Reflecting on a few lessons of history and five decades working in public health, FPH Board member **Patrick Saunders** says a resounding 'Yes please!' to local democracy and public health

THE Victorian fathers of my own city, Birmingham, pioneered astonishing reforms: taking the shambolic private gas and water companies into public ownership, constructing a massive £200m civil engineering miracle to carry clean drinking water 120 km from the Elan Valley in mid-Wales to the city by gravity, undertaking widespread slum clearances and house building, setting up a comprehensive and cheap public transport system and laying out an unparalleled network of public libraries and parks.

Despite the risks, these pioneers were driven by an ethical imperative to protect the poor and, crucially, were empowered by the establishment of local government through the Great Reform, Public Health and Welfare acts. Britain had become one of the most democratic countries in the world and local municipalities had a profound sense that they had been created to deliver public health and welfare. They did so with imagination and a common purpose marshalling the power of local democracy and its resources.

Of course, the health and welfare structures were much simpler than our current crowded administrative market which are so vulnerable to central fiscal and political ideologies and competing demands for investment.

Nonetheless many of us welcomed the return of public health to local democracy.

I plied my early career in local government, from 1975, the year after the public health 'divorce', to 1989. Public health was regarded throughout as our most important responsibility and as fundamentally *our* business. I naively assumed a seamless transition to these halcyon days, completely misjudging the scale and consequences of the political, ideological and service demands on local government. Austerity, enforced outsourcing to sectors with no duty to provide for the public interest,

> **Britain is now one of the least democratic countries in Europe, according to the *Daily Mail*, no less**

weakening of local democratic oversight and the inevitable systematic over-charging, have all contributed to an expensive hollowing out of local democracy and the reality that Britain is now one of the least democratic countries in Europe, according to the *Daily Mail,* no less.

The Local Government Association (LGA) bemoans the marginalisation of local elected members from sustainability and transformation plans and, while directors of public health have reported strategic *input* to them, *outputs* have been marginal. Public health suffers as a result, but we must also accept some responsibility. Natural allies are behaving as anything but, as demonstrated by the NHS taking to the courts to defend its *duty* not to fund evidence-based and cost-effective interventions, and some in public health are bemoaning the 'naivety of speaking truth to power' and meekly accepting the inevitability of austerity.

Of course, there are also many inspiring examples of public health professionals and local councils we can build on: the new generation of mayors making brave decisions, the Chartered Institute of Housing and the LGA taking bold positions, and councils collectively challenging government policy with sober evidence. We need more of this and must make it easier for them.

There may well be no significant extra funding for public health despite an apparent shift in the national political consensus, but we can influence local priorities and deployment of resources, and mobilise communities to lobby their elected representatives. The latter was identified by an expert panel at the September Public Health England conference as the single most important step in terms of tackling air pollution – and it was right.

Patrick Saunders
Visiting Professor in Public Health
University of Staffordshire

Information

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Themes for 2018 include Brexit and public health funding.

The magazine of the
UK Faculty of Public Health
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Autumn 2017

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Cover image: ©Mother & Child by Richard Ansett, Zero2 Expo

Welcome

IF YOU study virtually any public health or social problem in adult life, your systematic review will turn up interventions in early years as a crucial component of prevention. Think domestic violence, teenage pregnancy, a life of crime, poor school performance, truancy, a tendency to addiction… These are problems that intervention in early years – family support, education support, parenting advice and parental training – can address. The iconic trials by experimental social scientists, particularly in the US, showed the way. The 'Six Sound Trials' described by Angela Harden and Ann Oakley, including the Perry Preschool Study and the Quantum Opportunities Program, showed how vital education and support were, both to children in their early years 'at risk of school failure' and to help adolescents over the difficulties they faced.

When the crash hit Britain in the late 2000s many public health practitioners feared the promising improvements in teenage pregnancy would be lost. The return of a future without hope, one million under 25s unemployed, no opportunities for advancement in education and careers… Having a baby had always been a stereotype of love, and life on the dole. But it didn't happen. Teenage pregnancy rates continued to decline – until now at least. Whatever options Austerity Britain offered, getting pregnant didn't return.

I believe the reasons for this were not in the present but a generation back, in the late 1990s. I believe the programme of Sure Start, Sure Start maternity grants, Sure Start-plus for teenage mothers, combined with the minimum wage, the working families tax credit and commitments to reduce teenage pregnancy and child poverty, all had a part in immunising the next generation against what had been a cycle of young mothers begetting young mothers… Should we be surprised the infant mortality fell by a third overall in the UK to 2009? Should we be surprised that in

2017 infant mortality got worse for the first time since records began, with child poverty climbing again, and Sure Starts and parenting programmes slashed?

We have the experimental evidence supporting early years intervention, cited by the Cochrane, Acheson and Marmot reports. We now also have the growing body of epidemiological evidence on the long-term effects of adverse childhood experiences compiled by Mark Bellis and colleagues. This triangulates with a growing knowledge of what is going on in the brain in early years to hardwire positive or negative behaviours and attitudes which will last a lifetime. These interrelationships between neurophysiology, sociology and experimental observation were described in the Faculty of Public Health's statement on the role of public health in the prevention of violence.

As we do more research we must not be afraid to investigate and measure such nebulous concepts as love, friendship and play. These are the glue that keep us together, enable us to overcome adverse childhood experiences and be better parents and members of better communities. And we must continue to advocate for rebuilding our early years interventions and services for the protection of the next generation and the benefit of all our society's health.

John Middleton

FPH launches targeted campaigns on Brexit and PH funding

THE Faculty of Public Health's (FPH's) Policy and Communications Department would like to thank all of our members for making 2017 such an incredible year for us. At the beginning of the year we came to you for help in setting our agenda; we asked you what you thought our small staff team should prioritise in order to make the largest positive impact on the health, happiness and wellbeing of the public. Following this consultation, in May we announced that we would be launching 2-3 year influencing campaigns on the topics of Brexit and public health funding – but we told you we still needed your help to determine our vision for the campaigns and what exactly we would be calling for, and we needed your expertise and time to help us deliver them.

You have delivered for us in so many ways, and your participation has truly heralded new ways in which FPH can deliver its policy campaigns. For example, we've established project groups for each of the campaigns, comprised of FPH staff and, for the first time, specialty registrars (StRs) who have joined our campaigns as part of their training. StRs on our 'activity placements' scheme for Brexit and public health funding will have the opportunity to fulfil a wide array of curriculum requirements as they develop campaign strategy, conduct new research, gather evidence, lead stakeholder engagement, and learn how to influence at local, national, and international level. We are truly delighted to have them on board and we know the campaign work would not be possible without their contributions.

But what are the campaigns actually calling for? Well, as you are no doubt aware, Brexit and public health funding are complex and very broad issues, and there are so many fronts on which we would like to be present. We know, however, that we will have the greatest chance to succeed if we limit what we work on to a small cluster of issues that we are best placed to act on and that we believe we can win. To arrive at these policy calls, we consulted with more than 50 different stakeholders, including the Public Health Minister, and you and your fellow FPH members to determine a longlist of potential policy calls for each campaign. We then convened Advisory Boards for each of the campaigns – comprised of FPH's own expert membership – to help us shortlist our calls.

In the New Year we will be announcing the specific policy issues within Brexit and public health funding that will form the bedrock of our campaigning work over the near-to-medium future. We will no doubt once again be calling on your help and support to make sure we're getting it right and we're doing it right. Early in the New Year we'll be providing a list of ways in which you can feed into the campaigns, from participating in policy workshops, to serving as media spokespeople, to connecting our project group up with some data you think we could use to make our case, to developing the narrative and messaging of our campaigns. If you are interested in being involved please email policy@fph.org.uk

Once again, thank you so much for all of your support. We hope you have a very happy new year.

Lisa Plotkin
FPH Policy Officer

News in brief

UK eliminates measles
The elimination of measles has been achieved in the UK for the first time, the World Health Organization says. The global health body classes a country as having eliminated the disease when it has stopped freely circulating for at least three years.

Sickle cell screening working well
The first evaluation of the NHS Sickle Cell Screening Programme has found that it is successfully identifying newborn babies with the disease enabling them to receive penicillin early and parents to get education and support early, both of which are known to reduce morbidity and mortality. The research by King's College London was published in Archives of Disease in Childhood.

Babies' brains damaged by pollution
Seventeen million babies under the age of one are breathing toxic air, putting their brain development at risk, UNICEF has warned. Babies in South Asia were worst affected, with more than 12 million living in areas with pollution six times higher than safe levels. A further four million were at risk in East Asia and the Pacific.

Sporty people 'drink more alcohol'
People in Wales who exercise regularly are more likely to drink above the recommended alcohol allowance than those who do no sport, the National Survey for Wales found. Fifty-eight percent of people who exercised three times or more a week drank within the limit compared to 77% of people who did no exercise.

Curbs on wood burners sought
London Mayor Sadiq Khan is seeking powers to ban wood burning in the most polluted areas of the capital. Mr Khan wants to introduce a network of 'zero-emission zones' where the burning of wood or coal is completely prohibited.

Middle-aged told to walk faster
Middle-aged people are being urged to walk faster to help stay healthy, amid concern that high levels of inactivity may be harming their health. Public Health England said the amount of activity started to tail off from the age of 40. Just 10 minutes a day could have a major impact, reducing the risk of early death by 15%.

