these functions which we have set out in this document.

The document has gone through several iterations. It started as a standards document because we wanted to set standards for county councils and unitary authorities. A consultation version was posted on the FPH website last year. Plenty of discussion followed! And we realised two things: first, what we had was a document which set out functions, not standards; and second, we couldn't be too prescriptive about who does what – public health is practised in different ways in different places. So we felt that it would be more useful to set out the functions that every local public health system must fulfill. In one place most of the work may be taken up by one organisation, and in another place by a network of collaboration.

Edmund Jessop
Vice President for Standards
Faculty of Public Health

The standards can be accessed via: http://bit.ly/1jborqB

DEBATE: Is evidence-based public health policy going out of fashion? Clare Bambra says evidence is being consistently ignored, while Steven Pleasant believes it still is a vital tool

Politics, not research, has the final say

SINCE 1997, the role of evidence in policy-making has been increasingly emphasised by successive governments. Subsequently, there has been a massive increase in the volume of university research into the effectiveness of public health interventions.

Yet most analyses find that there has been very limited impact on policy. Research into evidence-based policy (EBP) in public health would confirm elements of this analysis, with differences over what constitutes 'good' evidence and what evidence is 'needed' by policy-makers. Researchers always want more research. 'Doing nothing' is not an option for policy-makers.

However, there are clearly more than cultural differences behind the evidence façade. In a democracy, decisions will be informed by ideology, values, public opinion and lobbying. There have been several prominent cases in public health that have demonstrated this 'primacy of politics'.

In July 2013, the Government announced that it had decided to scrap the proposed 40p minimum unit price for alcohol in England because there was "not enough concrete evidence". This was despite strong economic modelling of likely effects and real-world evidence of effectiveness. There was huge press speculation about the influence of industry lobbyists. This was

YES

accompanied by the shelving of plans to introduce standard packs for tobacco. Amid speculation about the influence of industry lobbying, the cited reason was that we needed to "see how it works in Australia".

The roll-out by Public Health England of the NHS Health Check scheme continues. While a Cochrane review found no evidence that health checks were effective, it was felt there was nonetheless "an urgent need to tackle the growing burden of disease which is associated with lifestyle behaviours and choices". These political aspects of national public health policy-making are more likely to be replicated locally, following the move of public health responsibilities to local authorities and Health and Wellbeing Boards. This increases the democratic accountability of public health – and introduces the potential pitfalls of party politics.

Politics has primacy, which limits the role of evidence in a democratic system. The pure EBP dreamed of by some is unrealistic. There is undoubtedly a need for principles, values and ideologies within any democratic process. Politics will always be ascendant. While this can be frustrating for researchers, we can, and should, only ever aim for evidence-*informed* policy.

Clare Bambra
Director of the Wolfson Research Institute for Health and Wellbeing
Durham University

A version of this article was published in the Journal of Public Health (Nov 2013)

People want well-informed decisions

COUNCILS increasingly have to make decisions that will have profound, far-reaching implications both on the way that they and their partners deliver services, and on the lives of local people. Whether this is in commissioning, pooling and aligning of budgets with partners, decommissioning of services, major transformation or all of these, local people need the confidence to know that decisions made in their name are high-quality, evidence-based and considered openly and accountably.

We have better knowledge than ever before of how the emotional, physical, social and economic conditions in which we are born, grow up and work shape our health directly and, indirectly, influence our life course and life chances. If councils want to improve the health and wellbeing of the people they serve, then solutions based on robust evidence have to be at the heart of the decisions councils make. In the current economic climate we simply cannot afford not to.

Blackburn, with Darwen Council, for example, has established an investment framework for their Public Health Grant which uses the World Health Organization's tool for evidence-informed decision-making in public health.

Alongside other Greater Manchester authorities, Tameside Council is on a journey to make the best use of resources to deliver improved outcomes

NO

for all children. This will be achieved through a new delivery model developed to optimise effectiveness of evidence-based interventions, by focusing on the early years of a child's life.

With increasing evidence available through Public Health England, the National Institute for Health and Care Excellence and others we are able to do more of what works and stop doing what doesn't. Yet all too often evidence is not presented in a simple, relevant format that enables it to be used to its maximum potential by service providers, commissioners and policymakers.

The tension between evidence-based decisions and those based on politics have often been greatly exaggerated, but I believe there are real dangers in depending on evidence-based approaches alone. Evidence will only ever be one among many factors influencing decisions, especially in a local government context where elected members draw on multiple sources of knowledge to reach decisions.

Despite a considerable reduction in their resources, there exists a massive opportunity for local authorities to make a difference. Realising this will depend upon the leadership of elected members, the capacity of the public health resource, the use of existing resources and the application of quality evidence to guide effective action.

Steven Pleasant
Chief Executive
Tameside Metropolitan Borough Council

Into the unknown

What are the challenges and opportunities and the career prospects for Specialty Registrars entering the new public health landscape, asks Beth Bennett-Britton

THE future of public health is assured, a necessity, a certainty. The importance of health protection, health promotion and organising and delivering equitable, effective and efficient health services is not in doubt, nor could it ever be.

The way in which our profession is structured to face these challenges is less certain. With rumours of a two-tier public health system, local authorities downgrading roles and the misapplication of the public health budget once the ring-fence is lifted, there are understandable concerns amongst public health registrars regarding the future employment landscape.

However, the public health profession is a resilient bunch with a strong tradition of positively and effectively managing change. We've lived through multiple reorganisations and been pioneers in enriching our specialty with those from non-medical backgrounds. We've been experts in instigating and managing huge cultural and political transitions, such as car seat belts, the smoking ban, food labelling and other evidence-based policy and practice.

In my short time as the Chair of the Faculty of Public Health's (FPH) Specialty Registrars Committee (SRC) I have been in awe of what an inspiring group the public health registrars are. They have taken the initiative to advocate on issues such as the independence of our institutions, create partnerships to promote sustainability and global health and launch innovative ways to promote public health messages.

