Laurie Taylor's talents are many and varied: writer, sociologist, actor, English teacher, criminologist, librarian and radio presenter. Now he can reveal he has another string to his bow: the ability to diagnose disease by looking at someone's face

WE'VE known for some time that we can smell 'sick people' but now, courtesy of research published in *Proceedings of the National Academy of Science*, we have evidence that our brain can sense incipient illness from simply gazing at a person's face.

Frankly, this is no great surprise to me. Even from an early age I could spot that my sister Madeleine was trying to bunk off school by pretending to be ill when it was obvious that she had tried to raise her temperature by running up and down the stairs and attempted to suggest the onset of a wasting disease by applying talcum powder to her cheeks. "There's nothing the matter with her," I'd tell my mother over the toast and Silver Shred. "She doesn't look ill. She's faking. Faking. Faking. Faking."

It was a skill that stood me in good stead during adolescence. While my mate Dave was constantly coping with girl friends who were suffering from colds or flu or what we generically referred to as "time-of-the-month problems", I quickly dispensed with any partner, no matter how attractive and intelligent, the moment her face proclaimed an imminent illness. "Only last night you said you loved me," Veronica complained on the night I told her we had to part. There was little need for me to do more than nod sympathetically. After all, I knew she would have far more pressing matters on her mind when in the next couple of days she found herself laid low with gastroenteritis.

> **Waiters can become positively churlish when asked for a change of seat on the grounds that the elderly woman on next table is going down with shingles**

It's not all been plain sailing. Being able to spot potentially ill people from their faces means that I frequently have to change seats on buses and trains and find it impossible to join anything resembling a group holiday. It also means that I prefer escalators to lifts and only frequent unpopular coffee bars and restaurants. (Waiters can become positively churlish when asked for a change of seat on the grounds that the elderly woman on next table is going down with shingles).

My present partner no longer questions my medical acuity. Only last month she complained about our lack of social life. "Why do we spend so much time at home slumped in front of the television," she said. "It seems such a waste of life."

She did not, however, choose to pursue the matter when I was able to explain that her bad temper was a symptom of the mild arthritis she could expect to contract some time next Tuesday morning.

Professor Laurie Taylor
Presenter
BBC Radio 4's 'Thinking Allowed'
Columnist
Times Higher Educational Supplement
Formerly Professor of Sociology
University of York

Information

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Themes for 2017 include the early years and alcohol harms.

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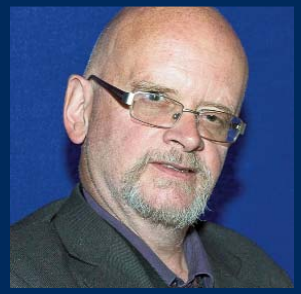


I WANTED to be an orthopaedic surgeon, but I couldn't hack it. So, when I arrived in public health, accident prevention was an early love. It was one of five priorities of the Coventry Health Promotion Committee and one of the most lively, with representation from Coventry road safety, the police and fire, community nursing and health promotion. We suggested making Coventry a no-drink-driving city by the year 2000 as part of our Healthy City goals, which captured interest from the *British Medical Journal* and the popular media. It contributed to shifting a social norm, making drink-driving much less acceptable, and there has been a long-term fall in road accident casualties through alcohol.

Accident prevention remains a neglected area of public health activity – more than 14,000 people die as a result of accidents across the UK each year. Workplace accidents are still a scandal, with nearly three deaths a week in 2014-15. This is likely to get worse, given the relaxation of health and safety regulations by the Coalition government and further weakening, if we allow it, post-Brexit. Some politicians believe we should have the same workplace regulation as India to enable us to compete in world markets. No, we should support our international public health colleagues in securing better working conditions across the globe, and we should expect our government to champion better working conditions from all the people we do business with.

Non-accidental violent injury has also been neglected until recently. (Alan Maryon-Davis writes eloquently about the latest terrorist atrocities on page 10). For both accidental and non-accidental, it is not just the number of deaths that is important, but the years of disability and dependence, the mental consequences, the fear, the regret, the shame, the guilt, the anxiety and depression, the quest for blame or absolution, that may follow accidents or violence. The economic and social consequences are enormous.

The Faculty of Public Health statement on the role of public health in preventing violence published last year provides a platform of evidence from which to take forward the work of our Global Violence Prevention Special Interest Group, which is holding a session at the FPH conference, and other SIGs. Violence accounts for around 600,000 deaths per year according to the latest *Global Burden of Disease* study. We describe a health inequalities approach to violence prevention: there is a five-fold difference in violent deaths between the richest and poorest. We also describe a life-course approach drawing greatly on the work of Mark Bellis and colleagues, and public mental health approaches championed by Sarah Stewart-Brown and Christina Gray.

Many of the root causes of violence are the same, be it child abuse, domestic abuse, community violence and hate crime, or violent conflict between and within nations: economic inequality and disadvantage, assertion of power, inability to negotiate and articulate needs in a non-violent way, absence of empathy and caring, and community development and governance. For some, violence is the only way of life they have known and the only way they can communicate. Our understanding of the social causes and the prevention of violence is coming together through triangulation of the epidemiology of adverse childhood experiences, the neurobiology of early brain development and the evidence from big social experiments. Examples include early years interventions, parenting studies and youth mentoring.

It's clear there is much more we need to do to address the damage caused by accidents and violence. If preventable, why not prevent?

John Middleton

■ *Find out more about violence prevention at 'Grace Under Fire – Global Violence Prevention Special Interest Group' on Day 1 of the FPH conference in Coalport 1&2, 1:30-12:30*
■ *Find out more about traffic accidents at 'Road Danger Reduction – establishing a new transport injury prevention Network as part of the FPH Transport Special Interest Group' on Day 1 of the FPH conference in Beckbury 1&2, 15:30-16:30*

Looking beyond the General Election to a healthy future

THE Faculty of Public Health (FPH) is calling on all members to join us in making sure that protecting the public's health remains at the forefront of the new government's agenda.

The next five years will undoubtedly be a period of great transformation. It's our job in FPH's Policy and Communications team to make sure that policy makers within the Government and the devolved administrations understand and prioritise FPH's views. Since the snap General Election was announced in the middle of April, we've been doing just that by working with FPH members and other allied professional organisations to stand up for our values.

In our General Election briefing, *Fit for Our Children's Future*, we outlined our three main priorities for the new government to address over this parliament: realising Brexit's 'health dividend', shoring up public health funding, and ensuring the specialist public health workforce is adequately staffed and supported.

We would like to thank all members who used our General Election member guide and briefing to work with us during the campaign and advocate our platform to candidates of all parties in their local constituency. It's been great to hear your reports about how candidates have responded and what is happening in your local areas. If you haven't reported back to us about your election activities, please use the contact details below to let us know how you got on.

Next steps for you to get involved
We'll be spending the bulk of our time over the next five years focusing on delivering our manifesto objectives to make sure that the Government and the devolved administrations get the public's health right. This is, as you know only too well, a tall order which is why we can't do it alone. We're counting on you to get involved in the following ways:

■ **Continue to have a dialogue with your new or returning MP**.
FPH needs champions in Parliament to speak up for its positions. Parliamentarians are much more likely to take up a cause if it impacts people in their constituency, and FPH members are well placed to use local data to make that case to them. A good first step is to write to your MP and request a meeting to discuss your concerns and FPH's national priorities.

■ **Let us know if you have expertise in any of our three new priority topics**.
This government has the chance to secure the health and wellbeing of future generations by building a health-creating society. We need to help the Government seize this opportunity. *Fit for Our Children's Future* identified the three focal points around which we'll be organising our efforts: **Brexit** (including consumer protection, research, farming and fisheries, and trade), **public health funding**, and the needs, training and development of **the specialist workforce in public health**.

> **Parliamentarians are much more likely to take up a cause if it impacts people in their constituency, and FPH members are well placed to use local data to make that case to them**

If you are interested in helping us advocate on any of the above topics or if you have any questions, please get in touch with us using the details below.

We have produced a suite of resources to support your advocacy work. Please visit http://bit.ly/2qZSRmv to access all of the documents mentioned above, along with other election resources from our key partners and allies.

We look forward to hearing from you!

Lisa Plotkin
Policy Officer
Faculty of Public Health
policy@fph.org.uk

■ *Join the debate at the Public Health Workforce workshop at the FPH conference, Day 2, Beckbury 2, 1.30-2.30pm*

News in brief

Get *Public Health Today* delivered to your door
If you are not already a member of the Faculty of Public Health and would like to receive *Public Health Today* every quarter, you can join as an associate member for £49 in your first year. Go to http://www.fph.org.uk/membership

We need your views on *Public Health Today*!
If you haven't already filled it in, could you please complete the readership survey about *Public Health Today*. You can find the readership survey at https://www.surveymonkey.co.uk/r/NLYTNHS It should only take 10 minutes. Your views are crucial to the future of FPH's flagship publication.

Interested in refereeing papers for the *Journal of Public Health*?
FPH's academic journal, the *Journal of Public Health*, is seeking members who may be interested in peer-reviewing papers. Peer review is an essential process in ensuring that submitted papers are judged fairly before a decision on acceptance or rejection is reached. If you are interested, please contact Naomi Conneely at jph.editorialoffice@oup.com, stating your areas of expertise.