INTERVIEW

Dr Andrew Furber has been President of the Association of Directors of Public Health (ADPH) since 2015. He steps down in January when he leaves his job as Wakefield's DPH to work for Public Health England. A former editorial board member of *Public Health Today*, he talks to us about his conversion to public health, working to support DPHs and our role in his story

`In the mountains I saw the light'

Look at the underlying causes, says Furber

What brought you into public health?
I started training originally as a GP and I remember light-bulb moments even back then, seeing a woman with end-stage chronic lung disease as a result of 40 years of smoking and thinking it was a pretty appalling way to die and entirely preventable. But the real light-bulb moment happened in Nepal. I was working in a district hospital and saw a young boy with TB and, just as I got to understand some of his circumstances – the fact that he was from a family of subsistence farmers, low-caste, illiterate, in a very remote village without any access to healthcare – I realised that it was these factors that were the underlying causes of his ill health and that to effectively deal with that you needed a different approach that wasn't just based on hospitals and clinics.

How much time did you spend in Nepal
Seven years altogether. I didn't know much about Nepal until I had the opportunity to work there. I went there initially for six months. Having been in a country you get contacts and understand some more of the opportunities. So then I got a job supporting the primary healthcare infrastructure. Pretty much the only way around the district was walking, so I spent a fair bit of time walking the hills of the Himalaya, taking photographs and eventually arriving at a health post to do the training and consulting, before turning round and going back. It didn't feel like work at all; it felt like a real privilege.

What are the biggest challenges for directors of public health at the moment?
I'm always impressed at how positive directors of public health remain despite some phenomenal challenges. They recognise that it's always been a challenging role, and in England, certainly, when we were in the NHS, I knew first-hand of public health budgets being cut and public health being marginalised at the expense of acute services.

Clearly the situation varies across the UK. In Wales there are some exciting things happening at a national level with the legislation that's been passed, the Public Health Act as well as the Wellbeing of Future Generations Act, and the development of Public Health Wales as a national public health body. Scotland has a government that has been sympathetic to issues of social justice and health and equalities which has helped them take some issues forward. Despite a more challenging political context in Northern Ireland they've still achieved some amazing things around physical activity at scale, and they are developing work with local government, as well as working more closely with health services.

Within England our place in local government has provided some amazing opportunities to engage with housing, transport planning and the environment in a way that we've never been able to do in the recent past. But in all of these countries the funding pressures are huge, and that is probably the number one concern of directors of public health at the moment: how you adequately resource the preventative activity that we know needs to occur if outcomes are going to improve, people are going to enjoy better health and wellbeing, and those pressures that we see on curative and care services are mitigated.

What is ADPH doing to help directors of public health with their main challenges at the moment?
It's certainly our view that if you've got strong, supported directors of public health then they are the best people to sort all this stuff out at the local level, to fight their corner around budgets and negotiate with other parties around what happens. So we support them in a number of ways by advocating for their role with government; we've just published the results of a survey of our members showing that, at least in England, around half of them are now managing not just public health but other council functions. Similarly we are aware that in Scotland, Wales and Northern Ireland there are wider responsibilities beyond the sort of core public health functions. So, in order to get that recognition for the important role that directors of public health play in the local place, we support them through information and policy advice. We run masterclasses on particular topics where they feel they need some further development. With the Faculty of Public Health and others we are concerned about the workforce and that pipeline of aspiring directors of public health, and that people are coming up through the system with the motivation and ability to take on the role. And then more recently we've started to engage with some of the people in public health training to give them the opportunity to do some work with us which will tick off some of their competencies but will also give them a bit of an insight into the role of directors of public health, so that, as they plan their careers, that might be an option they might wish to consider at some point in the future.

> **I would like to send a message to trainees to seriously think about getting involved in FPH work**

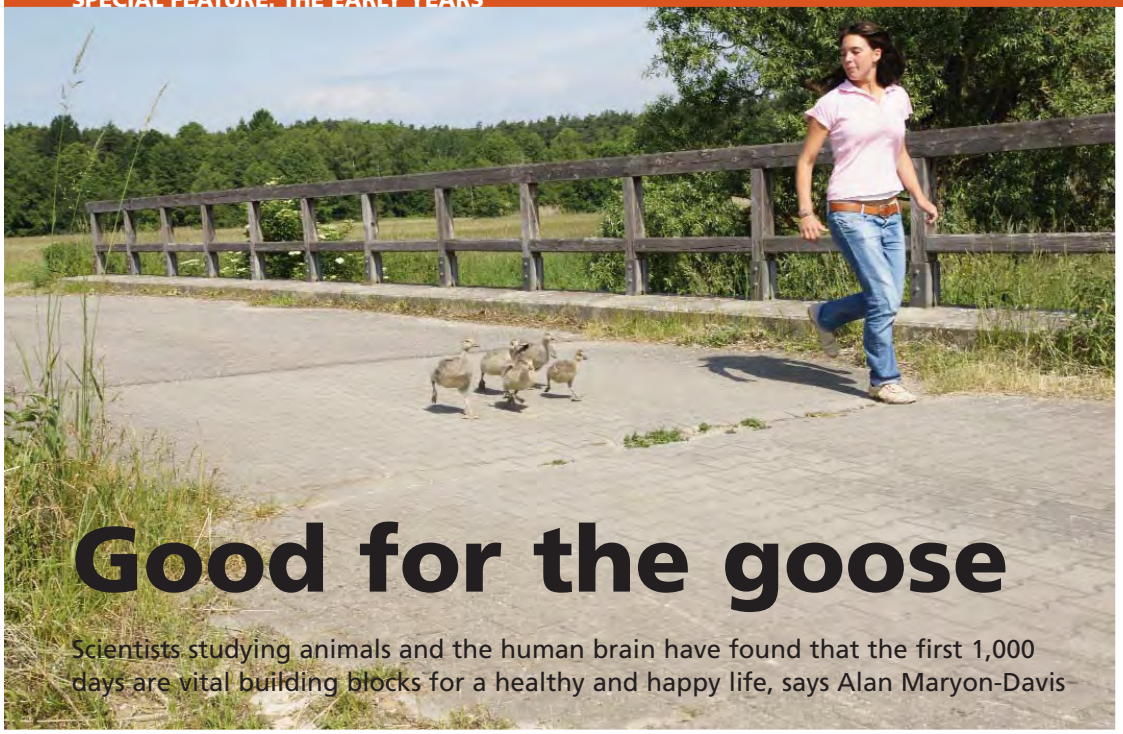
How is ADPH working with FPH and others such as Public Health England?
We are part of the UK Public Health Network which is really led by ADPH, FPH, the UK Health Forum and the Royal Society for Public Health. This gives us a chance to come together and agree actions on key issues. So we've had discussions on Brexit for example, and we've got discussions coming up on how health can be seen as a human right. On relevant or big issues we do collaborate where it makes sense, so for example we have a policy group on housing where we work very closely with FPH to ensure that we don't duplicate and that we're acting together to influence wherever we can.

What has been your biggest challenge in your work over the years?
The underlying issue is about how you create that compelling narrative for prevention, early intervention, improving health and wellbeing and protecting health, because the reality is that it tends to be the poor relation of acute services and curative and care services. It's how you create that vision of what a radically different system could deliver.

Is there anything that keeps you awake at night?
The on-going thing that troubles me is social injustice. There'll be children born in Wakefield today in very difficult circumstances who will really struggle to achieve the kind of quality of life that we would all want for our children, and that just seems unfair – that by the circumstances of somebody's birth their life should be determined. That's partly why I'm doing public health, and I think if I ever stopped doing public health I would still be doing something about that.

How important has FPH been in your own career?
FPH has played a very important role in my own story. I joined the Editorial Board of this publication as a trainee and was also involved in the International Committee and the Trainee Members Committee and that was really helpful in terms of getting an insight into some of the national thinking and politics. I've maintained my involvement either in the Faculty or in other national work since then, and I'm quite sure that's been part of my leadership development which has then naturally resulted in me taking up the ADPH role. So I would like to send a message to trainees to seriously think about getting involved in FPH work, such as special interest groups. Their professional development will really benefit from it. I wouldn't be where I am today without the Faculty of Public Health.

Interview by Richard Allen



Good for the goose

Scientists studying animals and the human brain have found that the first 1,000 days are vital building blocks for a healthy and happy life, says Alan Maryon-Davis

IT BEGAN with a clutch of newly hatched greylag goslings following instinctively behind the first waddling creature they clapped their little peepers on – which, in a famous experiment in 1935, happened to be psychologist Konrad Lorenz instead of mother goose.

Then, in the 1950s, Harry Harlow found that baby rhesus monkeys preferred the softness of a terry-cloth-covered dummy-mummy to an uncomfortable wireframe version with a milk bottle, and that baby monkeys separated from their mother soon after birth displayed odd or aggressive behaviour with other monkeys and in some cases indulged in self-mutilation.

At about the same time, British child psychiatrist John Bowlby, observed similar distress in children separated from their mother, and suggested that babies are born with an innate compulsion to have close contact with their caregiver – an idea he formulated as 'attachment theory.'

In the 1990s, Vincent Felitti studied the links between parent/child relationships, the domestic environment and child development and coined the term 'adverse childhood experiences' (ACEs). Together with Robert Anda, he conducted a retrospective study of 17,000 US adults which revealed strong links between childhood neglect, trauma or abuse and a range of subsequent mental and physical health problems.

Alan Maryon-Davis steps down as Editor – see page 18

More recently, neurophysiologists investigating the so-called 'plasticity' of the rapidly developing newborn human brain have found changes 'hard-wired' into synaptic connections in response to various demands and stresses in an infant's early life. These changes are often emotionally or behaviourally dysfunctional, affecting the child's relationships and learning.

But, fascinating though all this science is, it only serves to underpin what we know only too well – that the first 1,000 days or so are crucial in laying the foundations of a child's whole life. Time and again we see how things can go horribly wrong with vulnerable families, not only in our work but also in countless fly-on-the-wall TV documentaries.

So, what makes 'good' parenting? How can we enhance early learning? How can we best protect young children from ACEs or mitigate the effects? How can we extend quality childcare? What can national and local government, civil society and families do to help children have the best possible start in life?