Although we are faced with future change and challenges, there are also exciting opportunities to broaden our influence in less conventional spheres that affect health and inequality. For example, I

> **"There are exciting opportunities to broaden our influence in less conventional spheres that affect health and inequality"**

am about to start a placement at the University of the West of England, where I will be a 'Public Health Specialist in Residence' – working with the architecture, planning and transport departments to teach students about the impact of our environment on health outcomes. The SRC Career Profiles document (published on PHORCaST) provides a rich set of further examples of the breadth of careers of current consultants, such as the NHS Sustainable Development Unit, the National Institute for Health and Care Excellence, hospital trusts and Director of Adult Social Services and Public Health in a local authority.

Whilst the uncertainty of new structures presents opportunities, there are also legitimate risks. We need to continue to strongly voice our concerns about the new health system while working constructively within it to further our goals of improving health and wellbeing and reducing inequalities. To me this means seeing ourselves as one public health community, regardless of what organisation we are in. We need to work in close partnership, attuned to what is going on across the system and be fighting the public health corner wherever we are based.

Public health will continue to be a dynamic and challenging environment. As public health registrars with our careers ahead of us, we need to use all of our expert skill and "nimbleness" (to quote FPH's president) to seize opportunities and further our united goal. We've done it before, and from what I have seen, we can definitely do it again.

Beth Bennett-Britton
Chair of FPH Specialty Registrars Committee

It's a leaner, greener structure in Wales

IN 2009 NHS Wales underwent a very different reorganisation from the changes that occurred in England last year. We have seven Local Health Boards, responsible for the health of their populations, and three Trusts, including Public Health Wales.

Public Health Wales works with all the other partners to develop and lead the public health system in Wales. It provides services such as screening, health protection, microbiology and safeguarding as well as the health improvement and health intelligence functions. It employs most of the public health specialists in Wales, although each Local Health Board has an Executive Director of Public Health with a Local Public Health Team. It's a smaller and perhaps leaner model than the one in England. However, public health is not as integrated in local authorities as in England, and we have had to develop systems of joint working that deliver locally and nationally.

My impression is that there is more cohesiveness in Wales than in the English system. The system is based on partnership-working and collaboration rather than competition, and we have not adopted the market model seen in England.

One of my concerns is that it is extremely difficult now to benchmark outcomes and demonstrate success across the four nations. For example, we all used to collect the same information on screening, but policy has diverged so much that comparisons are now difficult to make. This is replicated in hospital care and primary care statistics. It's harder to compare like with like, and we've seen cherry picking of data in recent months. There's been a succession of reports about the NHS in Wales, coming from England, that have been negative and unwelcome.

> **It is extremely difficult now to benchmark outcomes and demonstrate success across the four nations**

I believe the Welsh Government is genuinely committed to getting the whole health system working together. It is currently consulting on a public health white paper and a future generations bill, and in other legislation there is a requirement for health impact to be considered in all policies. For example, active transport or green space will be considered in policy development.

We do have particular challenges in public health in Wales. Overall, the population is more deprived than in England, and a map of deprivation in Wales today looks much the same as 100 years ago. We are fighting to reduce health inequalities, but as long as those long-established communities that have lived with generations of deprivation exist, it will be an uphill struggle. And just as in the rest of the UK, we are striving to achieve positive population-level behavioural change whilst powerful commercial interests are pushing in the other direction.

Rosemary Fox
Director, Screening Division
Public Health Wales

The Scottish Parliament Building, Edinburgh

Whether it's yes or no, same problems remain

THERE can be few people in the UK who are not aware that on 18 September 2014 people aged 16 and over who are resident in Scotland will be voting on a simple question: "Should Scotland be an independent country?" Earlier this year, a self-selected group of members of the Faculty of Public Health met and discussed the consequences for public health of either a Yes or a No vote from the referendum. A full position statement is being developed on the back of the workshop; but a number of broad themes emerged.

Both the Yes Scotland campaign and the Better Together campaign are curiously quiet about healthcare and public health. Those who want Scots to say "yes", seek to reassure them that nothing will change in relation to the NHS in Scotland, that it will remain affordable, and that cross-border healthcare will remain unaffected. Indeed they argue that *only* independence will allow Scotland to act directly and decisively to reduce the inequalities that give rise to poor health. In contrast, the "no" camp maintains that education and health are financially better protected in the context of the UK and contend that it is the UK working collectively that will more effectively reduce poverty and protect social welfare.

Whatever the outcome, change will only come after a lengthy process of negotiation between the Westminster and Scottish governments post-referendum. This will be shaped not only by the referendum result, but also by the Westminster parliamentary elections in 2015 and – probably – the run-in to the Scottish parliamentary elections of 2016. The likeliest outcome is that the opportunity will be taken to redefine the constitutional and financial settlements between Scotland and the UK irrespective of the result. This will almost certainly mean more powers and all the responsibility.

> **Whatever the outcome, change will only come after a lengthy process of negotiation**

So what will be the impacts on public health? As a priority area for governmental action, the simple answer is: not much in the short term. The group considered that:

- dealing with the social, economic and cultural determinants of health will remain an absolute focus
- money will remain tight
- structural or functional change in public bodies will continue to occur from time to time.

The group were in no doubt that the problems post-referendum Scotland will face are those that it already faces. How it will use whatever new freedoms it has to spend or act will be detail we can't wait to engage with.

Rest assured, we'll let you know how things are going.

The Cross-Borderer
(The author is English, though of Scots descent, working and paying tax in Scotland, but not entitled to vote in the referendum)

Growing in confidence and gaining respect

THE Public Health Agency (PHA) in Northern Ireland is just over five years old and serves a total population of 1.8 million people. It came about after a review of public administration in Northern Ireland and the amalgamation of four local health boards with a range of other public health functions. With just under 300 members of staff, and an annual budget of almost £100m, the primary functions include health protection, health improvement, service development (commissioning) and screening, and research and development.