UKPHR needs assessors
Can you volunteer to become an assessor on the UK Public Health Register? All assessors are trained. Clear guidance is provided and support is given through buddying, moderation and development days. The next training session for new assessors is on the 3 and 10 October 2017 at UKPHR in Birmingham. Further information at http://bit.ly/2rEJp9W

A History of Public Health in Post-War Britain – free online course
Understand where public health has come from, why it looks the way it does and where it might go next. The Mass Open Online Course starts on 26 June 2017 and is run by the Centre for History in Public Health, London School of Hygiene & Tropical Medicine and FutureLearn. Go to www.futurelearn.com/courses/public-health-history

Gillian Leng CBE is the Deputy Chief Executive at NICE, the National Institute for Health and Care Excellence, and a visiting professor at King's College London. She trained in medicine at Leeds, and spent several years in research at Edinburgh. She specialised in public health medicine, and worked as a consultant before moving to NICE in 2001

'First, let's look at the evidence'

We know you want focus, says Leng

Why is it important for NICE to partner with FPH at the conference?
First and foremost to promote the role of evidence in improving the health of the public. We're always looking for ways people can support our committees and review the evidence, as well as asking for comments and feedback on draft products. But what's particularly important for us is the Faculty's role in helping to disseminate our guidelines and quality standards and helping to encourage use of evidence through things like continuing professional development [CPD] So there's a number of very important reasons why we should be working with the Faculty.

What is your main message to the conference?
To remind everyone why looking at the evidence first is really important. Our reputation is based around the fact that our guidance is robust, evidence-based and takes cost into account. So, if at the local level you've got a priority area where NICE has looked at the evidence, go there first, see if it's relevant. And if we've produced return-on-investment tools, look at those too, because we all know that finances are tight at the moment. It sometimes gets forgotten in amongst other local pressures and priorities, but the public health professional group has an important responsibility in this area.

How can public health professionals get the most out of NICE?
Often we hear that people at a local level want to be clear where the most important areas are that they should address, so we produce quality standards which really do help with that focus and prioritisation. They are very much a distillation of evidence-based recommendations, usually about five, ten maximum, in a particular area, for example smoking. Based on feedback from people in the field, we identify where we know most change is needed, so our quality standards are already prioritised as important areas to address, and they come with outcome measures. They can be easier for elected members to get to grips with, and you can demonstrate you are making improvements because there are associated measures with them. That's the core rationale for using them: focus and measures. As an example, one of the statements in our obesity in adults quality standard relates to vending machines in local authority-operated premises and is absolutely clear that those vending machines should have healthy options in them, they shouldn't just be providing sugary drinks and crisps. And we know there are examples of where things have changed as a result. So if a director of public health wanted to pick that and wanted to do something about it, it's not difficult to go out there, get some data back and then track improvements.

What would you like to see in terms of synergies between NICE and Public Health England?
NICE needs to work closely with Public Health England. We recognised the importance of that relationship last year when we established a formal partnership arrangement. The key elements of that arrangement are alignment and mutual support because we know from years of experience that there's nothing more frustrating for people at local level than seeing national organisations doing the same thing as each other or providing conflicting advice, and you end up with people losing faith in what you're doing, so it's really important that we do demonstrate how we are working successfully together.

How did you get interested in public health?
I was a medical student doing a cardiology attachment. In those days, the treatment for heart attacks was nothing like as good as it is now, so people were either left with more morbidity or they were dying, and it struck me that we really shouldn't be putting all our efforts into managing disease in hospital, and there should be much more emphasis on prevention. We were getting the balance wrong. And then, not that much later in my career, I spent quite a number of years researching the factors that caused cardio-vascular disease and at that point got interested in evidence and what we might do to focus on, not just prevention, but also treatments to get best value for money by using the evidence more.

What achievements are you most proud of in your career?
One of the things I took responsibility for at NICE was setting up NHS Evidence – an online portal that brings together the best resources for practitioners in the UK. It was something Lord Darzi recommended in his report. So I was asked to do that as I'm very familiar with what makes good evidence and what a good guideline looks like. To support that we set up an accreditation programme for guidelines – I was quite proud of that because it's actually driven quite a lot of improvements across the UK in how organisations, including NICE, develop their guidelines. I was really pleased with the fact that we did manage to deliver that project to time and to budget which is quite unusual for IT projects. That was a huge success.

What was your biggest challenge?
An on-going challenge is the one of changing what people do. We can do the best bit of evidence review, we can produce the best guidelines, but it makes no difference to the health of the public and people's care if it's not used. Thinking about how we get things embedded, how we change behaviour has been really challenging. Over the years we've worked with professional organisations on this, which brings me back to why the Faculty is so important because professionals do respond to things that are put in exams and they do respond to CPD requirements, so those are important vehicles for NICE.

Is there anything that keeps you awake at night?
We've done some great things over the years, in helping to prevent disease – a combination of public health and pharmaceutical interventions. The challenge in all that is that, as we're all living longer, we have a lot more comorbidities, a lot of people with multiple things wrong with them, and a lot more people sadly with dementia. So the challenge is how do we reduce that period of comorbidity. It's been a long-standing public health challenge to increase your healthy life years and decrease your unhealthy life years but at the moment we're struggling with that second bit.

What other major challenges are facing public health at the moment?
Clearly we have to mention antimicrobial resistance. NICE has a number of areas of work addressing this, including new guidelines for common infections to make it clear when antibiotics are appropriate and when they are not, and we have also produced a guideline on antimicrobial stewardship. We will also be looking at new antimicrobials as they come onto the market as part of our drug appraisal programme. Most of these we expect to be versions of antibiotics that are already in use. But there will be one or two completely game-changing anti-microbial drugs which are not like ones we've seen before and looking at those and how we best use those in the system is also going to be part of NICE's role moving forwards.

Interview by Richard Allen

NICE AT THE FPH CONFERENCE:
- Gillian Leng will speak in the Opening Plenary – 'The role of evidence in public health reform at a national and local level' (Day One, 10-11am, Iron Bridge 1&2)
- Round Table Event – 'Using NICE resources to make the case for prevention – practical support for public health teams working with Sustainable Transformation Plans' (Day One, 12.45-1.45pm, Beckbury Suite 1&2)
- Gillian Leng will be on the panel for the Public Health Question Time (Day Two, 3-4.15pm, Iron Bridge Suite)

Meet the FPH award winners!

THE eve of the Faculty of Public Health (FPH) Conference and Expo is the occasion of our annual public health awards when the great and the good celebrate the outstanding achievements of FPH members and the wider public health community.

The FPH awards dinner and ceremony has grown in size and stature over many years as retiring members have kindly donated funding for new annual prizes.

In total more than 40 awards and honorary fellowships were presented this year with winners decided by the FPH President, Fellows and various FPH committees.

Among this year's winners is Anne Johnson who was awarded the prestigious Alwyn Smith Award for her work chairing the Academy of Medical Science working group which led to the publishing of the *Improving the health of the public by 2040* report in September.

Anne has spent most of her research life helping to improve knowledge of sexually transmitted infections, and the prize also acknowledged her leadership within the public health academic system and her membership of the FPH Academic and Research Committee over many years.

Another winner is Helen Adcock who was awarded the FPH Outstanding Contribution Award for her leadership of the Part A Development Committee and Part A Examinations Board during a period of unprecedented scrutiny by the General Medical Council (GMC). The judges felt Helen's contribution was crucial in FPH achieving final GMC approval for the modified Part A exam.

Sushma Acquilla received the Wilfrid Harding Award for outstanding efforts and achievements for FPH with the judges particularly highlighting her work in the State of Odisha and Madhya Pradesh in India supporting the Government of Odisha to develop its public health curriculum, capacity and expertise. Sushma also chairs the Special Interest Group on India and is Vice-chair of the FPH Global Health Committee.

Daniel Carter received the Global Health Award for his work as lead health adviser for the Department for International Development in the Democratic Republic of Congo. Recently, Daniel coordinated a large outbreak response for Yellow Fever and advocated for improvements to primary care, including increasing health worker salaries.

John Middleton said: "The competition for these awards was incredibly tough this year. I want to offer my congratulations to the winners but also to all of our awards nominees.

"This year's awards are another reminder that all our members are doing inspirational, impactful work to improve the health and wellbeing of people not only across the UK but all across the globe. We can be hugely proud of the vital role our members play every day, and it is so important that the faculty takes a moment to celebrate their commitment and achievements."

In advance of the awards ceremony, *Public Health Today* talked to some of the other prize winners about their work and what the awards mean to them.

KYLA THOMAS and South Gloucestershire Council won the Sarah Stewart-Brown Award for Public Mental Health. Kyla is a consultant in public health at South Gloucestershire Council and a clinical lecturer in public health medicine at the University of Bristol and lives in a village near Bristol where she enjoys dancing in her bedroom and filling her wardrobe with internet bargains. She's been an FPH Fellow since 2016.

How does it feel to win the award?
It's very exciting for the team's hard work to be recognised nationally and winning the award lifted our spirits following a divisional review and restructure. It has also given us the motivation to continue to advocate for public mental health.