You'll find all these questions addressed in the following pages, along with the ever-present undercurrent of inequalities. Childhood adversity is exacerbated by low income, poor housing and the many stresses that flare up in families struggling to cope. And fuelling this fire is the current policy of austerity which is decimating children's services across the board – health visiting, children's centres, psychological support, childcare and so much else.

Austerity hurts – and it hurts our children most. Like Konrad Lorenz's deluded goslings, it needs a radical re-think. And the sooner it becomes history, the better.

Alan Maryon-Davis
Editor in Chief

The developing brain and neurosciences

RESEARCH about the infant brain has major implications for care and education in childhood and across the life course. The growth of a child's brain is profoundly influenced by its social environment and its relationship with primary carers. These are shaped by family circumstances and the wider determinants of health such as housing and family income.

Babies expect positive interaction with carers and respond positively to soothing and affection. Adverse circumstances in early childhood, such as neglectful parenting or household mental illness, put pressure on the infant's fundamental physiological and psychological systems for self-regulation and planning ahead. This can have consequences for a child's self-esteem, cognitive capacity and risk-taking.

Two particular neurological systems modulate these reactions:

- The limbic system registers emotional information. This can be unsettled by chronic stress which disrupts the infant brain's developing architecture and damages learning. because responses related to cortisol functioning cannot be turned off. This hormone shuts down important physiological functions and leaves some children in constantly heightened and defensive states. One consequence is that the amygdalae cannot do their work of helping a child to self-regulate emotion, and so the thinking parts of the brain cannot function well. Whilst cortisol is vital for healthy brains, excess cortisol has been called "toxic" and "catastrophic".
- The polyvagal system connects the gut, heart, face and brain through the vagus nerve. Secure attachment and more relaxed responses to threat are linked to better vagal tone which is a good indicator of good physical and mental health over the life course. Vagal tone can be measured and greater variability is beneficial. The polyvagal system modulates between the autonomic nervous system and the central nervous system to handle three different levels of response to threat. The first freezes our physical systems to keep us safe. The second rapidly releases cortisol, adrenalin and noradrenalin to stimulate fight-or-flight reactions. It is damaging for a child to remain in this state. The third, where the perception of threat is low, allows the child to develop affirming relationships with well-attuned carers who use 'motherese' more often. This helps children improve speech appreciation, promoting language and cognitive development.

Recent research in the neurosciences has shown strong connections between the infant brain, family life and wider social influences. There have been concerns. Poor and premature translation into practice has raised worries about over-extension. There has been criticism that the focus on the infant brain might distract attention from the wider determinants of health. However, recent US findings about the relationship between poverty, family income, the size of a child's cerebral cortex and cognitive and educational performance have stimulated radical interest in improving financial resources for families.

Liam Hughes
Former National Adviser for Healthy Communities
Local Government Association

The art of giving a child the best start

OUR entrance into this world has an impact that stays with us throughout our life. The time from conception to the age of two is a window of opportunity that sets a baby on a particular positive or negative trajectory.

We're on a mission at Zero2 Expo to stimulate dialogue, inspire changes and action in the first 1,001 days of life by engaging parents, the public and communities to understand the need for new approaches, clearer pathways to better support, and encouraging more strategic investment. Zero2 Expo has commissioned artists and scientists to participate in a multimedia exhibition, with talks, films and workshops, that is set to tour the UK and Internationally between now and 2021.

Our pilot exhibition in the House of Commons in 2016 attracted 4,000 politicians and staff and was key to getting perinatal mental health a focus for NHS England and local transformation plans throughout the country. The positive response to this first exhibition encouraged us to develop the initiative further and Zero2 Expo emerged.

Already local authorities in Warrington and Cardiff have confirmed their interest in securing the exhibition locally and Abu Dhabi internationally. Muna Abdel Aziz, Director of Public Health, Housing and Neighbourhoods at Warrington Borough Council, has commissioned the Zero2 Expo as part of their Best Start in Life work to disseminate the 1,001-days messages to parents and other carers.

A less than optimal first 1,001 days can have lifelong negative effects, particularly on those living in poverty. A World Health Organization study found that preventing some of these stressors can more than halve drug use and violence, and reduce teenage pregnancies by a third. A happy and healthy 1,001 days are crucial to ensuring a good start, and improving long-term outcomes in health, relationships, education and employment. We believe this is the biggest public health message of our time, and it is crucial that we spread the word.

If you wish to commission our Expo to come to your city, please get in touch: alex@zero2expo.com

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DEBATE: Should childhood vaccinations be mandatory? Speaking at a recent British Medical Association debate, Farah Jameel and Eleanor Draeger argued that opting out is negligent, while Kiara Vincent and David Smith said parents should not be coerced

I was told I would never see a measles case

YES

PROPOSING the motion, Dr Farah Jameel, GP, London, said: "Great progress has been made through vaccination programmes, and in the last 20 years more than one in five of all childhood deaths have been averted due to measles vaccinations… But the spectre of the anti-vaxxer movement is upon us, and wherever it gains a foothold we see the reversal of these public health gains…

"We should condemn the movement strongly and without reservation and ensure that policy makers and MPs listen… Parents who willingly choose not to vaccinate their children, despite the safe evidence base, are displaying negligent behaviours that are in some cases seriously harming the health of children, who have no say or control over this decision, and in extreme situations costing lives."

In supporting the motion, Dr Eleanor Draeger, then deputy chair of the British Medical Association's consultants committee, said: "I qualified in 2000 and when I was at medical school I was taught about measles as a historical disease that I would probably never see… In 2007, I saw my first case of measles in a 10-month-old baby who was really, really unwell – wasn't hospitalised but spent 10 days dehydrated and seeing the GP every day with constant fear for their health. That 10-month-old baby was my son… He has had every vaccination but at 10 months he was too young for his first MMR. The reason he had measles is because of the fall-out from Wakefield's paper*… Something which should have been historical in my career isn't historical anymore… We need to understand that these illnesses are completely preventable by vaccination."

This is a battle for hearts and minds

NO

SPEAKING against the motion, Dr David Smith, Yorkshire Regional Council, said: "To be clear, we absolutely need to increase vaccination rates. But who are these 'evil' anti-vaxxers? To me these are parents, loving parents, concerned parents, who feel that they are doing the best for their children…

"This is a group of people who are deeply mistrustful of us. This is a battle for their hearts and minds and how are we choosing to do this? How are we choosing to battle for them? Are we going to ask this government whether we think it's right to force-treat these children? This is not the way… This would condemn them… If we go to war with these concerned parents they will never bring their kids to us again… When those kids get ill and we can do something, we will not be given that opportunity… You don't win these hearts and minds with condemnation, you win with compassion."

Also opposing the motion, junior doctor Kiara Vincent, said: "These parents already distrust the medical community. They are often scared of their children being harmed by medical intervention, and we shouldn't alienate them further… We need to educate them, support them and ensure the correct information is available."

The motion was passed as a 'reference' to be further considered by the BMA in more depth.

Information:

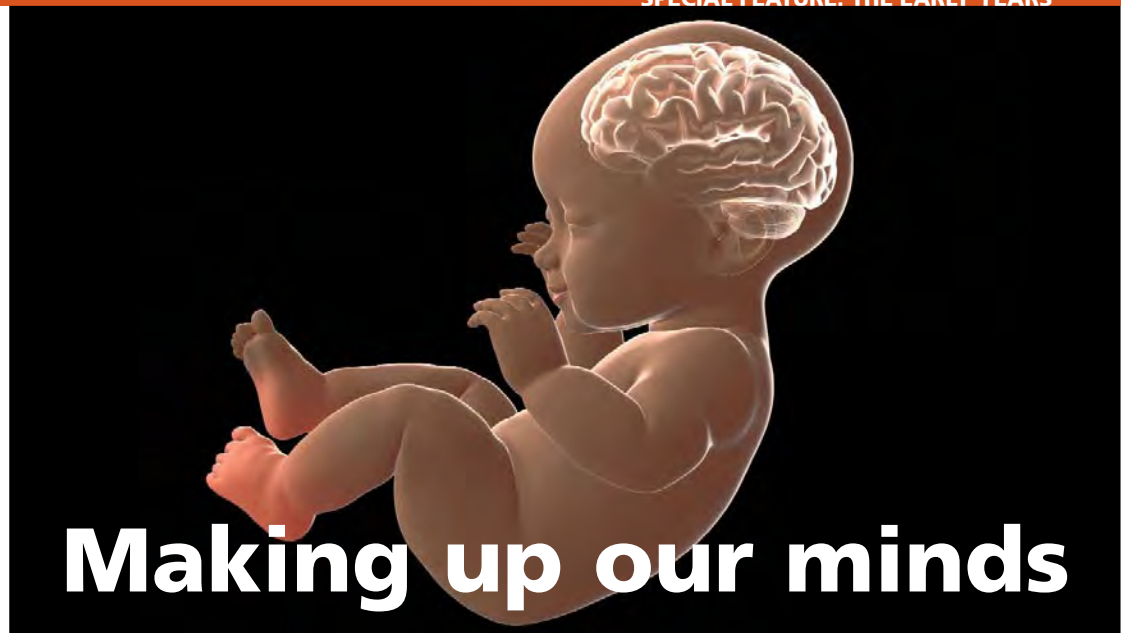
THE combined measles, mumps and rubella (MMR) vaccine is normally given to children in two doses: the first within a month of their first birthday as part of their routine immunisation schedule; the second before starting school, usually at three years and four months. The target coverage for herd immunity is 95%.

The fallout following the major media scare triggered by Andrew Wakefield's now notorious 1998 paper in the *Lancet**, purporting to show a link between the combined vaccine and autism, led to coverage slumping to below 85% by 2005.

That paper has since been widely discredited and its findings refuted, but coverage rates have been slow to recover, in part due to continuing publicity given to those lobbying against universal childhood vaccinations (the 'anti-vaxxers'). However, in 2016 national vaccine coverage of the first MMR dose in five-year-olds in the UK reached the 95% target.