The PHA works closely with the academic Centre of Excellence in Public Health through a number of joint appointments. Whilst we are an independent body, we have joint responsibility with the Health and Social Care Board (HSCB) for commissioning services from Health and Social Care Trusts.

Through this relationship we continue to have access to the appropriate levers of power and have a real influence on strategy development across health, social services and primary care.

The PHA develops the majority of strategy at a regional level across Northern Ireland. Some staff within health improvement work very closely with individual trusts to deliver specialist programmes of care. Each trust delivers integrated health and social care to approximately 350,000 people. To assist the HSCB and PHA in their commissioning role there are Local Commissioning Groups (LCGs), roughly the equivalent of a Clinical Commissioning Group in England. LCGs are made up of GPs and a range of health and social care professionals including public health consultants and voluntary sector representatives.

Our health protection staff, most of whom have a mixture of general and specialist responsibilities, ensure the provision of sustainable services. Should a major emergency arise, non-health protection staff across the PHA can be redeployed to meet emerging pressures.

Service development and screening staff take the lead in commissioning and cover scheduled and unscheduled care and other specialist areas. Screening programmes are similar to programmes elsewhere in the UK. Our biggest challenge is providing for an ageing population whilst demand on services grows and budgets decline.

Transforming Your Care – our current health service development strategy – aims to shift healthcare out of hospitals and into primary care. We also have a rapidly-expanding remit to input into quality and safety reviewing when things go wrong through our Serious Adverse Incidents process.

Health improvement has grown rapidly within the PHA with major interest in community development, health inequalities and cooperative working with multiple partners. We recognise our resources are limited so we need to work with others to deliver on shared agendas.

The PHA is growing in confidence, working with others and gaining respect as an organisation which delivers.

Paul Darragh
Chair
British Medical Association, Northern Ireland

Price worth paying?

The Responsibility Deal has shown that health and industry aims are completely at odds. We must now choose between the two, says Mark Bellis

THE Responsibility Deal promised real change in the alcohol industry's behaviour, faster than could be accomplished by legislation. It sounded too good to be true – and it was. However, public health requires testing what works. Engaging initially with the deal was the right thing for us to do. It meant being part of discussions that would otherwise have just been between policymakers and industry. However, evidence-based interventions were almost without exception omitted as the deal progressed. Ultimately, it appeared to be impeding measures such as a minimum unit price (MUP) for alcohol that could really improve health.

The largest pledge in the deal aimed to remove a billion units of alcohol consumption by reducing the alcohol content of some drinks. It had potential, but much depended on product marketing and consumer reactions. Alcohol consumption might increase if people felt they could drink much more of a lower strength product. Actually, the average drink strength in the UK has increased in recent years as market share moves from beers to wines and spirits. Retailers' loyalty-card data could have helped us understand these issues better, but there appeared to be no appetite from industries in the deal to genuinely understand its public health rather than its public relations value.

The alcohol industry has invested massively in PR through lobbying, advertising and social media to get messages across, often to the detriment of public health ones such as MUP. The sad truth is that the alcohol industry currently controls most public messages on alcohol – including those on health. The industry funds the national alcohol information resource Drinkaware and typically allows ineffective messages, such as "drink responsibly", a diminutive presence on adverts and products – on a voluntary basis. Without change, it is difficult to see how important information about alcohol's links with cancer, injury, child maltreatment, violence and other harms will ever reach the public at scale.

To balance public information on alcohol, we need political support for something similar to tobacco health warnings. All alcohol products, adverts and other media should carry punchy health messages. These should be mandatory, prominent and formulated entirely independently from industry. Such information is not 'nanny state,' but helps move us away from a 'nanny industry' that subtly uses adverts, social media and sponsorship to guide adult and child behaviour.

Public health professionals need a good grounding in new media as well as access to expertise to balance industry's carefully crafted strategies. Our toolkit also requires economics and law; both of which are often used as reasons not to implement evidence-based health measures. For example, MUP needs to be seen as a proportionate health measure in European law, widely understood as good for the economy, and publicly recognised as beneficial to everyone – except those profiting from selling cheap alcohol to heavy drinkers. Winning the public debate is essential. Otherwise future politicians could simply scrap MUP to improve their ratings.

"We need more evidence about what works" is no longer a credible defence for those formulating alcohol policy. Independent, integrated and informative messages about alcohol health harms are an essential basis for change. MUP and stronger controls on sales and advertising will reduce disease and deaths. The Responsibility Deal has persuasively demonstrated that health and industry aims are vehemently opposed. The choice now is whether the profits of the alcohol industry or the health of the public is the bigger political priority.

Mark Bellis
Director of Policy, Research and Development
Public Health Wales

Voters will one day look at smoking rates

A YEAR ago there were real concerns about how councils would react to their new public health responsibilities. There was talk of councils raiding the public health budget to fill potholes or making decisions based on petty prejudice, not evidence. The reality has been that councils are thinking creatively about their new role. They are asking the really important question: how do we use all of our resources – not just a modest ring-fenced budget – to improve our residents' health? In that light, evidence that councils are using small elements of their public health budget to affect the wider determinants of health should be applauded as we seek to make improving people's health everyone's business.

Top-down targets have not been successful in improving health outcomes. It is now up to local, political, professional, clinical and community leaders to identify what can make most difference to health. In local government we are asking difficult questions about established ways of working and drawing on years of experience of delivering better outcomes with less money. Where services are not delivering value they will be decommissioned and replaced by services that can deliver on our huge ambitions for local people. To be blunt, local government has been surprised at the relative lack of rigour in the commissioning and monitoring that went on in the old system.