Tell us why you won?
Writing the mental health needs assessment was one of the first major pieces of work I had to do when I returned to public health specialist training in January 2014 after being Out of Programme for Research (OOPR) for three years. I remember feeling quite nervous about the responsibility of leading the work. However, I was well supported by the Programme Lead, Public Health Consultant, Director of Public Health and our major stakeholders. Our aim is to give thousands of people the chance to improve their own mental health.

How do you plan to spend the award prize?
We want to embed user voices and improve our local mental health promotion messages by developing a series of 'Talking Heads' videos and podcasts with a range of people talking about their mental health and how they stay well.

Is there any other way you plan to use the award?
I would like to write a blog and share the positive news more widely within the council, possibly to be featured on our intranet home page. We're lucky to have senior leadership support for our work. I was very excited when the chief executive and lead councillor signed up to 'Time to change'.

CAROL BRAYNE won the FPH Synergy Award. Carol is Professor of Public Health Medicine and Director of the University of Cambridge's Institute of Public Health and has been a member of FPH for more than 25 years. She lives in rural Cambridgeshire and enjoys cycling.

Tell us why you won?
I hope it is that I have helped to make a tiny difference in linking different communities of importance to current and future population health. I am very mindful of the many who also strive to do this.

How can FPH members find out more about the work you've done?

Talk to me, email me and look up the Institute website www.iph.cam.ac.uk

What do you like most about being an FPH member?
I've heard many people criticise FPH over the years and have done it myself. In the end I realised it is better to roll up my sleeves and try to do my best to help our discipline. FPH is an important voice and we need more members to get involved so we can be even more effective.

What are you most proud of in your career?
I find these questions difficult – everything I do is about team work. I've worked hard to maintain funding for cohort studies that provide evidence on contemporary dementia for policy and scientific understanding, but I've also invested major time and intellectual energy in setting up the Masters in Epidemiology in Cambridge and the Directorship. It is incumbent on those of us who are privileged to hold leadership positions to try to inspire future leaders, teachers and researchers towards more sustainable approaches to population futures.

GRACIA FELLMETH won the Sian Griffiths Award. Gracia is in her final year of her PhD in Population Health at the University of Oxford. Her doctorate has involved spending a year interviewing migrant and refugee women living on the border between Thailand and Myanmar. She's been a member of FPH since joining the Public Health Training Scheme in 2008.

How does it feel to win the award?
It means a lot to me. I have always been interested in combining academia with global health work, and one of the most exciting placements I did as a trainee was with Professor Griffiths at the Chinese University of Hong Kong. It was Sian who got me interested in migrant health, and she was an inspiration both academically and personally.

Tell us why you won?
I hope that FPH recognised the fact that mental health in low-income settings is a severely neglected field, despite being one of the greatest contributors to morbidity worldwide. I see it as a core duty of public health to seek out and help those most in need.

How can FPH members find out more about the work you've done?
I have published papers about the work I have done on the Thai-Myanmar border and I'd be happy to share these with anyone interested. A reflective piece I wrote after a difficult event was also covered by the BBC and can be found here: www.bbc.co.uk/news/magazine-38423451

MALICK DANSOKHO won the Sam Ramaiah Award. Malick graduated from medical school in Berlin in 2015 before moving to Liverpool to start foundation training. In Berlin helped refugees to access health services and the experience sparked his interest in migrant health. He's now a Foundation Year 2 Trainee Doctor at Warrington and Halton NHS Foundation Trust and spent four months in Halton's Public Health Department last year.

Tell us why you won?
It was for the Health and Wellbeing Needs Assessment for Unaccompanied Asylum Seeking Children which I carried out for the Public Health Department of Halton Borough Council. It was used to inform the Council's strategic response to the challenges faced by these children. My report was then shared with local authorities across the North West Region. My work was an important first step to improving health and wellbeing for this particularly vulnerable group of people. This work was only possible because of great support by both the whole public health team at Runcorn Town Hall and the council's senior management team.

How can FPH members find out more about the work you've done?
Both the full report and an infographic summary are available online on the web page of the Association of Directors of Children's Services adcs.org.uk/safeguarding/article/uasc-health-and-wellbeing-needs-assessment

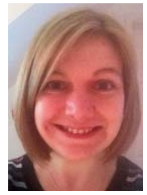
How do you plan to spend the money?
I am thinking of making a donation to Sola Arts who are a small charity supporting vulnerable people in communities across Liverpool. They work with refugees, people from minority ethnic backgrounds, but also people living with dementia and their carers. I like the way they use creativity as the basis for much of their work.

Why do you think it is important for FPH to have these awards?
Awards are a wonderful way to encourage people to carry on with the work. It is also a useful means to raise awareness and draw more attention to specific issues.

JOANNE MCCARTHY won the Ann Thomas Prize. She's a fourth-year public health registrar who has just finished a placement with the team at Abertawe Bro Morgannwg University Health Board. She's currently based with the Policy, Research and International Development division in Public Health Wales. She's been a member of FPH since 2013 and lives in Cardiff.

How does it feel to win the award?
I am really chuffed! It's for achievement in FPH's Part B examination which I failed the first time I sat it. It is only due to colleagues in Public Health Wales taking time out of their own work schedules to help me prepare for the re-sit that I was able to perform well, so definitely all down to my lovely colleagues!

Are you looking forward to the ceremony?
I'm really looking forward to it, hearing about what others in FPH have been up to over the past year and their achievements, and obviously enjoying some delicious food.



What will you spend the money on?
Those of us who took Part B last year had colleagues organising mock exams, letting us practice scenarios and giving up loads of their time for us, so I owe a lot of people lunches.

DAVID MCCOY won the Humanitarian Award. He's Professor of Global Public Health at Queen Mary University London and a director of global health charity Medact. He's looking forward to the awards dinner dessert and hopefully getting to dance with the FPH President. He grew up in Malaysia but now lives in London.

How does it feel to win the award?
It feels awkward because I've always been a bit sceptical of individual awards and rankings. But if this award is recognition of my work with Medact, or the People's Health Movement, or my global health work at Queen Mary University London, then I will share it with many other people.

Why do you think it is important for FPH to have these awards?
It's important to celebrate the discipline of public health and whatever successes we may have in making the world safer, fairer and better. But awards are about recognition, and we need to think about what we are seeking to recognise. Given many aspects of the current state of the world, it feels like we need to do more to recognise the work of the underdogs or those operating through non-mainstream and non-establishment perspectives and platforms.

What are you most proud of in your career?
According to Emily Bronte "proud people only breed sad sorrows for themselves". So I prefer to be constantly unsatisfied with what I do.

If you were able to give yourself one piece of advice when you were starting out on your career, what would it be?
That's a difficult one because I don't think I've ever had a career. I've had a bunch of jobs and a vocation, but have never had a career plan as such. So maybe my advice would be: "Don't listen to other people's career advice and go with your gut and your heart." I've been lucky to have had a diverse and interesting career.

What do you like most about being an FPH member?
Getting awards!

From the CEO

I AM looking forward immensely to the FPH conference this year in Telford, an area with a rich background in the Industrial Revolution. I'm taking into it insights about how we can learn from history which I gained from another inspiring conference earlier this year.

There were nearly 3,000 delegates from 82 countries at the 15th World Congress of Public Health in Melbourne in April. There were too many highlights to list but a few stand out: the President of Uruguay, Tabaré Vázquez (an oncologist) speaking passionately about his anti-tobacco battle with Philip Morris; Bettina Borsch's call for solidarity among the profession and society in tackling the re-emergence of fascism; Martin McKee's plenary on 'Enemies of the People'; Sharon Friel's themes of 'Despair, Vision, Hope' reasserting the power of citizen networks to effect change outside traditional methods.

Elsewhere on the programme lay riches in learning of other cultures. Tesfay Gebregzabher Gebrehiwot from Ethiopia described the hugely challenging environment in which he tackles sexual and reproductive rights issues, where forced sex in marriage is a regular occurrence and young girls are 'given' to rich men. Colin Tukuitonga spoke movingly about the challenge of climate change and life-threatening sea-level rises to the peoples of the 22 Pacific island countries and territories.

At a personal level the 'off-programme' informal learning was hugely beneficial – not just the considerable networking opportunities but the chance to see and hear and reflect on Australian history.

I learned that the Aboriginal view of health encompasses the mental, physical, cultural and spiritual – with land and environmental health a central aspect – and when the harmony of these inter-relationships is disrupted, aboriginal health declines. The atrocities committed against Australian and Torres-Strait-Islander indigenous peoples in the past 150 years – genocide, forced separation, slavery, the active discrimination of the 'White Australia' policies – persist in the devastating consequences to their current health and wellbeing.

What struck me is how these intertwined histories are a learning experience in themselves: standing up for what is right – at the right time – can be extremely difficult. But trying to fix things later is much, much harder.

David Allen

■ *Want to find out more about international issues? Why not attend the Global Public Health event at the FPH conference, Day 1, 2pm, Iron Bridge 1&2*

Celebrating 100 years of women in health

IT IS with great pleasure and great pride that the Faculty of Public Health (FPH) is joining in this year's national celebration of women's contribution across all forms of medicine and health.