The World Health Organization European Regional Verification Commission has recently confirmed that the UK has officially 'eliminated' measles for the first time (defined as having sustained interruption of endemic transmission for at least 36 months).

* Wakefield AJ, Murch SH et al. 1998. Ileal lymphoid nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children [retracted]. *Lancet*. 351, 637-41.



Making up our minds

Leaving a young child in a stressful situation creates faulty wiring in its brain that can have devastating consequences, says Robin Balbernie

THE human brain is designed to change in response to the social as much as the physical environment. Our habitat is one of relationships rather than one governed by climate and geography. We adapt to culture via the family in order to become a member of society, and this occurs on both the psychological and neurological level of the mind.

At birth much of the baby's brain has yet to be wired up. Most of the neurones that an individual will have for their lifetime are present at birth; but the fibres carrying outgoing signals, called axons, and those that gather in signals from others, dendrites, are mostly not in place. Their synaptic connections take up a lot of volume, and so by ensuring that the bulk of their formation occurs after the baby is born the process of giving birth is safer for all concerned.

This also means that the structure of the brain in certain key areas will be influenced by the quality of relationships and general stimulation within the family for better or for worse. The human brain is at its most adaptable, or 'plastic', during this initial period of formation – the 'First 1001 Critical Days' of existence.

The early developing brain needs appropriate input in order to create neuronal connections during the windows of opportunity afforded by the normal assumption that 'this is it' for life, stabilising them through a process known as myelination and discarding the rest in the interests of efficiency and available space. Brains also form circuits in an 'experience-dependent' manner, learning from experience, a process that never ends. A straightforward way of thinking about this is to remember the two phrases "neurones that fire together wire together" and "use it or lose it". If the environment is one that causes the child to consistently feel unsafe and fearful, at the worst extreme experiencing toxic stress, then this will be reflected in the final survival, threat-reactive, circuits of the brain. Without help such a child might go through life responding to even minor problems as if they were a dangerous life-threatening situation. Such children both cost the country a fortune and cause untold collateral damage as they go through life.

waves of synaptic growth. Each area of the brain in turn goes through a process of synaptic proliferation and then pruning, these sequential phases of development ensure that the correct circuits are in place to match the specific demands of the individual environment. This is known as 'experience expectant' brain growth.

The brain will preserve the circuits it appears to need to adapt to a particular environment, there is a neurological

> **Brain plasticity both makes us human and is our most serious Achilles' heel**

Brain plasticity both makes us human and is our most serious Achilles' heel. The longer a child's brain is left in a stressful setting the harder it will be to create new more benign neuronal networks and re-set the stress response; but only if they are lucky enough to be noticed and helped. But it is never impossible – it just takes a greater investment of resources and effort as time goes by. And the most cost-efficient, and kindest, time to help is while the brain is at its most adaptable, from conception to age two.

Robin Balbernie
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Putting it down to adverse experience

CHILD abuse and trauma is a major public health issue. Adverse childhood experiences (ACEs) are stressful experiences occurring in childhood that either directly harm a child or the environment in which they live. The term ACEs includes child maltreatment and living with household adversity such as parental substance abuse or domestic violence. Experiencing ACEs is associated with poorer mental and physical health.

Attachment theory helps explain the finding that having a trusting relationship with an adult can mitigate the effects on a child of having multiple ACEs. A child who has a secure attachment to their parent or other adult will seek closeness to them when upset or anxious. This closeness reduces their fear so they are free to explore and engage with their world, knowing that if needed, they can return to their safe base.

Public health professionals are ideally placed to advocate for the prevention of ACEs and promotion of secure attachment. *Resilience*, a film about the science of ACEs (http://kpjrfilms.co/resilience/), has recently been on tour around Scotland. Being on the panel for my local screening one Saturday morning I was awed by the cinema packed full of people who had chosen to spend part of their weekend there. This event led onto collaboration with local authorities and the voluntary sector, as well as other directorates within the health board, to plan and develop actions to prevent and mitigate ACEs.

Evidence-based parenting programmes, such as Incredible Years, aim to promote positive parenting. Financial and housing security, along with supportive relationships, is needed to support the conditions for 'good' parenting. Therefore action to tackle poverty and income inequality is also required. Schools can play an important role in mitigating ACEs as teachers and other school staff can provide secure attachments for children by being sensitive and responsive to the child's needs.

As with other major public health issues, changes to legislation will help protect children and promote their rights and health. Physical punishment of children is associated with a range of adverse outcomes including emotional and behavioural problems, anxiety and depression, and physical abuse. The Scottish Directors of Public Health, along with organisations such as NHS Tayside, are advocating for children in Scotland to receive the same legal protection against assault as adults by calling for a ban on physical punishment of children.

Get involved in FPH's mental health work. Contact Christina Gray, Chair of FPH's Public Mental Health Special Interest Group, at CZGray@somerset.gov

Tamasin Knight
Consultant in Public Health Medicine
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FPH Public Mental Health Special Interest Group
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Children are in a special situation

SO MUCH of public health today is about the health of the public tomorrow. Aspects of physical and social environments during our formative years, such as air quality, diet and education, impact health outcomes, opportunities and inequalities over our lifetimes. Where these are influenced by the conduct and decisions of political and commercial actors, or by personal and community practices, we can often identify what could improve health across society.

However, that measures can be deemed successful in terms of health protection and improvement does not mean they are immune to ethical complexities. These complexities are accentuated when we remember that public health ethics focuses not just on individual decisions and conduct, but on the use and legitimacy of (sometimes coercive) governmental power to protect and promote health. To be justified, we must explain when and why public health should be a, at times *the*, priority, for example, in family decision-making, the exercise of commercial freedoms, or political decision-making.

For children, distinct ethical factors arise. In its report *Public Health: Ethical Issues*, the Nuffield Council on Bioethics refers to "the special situation of children". This reflects how political philosophy treats children as special for two reasons: their particular vulnerability and their more limited decision-making capacity and greater susceptibility, for instance, to advertising and marketing. There are particular responsibilities for public agencies to advance children's interests because in many situations children cannot do this alone.

There can, of course, be marked disagreements about what serves or harms a child's interests, and who should have the right to make such a determination: think, for example, of the cases that have ended up in court about the MMR vaccine. Robust ethical advocacy is required to establish how and why long-term health promotion should be a priority. This means acknowledging children's special status, the scope of consequent public responsibilities, and the ways to balance short- and long-term health against competing values and interests.

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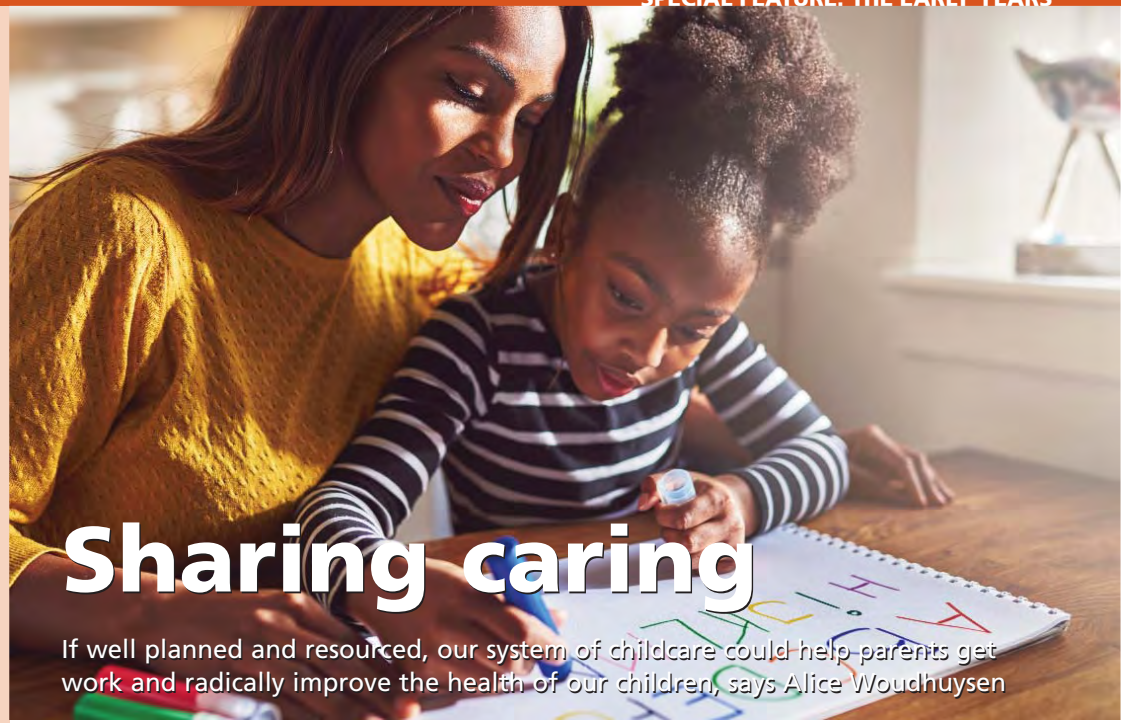
Join FPH's Ethics Special Interest Group at farhang.tahzib@gmail.com



Sharing caring

If well planned and resourced, our system of childcare could help parents get work and radically improve the health of our children, says Alice Woudhuysen

THERE are four million children in the UK living in relative poverty and the number is projected to rise to 5.1 million by 2021-22, driven in large part by cuts to working-age benefits.

Growing up in poverty affects a child's life chances, jeopardising educational and health outcomes. A recent survey carried out by the Child Poverty Action Group (CPAG) and the Royal College of Paediatrics and Child Health found that poverty and low income are having a profound impact on the health of UK children.* Otherwise healthy children are at risk of becoming unhealthy due to poor nutrition and cold and cramped housing conditions caused by poverty. And poverty can exacerbate the difficulties facing children with pre-existing health problems.