The new Health and Wellbeing Boards are crucial to delivering health improvement. This is based on a shared understanding of health and wellbeing needs, a set of agreed priorities and the deployment of pooled resources to achieve lasting health improvements. The positive finding of recent King's Fund research is that, overwhelmingly, local authorities have given strong support and commitment to Health and Wellbeing Boards. People in local government see them as the key driver of the local health system: identifying health needs and assets, engaging communities in a dialogue about their health, setting priorities and influencing commissioning plans.

Looking forward, a key challenge will be ensuring that progress is sustainable in an increasingly grim financial context. To maintain our momentum, the democratic accountability that now surrounds public health will be vital. It is taking time for the public to become aware of the changes in responsibility for public health. I look forward to the day when, deciding which way to vote, residents are as interested in smoking rates as they are in schools.

Local government is excited about our renewed role in improving our residents' health and we are confident we can make a real difference. We recognise this new responsibility has come at a time when our budgets are tight but we have a track record of doing more with less. We have long experience of reshaping services and a culture that understands that sometimes you need to invest to save.

All of this experience, allied to the huge range of skills and talents we now have through our public health workforce gives me real confidence that our ambitions for the public's health can be matched by real change up and down the country.

Jonathan McShane
Cabinet Member for Health, Social Care and Culture
London Borough of Hackney
Chair
Public Health System Group

Medics less likely to work for councils

THE British Medical Association's Public Health Medicine Committee commissioned its Health Policy and Economic Research Unit to carry out a survey among public health professionals.

The survey had two purposes: to find out the state of the current public health workforce (both where they are physically based and how they feel about the changes to their profession) and their feelings about the future. The survey report can be found at http://bit.ly/1kbU0ug

One key finding is that medical professionals are much less likely than their non-medical counterparts to work for local authorities, and this trend is likely to increase because they report it less likely they will want to work for local authorities in the future.

Furthermore, around half of the respondents report having considered leaving public health in the past three years. Overall, however, respondents are content with their pay, terms and conditions.

Strong concerns were raised about the issues of lack of professional independence, future workforce numbers and an increase in bureaucracy. The majority of respondents did not believe that the reforms had benefitted public health in England.

The experience of those working for local authorities is varied, reflecting large differences in performance across local authorities. There is a perceived lack of political independence of Public Health England (PHE) from the Department of Health, and the workforce is calling on PHE to improve its national leadership role.

Hannah Jongsma
Policy Analyst
British Medical Association

We have to do better at alliance-building

THE survey by the British Medical Association gives a useful snapshot of the concerns in the public health profession. The survey shows that most public health staff remain committed to the profession – a particularly strongly held view among trainees and non-medics.

Three issues stand out:

- Despite the appalling framing of the question in the survey, there is real concern about pressure on public health budgets. ("Has your public health budget been raided?" should be included in public health training as an example of how not to conduct objective surveys).
- There is a continued worry among a minority about the independence of the director of public health (DPH).
- The majority of medics do not think that non-medics can do all aspects of their job.

I think the context is hopeful. Local government is energised by its new role. There have been two national conferences organised by the Local Government Association (LGA) on public health. Similarly, the LGA and the Society of Local Authority Chief Executives and Senior Managers (SOLACE), in partnership with others, have produced a number of briefings and reports on public health and its role in local government.

Cuts have meant that some public health funding has been re-allocated to other council services. Sometimes this has resulted in a strategic opportunity for greater action on the social determinants, and in others this has just been a crude attempt to balance budgets. Local authorities are in a situation not of their own making – their budgets are under sustained attack. Public health, like all council departments, is under pressure. Sometimes this has been handled badly at the top of local authorities, but the public health profession needs to sharpen its act too. We have to be better at alliance-building and developing strategies and tactics for change.

I'd like to see the evidence for loss of independence. Where are the local examples of DPHs using this duty to raise concerns that would otherwise not have been heard? In a local democratic system I think it is more important to ensure that there is a range of effective independent voices. Public health has a key role in ensuring that overview and scrutiny, trade unions, the voluntary and community sector and Healthwatch are empowered to be effective.

I am quite comfortable if medically trained public health specialists can demonstrate that there are some areas of practice that only they are competent to address. However, we need to be very clear what these areas are and how many of these posts we might need. Doctors are expensive, and cash-strapped local systems will need to be able to justify them.

These are tough times, but local public health is now in the right place. The profession now has privileged access to advise and influence local politicians. We need a clear strategy to develop alliances with local government. We need to reflect on the current balance in the profession between medics and non-medics and which aspects of our professional skill-set need to be modernised.

Mark Gamsu
Visiting Professor
Leeds Metropolitan University

The health police dismisseth the smokers – just

DOESN'T time fly? I can hardly believe it's been a year since we moved to the Council. We have survived the transition and are still feeling our way in the works of local government.

I'm just about to start another thrilling day at the Council. There's a Full Council Meeting today, and my major challenge will be to stay awake because only councillors are allowed to speak! Being very new, I sometimes forget this – must make sure my hand doesn't go up again. I got a very black look from the Chairman when I tried to engage in the debate last time.

Thinking about the Full Council sends a shiver down my spine. It brings back a another horror which occurred at the Annual Budget meeting – my first.

The place was packed out. Last on the agenda was the new ring-fenced public health grant. I had hoped this would slip quietly through. But no, chaos ensued!

Why was the grant ring-fenced? What has teenage pregnancy to do with us? Improve life expectancy? Why? Don't we have too many old people to look after already?

Then of course, smoking. Yes, you guessed it: several councillors are committed smokers. Who are this nanny lot of public health police? And why are they telling us what we can and cannot do?

Fortunately Administration has a majority, so it got voted through – by a hair's breadth.

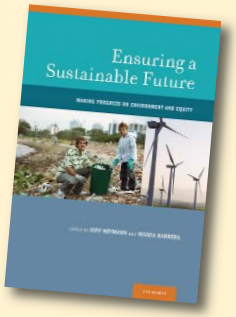
Just another red letter day at the Council.