The Medical Women's Federation, the lobbying body for women doctors, is marking its centenary. The Royal College of Physicians (RCP) is working with all the medical royal colleges and their faculties to showcase the achievements of women doctors.

FPH is, however, extremely well placed to go beyond this. Uniquely amongst the royal colleges, FPH has fully embraced the multidisciplinarity of its senior workforce, acknowledging and supporting the achievements of women from a range of backgrounds as well as medicine, and welcoming them into its public health family.

A substantial proportion of women in public health have gone on to reach major strategic positions in their chosen spheres of work, whether in service, academe, research, international health, policy or development of the workforce. FPH, as an early promoter of family-friendly practices in the workplace and in training of its specialists, is justly proud of its long-standing track record of gender equality, so that women have been able to reach their career potential and make their full contribution to improving the public's health.

This summer, FPH, via the RCP website, will be showcasing two women who have made a significant contribution to public health; one from the past, Dr Dame Rosemary Rue (pictured above), and one from the present, Professor Dame Margaret Whitehead. In addition, a short presentation will be made available for downloading from FPH's website of the particular achievements of a range of prominent women, current and past, working in different areas of public health.

At the FPH conference in Telford on Day 2, 21 June, the two plenary panel sessions on 'Global Health: How does Public Health Work in a Challenging World' (am) and on 'Public Health Leadership in Local Communities' (pm) will include specific speakers to lead discussion as part of the debate on how women in public health can best make their contribution to these agendas.

Please join in by sending us your nominations for women from public health's past and present whom FPH can showcase as part of this year's celebrations. Please also contribute in person to the conference debates or email suggestions of how women can best make their contribution to the two agendas so that these can be included in the presentation at a later date.

Sue Lloyd
Sue.lloyd@lbbd.gov.uk
Jenny Wright
Jenny.wright7@btinternet.com

Effectively doing what's good and right

IN CONSIDERING health, it is easy to get caught up in technicalities and forget that it is grounded in values and moral norms that fundamentally guide decisions, behaviours and practice. With growing pressures and threats to public health systems, services, independence, leadership and workforce, there has been a risk that public health is considered merely a diverse set of technical specialties, serving organisational, political and corporate interests.

Yet, lessons from the Ebola outbreak, widening inequalities, the migrant crisis, climate change and other challenges have highlighted the critical need for greater appreciation of the public health moral mandate. There is growing recognition of ethics as a core public health competency and the importance of consideration of public health approaches and values to meet such challenges.

Public health ethics is a growing discipline, distinct from bioethics, and is concerned with populations – how we should live together. It has a key role in decision-making, policy and practice. Ethical considerations, far from being mere 'navel gazing', are an opportunity for the public health family to engage in rigorous, systematic and challenging reflection on actions and activities contributing to shared outcomes – effectively doing what is good and right.

The mandate to ensure and protect the health of the public is inherently a moral one. It carries with it the obligation to care for the wellbeing of communities, and it implies an element of power to carry out that mandate. The need to exercise power to ensure health and at the same time to avoid potential abuses of such power are at the crux of public health ethics.

There has been a growing involvement of the Faculty of Public Health (FPH) in public health ethics: working with partners to advance understanding of the issues; developing appropriate competencies and educational and training activities; and working towards ensuring ethical practice in all its activities. FPH has brought together practitioners, ethicists, academics, policy-makers and others to guide this work and ensure that there is greater awareness of the moral mandate and mission of public health in policy, research and practice.

FPH has set up a standing Public Health Ethics Committee reporting directly to its Board, as well as an ethics network and local ethics fora. The committee will provide a focus for robust ethical analysis and response to public health issues, and advise and support FPH in further embedding ethical principles and understanding into its policies, practice and governance. Its key initial priorities are to promote education, training and learning, generating further understanding on such issues as the nanny state, the intervention ladder and prioritisation. The local public health ethics fora and network will provide spaces for practitioners, ethicists and other partners to reflect and work together to meet public health challenges.

You are welcome to contribute to our work with public health ethics. For further information and ideas contact: ukpublichealth.ethics@gmail.com

Farhang Tahzib
Chair
FPH Public Health Ethics Committee

■ *A session on 'Ethical Foundations for Public Health: Implications for Policy and Practice' will be held on Day 2 of the FPH conference 10-11am in the Beckbury Suite*

How Mexico came to wage war on sugar

THE staggering reality of obesity and diabetes in Mexico – 75,000 amputations and 98,000 deaths each year from diabetes – represent a terrible human drama, especially for poor families, and threaten to collapse the health system in this OECD-member country.

In fact, Mexico faces one of the worst obesity epidemics in the world, with seven in 10 adults and around a third of schoolchildren overweight or obese. Public health challenges include incomprehensible food labels, rampant marketing of junk food to children, unhealthy school food, a lack of universal access to potable water and a culture of excessive intake of sugar-sweetened drinks. Mexicans consume 163 litres per capita a year, one of the highest rates in the world. One in three Mexican children is expected to develop diabetes in their lifetime.

In the documentary *Sweet Agony: The Toll of Junk Food*, Don Gonzalo (pictured), a 45-year-old bus driver, shares how he ate junk food and drank three to four Cokes a day, became diagnosed with diabetes, suffered amputations and sold his family's assets to pay for dialysis. Gonzalo's story is interwoven with testimonies of people living with diabetes-related blindness and amputations in other parts of Mexico.

In the south-eastern state of Chiapas, where infants drink soda from the bottle and diabetics gather in self-help groups, Coca-Cola advertising is displayed on billboards in indigenous languages, vending machines bear government seals, and hospitals lack water fountains. "This is criminal. No other product is more available than soda," says Dr Marcos Arana of the Right to Health Observatory.

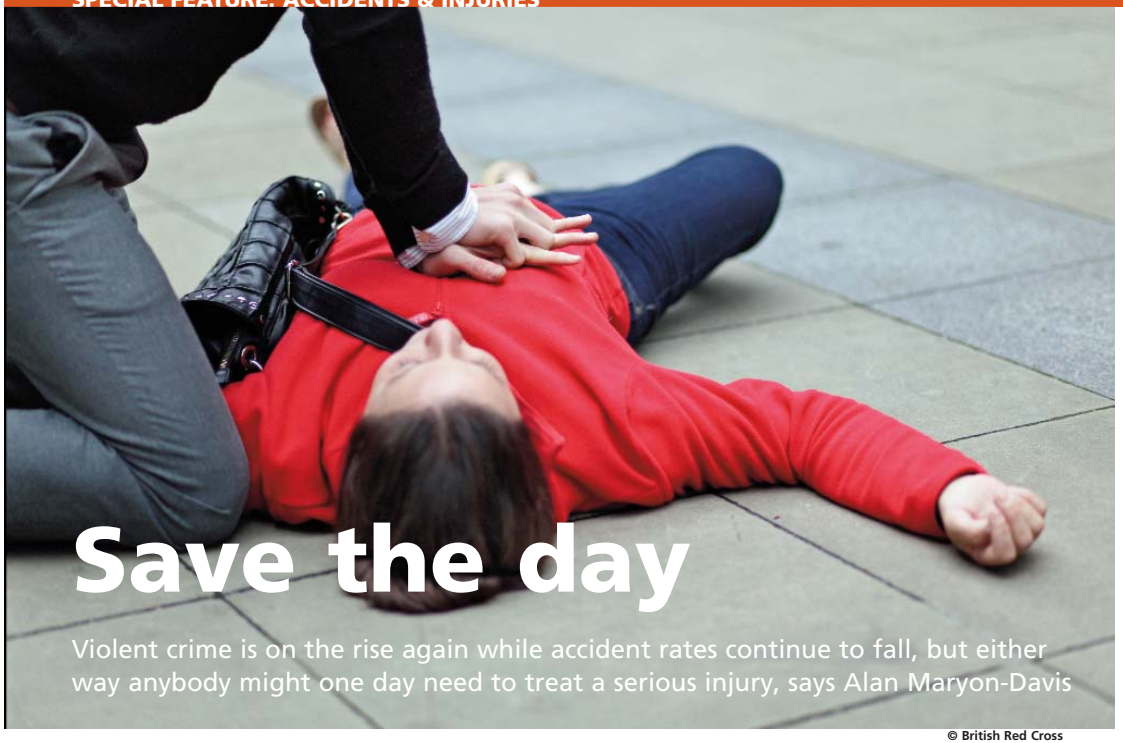
The film tells the tale of Mexico's landmark peso per litre tax – approximately 10% – on sugar-sweetened drinks and industry efforts to censor information campaigns and lobby to block the bill.

During the first year of the tax in 2014, Mexican households reduced purchases of taxed beverages by 6% and increased water consumption by 4%. The tax is also projected to prevent 189,300 new cases of Type-2 diabetes and yield healthcare savings of $983m (£759m).

"If we don't think about prevention, we are doomed," warns Dr Salvador Villalpando of the Children's Hospital of Mexico. "We may start seeing kids or teenagers at 15 or 17 years of age who will probably suffer mortal heart attacks at the age of 30 or 34."