Tackling poverty requires a range of interventions, including tackling health inequalities and helping families into work. Yet the ability of parents – and in particular mothers – to enter or increase their hours of employment very much depends on their ability to access affordable and quality childcare. Not only can access to flexible, affordable childcare reduce pressures on family income by enabling and supporting parental employment, there is also robust evidence suggesting that children's early years are critical to their long-term outcomes and poverty risk as adults, regardless of their background. At its best, childcare can bring on children's development in the early years.

However, childcare remains one of the most expensive items in the budgets of many families with young children. CPAG's new *Cost of a Child* research** has found that the overall cost of raising a child over 18 years, including rent and childcare, has risen since 2016 from £151,600 to £155,100 for a couple and from £182,600 to £187,100 for a lone parent. Childcare now comprises nearly half of these costs.

> "At its best, childcare can bring on children's development in the early years"

The government is going some of the way to make childcare more affordable: public expenditure on childcare and pre-school education is reported to be at an all-time high, at around £7.1 billion per year. Families on low incomes are eligible for 15 hours free childcare for two-year-olds; those on Universal Credit have seen an increase in support to 85% of childcare costs since April 2016, and some working families will get more help through the government's extension of free childcare for three- and four-year-olds from 15 to 30 hours a week from April 2017.

But the current system is far from perfect. The government lacks a coherent vision for childcare, and there are also serious problems with quality and pay in the sector. That is why CPAG has been calling for a national childcare strategy which would include measures to make two-year-old places universal; fully fund a high-quality model of the 30-hour free entitlement; scrap the rule which restricts entitlement to the extra 15 hours to working parents; increase support for children's centres; and develop comprehensive, out-of-school and holiday childcare through extended schools.

Properly designed and funded, the UK's childcare system has the potential to help parents into work and protect the wellbeing of future generations. Poverty is not inevitable. With the right policies in place, every child can have the opportunity to do well in life, and we can all share the rewards of living in a healthier, fairer society.

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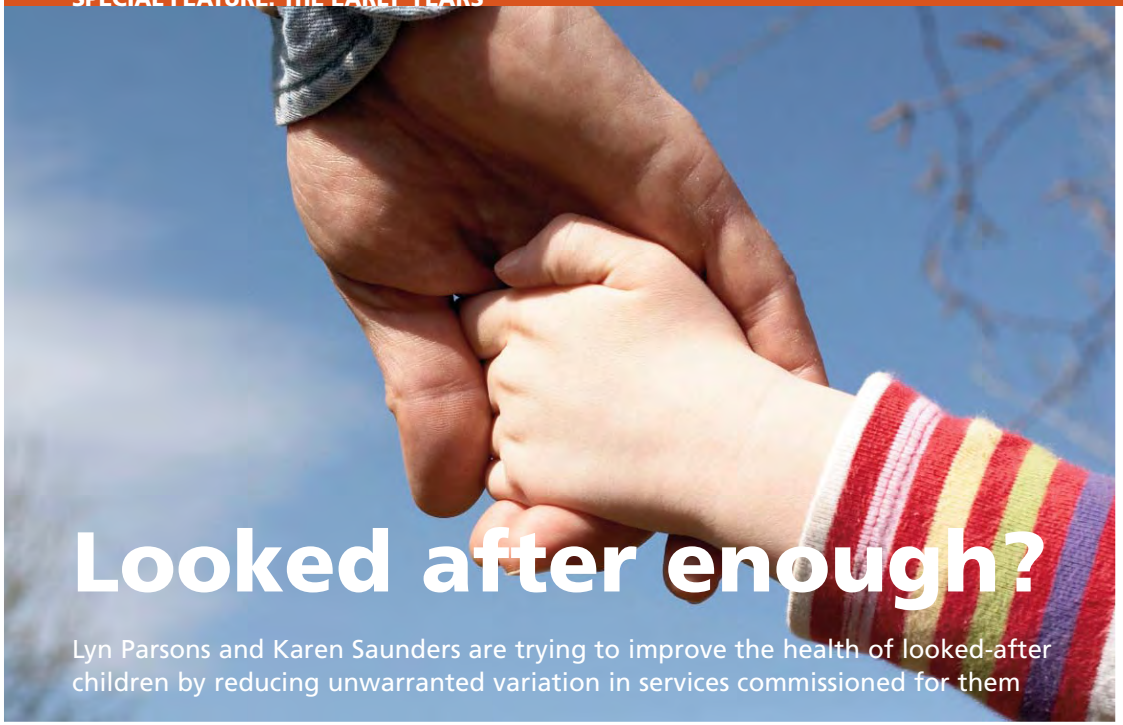

Looked after enough?

Lyn Parsons and Karen Saunders are trying to improve the health of looked-after children by reducing unwarranted variation in services commissioned for them

THE term 'looked-after children' generally means children who are looked after by the state, although the exact definition varies across the devolved nations. According to the National Society for the Prevention of Cruelty to Children there are currently more than 94,000 children in care in the UK; 60% because of abuse or neglect.

Looked-after children have the same health risks as peers but these are often exacerbated due to previous adverse experiences. For example, children in care are four times more likely than their peers to have a mental and emotional health difficulty. An estimated 20 to 35% of sexually exploited children are in care. Thirty-four percent of care leavers were not in education, employment or training at age 19 compared to 15.5% of the general population. A third of those leaving care return home to their family; however 30% of children who return home are back in care within five years. The cost from failed reunification of children returning home from care is around £300 million a year and the cost of appropriate support and services to families where children are returning home from care is around £56 million a year.

There is a range of guidance across UK countries to improve the health and wellbeing outcomes of looked-after children including, in England, statutory guidance, *Promoting the health and well-being of looked-after children*, aimed at local authorities, clinical commissioning groups and NHS England. This guidance includes requirements that statutory health assessments be undertaken for looked-after children throughout the duration of their time in care. These measures, guidance and aligned tariff arrangements should be used to ensure a quality health assessment for all looked-after children. However, variation has been identified in relation to the commissioning arrangements, the quality and payment processes, and there is an opportunity to identify whether this is unwarranted variation. To investigate further, NHS England work is underway looking at unwarranted variation in management of health assessments.

The aim of the Looked After Children Unwarranted Variation Project is to improve the health outcomes of this group across England by reducing any unwarranted variation in measurable benefits of services commissioned for this group. The project commenced in December 2016 led by a project manager seconded from their post as a designated looked-after children's nurse, who is an expert in this area of complexity. The project will continue until March 2018 and the outcomes will be of interest to wider stakeholders including those working in children's services; public health and the voluntary sector. The work is supported by the National Safeguarding Steering Group Looked After Children Forum which has expertise from across England made up of providers, commissioners and looked-after children doctors and nurses. To address potential issues of unwarranted variation across the system, a suite of commissioning tools is in development combining the science of the underpinning legislation with the art of commissioning and service delivery to decrease unwarranted variation. In addition, the project manager is supporting the strengthening of looked-after children's networks throughout England. Public Health England in the West Midlands has actively supported this work providing advice, data and wider input and will assist in dissemination of the final product at local and national level.

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The price we pay for being so adaptable

ARGUABLY one of the reasons humans have been so successful as a species is our extraordinary ability to adapt to a vast range of different environments. The price we pay is being born remarkably helpless compared to other animals and relying on our parents and others to nurture, educate and protect us as we adapt to prevailing physical and social conditions.

At the centre of this process is our own personal super-computer growing from around 25% of adult brain size at birth to 80% at age two years. During that time neurological connections are laid down at the rate of more than a million per second and subsequently pruned back to establish an infrastructure and associated thought processes that reflect our childhood experiences. What happens to us as children, including in utero, affects our propensity for empathy, violence and other emotional and cognitive processes throughout life.

In 1998 Vincent Felitti measured the impact of Adverse Childhood Experiences (ACEs) on the subsequent health of adults in the USA. These ACEs include those directly experienced by children (physical, sexual and emotional abuse and neglect) and those resulting from their home environment (domestic violence and parental separation, alcohol, drug, mental health and judicial problems amongst household members).

A recent global meta-analysis identified that individuals who experienced four or more ACEs (compared to those experiencing none) grow up to be twice as likely to smoke and develop cardiovascular disease or cancer prematurely; four or five times more likely to become a teenage parent, develop depression or use illegal drugs; and over seven times more likely to be violent. Such ACEs and their consequences appear in all types of communities with 1 in 10 adults in England and Wales having suffered four or more ACEs. However, they are more common in the poorest and consequently represent a critical link between poverty and ill health across the life course. They mean successive generations never reach their true potential, and health services are stretched to meet the additional healthcare needs of adults suffering health problems rooted in their childhood.

Following a national survey and reports in Wales on the prevalence of ACEs and their repercussions on physical health, mental wellbeing and health-service use, the Welsh government supported a new national ACE resource hub. This cross-government initiative involves departments for families and communities, education, social services and public health. The hub will support and align public services so that they can better prevent ACEs. It will help build resilience in children so that those exposed to ACEs can avoid at least some of the associated life-long harms. Equally, it will work with adult and child health, educational and judicial services to encourage trauma-informed approaches that can tackle a history of ACEs and not just their most recent repercussions.

Wales is at the beginning of its ACE journey, but awareness-raising materials such as an ACE film (www.aces.me.uk) are already available and ACEs are becoming part of the lexicon used by national programmes such as Flying Start, multi-agency Public Service Boards and policy initiatives across government. Wales is well placed to adopt an ACE approach with its recent Well-being of Future Generations Act holding all public services and government accountable to a long-term, sustainable vision of health. ACEs are part of this vision and make it clear that parents, professionals and politicians all have a responsibility to inspire the best from the infinite possibilities that every child represents.