'The Secret DPH'

Seeking equity with practical examples

WHEN I first opened this book I was half expecting a detailed discussion of global climate change and its effects on poor and disadvantaged communities. This is certainly mentioned; as Chapter 2 points out: "Global warming can be considered as the largest transfer of environmental health risks from rich groups... to poor groups (who contribute very little but who include the majority of those most at risk from climate change's impact)." However the book is about much more than this. Its various authors consider in some academic detail, including comprehensive references, the social as well as the physical environment. They discuss how to promote equity with practical examples of projects which are economically feasible. For UK readers it is perhaps disappointing that almost all the examples are from the Americas with none from Europe. I found those focusing on Canadian environmental issues of most personal interest probably because of similarities to the UK. Chapter 4 has a description of the setting up and operation of a recycling project in the oldest and poorest part of Canada's wealthiest city. It included refreshingly down to earth sections on the difficulties of evaluating any of the project outcomes and lessons learned. Similarly, Chapter 10 gives a detailed description of a study measuring access to healthy foods in different areas of Montreal which showed that, unlike previous such studies, access was not related to the socioeconomic status of the area. It also described the realities of annual bureaucratic battles with a borough administration to set up and run something as simple as a market for fresh produce.

The editors state at the beginning of the introduction they wanted to find feasible solutions to a critical question, which made me expect that each chapter would logically follow the next, building up the arguments. This is not the case as each chapter is an essay on its own and does not necessarily obviously follow the last. As is inevitable with any multi-author book, the style and content of chapters is variable. I found some of the tables and figures particularly difficult to interpret as the print was very small, and I suspect they would have been much better in colour. This book is certainly not something to be read from cover to cover in one sitting, but rather to dip into from time to time to read aspects of particular interest.



Sally Millership

Ensuring a Sustainable Future: Making Progress on Environment and Equity
Edited by Jody Heymann and Magda Barrera M.

Published by Oxford University Press
ISBN 9780199974702
RRP: £50

How the other half lives with mental illness

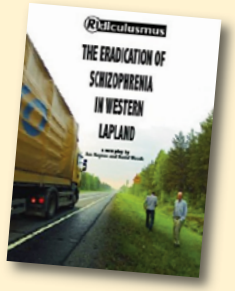
IN THE theatre bar, everything is normal... until half the audience is suddenly taken off somewhere else. The rest of us take our seats. On stage, a mother talks at her withdrawn teenage son. A man appears, talking angrily, but about what? And now they seem to be treating him as if he's ill, but that doesn't make sense to him. Or us. The mother's words become bizarre, disjointed; everything said is at cross-purposes, confused, anxious. The family seems to be becoming fragmented, out of control.

Then we realise that a second play is underway at the same time through an open door behind our players, and the other half of the audience is watching it. It's as if someone else knows what's going on but we're excluded from that understanding. Now, someone is shouting, and we have to concentrate to hear our play over theirs. But voices leak through, and we can't help but be distracted. Who's in charge here? The two plays spill into each other. Theirs sounds like a hospital ward. For a moment their lines are identical to ours. Now we hear shouted, fragmented words. What's happening in there? One of the sons, curious, goes to listen at the door. Then he has slipped through and is now part of the other play instead. Suddenly, the lights come up. Back to the bar.

The audiences change places. We watch the other play, set in a hospital, but we can also hear our earlier play, the one set at home – they merge. Family members change roles, lose power, sanity. We witness an intricate illustration of the confusing, frightening, disjointed experience of schizophrenia in families and institutions.

This touring production by Ridiculusmus Theatre Company was inspired by Open Dialogue treatment which has apparently transformed life for people with psychosis in Western Lapland. In the 1980s, psychiatric services were run-down and there was a high incidence of schizophrenia. Open Dialogue brought together professionals, families and patients' networks to provide consistent, non-institutional support and appears to have resulted in 75% of patients with psychosis being able to live at home and return to work or study within two years. And, at two-year follow-up, only 20% needed antipsychotic medication.

Open Dialogue is being presented to large numbers of NHS and local authority staff and managers as a highly effective way of helping people and families while avoiding institutionalisation. It's not often we have a chance to hear about interventions that appear to radically improve health and treatment on a large scale.



Andy Beckingham

http://opendialogueapproach.co.uk or call 020 3290 6333

The Eradication Of Schizophrenia In Western Lapland
Jon Haynes and David Woods

Next performances: Summerhall Festival, Edinburgh,1-24 August 2014

From the CEO

RECENT weeks have continued to reaffirm in my mind the importance of the public health sector to civil society and the potential to achieve real and lasting change and progress for the human race. If that sounds overly ambitious or perhaps a little trite, let me explain: I was fortunate enough to be able to attend the 67th World Health Assembly in Geneva in May and to hear Dr Margaret Chan address the assembly. Personally, I found her conviction, enthusiasm, realism and challenge hugely inspirational. She spoke of the reasons for the recent spread of poliovirus – conflict, movement of migrant populations, weak border controls and poor immunisation programmes. She spoke of the growing concerns from leading economists and development banks of social inequalities – a recognition that rising economic exclusion and inequality affects the stability of economies and risks future prosperity. Dr Chan highlighted increases in air pollution, obesity and diet-related non-communicable diseases, but also that foreign investment agreements are "handcuffing" governments and "restricting their policy space". She identified that new cancer cases are at an all-time high and that US$1.2tn were spent worldwide in 2010 – a recognition that no country is rich enough to spend its way out of the problem.

I won't try to précis the speech (you can read it for yourself at http://apps.who.int/gb/e/e_wha67.html) – suffice to say I was moved to reconsider how FPH can add its weight to the challenges of Global Health. Discussions have been taking place at our International Committee and with Members and Fellows and partner organisations. There does appear to be a real interest in this work and in FPH playing a role. I look forward to further discussion on this and many other issues at our annual conference: Glo-cal Health – Making a World of Difference. If we haven't yet met, please stop me at the conference and say hello!