Sweet Agony is produced by the Mexican consumer rights organisation El Poder del Consumidor and Cacto Producciones. *www.sweetagony.org*

■ *An edited version of Sweet Agony will be screened on Day 1 of the FPH conference in the Coalport Suite at 3.30pm and will be followed by a panel discussion*



Save the day

Violent crime is on the rise again while accident rates continue to fall, but either way anybody might one day need to treat a serious injury, says Alan Maryon-Davis

© British Red Cross

THE recent horrific terrorist incidents serve as a grim reminder, as if we needed it, that not all injuries are accidental. Many are intentional and violent. According to the Office of National Statistics, violent crimes against the person, having fallen steadily over recent decades, seem to be on the increase again. Whilst the British Crime Survey shows the public's experience of violent crime at an all-time low, latest police data reveal some alarming increases, with sexual offences and knife crime leading the upsurge.

Another harsh truth highlighted by the terror campaign is that not all injuries are physical. The psychological damage can be immense, among families and communities as well as the survivors themselves. To natural grief will be added pathological levels of anxiety and depression. An undercurrent of fear and rising tension will affect us all to a greater or lesser degree. And we can expect to see more 'social injury' in the form of collateral damage to society – rage, suspicion, hatred, division, retribution and repression.

Aside from all this is the ever-present background of accidents – on the roads, at home, in the workplace and at play, sport or leisure. Again, the figures come from a wide variety of sources and are of varying reliability, but the trends are broadly encouraging. Prevention is key and safety measures seem to be increasingly effective. Public education plays a crucial part – but so too does regulation. Some of the greatest life-savers have been such enforcements as seat belts, crash helmets, road traffic legislation, health and safety at work, and much else. But it's a delicate and contentious balancing act between laissez faire and nanny state.

> **Some of the greatest life-savers have been such enforcements as seat belts, crash helmets, road traffic legislation, health and safety at work, and much else**

Finally, there's the role of first aid. Recent research has found that, whilst the great majority of people will call 999 if they find themselves at the scene of a serious accident, only about half will attempt any first aid while waiting for the ambulance. And yet we know that around 60% of pre-hospital deaths from injury are potentially preventable with first aid. All too often victims' lives literally ebb away through uncontrolled bleeding after an incident, be it a car crash, stabbing or, as in Manchester, shrapnel from a makeshift bomb. Many lives could be saved if someone in the first few precious seconds knew how to improvise a pressure pad or tourniquet from whatever is to hand.

Training in basic first aid is fundamental and many argue that it should be a key part of everybody's formal education. But meanwhile we can at least promote the use of free first aid apps such as those provided by the British Red Cross or CitizenAID. Anybody might one day be the sole person who can save a life – or not.

Alan Maryon-Davis
Editor-in-Chief

Massive emotional, physical and financial cost of child accidents

UNINTENTIONAL injuries are a leading cause of A&E attendance, emergency hospital admission, morbidity and premature mortality for children and young people in the UK. There is a strong link with health inequalities, with children from the most disadvantaged families far more likely to be killed or seriously injured.

Following an analysis of the data, Public Health England (PHE) has recommended focusing on two priority areas: unintentional injuries in the home for children under five and injuries on the road for older children and young people.

Every year in England, 60 under-fives die from accidents in the home, – one in 12 of all deaths at that age. There are also 40,000 emergency hospital admissions and 450,000 visits to A&E. The five priorities for the under-fives are:

- choking/suffocation/strangulation
- falls
- burns and scalds
- poisoning
- drowning.

Police records show an average of 460 deaths and 7,150 serious injuries to children and young people under 25 in England each year. Injuries increase when children start walking and cycling independently and peak when young people start driving.

The personal costs of a serious accident can be devastating, impacting on education, employment, emotional wellbeing and family relationships. A severe bathwater scald will leave a child disfigured after years of painful skin grafts, while a road accident can lead to permanent brain damage.

Financial costs to the NHS run to millions of pounds for emergency hospital admissions alone. But there are also significant costs to local councils and society as a whole. The lifetime costs for a three-year-old who suffers a severe traumatic brain injury is close to £5m.

Public Health Outcomes Framework indicator 2.7 covers reducing hospital admissions from unintentional injuries for children and young people. Preventing accidents is one of the six High Impact Areas for health visiting and part of PHE's priority area Giving Children and Young People the Best Start in Life.

To support work in this area PHE, in association with the Child Accident Prevention Trust (CAPT), has produced a range of guidance. This describes how local councils and their partners can achieve a step change for children, often at low or no cost, by mobilising existing services through workforce development and more effective commissioning.

© CAPT

In this way, evidence-based interventions can be integrated into service specifications and frontline staff supported to build safety advice into routine contacts with parents. Strong local partnerships are key, whether to support safety in the early years or to reduce road injuries, encourage active travel and create liveable streets.

Free downloadable resources following Child Safety Week (5-11 June) encourage local partnerships and provide a launch-pad for engaging activities for families – visit www.childsafetyweek.org.uk. Local authorities with high early-years injury rates may benefit from free Department of Health-funded support to improve capacity and collaboration.

Following the launch of PHE's latest guidance in March 2017, CAPT is rolling out a package of specialist support to local authorities, with subscribers benefiting from discounted educational resources, training, mentoring and consultancy services. Further info from www.capt.org.uk

Public health professionals can act as champions for child safety, prioritising the accidents that matter, mobilising services and developing partnerships. The benefits to children and young people, and their families and communities, are immense.

Katrina Phillips
Chief Executive
Child Accident Prevention Trust

Safe-Tea in numbers – how to stop scolds

HOT-drink scalds in pre-school children are alarmingly common, accounting for more than 30,000 A&E attendances in England and Wales every year. They can be life-changing, physically and mentally, and bear a significant burden on the NHS. Children's burns are more common in areas of deprivation, where a lack of caregiver first-aid knowledge can significantly worsen the outcomes. Hot-drink scalds are preventable – by keeping hot drinks well away from children – yet instigating such behaviour change in a nation of tea (and coffee) drinkers is no trivial matter.

A major barrier is that caregivers are not aware of how easily these injuries can happen and how serious burns from hot liquids to young children can be. Peak prevalence is in one year-olds, who have delicate skin that burns quickly and easily. These young children take their parents by surprise, being able to reach higher and move more quickly every day, without understanding the danger of hot liquids.

Through public involvement, and close partnership with the Child Accident Prevention Trust and Flying Start (the Welsh Government's early years programme for families living in disadvantaged areas), the Children's Burns Research Centre at Cardiff University has designed and developed the 'Safe-Tea' intervention. This is a multi-media campaign that includes a suite of novel materials including reach-charts, fridge magnets and videos. These materials support one-to-one and group discussions, demonstrations and activities with parents to highlight key messages at home visits, playgroups and childcare centres.

Initial results have been positive. The campaign has improved knowledge of the risk of hot drink scalds and correct first aid. Crucially, parents report feeling more vigilant around hot drinks and empowered to correct the behaviours of others at home. Materials will be further tested with diverse communities in East London, and a future controlled trial will test the effectiveness of the campaign in reducing incidence of hot-drink scalds.

Verity Bennett
Research Assistant
Alison Kemp
Professor of Child Health
The Scar Free Foundation Centre for Children's Burns Research
Cardiff University

DEBATE: Should cycle helmets be compulsory for children? Luke Griggs says kids need the extra protection, while Chris Rissel says using the law sends the wrong message

One day they'll be as accepted as seatbelts

CYCLING is a healthy way of travelling – as well as a hugely popular sport and pastime for individuals and families alike. Sadly however, all cyclists, regardless of experience, are at risk of accidents.

At Headway, we are passionate about encouraging cyclists to wear helmets, while also supporting calls for other cycling safety measures to be introduced, such as better infrastructure.

The evidence is clear: cycle helmets are effective in reducing the number of people killed or seriously injured while cycling. This is supported by numerous peer-reviewed scientific studies and is shared by well-respected professional bodies including the British Medical Association, the Association of Paediatric Emergency Medicine and a great many doctors and neurosurgeons across the UK and indeed the rest of the world.

But surely this should also be about common sense? Many of us think "it will never happen to me", but, alas, cyclists are consistently high on the list of road traffic casualties. The unavoidable truth is that cyclists are vulnerable road users, so doesn't it make sense to protect yourself as best you can?

Some might say they don't need to wear a helmet as they are experienced cyclists

YES

and have not had an accident in 20 or so years' cycling; but the same could be said for the driver who for two decades went accident-free until, through no fault of his own, he was hit by another vehicle. For perhaps the first and only time as a driver, did he fully appreciate the value of his airbag or seatbelt. You hope you'll never need to be saved by your seatbelt, but only when you are do you appreciate its value. Why should cycle helmets be any different?

People objected when the wearing of seatbelts became compulsory; they claimed it wasn't necessary for motorcyclists to be forced to wear helmets; some even argued that bans on the use of hand-held telephones was a step too far. And yet the safety benefits of these initiatives are now irrefutable, while in time the public has come to accept and understand their life-saving importance.

We believe helmets should be compulsory for all child cyclists, who do not possess the same level of competency or experience as adults and are therefore more vulnerable. We also support calls for a range of additional measures to improve cyclists' safety, including more dedicated cycle lanes and educational campaigns aimed at both cyclists and motorists.