Get involved in FPH's Children and Young People Special Interest Group. Contact co-chairs Karen Saunders (Karen.Saunders@phe.gov.uk) and Ingrid Wolfe (ingrid.wolfe@kcl.ac.uk)

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It could become every mother's bosom buddy

BABY Buddy is a free app with accessible and interactive content. Developed by the charity Best Beginnings, it is a personalised, cost-effective tool to help public health teams across the country improve outcomes in pregnancy and early years.

Best Beginnings works with multi-disciplinary healthcare staff and local communities to integrate Baby Buddy into care pathways. This involves training professionals and community 'champions' to make best use of the resource in reaching parents, particularly higher-risk parents. Baby Buddy includes:

- over 300 video clips of parents sharing stories and professionals giving advice
- over 500 answers to frequently asked questions
- 10 fun features designed to encourage self-care behaviours, enhance communication between parent and health professional, and drive positive behaviour change.

Baby Buddy can help make every contact count by helping goal-setting and progress-tracking, with plenty of positive feedback. The health professional can use Baby Buddy as an aid to co-creating the parents' care plan and incentivising adherence.

Behind Baby Buddy sits an analytic tool to track uptake and usage by locality, age, gender, ethnicity, language, education, employment and training. It also allows us to identify which videos Baby Buddy users are watching, what questions they're asking and which features they're using, as an anonymised data set. We feed all this into a quarterly report for our public health commissioners to measure the reach and impact in their local populations.

Alison Baum
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Best Beginnings
shabira@bestbeginnings.org.uk

Coming together to transform maternity

WE ARE now more than a year into implementing the vision set out in *Better Births*, the national review of maternity services in England, aiming to deliver safer and more personalised care for women and their families.

I am delighted to see significant progress across the country especially given maternity services are fundamental to every family and every community, and, if we get care right during pregnancy, birth and early years, we set up the next generation to thrive.

Nationally, the NHS bodies have come together with a shared commitment to implementing *Better Births*. However, transformation can only be achieved locally. That is why areas are coming together as local maternity systems (LMSs) joining clinicians, providers, clinical commissioning groups, local authorities and families themselves to plan and deliver maternity services and meet the needs of women, babies and families in their area.

Some LMSs are already going further, faster, and in November we identified seven early adopters who will lead the way so that others can learn from their endeavours. They are testing a range of new and innovative ways of working, including using small teams of midwives to offer greater continuity of care to women and making use of electronic records to provide more joined-up care.

I am hugely excited that my local services are one of these fabulous early-adopter areas, and we have recently launched, Birmingham and Solihull United Maternity and Newborn Partnership (BUMP) with a particular focus on providing women with greater choice, consistency and continuity via a single point of access.

> **Transformation can only be achieved locally**

Women have told us that continuity of carer is really important to them, and we are working to provide 80% with continuity through access to a small team of six to eight midwives throughout their pregnancy and postnatal care. This will be piloted over the next year.

We have also successfully launched seven Maternity Choice and Personalisation Pioneers and are already learning from their experience. Pioneers have been focusing on how to best implement personalised maternity care budgets (PMCBs), and at the end of June almost 700 women were accessing these, expressing their preferred choices and, with the support of their midwife, taking control of the care they receive. This is the first step towards the target of 10,000 PMCBs in place by next year.

As momentum continues to build, we need more and more people to get involved and help transform the care we provide to women and babies, not just for now but for generations to come.

Sarah-Jane Marsh
Chair
Maternity Transformation Programme
NHS England
Twitter: @BWCHBoss

Mothers need early support to breastfeed

BREASTFEEDING rates in England have remained static for the past few years. Most mothers want to breastfeed but many lack the confidence and experience to do so. Breastfeeding, while natural, is something that mums and their babies learn by doing, and early support is crucial.

It is a topic that continues to provoke strong debate among the public and within the healthcare profession. Breastfeeding and non-breastfeeding mothers often report feeling judged on their choice, especially mothers who breastfeed in public. Breastfeeding is often referred to as a "lifestyle choice" which exacerbates the issue by placing the responsibility on the shoulders of mothers.

The *Lancet* breastfeeding series shows the benefits to babies, mothers and society. It demonstrates how populations benefit from improving breastfeeding rates, and UNICEF's Call to Action makes the case for a change in how we approach this important public health issue. Creating a wider culture of encouragement and support will help make a mother's experience all the more positive.

The Department of Health has tasked Public Health England (PHE) to lead a national programme to promote breastfeeding as the normal way to feed infants for the first six months. We are working with local authorities, NHS Digital and NHS England to improve the quality of the data we collect, and we are supporting local maternity systems to ensure there are accessible, evidence-based, breastfeeding support services, particularly in the early days and weeks after birth, in local community hubs. Last year PHE published a resource for local authorities to support commissioning of infant feeding services.

PHE provides breastfeeding resources for professionals and the public through its Start4Life Information Service for Parents. In addition, earlier this year we launched the Start4Life Breastfeeding Friend Chatbot. Accessible via Facebook Messenger, the ChatBot provides answers to users' breastfeeding questions, any time of the day or night, from getting started to continuing breastfeeding after weaning. You can access the bot on the Start4Life Facebook page.

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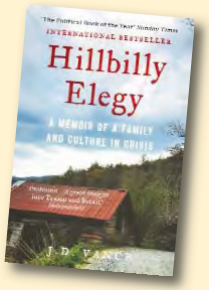
The lost tribes of America's mid-West

OFTEN described as the book that explains Trumpism, *Hillbilly Elegy* is the bestselling memoir by marine-turned-lawyer JD Vance about what it was like for him to grow up in a poor, Scots-Irish community in the middle of America. A moving and personal tribute to his Ohio and Kentucky family, this book offers an incisive glimpse into what has happened to the people of America's former manufacturing heartland over his lifetime.

Vance's conclusion is that the American Midwest has a problem, but it's not just a problem of macroeconomic decline, although that has certainly not helped. Rather, Vance argues that families like his –'hillbillies' – have problems that are rooted far deeper than economics can explain. "There is a lack of agency here," Vance writes when describing the hopelessness of his community. "A feeling that you have little control over your life and a willingness to blame everyone but yourself."

While some may not agree with Vance's main thesis, his story nonetheless is a very compelling read. From the inadequacies of his local school, to the opioid crisis affecting his family and thousands of others, to the proliferation of conspiracy 'news' outlets, and the wars in Iraq and Afghanistan that he and his neighbours went off to fight, the picture Vance paints is of a widening gulf of inequality and deprivation that currently shows no signs of receding. Millions of people live in communities like his.

This memoir is a must-read for anyone who wants to understand the complexities of what makes some communities fail while others elsewhere thrive. If you're hoping to get a straightforward answer, then this account will disappoint you. If you're looking, however, for a more nuanced explanation that unpicks some of our prevailing ideas about how social class, ethnic identity, and economic opportunity interact then this is the book for you. Similarly, if you're looking for narratives that make a case for a health-in-all-policies approach to local community planning you won't find a better clarion call. *Hillbilly Elegy* suggests with humour and skill why some local government policies have failed the very communities they were meant to help and puts forward a vision for how future policy can potentially right those wrongs. There is a sense that Vance's vision is only partially formed or still in first draft, but it's a promising starting point.



Lisa Plotkin

Hillbilly Elegy: A Memoir of a Family and Culture in Crisis
JD Vance

Published by Harper Collins
ISBN 9780008220563
RRP: £9.99 (paperback)

Always look on the bright side of life

WHY, after decades of messages telling us that smoking, eating sugar and having unprotected sex are likely to lead to an early grave, do millions of us continue to do so? This is, of course, one of the great challenges of public health.

Tali Sharot believes she may have at least part of the answer: human beings are built to be inherently optimistic. Despite overwhelming evidence to the contrary, we tend to think: "It won't happen to me." But then why would the human brain have evolved a habit that appears to be self-destructive? Because in other circumstances, this 'optimism bias' is beneficial, Sharot argues. "Data pointing toward the upside of optimism is plentiful; optimists live longer, are healthier and happier, make better financial plans, and are more successful," she says. For example, a study that tracked 238 cancer patients found that pessimistic patients were more likely to die within seven months than optimistic ones. It seems that the advantages of optimism outweigh the disadvantages.

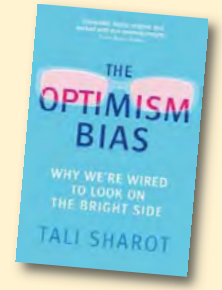
Through close study of brain activity, Sharot, an associate professor of cognitive neuroscience in the department of Experimental Psychology at University College London, has traced the ways that the brain manages to turn "adversity into opportunity". She says: "Our minds seek and adopt the most rewarding view of whatever situation befalls us."

Sadly for her argument, one of the examples she chooses is Lance Armstrong who 'beat' cancer and went on to win seven Tours de France. But after she wrote the book he was stripped of his titles for taking performance-enhancing drugs. He wasn't an optimist; he was a cheat.

This lively and readable book also contains some examples of where optimism can go spectacularly wrong. Perhaps the most terrifying is Stalin's refusal in 1941 to believe that Hitler was about to invade the Soviet Union despite numerous warnings. Then there is the financial crisis of 2008 in which investors, homeowners, bankers and regulators all expected better gains than were realistically warranted. Another intriguing case study for all project planners is the Sydney Opera House which ran 10 years and *14 times* over budget.

The UK government has tried to address the problem of the optimism bias by including specific guidelines in its Green Book which provides an overall methodology for economic assessment. It states: "There is a demonstrated, systematic, tendency for project appraisers to be overly optimistic."

The overall message seems to be moderation. As with with red wine, a little optimism does you good – just don't over do it.