In other news, our consultation on FPH strategy continues; there has been - helpful feedback and discussion in Nottingham, Edinburgh and London in recent weeks. A workshop is on its way at the conference. Please do engage and feed in your thoughts – we need your help in developing and delivering the next five-year strategy.

Finally, a direct quote from Dr Chan: "Better health is a good way to track the world's progress in poverty elimination, inclusive growth and equity" – I'll sign up to that.

David Allen
Chief Executive Officer

Senior public health appointments

WITH the on-going uncertainty about the future of public health in England, Faculty Advisers and Faculty of Public Health (FPH) staff have worked tirelessly over the past year to ensure that all employers are fully supported to make appointments at the required national standards.

In 2013, the number of Advisory Appointment Committee panels increased considerably to 190 files opened compared to 136 in 2012 and 42 in 2011. FPH has a highly experienced network of knowledgeable regional Faculty Advisers who, with support and advice from the FPH office, monitor and influence every senior public health appointment in the UK, working with employers, recruitment specialists and Public Health England (PHE) to ensure that proper processes and standards around appointments are maintained. To this end, we have been largely successful. In a very small number of cases FPH has had to inform the employer that standards could not be maintained and has had to withdraw from the employment process. An escalation policy, based on the principle of discussion, has been established to ensure that no such decision is taken lightly.

FPH currently has a list of more than 250 names to put forward to employers as external assessors on appointment panels. For each appointment we try to individually match relevant assessors to the role. For three consecutive years, FPH has held assessor training days which have been very well received. The role of the assessor is crucial to ensuring competent people are employed in the system. FPH would like to extend gratitude to all our assessors who work on our behalf. FPH is also keen to ensure that all its assessors are up-to-date with current guidance and in a position to best represent FPH and the profession on panels. To this end, we have implemented a quality assurance scheme to ensure we continue to provide high quality assessors for appointments in the future.

Behind the scenes, FPH continues to ensure that guidance on appointments and job-description templates for senior public health posts are reflective of the current system. In October 2013, FPH produced two documents in collaboration with PHE, the Local Government Association (LGA) and the University and Colleges Employers Association (UCEA): on the appointment of directors of public health and on the appointment of consultants in public health. These documents, along with a large amount of other guidance, are available at www.fph.org.uk/faculty_guidance

FPH has also been a contributor to the British Medical Association and LGA workshop events on the employment of senior staff and is currently working with PHE and the LGA to develop guidance on multidisciplinary teams.

Ensuring high standards of senior public health appointments and the quality of the public health workforce is of great importance to FPH, and the current climate means little is straightforward. We will continue to work hard to influence employers to ensure that these standards are maintained. If members have concerns over appointments please let us know by emailing aac@fph.org.uk or by getting in touch with their local Faculty Adviser (http://www.fph.org.uk/faculty_advisers).

James Gore
Head of Professional Standards

In memoriam

Corinne Camilleri-Ferrante FFPH
1954 – 2014

Dr Corinne Camilleri Ferrante came to the UK from Malta as a medical student, and stayed on as a doctor to pursue a career initially in paediatrics, but thankfully she changed to public health after a period in community paediatrics.

Her passion was for the NHS, implementing evidence in practice and policy, and the training of future generations of doctors and public health specialists. From 1994 to 2000, she led the first Clinical Audit & Effectiveness Unit in East Anglia promoting both improvements and service design of screening programmes and clinical networks, such as for cystic fibrosis.

She took her interest in evidence-based practice and policy to the East Midlands Specialised Commissioning Group in 2005 and continued to do so in subsequent roles. However, her passion for training and education came to the fore when she became the Head of the School of Public Health for the East Midlands in 2008.

Corinne was a person who cared equally passionately for people and systems. As Head of the School of Public Health for the East Midlands, she took a personal interest in all aspects of the lives of the registrars and was able to pre-empt or help resolve problems that many trainers were unable to do. She would always listen to colleagues under stress and find a way of lightening the mood even if it involved a self-deprecating joke.

With equal passion and vigour, she would make her mark when faced with any challenge to the principles of comprehensive, equitable and effective healthcare for the NHS. When the Faculty of Public Health came out in opposition to the Health and Social Care Act 2012, she was an active member of the steering committee that produced the only published risk assessment of the Bill, which is still cited and referred to by many commentators.

She made her arguments diplomatically and effectively to challenges from clinicians, managers or politicians. She was never one to shy away from innovation and was an early adopter of programmes to improve service delivery, whether they involved service redesign, such as for screening programmes, or technology developments, such as ePortfolio for training programmes.

Her warmth, care and passion will be sorely missed by all those who met her.

Ronald Hsu

Jenny Roberts FFPH
1938 – 2014

Professor Jenny Roberts was one of the pioneers of public health economics and an early critic of the marketisation of healthcare. A miner's daughter from North Wales, Jenny won a National Union of Mineworkers scholarship to the London School of Economics (LSE) at the age of 21 and, in 1973, became a research fellow in LSE's economics department immersed in macroeconomics and the history of economic thought.

With political ideas beginning to emerge about developing an 'internal market' in the NHS, there was an urgent need for economics skills in healthcare, and Jenny was 'poached' to run a new government-funded training programme at the London School of Hygiene & Tropical Medicine (LSHTM), the very first economist on the staff. Within a short time, together with Brian Abel-Smith of LSE, she had set up a new MSc in health policy, planning and financing. Throughout the 1980s Jenny's research repeatedly demonstrated that NHS contracting between purchasers and providers of services was far too blunt an instrument to ensure high-quality care, and she was not afraid to make this very clear to the policymakers.