As a pro-cycling organisation, we want to encourage people to get on their bikes and enjoy cycling – but please, use your head and use a helmet!

Luke Griggs
Director of Communications
Headway – the brain injury association

Insisting on helmets means less cycling

ONE clear consequence of introducing mandatory helmet legislation for any age population, is that it reduces the number of people cycling. This happened in Sweden when legislation for children 16 years and under was introduced. It happened in Australia, where there was a 30-40% drop in cycling participation in both children and adults, and again in New Zealand.

Establishing regular cycling behaviour during childhood is an important predictor of adult cycling. Maintaining adolescent cycling is critical to this progression, and there are already many deterrents. Introducing helmet legislation for adolescents is a powerful deterrent to cycling – not only can helmets be uncomfortable, they are definitely not cool or fashionable.

We know there are many health benefits from cycling, and every cost-benefit analysis of cycling has concluded that the health benefits of cycling outweigh the injury risk and pollution exposure. The proposition that bicycle helmet legislation reduces head injuries is highly contested in Australia and New Zealand, with the most likely explanation for reduction in head injuries over time being due to general improvements in road conditions that has improved safety for all road users, including pedestrians and

NO

motor vehicle drivers. Analyses in Canada have similarly concluded that bicycle helmet legislation had no effect on rates of head injury hospital admissions.

Of course, young children will crash while they're learning to ride a bike. Most parents will try and protect their children as best they can during these times of mastering new sports or skills, and initially using a helmet may be useful. However, to bring the weight of the law and use police to threaten families with fines is completely out of proportion to the developmental task of learning to ride a bicycle. Most people can accurately assess the risk of cycling for themselves and their children given where and how they are riding (eg. slowly on a bicycle path has a low level of risk), and this is modified by skill,experience and maturity.

Using a legal sanction to insist on wearing helmets communicates to parents that cycling must be dangerous, which is at odds with objective levels of risk involved. Framing cycling as dangerous can be an actual deterrent to cycling, with many people saying they do not cycle because "it's too dangerous" regardless of the actual context. Helmet legislation contributes to negative perceptions of the safety of cycling, and this adverse consequence can start early.

Chris Rissel
Professor of Public Health
University of Sydney

On the safe side

People want to walk and cycle more for the sake of their health and the environment, but they are put off by safety concerns, says Andy Cope

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THE benefits of travelling by bike and foot are well known; there is a considerable body of supporting evidence in academic literature, and the benefits of active travel are well documented in the media on a near daily basis. And yet the proportion of trips made by bicycle remains stubbornly low, at 2%. People want to change how they travel but they're worried about safety.

In the biggest survey ever conducted on attitudes to cycling in the UK, Bike Life (2015), 67% of more than 10,000 respondents felt that more people riding bikes would make the area a better place to live and work. Three quarters support more investment in cycling and nearly eight in 10 (79%) said they wanted improved safety for people riding bikes.

Government data on relative exposure by mode type emphasises the risks associated with walking and cycling. Casualty rates are far in excess of those for most motorised modes (except motorcycles). According to the British Social Attitudes Survey (2015), 64% of people think it is too dangerous to cycle on the road.

The need to rebalance the way we travel is stronger than ever, not least because walking and cycling are part of the solution to so many challenges we face – from air pollution to congestion, obesity and physical inactivity. It is essential we find ways to encourage more people to walk and cycle if we are to make the most of the associated health benefits. Overcoming the challenges of traffic exposure is absolutely key in this respect.

Governments are now enshrining ambitions for increased cycling and walking in national and local strategies, with the latest example being England's first ever Cycling and Walking Investment Strategy. It aims to double cycling activity

> **The need to rebalance the way we travel is stronger than ever, not least because walking and cycling is part of the solution to so many challenges we face**

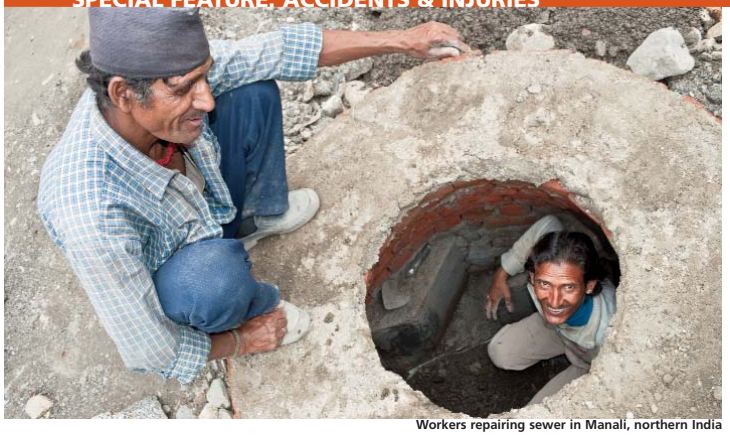
by 2025, reduce the number of cyclists killed or seriously injured on England's roads each year, and reverse the decline in walking over recent years.

One of the ways this can be achieved is through more balanced investment in transport infrastructure – improving local roads and streets, and designing and maintaining them to be safe and pleasant for all who use them. The 2015 Budget commitment to create a ring-fenced Roads Fund solely for national infrastructure will further marginalise local transport planning. Current plans, up to 2020, will see more than £1.1 million per mile being invested in maintaining national roads, which make up just 3% of all roads.

This level of investment contrasts starkly with the £27,000 per mile investment available to maintain local roads, which account for 97% of England's road network. There is a pressing need to improve local roads to give people real choice in how they travel and inspire the next generation to walk and cycle. Investment in local roads and in cycling and walking infrastructure can help all road users by reducing traffic.

Sustrans' new five-year strategy sets out a vision to make it easier for people to walk and cycle. Delivering solutions that learn from the lessons of the past by combining infrastructure, behaviour change and the involvement of communities will help us all to be healthier and happier, and create safer routes and more liveable places for generations to come.

Andy Cope
Director of Insight
Sustrans



Workers repairing sewer in Manali, northern India

Another day, another deadly sewer gas

INDIA'S newspapers carry daily reminders of the grim consequences of non-compliance with health and safety law and lack of awareness among employers and workers. Catastrophic incidents such as the Bhopal tragedy draw our attention all too briefly to the consequences of indifference to safety standards. But the countless smaller accidents over the years are no less serious.

The lowest-paid workers and the unorganised workplaces – employing millions in low- and middle-income countries – tend to be the most hazardous and least protected from accidents. A worker who opens a manhole is exposed to deadly sewage gases. Others are accidentally electrocuted through lack of training. Those who live and work on rubbish tips constantly risk entombment. Subsistence farmers regularly die from acute pesticide poisoning.

Yet in poorer countries, these incidents rarely provoke much public interest. The poorest often casually accept the daily loss of life in small workplace accidents because it's so common – often seen as an inevitable consequence of work and the casual corruption that overlooks safety measures.

One of the difficulties in making improvements is that action is needed at many levels. Governments can pass laws, but they need enforcing, monitoring, protecting against corruption, and equipment needs ongoing maintenance. And who, in a huge and casual garment industry in the slums, is going to get desperately poor women workers to attend basic fire safety training?

The papers here reported how the local administration had refused a temple permission for a firework display on safety grounds, but allegedly received death threats – so it went ahead, and fire killed a hundred people. There are other inequalities too. Of the thousands of domestic and other fire deaths in India, 75% were rural, and 80% were among women.

> **Governments can pass laws, but they need enforcing**

` The scale of the problem is daunting, although low-income countries often have good records of challenging inaction on a large scale – witness India's massive grass-roots anti-corruption movement and ability to mobilise vast armies of village health activists. But more ethical action by wealthy countries is also necessary to reduce the giant inequalities that maintain dangerous working and living conditions in poorer nations. Business owners' rising costs caused by unfair global trade can damage safety measures. Factory fires in India will keep happening and women and child workers will continue dying as long as the UK and other wealthy countries fail to commit to global economic change to reduce poverty and the income inequality that promotes accidental death among the disadvantaged.

Andy Beckingham
Consultant in Public Health
Fernandez Hospital
Hyderabad, India

Creating the unknown to share the space

DECLUTTERING is an increasingly common component of urban street design. By removing the majority of road signs, signals and markings it produces a lack of clear direction and segregation and creates a sense of 'unknown.' This increases drivers' cautiousness, lowers speeds and allows pedestrians to make eye contact with drivers and cross the street 'informally'. By giving no one priority, all street users are required to negotiate and share the space.

Most of the major schemes have reported an increase in safety with a reduction in people killed or seriously injured. Some have reported no change in the number of minor incidents but, crucially, slower speeds mean reduced fatality rate if hit.