Richard Allen

The Optimism Bias
Tali Sharot

Published by Robinson
ISBN 9781780332635
RRP: £15.22

From the CEO

I WAS recently asked to speak at the Vision UK conference in Birmingham to offer my reflections on the sight-loss and public-health worlds I have inhabited over my career. This was a strange but uplifting experience for me. I met old colleagues as well as new ones from both worlds (and introduced them to each other) but at the same time reinforced my commitment to diversity.

I was asked to speak on 'Practical steps to ensure people with sight loss enjoy health in all aspects of life' to around 100 professionals and service users. Many were blind or partially sighted and among them were commissioners, nurses, rehabilitation workers and optometrists as well as public health consultants and registrars. There were two pieces of learning on the subject of diversity that I took away which I hope will be of interest.

The first is on the psychology of perception and how we make sense of the world – and how it can lead us into 'silo-thinking'. It is easy to see how we can be drawn into such an approach by looking at a simple comparison with our personal lives. Just as social media reinforces our pre-conceived ideas about who we are and what we think in an entirely conscious way (by who we 'friend', what we 'like' and with whom we choose to engage), in our working worlds we need to remain open to fresh approaches and shaking the box up. Being aware of our cognitive biases – groupthink, confirmation bias, in-group bias and stereotyping – helps improve our own self-awareness and can help us with wider engagement. This engagement needs to welcome the diverse 'others' – the people with whom we disagree, who think differently and have different priorities. Understanding the 'other' is a critical part of understanding oneself: we need to see ourselves through the eyes of others.

In my presentation I gave what I hope was a reasonable summary of the data, the trends, the public health issues and approaches, and the tools available to help people with sight loss at a societal level. But I was also clear that often it is the personal testimony of those affected by an issue that moves the decision-makers – hopefully not just to realisation but to action.

And so to another aspect of diversity and two individuals with stories to tell. Nicky is a young HR professional, whose life has been transformed partially by the recent and dramatic deterioration in her sight – but more by the unthinking, uncaring approach of her employer who was unaware, uninformed and uninterested. Not only did Nicky quickly move on to a more supportive employer where she has thrived, she made a conscious decision to help others avoid a similar experience. At just 28, she has trained in neuro-linguistic programming and established a business providing consultancy and help to others struggling with their personal approach to disability. She is helping others regain control, independence and confidence.

But then we heard from Claire, a midwife from Worcester, who lost a significant amount of her sight 12 months ago while she was completing her Masters in Public Health. Well qualified and experienced, she is desperately searching for an opportunity to apply her public health skills. But – as a black, disabled woman – her story of direct discrimination from employers and recruitment agents shocked a fairly hardened room. While attending interview, she caught the manager gesticulating to the receptionist that she be told: "The manager isn't here. We'll have to cancel your interview."

We all have stories of interviews not going as well as we might want, but this experience simply wouldn't happen to most people. Claire's reaction was to grieve over her new reality; she barely stepped outside her house for a year. But the reception she received from that room of 100 people will help move her to a more positive place and, in time, rebuild her life. (If anyone out there wants to help, please get in touch).

So my message is one of hope in diversity; we can receive huge support from our networks but in building them we need to welcome diversity of views and perspectives and of individual talents.

David Allen

News in brief

Nominations for International Registrar now open!
Nominations opened on 4 December for the election of an International Registrar. The post is open to all FPH Fellows but candidates must be proposed by a voting member of the FPH Board. A post description, together with a nomination form, can be found in the nomination pack at www.fph.org.uk/work_for_fph The deadline for nominations is Monday **8 January 2018**. Neil Squires, our current International Registrar, is eligible to stand for re-election for a second term of two years.

Election of Local Board Members
Nominations will open on **15 January 2018** for the election of Local Board Members for Scotland and Northern Ireland, and the English regions of Yorkshire & the Humber and South Central. The posts are open to all FPH members who are eligible to vote in these constituencies. The nomination papers will be available on the FPH online members' area (http://members.fph.org.uk/) or from carolinewren@fph.org.uk

NCDs special interest group
After a positive response from delegates at this year's FPH conference session a new special interest group (SIG) has been set up: 'Addressing NCDs in low and middle income countries'. The SIG will advocate for action to address the rising burden of NCDs; support other global health SIGs to take forward work in this area; and act as a resource to FPH and its members on knowledge related to NCDs. If you are interested in joining the group, please go to www.fph.org.uk/current_special_interest_groups

Did you write a thesis for the Part II exam before 2006?
FPH has in storage Part II examination theses completed by registrars on the training scheme up until 2006. As part of a review it has now been decided that these theses will now be disposed of. If you submitted a thesis as part of your training and would like to arrange for it to be collected, please email the relevant details to the Education & Training team at educ@fph.org.uk before the **21 February 2018**.

In memoriam

Angela Mawle
1945 – 2017

THE loss of Angela Mawle at an early age from cancer has deprived public health of a passionate advocate at a time when we desperately need to rediscover our voice. Angela crammed many lives into one as a nurse, horse rider and cyclist, environmentalist, local politician, and as the fulcrum of the United Kingdom Public Health Association (UKPHA).

Inspired by her faith and her commitment to public health and social justice, Angela was a force to be reckoned with and did not suffer anti-health forces and bureaucratic resistance gladly. She nevertheless managed to combine a fiery sense of mission with warmth, charm and good sense. Her partnership with husband Michael and the support of Phaedra, George and Liz were the rocks from which she ventured forth to do battle. Pam and I had the privilege of knowing them all well in our Southampton days in the 1980s when resistance to the ravages of Thatcherism drew us all close. Later, as Chairman of the UKPHA I played a supportive role to Angela, who had built it up to be a major influence on public health policy with an annual conference of over a thousand delegates; vibrant special interest groups and an ability to command the ear of ministers to unwelcome lobbying. It has yet to be replaced.

Not for Angela were the attractions of a conventional career, of personal recognition or of conventional honours. Rather she was driven by the noblest of ambitions, that of protecting and improving the health of the people who she served, the planet that sustains us all and the wellbeing of her precious horses.

Angela will be badly missed but her example should be inspiration for the new generation who must provide leadership for public health.

John Ashton

Ernest George Knox FFPH
1926 – 2017

GEORGE Knox changed my life. I went to see George to ask if I could use the mainframe that he was responsible for [as Professor of Social Medicine at Birmingham University's health services research centre] to run some research from my work in general practice. George was helpful and then said: "We have a lectureship…" It was as though a door had opened onto a different world.

I was taught by George as a student; I remember him as someone who you could argue with. Back then that was a surprise. When I became a lecturer in his department, I realised that anyone could argue with George, including George. He had a new idea every day and was never bothered if it turned what he said yesterday on its head. That was something of a problem when he supervised my faculty membership thesis, because every time I saw him he thought of a new way of tackling the problem. After turning everything on its head yet again, I said: "This is almost back to where we started." "Time to send it in then," he said.

George's constant innovation often threw people. When he bought the department's first word processor the secretaries never got a chance to use it because George discovered that he could programme it and then had an idea about standing stones, which led him to monopolise the thing for the next year.

George's ideas were frequent and often very good. When he retired I did an analysis of how often he was quoted. Every five years George wrote at least one paper that was still being quoted 10 years later.

George encouraged good people and you could always talk to him. Coffee time was an institution and worked as an effective communication tool. He was totally honest. He was in some ways ill suited to be a head of department; he had a contempt for management, based I think on a belief that anyone any good could manage themselves. That led him to believe that managers were an overhead that wasn't needed.

Several years after he retired, when I was Regional Director of Public Health, we had a pollution episode in the river Severn one Friday that gave tainted water to about two million people, including George. We had it sorted by late on Sunday afternoon. I was about to go to bed having hardly slept for 48 hours when George phoned: "It's a cover up, isn't it."

It wasn't, but I spent 20 minutes taking him through the details. I thought I owed him that.

Rod Griffiths

Basil Slater OBE FFPH
1928 – 2017

BASIL Slater was, in turn, a GP, a researcher in primary care, a Royal College luminary, a government medical officer, and finally a consultant in public health medicine. Along the way he also became the first ever GP advisor to the Royal Navy.

Originally from West Lothian, Scotland, Basil qualified at Edinburgh and, after national service in the Royal Navy Volunteer Reserve, was a GP in Harrow, Middlesex, for 18 years. He was always keen on research and soon embarked on a string of projects, initially based on his practice population and later various wider studies in collaboration with the Royal College of GPs. His involvement with the college steadily increased as he became, first, honorary secretary, and later, chairman of the awards committee. During this time, he was himself awarded a Council of Europe travelling fellowship to study primary care and had the honour of being appointed the first GP advisor to the Royal Navy. He received the OBE in 1972 and subsequently became Fellow of the (then) Faculty of Community Medicine.

In 1973 Basil upped sticks and settled in Dalkeith, Scotland, to resume front-line general practice – but after two years he joined the Scottish Home and Health Department (SHHD), eventually as principal medical officer working on a wide range of areas including acute services, primary care, maternal and child services and regional medical services. His ultimate post at SHHD was as director of the Scottish Health Service Planning Unit.

Never quite comfortable as a civil servant, Basil switched to public health medicine to be 'nearer the action' and was appointed medical administrator for the Edinburgh Royal Infirmary and consultant at Lothian Health Board, finally retiring from the infirmary in 1995. Fittingly, his multifaceted medical career had taken him full circle to his beloved alma mater.

Alan Maryon-Davis

Deceased members

The following members have also passed away:

Huw Francis FFPH
Jeera Hayden FFPH
Laurence Wells FFPH

CPD audit – feedback for members

NOW that the continuing professional development (CPD) audit for the year 2016/17 is over, the time has come to provide our members with some feedback.

Overall, 90.2% of audit submissions were found to be satisfactory, but this means that nearly 10% were unsatisfactory. Looking back at the results, there were two main reasons for this:

- Fewer than 40 CPD credits were supported by a satisfactory reflective note
- Fewer than 25 CPD credits were clearly linked to the Personal Development Plan (PDP).