Over the following decade she turned her economics spotlight on the relatively unexplored area of communicable disease, looking at the economic impact of gastroenteritis, hepatitis, healthcare-associated infection and influenza. Her analyses helped to highlight the cost-benefit of robust infection control systems, and in 2002 she was appointed Professor of Economics of Public Health. As instigator of LSHTM's world-renowned Collaborative Centre for the Economics of Infectious Disease, Jenny is recognised as having been a prime champion in this globally crucial field of study.

Jean Weddell FFCM
1928 – 2014

After qualifying in medicine in 1952, Jean Weddell volunteered to go out to war-ravaged South Korea to help set up a children's hospital there, and then to Jordan to work on tuberculosis control. This was followed by several years at the recently established MRC Epidemiological Research Unit in Cardiff, under Archie Cochrane (later first president of the then Faculty of Community Medicine – now FPH). She initially helped code the Vale of Glamorgan Blood Pressure Study and later worked on the Cardiff cervical cytology survey.

One study led to another – anaemia, stroke care, treatment for varicose veins – and in the late 1960s Jean moved back to St Thomas's Hospital Medical School to lead the London arm of what was arguably the first large-scale randomised controlled trial in the UK, a two-centre Medical Research Council study on the management of mild-to-moderate hypertension.

At St Thomas's Jean worked closely with Walter Holland (another FPH president) and, as a senior lecturer, was involved in many major projects, including computerised information systems for perinatal care and child health, cancer registration and a register for people with learning difficulties. She also coordinated the local specialty training programme in community medicine.

In her spare time, Jean was a keen music and theatre lover and had a national reputation in the world of church-bell ringing.

Deceased members

The following members have also passed away:

Kenneth Edmondson
Lindsay Elliott
Stanley Ludkin
Roger Machell

Letters

In Zimbabwe today, as in many African countries which are now independent politically, there is a dramatic demographic change. The water catchment area for the capital city, Harare, was for a maximum of 600,000 people and even that has not been fully networked yet for financial reasons – not that either political camp wishes to deprive voters of access to clean, potable and affordable water supplies. The objection I have to the views expressed by Baroness Kinnock [The Final Word, *Public Health Today,* Dec 2014] is that this is somehow denied by the political leadership in our country. Although we have made mistakes and taken wrong turnings (according to the predominant policies of more developed countries) I do not believe it to be in the interest of any politician, especially the leadership of the party, to refuse any genuine offer of assistance.

I also believe the Faculty should not be used as a vehicle for any political statement.

Be that as it may, the ad hominem approach to any public health issue is counterproductive as the basic fact is that the environment in Africa has changed dramatically, especially demographically.

Now, the city of Harare is expected to supply water to more than three million people with its ageing and deteriorating infrastructure. If that can be helped by financial or expert means without any political overtone, I am sure, having lived here for more than 46 years, it will be gratefully accepted.

Timothy Stamps
Health Adviser in the Office of the President and Cabinet
Zimbabwe

FPH in brief

FPH annual general meeting
The 42nd annual general meeting of the Faculty of Public Health will be held on Thursday 3 July 2014 from 12.40 to 1.25pm in the Reynolds Building, Sackville Street Campus, University of Manchester. The agenda papers are available on the FPH online members' area (http://members.fph.org.uk/) or, on request, from Caroline Wren at carolinewren@fph.org.uk, tel: 020 3696 1464.

Coming up in the *Journal of Public Health*
In the up-coming edition of the *Journal of Public Health,* there is an article on how you can make robust decisions about health interventions without trial evidence. There is also a piece about the English north/south divide, examining its scale and presenting comparative data for the east/west division in Germany. It also discusses the Public Health England's programme of work, *Health Equity North.*

FPH Transport Special Interest Group (SIG)

THE Transport & Health Study Group (THSG) manages the Transport Special Interest Group (SIG) for the Faculty of Public Health (FPH). FPH inherited this from the UK Public Health Association. FPH members can involve themselves in this programme of work in one of two ways. They can join the Transport SIG or they can join THSG directly. The main difference is that joining the Transport SIG is free for FPH members whereas joining THSG costs £5 a year. Membership of THSG also brings a licence to download and use ebook *Health on the Move 2,* which is a comprehensive account of the relationships between transport and health, and a preferential subscription rate to the *Journal of Transport & Health*.

THSG is a scientific society and public health campaigning organisation interested in all aspects of the relationship between transport and health. Particular issues it has been active on include:

- active travel
- disability and transport
- health impacts in the economic assessment of transport projects
- the promotion of the rail/cycle combination
- healthy street design
- a shift in infrastructure spending away from roads towards rail and cycling.

THSG mainly functions electronically and telephonically although its latest AGM did vote to hold more meetings. It held a meeting in March 2014 on High Speed 2 and a further meeting on the case for using health service money to support active travel will be held in the North of England in the next few months.

THSG has two arms: science and policy. The Co-Chair (Science) is Jenny Mindell with Adrian Davis as her Vice-Chair and the Co-Chair (Policy) is Steve Watkins with Nick Cavill his Vice-Chair.

These account to an executive committee and a European committee, currently with representatives from the UK, Spain, Ireland, Sweden, Malta and the Netherlands.

THSG also has a panel of advisers. The role of adviser is designed for people who are too busy to serve on our committees but are interested enough to give us the benefit of their advice. It circulates information to advisers at the same time that it does to its executive and they may comment if they wish. Some advisers are chosen for their professional standing, others to help maintain contact with related organisations. THSG has a multiparty group of parliamentary advisers.

It has a joint committee with various other professional organisations, including FPH, the British Medical Association, Sustrans and the Chartered Institute of Logistics and Transport. This is called the Professional Alliance for Transport and Health and is currently chaired by Dominic Harrison.