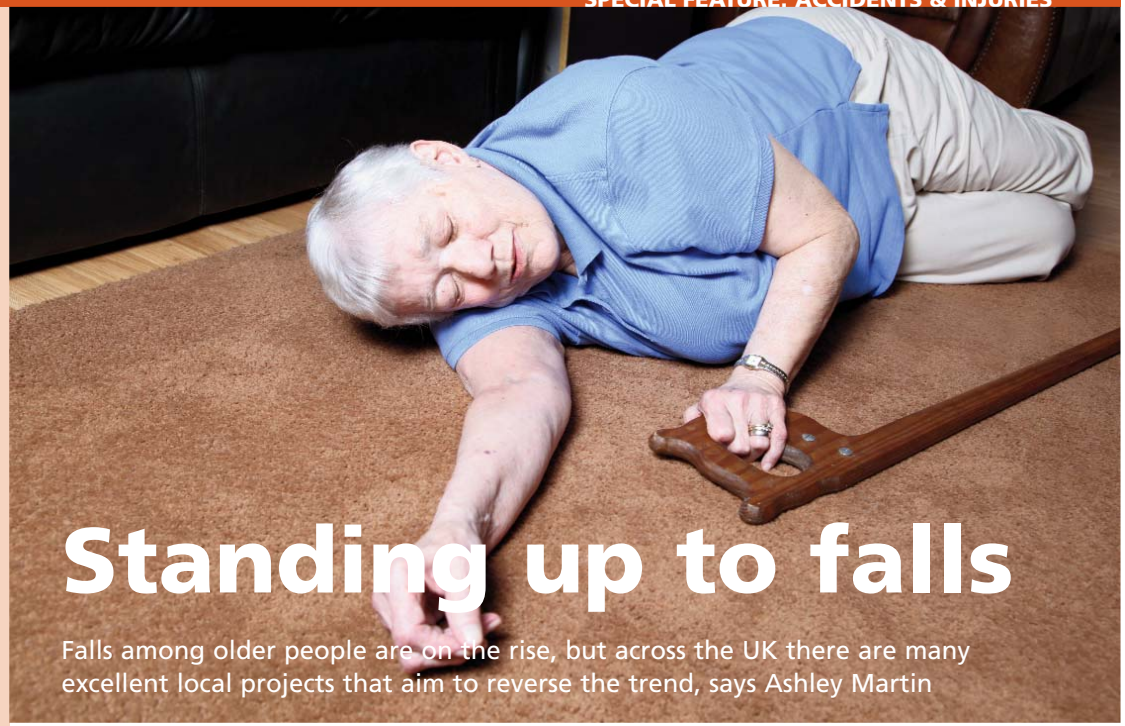
Figures suggest an increase in footfall after installation of shared space schemes, despite anecdotal evidence of avoidance due to safety fears. Objectively, reduced vehicle numbers and speeds lead to reduced air and noise pollution, but there are intangible benefits too. Shared space seeks to redress the dominance of motorised vehicles and promotes a psychological switch that says "walk here if you want" rather than "you must wait".

Whilst critics brand shared space a trendy gimmick, decluttering is still on the rise. The latest street design manuals promote shared space, but point to lessons learned, for example, shared space schemes on roads with too high traffic flows, leading to councils having to reinstall formal crossing points. There is also better recognition of the needs of people with sensory disabilities, many of whom find shared space impossible to navigate due to the lack of kerbs and building lines.

The government's Cycling and Walking Investment Strategy means that those involved in planning streets can't shy away from responsibility anymore. Shared space empowers pedestrians to assert their right to be there, but after so many years of having minimal rights, it is not surprising that people are afraid to do that.

Perhaps part-decluttering, where some signs indicating shared space and 20mph speed limits are retained, is the short-term answer whilst we continue to develop a new understanding of our interactions in public space.

Rebecca Cox
Principal Technical Advisor
Living Streets



Standing up to falls

Falls among older people are on the rise, but across the UK there are many excellent local projects that aim to reverse the trend, says Ashley Martin

FALLS among older people is one of the major issues facing the NHS today.

In 2014/15 more than 282,000 people over the age of 65 were admitted to hospital in England because of a fall, with falls being the leading cause of accidental death in older people. These numbers are rising.

The cost to the individual and their families is extensive. Falls can reduce the number of disability-free years and destroy confidence, leading to loneliness, isolation and a loss of independence.

As well as the huge and unnecessary time and capacity pressures that this places on our hospitals and their staff, the monetary cost is also huge. There are more than 70,000 hip fractures each year, with the annual cost of these, including medical and social care, equating to around £2 billion.

Across the UK there are many excellent local initiatives that aim to halt and cut the rising number of falls among older people. The Royal Society for the Prevention of Accidents (RoSPA) is currently running the three-year, Department of Health-funded falls prevention programme, Stand Up, Stay Up, which aims to bring some of these initiatives together and stimulate new and innovative strategic approaches.

The programme engages with and involves those working to prevent falls among older people, as well as those people who have had or who are at risk of having a fall later in life, through two branches of work.

Firstly, organisations and professionals are encouraged to join up to be part of a national network that will share guidance and best practice, highlight new resources and provide opportunities for those working in the community to receive training in falls prevention.

'Secondly, the initiative is working with

> **Falls can reduce the number of disability-free years and destroy confidence, leading to loneliness, isolation and a loss of independence**

10 local project partnerships in areas with high public health outcome indicators for falls across England. Their work is being supported to help them put falls prevention at the heart of their strategic development, in order to deliver long-term change. Each partner area will also be delivering an innovative community intervention.

An example of these local project partnerships is Bishop Creighton House, an established voluntary agency which works with community health teams in Hammersmith and Fulham. The borough is the second-worst in London when compared to the city's average for injuries due to falls in people aged over 65.

The Stand Up, Stay Up programme will support partnership-working and reduce the number of injuries from falls, giving the over-65s increased confidence and reducing social isolation. Elements of a 'Steady and Stable' session – an evidence-based programme that helps to improve balance, strength and confidence through specific exercises – will be delivered at the start and end of all Bishop Creighton House classes. It is hoped that popularity will grow and an established Steady and Stable class can be delivered. All volunteers there will be taught how to deliver strength and balance training, and an outreach programme will also be delivered to the housebound.

For more information on Stand Up, Stay Up, and for details on how to sign up to the national network, please go to www.rospa.com/standupstayup.

Ashley Martin
Public Health Project Manager
Royal Society for the Prevention of Accidents

Road Accidents in Britain 2015

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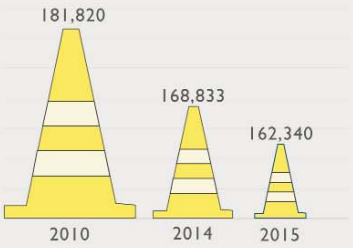
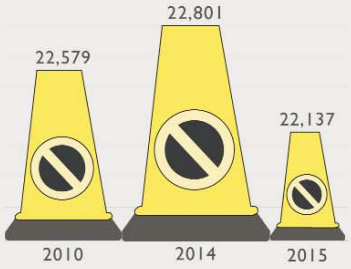
london college of communication

Headline Statistics

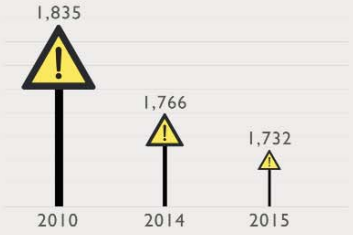
Slightly Injured



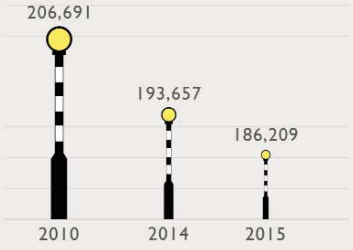
Seriously Injured



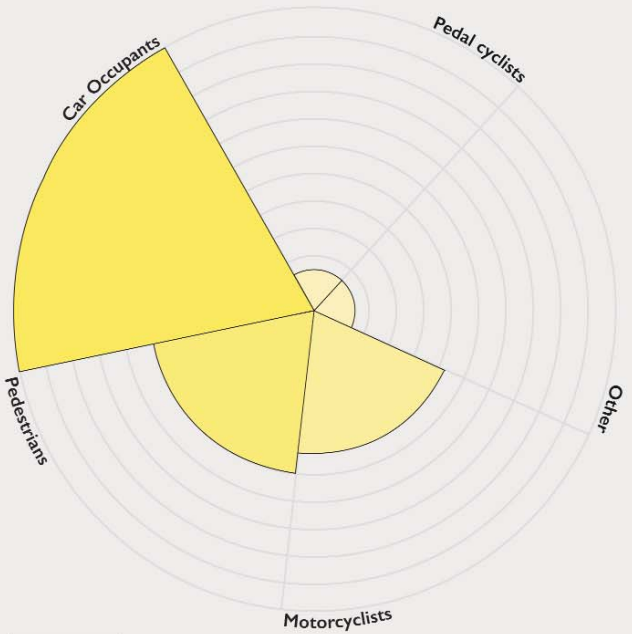
Killed



All Casualties



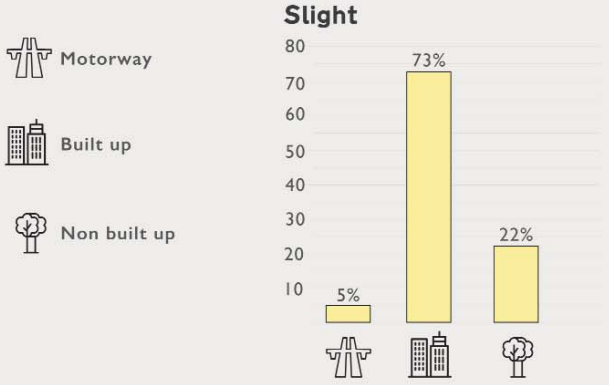
Road Fatalities by road user type



Total fatalities 2015

1,732

Casualties by severity and road type, GB: 2015



Car Occupants

44%

Car occupants continue to account for the largest proportion of casualties of all severities.