In this short article, we hope to provide you with some guidance as to how you can avoid these pitfalls should you be selected for audit next spring.

The General Medical Council (GMC) requires doctors to "reflect on what you have learnt from your CPD activities and record whether your CPD has had any impact (or is expected to have any impact) on your performance and practice. This will help you assess whether your learning is adding value to the care of your patients and improving the services in which you work." This is confirmed by the Academy of Medical Royal Colleges and has been adopted and approved by FPH for all our members.

A current standard for a satisfactory audit is that "a minimum of 40 credits must be supported by reflective notes that have been assessed as 'satisfactory'". How do we determine if a reflective note is satisfactory or not? FPH's online CPD diary provides a framework of four questions to help guide members when reflecting on their CPD activities. On page 34 of the FPH's CPD policy, there is a very useful table which summarises the characteristics of POOR / BORDERLINE / GOOD answers to these four questions. A satisfactory reflective note is one in which at least three elements are assessed to be either borderline or good. A common observation during the audit was that some of the reflective notes read more like "descriptive notes of a learning activity" as they did not contain any genuine reflection. Reflecting on an activity (what I have learned and what I need to do as a result) is different from reporting on an activity (who did or said what).

When writing your reflective notes, you may wish to refer to the table on page 34 of the FPH CPD policy to ensure that your notes are of good quality.

The GMC also requires doctors to "think about how your learning will support the needs of your patients and teams, the organisations in which you work and the wider community." Whilst most members will discuss their learning needs and agree a PDP during their annual appraisal, in recommending that "planning and evaluating your CPD needs and opportunities should be managed on an ongoing basis, not just at your appraisal" the GMC recognised that learning needs may change over time. This is equally true for all healthcare and public health professionals.

Another standard for a satisfactory audit is that "a minimum of 25 credits must be directly related to the PDP." You can satisfy this requirement by making clear the linkage between one of your PDP objectives and a specific CPD activity in your answer to the first of the four questions in the online CPD diary. In addition, FPH's online CPD diary provides the ability to record your personal development needs and to directly link your PDP objectives to individual CPD activities. It is therefore recommended that you use this facility. One of the challenges we faced this year was that some appraisers agreed PDPs were more or less organisational objectives rather than personal development needs. As a result, it was sometimes impossible to identify the direct link between individual PDP and CPD activities.

You may wish to review your own personal development needs and to record them in the PDP that is provided in the online CPD diary, as recommended.

We hope that you will bear this feedback in mind when you complete your online CPD diary over the coming months. CPD Advisers will be running Regional CPD Roadshows from October, to provide further updates and (when requested) one-to-one support for our members. This will be in addition to the session(s) on 'How to write reflective notes' that we run annually during the FPH conference.

If you have any questions, please contact your local Regional CPD Advisor. Contact details may be found at www.fph.org.uk/faculty_advisers

Toks Sangowawa
Director of CPD
Andrew Terrell
CPD Adviser

The end of an era for *Public Health Today*

AFTER seven years as Editor-in-Chief of *Public Health Today*, Alan Maryon-Davis has decided to pass on the blue pencil. The winter edition, due in the New Year, will be his last.

Throughout 2018 the magazine will be undergoing exciting new changes, and we are looking for someone who can take over from Alan and lead this transformation.

The editorship role involves chairing the Editorial Board's four meetings a year (mostly virtual) and, in collaboration with the in-house team, leading the commissioning and shaping of the magazine's new format and content.

Alan says: "I've very much enjoyed working on *PHT* and I've learned a lot over the years. Now is the right time to hand over the reins and I would encourage anyone who's interested, especially if they've had previous editorial experience, to put themselves forward."

If this could be you, please contact Richard Allen, Production Editor, at richardallen@fph.org.uk

We are also looking for new members of the *Public Health Today* Editorial Board to advise on the current public health agenda, set the tone of the magazine and steer it in new and exciting directions.

Using the survey of the readership conducted earlier this year, we will be looking all aspects of the magazine including design, content, advertising, finances and production.

If you have an interest in or experience of writing, journalism, current affairs, membership engagement, graphic design or marketing, you could make a valuable contribution to the work of *Public Health Today*.

Anyone interested should contact Richard Allen, Production Editor, at richardallen@fph.org.uk for further information.

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to FPH between May and September 2017

Honorary Fellows
Ala'Din Alwan
Raman Bedi

Fellows
Deborah Watson
Gail Findlay
Gillian McLauchlan
Osman Dar
Alison Furey
Gurmukh Kalsi
Mary-Ann McKibben
Vivienne Robbins
Rishma Maini
Catherine Schooling
Christopher Hatton
Ali Latif
Amanda Burls
Augustine Pereira
Claire Currie
Emily van de Venter
Eszter Vamos
James Crick
Joanne Morling
Lynn Gibbons Martin
Mark Pietroni
Michael Edelstein
Muhammad Sartaj
Raffaele Palladino
Serena Luchenski
Simon Fraser
Sinead McGuinness
Tazeem Bhatia
Ines Ferreira Pita de Campos Matos
Masoud Solaymani-Dodaran
Albert Lee

Honorary Members
Peter Schroder-Back
Philip McLoone
Catherine Hannaway

Members
Subhadra Rajanaidu
Nicholas Leigh-Hunt
Robin Ireland
Naomi Morris
Juliet Ibrahim bin Ibrahim
Anees Ahmed Abdul Pari
Anjana Roy
Caroline McLuskie
Caroline Vass
Colin Sumpter
Daniel Todkill
Emily Parry-Harries
James Mallion
Kathryn Porter
Lilanganee Telisinghe
Petra Manley
Shannon Katiyo
Yannish Jones Naik
Andrew Cross
Katharine Warren
Kirsty Anne Hewitt
Christopher Allan
Ruth du Plessis

Diplomate Members
Ali Murad
Joht Singh Chandan
Leila Reid
Sharif Ismail
Amir Kirolos
Anna Ray
Jennifer Taylor
Laura French
Megan Harris

Specialty Registrars
Amoolya Vusirikala
Anamika Basu
Andrew Turvey
Annie Reynolds
Arrthi Pangayatselvan
Catherine Taylor
Christopher Emmerson
Claire Gilbert
Claire Mawditt
Clarissa Oeser
David Smith
Elizabeth Pierce
Emily Humphreys
Isaac Ghinai
Jennifer Mack
Jonathan Lawler
Leifa Jennings
Lisa Burn
Louise Brennan Robinson
Louise Gill
Lucy Rutter
Lynsey Claire Duff
Mark Pritchard
Megan Evans
Rachel Staniforth
Ravi Lukha
Rebecca Briscoe
Rosemary Baker
Samihah Moazam
Sarah Charlotte Woodhall
Sarah James
Thomas Callender
Thomas Dunn
Tracey McCullagh
Victoria Kirkby
Youssof Oskrochi

Practitioner
Amena Dil-Mohamed

International Practitioners
Gregory Fant
Man Fung LO
Manu Mathur
Marie Charles
Saeed Noibi

Student Members
Hashal Sami Al-Basri
Uloma Ekechi
Vanessa Kies
Barbara Delage
Catherine Coleman
Hazik Bin Shahzad
Letitia Tyrwhitt
Moses Ikpeme
Phyu Sin Aye
Ritika Parasrampuria
Tessa Roberts
Toyin Jesuloba
Veena Paes
Victoria Ann Thickett

Associates
Amanda Rodrigues Amorim Adegboye
Anna Humphreys
Annaliese Ashman
Annalise Verity Johns
Carolyn Arscott
Elodie Besnier
Francisca Oyaole
Helen Callaby
Ifeoma Jennifer Onyekwulu
Jennie Chapman
Jessica Moore
Kushal Barai
Marylou Murray
Mercy Sanya
Alan Curley
Dave Bradburn
Fiona Smith
Adam Daniel Fox
Alison Woodley
Benna Waites
Carian Barber
Catherine Pape
Charlotte Moran
Clare Ford
Daniel Janes
Elaine Lane
Emily Buckley
Emma Jones
Georgina Allen
Helen Jayne Sullivan
Jennifer Clare
Joanna Instone
Jonathan Morgan
Katharine Sheldon
Katie Megan Smith
Laura Purnell
Linda Convery
Lucy Clarke
Maureen Hillier
Oliver James Wilding
Sandra Hood
Shakira Leslie
Sharon Ellen Noonan-Gunning
Sian Powell
Simone Reilly
Valerie MacDonald
Wendy Rowley
Tolulope Jeje

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Hayley Teshome Tesfaye
Mei-Li Komashie
Ruth Goldstein
Serena Luchenski
Andrew Graham
Clare Ebberson
Emily Van de Venter
Heidi Douglas
Emer O'Connell
Helen Cruickshank
Jennifer Connolly
Matthew Fung

Generalist portfolio route
Caroline Abbott

Defined specialist portfolio route
Anjana Roy
Caroline Jeffreys
Nicola Rosenberg
Gwenda Hughes

Practitioners
Carolyn Hunter-Rowe
Laura Everett-Coles
Marie Cann-Livingstone
Pam Turton
Philippa Walls
Tinashe Jonga
Chimeme Egbutah
Emma Cahill
Helen Sullivan
Joanne Pitt
Maria Payne
Stephen Marks
Victoria Hannah
Beverly Jones
Jennifer Green
Paul Trinder
Sibusisiwe Mutambara
Annemarie Hankinson
Gareth Walsh
Jonathan Herbert
Mark Harold
Nabiha Khalifa

GENERAL MEDICAL COUNCIL REGISTER

Peter MacPherson
Joanne Morling
Shilpa Nayak
Joshna Mavji
Claire Winslade
Emma Fletcher
Anees Abdul Pari
Ali Latif