Stephen Watkins
Co-Chair (Policy)
Transport & Health Study Group

Welcome to new FPH members

We would like to congratulate and welcome the following members who were admitted to the Faculty of Public Health (FPH) between March and May 2014

Fellows
Sara Blackmore
Rosalind Blackwood
Wendy Burke
Marie Casey
Kakoli Choudhury
Matthew Day
Stephen Dorey
Nadia Inglis
Ishani Kar-Purkayastha
Kate Lees
Annette Luker
Judith Mills
Susanna Roughton
James Smith
David Taylor-Robinson
Saloni Zaveri

Members
Declan Bradley
Valerie De Souza
Monica Desai
John Ford
Frederike Garbe
Eleanor Garnett-Bentley
Kiran Loi
Charlotte Matthews
Susanna Mills
Keerthi Mohan
Patrick Pietroni
Duncan Vernon
Toni Williams
Justin Wong

Diplomate members
Anees Abdul Pari
Olukemi Adeyemi
Adeola Agbebiyi
Mattea Clarke
Susannah Cochrane
Joanne Darke
Heidi Douglas
Clare Ebberson
Mary Hall
Catherine John
Mei Hung Leung
Caroline McLuskie
Charlotte Pavitt
Ellen Pringle
Martin Seymour
Katie Claire Smith
Ruth Speare
Leonora Weil

Specialty Registrar members
Christos Mousoulis
Sepeedeh Saleh
Helen Skirrow
Sam Williamson

Want to be at the heart of FPH's standard setting work?

ARE you up for the challenge of being an FPH examiner? Do you have an eye for detail and an interest in education?

The Faculty of Public Health (FPH) is seeking to recruit examiners for the Member of FPH (MFPH) Part A and Part B examination.

Examiners play a vital role in the delivery of the MFPH examinations, and this is an opportunity to contribute whilst providing exposure to a number of stimulating personal development opportunities.

Examiners will have the opportunity to contribute to question-setting, marking and the development of the examination, with full training being provided.

Basic criteria for appointment:

- has held the MFPH or relevant higher qualification for at least three years
- has held a consultant or senior specialist post for at least three years
- is able to demonstrate that they are up to date in their continuing professional development (CPD) requirements.

Information about the role can be viewed on the FPH website in the examinations section at http://www.fph.org.uk/exams

Interested parties should submit their CV and a covering letter, noting their preference for either the Part A or Part B exam and indicating their willingness to undertake the tasks and priorities required. Applications should be emailed to educ@fph.org.uk

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Charles Beck
Sara Blackmore
Jonathan Cox
Matthew Day
Helen Elsey
Stephen Gunther
Sue Hogarth
Baldish Kaur
Katrina Spence

Generalist portfolio route
Susan Lloyd

Defined specialist portfolio route
Sarah Addiman
Sian Evans
Gareth Holyfield

GENERAL MEDICAL COUNCIL REGISTER

Victor Aiyedun
Monica Desai
Fiona Hamilton
Matthew Harris
Nadia Inglis
Paula Whittaker

FPH Local Board Member elections

WE ARE pleased to announce the results of the Local Board Member elections as follows:

- North East – Toks Sangowawa
- South West – Sally Pearson
- London – Helen Walters
- South East Coast – Farhang Tahzib
- East of England – Alistair Lipp (second term)
- Wales – Hugo van Woerden

All those elected will take up post immediately following the close of the FPH AGM on **3 July 2014**.

Her experience of long and gruelling Olympic training helped **Helene Raynsford** cope with chemotherapy. But it was working in the NHS that reminded her she didn't have to accept the first programme of treatment she was offered

BEING an irritatingly optimistic person, I grasped public health transition with both hands. With no consultant colleagues, I had the opportunity to lead on the Health & Wellbeing Strategy. Just as I felt it was my time to shine, I was dealt the curve ball of breast cancer. Owing to family history I had been on an MRI screening programme for five years, but naively never thought it would happen to me.

At the point of diagnosis, I didn't process it and was swept onto the pre-defined treatment pathway. Chemotherapy was far from a walk in the park, but I treated it like the long and gruelling winter training from my days in the British Rowing Team.

Not long before the end of my chemo, I went to meet the surgeon responsible for my double mastectomy and reconstruction to discuss options and found that there was only one: they would do one mastectomy, leave me for 18 months, then do the other side and reconstruct both. I was also told reconstruction would use muscles from my back and, as a wheelchair user, would affect my mobility and independence.

This was the point at which my world fell apart. If I didn't have reconstruction for 18 months then I would be forced to face my fear of waking up without a breast and the reality that I had cancer. An operation reducing my independence would mean cancer's impact staying with me for the rest of my life.

For me, this one consultation was the biggest knock of the journey. I'd coped with the diagnosis and even planned my wedding before starting treatment. I'd worked through the first six rounds of chemo and only now, with someone giving me 10 minutes to hear what they had chosen for me, did it stop me in my tracks.

> **Without realising it I had become a barcoded object on the conveyor belt**

Having worked in the NHS, I realised there must be choices somewhere and asked my GP to be referred for a second opinion. Chemo takes away your identity as a woman – with hair loss, body shape changes, loss of fertility. Without realising it I had become a barcoded object on the conveyor belt. In my first consultation with the alternative surgeon I became Helene again, and it was all about what was right for me, rather than following a rigid pathway.

One year on, I'm still on daily intravenous treatment, but the individualised approach enabled me to have a double mastectomy and reconstruction all in one operation. This protected me from the psychological effects I feared, did not affect my mobility, and I am back doing the job I love.

I often hear people refer to me "fighting cancer", but this doesn't ring true. I fought for options that should be open to everyone. While I do not dispute there are lifestyle changes that benefit patients, those who fought my cancer were colleagues who have worked on the evidence-base along with our research and clinical counterparts.

So, from a patient to all those who played a part in saving my life, thank you! I hope that this story will prompt us all to think that behind every care pathway we commission there is a person with individual needs.

Helene Raynsford
Public Health Service Manager
Wokingham Borough Council

(Helene Raynsford won Paralympic Gold at the Beijing 2008 Summer Games in single sculls rowing and is a full-time wheelchair user)

Information

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