Of all 111,708 car occupant casualties

Cyclists

6%

Overall pedal cyclist casualties were lower in 2015 than any year since 2010.

Of all 18,845 cyclist casualties

Motorcyclists

21%

Motorcycle user fatalities had the largest increase in 2015.

Of all 19,920 motorcyclist casualties:

Pedestrians

24%

A total of 409 pedestrians were killed in 2015, down from 446 in 2014

Of all 24,073 pedestrian casualties

Influencing factors

There is no single underlying factor that drives road casualties. Instead, there are a number of influences. These include:

Travelling distance (which is partly affected by economic externalities)

Weather
Good weather tends to *increase* casualties and bad weather tends to *decrease* casualties.

Behaviour & Attitude of drivers, pedestrians, and riders

Mode of transport used

Designed by
Alison Congdon

Cruel, cruel summer

Summer brings extra hazards from outdoor activities, so it is a timely moment to consider how first aid should become a life skill for all, says Emily May

WARMER weather can prompt more people to embrace an active lifestyle and do more outdoor sports such as cycling and football. But the extra time spent outside can lead to accidents, injuries or ailments that take the fun out of summer. From dehydration and sunburn to more severe barbecue burns or broken bones from falling off a bike or a bad tackle, this raises the question of how best to respond in these situations.

Given the increasing pressure on A&E departments and emergency services, the British Red Cross believes it is crucial that people feel confident and willing to give basic first aid in both minor and major situations.

Recent research found that in cases of life or death 93% of people will call 999 for an ambulance, but around half do not attempt any first aid while waiting for emergency services to arrive. Yet up to 59% of pre-hospital deaths from injury are potentially preventable with first aid. This is a public health problem that needs to be addressed.

The Red Cross has pioneered an approach that makes first aid easy and fun to learn and simple to do. The aim is to position first aid as an essential life skill that everyone can do, rather than a trained few. Just knowing a bit of first aid can make a big difference.

In 2016 the British Red Cross helped 267,815 people learn first aid across the UK. This included training in the workplace and education in schools and communities. Many more people were reached through digital and media channels, such as the British Red Cross first aid app which has been downloaded more than 850,000 times in the UK since its launch in 2011.

> Up to 59% of pre-hospital deaths from injury are potentially preventable with first aid

But it doesn't stop there. In order for everyone to gain some first aid knowledge, the Red Cross goes further than educating. It also advocates for everyone to have the opportunity to learn first aid, starting at school, as well as when learning to drive and through public health initiatives.

Children as young as five years old can learn basic life-saving skills, including how to keep themselves safe. It's a no-brainer that they should learn this in school. In order to spread the word the British Red Cross has been working in partnership with St John Ambulance and the British Heart Foundation to influence the Government, MPs and other organisations to support first aid as a mandatory part of the curriculum in schools.

First aid could easily be taught through existing subjects, such as personal, social, health and economic education (PSHE – England only). However, without the obligation to teach PSHE, nor first aid as a mandatory component, coverage is patchy.

In March 2017 the Government announced its intention to make PSHE statutory in the future, creating an exciting opportunity for children and young people in all schools across England to learn key life skills, including first aid. This is a promising step towards creating a generation of lifesavers. Fingers crossed for further progress following the General Election.

Emily May
First Aid Policy & Advocacy Manager
British Red Cross

To have more first aid advice at your fingertips, download the charity's free first aid app at www.redcross.org.uk/en/What-we-do/First-aid/Mobile-app

Water a bigger hazard than fire or cycling

DROWNING remains one of the main challenges in the accident prevention arena, with an average of around 400 people dying each year in the UK from an accidental drowning or natural cause while in the water. Drowning accounts for more accidental fatalities annually than fire deaths in the home or cycling deaths on the road. Provisional figures for 2016 suggest that 300 people died accidentally in UK waters, although this number is expected to revise upwards subject to coroners' findings.

Of particular concern are men and boys, who experience a hugely disproportionate number of deaths compared to women and girls (228 compared to 45 in 2016), while young men aged 15 to 24 and those aged 40 to 49 also experience high numbers of drowning. In terms of geography, the beach/coast/shore (93 deaths in 2016) and river locations (70 deaths) pose the greatest risk.

From assessments made of sources such as coroners' reports, we know that a large proportion of those who drown never intend to be in the water in the first place – 122 in 2016, with 77 of those having died while out walking or running.

It's also worth noting that the accidental and natural cause figures do not include those drowning deaths from suicide, which number around a further 200 each year.

The Royal Society for the Prevention of Accidents works with organisations such as the Royal National Lifeboat Institution, the Maritime and Coastguard Agency and the Royal Life Saving Society as part of the National Water Safety Forum (NWSF) to tackle the issue. Last year the NWSF launched its first Drowning Prevention Strategy which aims to halve the number of drowning deaths by 2026. It was put together following a World Health Organization report that recommended each country to have a national water safety plan.

> A large proportion of those who drown never intend to be in the water in the first place

Highlighting the key areas of focus, the strategy asks stakeholders to support the development and delivery of local strategies that will contribute to the national plan. It also acts as a framework to guide the work of organisations and individuals who are interested in and have a responsibility for drowning prevention and water safety.

During its first three years, the strategy aims to address the following targets:

- Every child should have the opportunity to learn to swim and receive water safety education at primary school and, where required, at Key Stage Three
- Every community with water risks should have a risk assessment and water safety plan
- Better understand water-related self-harm
- Increase awareness of everyday risks in, on and around water
- All recreational activity organisations should have a clear, strategic risk assessment and plans that address key risks.

David Walker
Leisure Safety Manager
Royal Society for the Prevention of Accidents

www.nationalwatersafety.org.uk

In search of a 'vaccination' for 'vehicle killings'

IN 1920s AMERICA, the media referred to road traffic crashes as "motor vehicle killings". Concerns were raised about the connotations of this expression, and the "accident" was born, thus unleashing a global epidemic that we are still far from controlling. Yes, there have been benefits of the motor revolution, but the negative consequences are vast.

The UK Department of Transport regularly states how safe our roads are. But for some groups the risk is still unacceptably high, and any road death is unnecessary. Sweden has recognised this with Vision Zero. Furthermore, our current laws are often at the expense of greater public health good. Few children are killed or injured as pedestrians, mainly because few 'play out' alone and many travel everywhere by car.

The lack of a simple 'vaccination' for preventing road accidents is often lamented, but the reality is that we do have high quality evidence-based interventions available to us. The World Health Organization has outlined its 10 strategies for keeping children safe on the roads. Here are three that are particularly important to the UK:

- For when we absolutely have to transport children by car, appropriate restraints are essential. Booster seats until kids reach adult height, so that seat belts sit properly across the shoulder, need to be explained better to parents.
- For older teenagers and young adults, for whom road traffic crashes are the leading cause of death and disability, graduated driver licensing is urgently needed. It works in the US, Canada, Australia and New Zealand.
- For all of us, 20mph as the default speed limit. Let's forget this idea of 'protecting' schools with 20mph zones, while leaving the limit 30mph outside kids' homes. Let's help older people cross the road at their pace. Let's reduce air and noise pollution. Let's increase the viability of local businesses. Let's increase active travel. All are proven benefits of lower speed limits.

In fact, a 20mph default speed limit could be the public health 'vaccination' that we've been looking for.

Sarah Jones
Consultant in Environmental Health Protection
Public Health Wales

Violence in the home: midwives on the frontline

DOMESTIC violence is common; around 1.2 million women a year experience its devastating effects, and two women a week are killed by their partners in the UK. It's a challenge for all healthcare professionals, but particularly so for midwives as around 30% of domestic violence starts or worsens during pregnancy, a known high-risk time. It's not just the mother who is at risk: domestic violence has overtaken gestational diabetes and pre-eclampsia as the leading cause of foetal death. Domestic violence during pregnancy also doubles the risk of premature birth and low birthweight for babies.

Spotting domestic violence is not always straightforward. This is why the National Institute for Health and Care Excellence (NICE) (2016) advises that midwives – and indeed all health professionals – need to be proactive in encouraging women to come forward and disclose when they feel unsafe. Simple actions, such as clearly displaying safety and contact information in waiting areas, may promote disclosure. It is crucial that this information is available in appropriate and accessible language.

Midwives should routinely ask all women (at appropriate stages of their pregnancy) about the presence of domestic violence. This is often easier said than done. Midwives need to see women on their own in order for these discussions to take place, which requires them to be creative during their contacts with the women they are caring for. Many partners enjoy and want to be involved in their partner's pregnancy. Midwives welcome this, but it does mean that they need to seize opportunities (such as showing women where the toilet is in the birth centre or hospital) to engineer time alone with a woman. Documenting time alone with a woman, as well as domestic violence enquiries, are all part of routine care for community midwives.

> **Evidence suggests that women want to be asked about domestic violence, but it is clear that for many women disclosure can be loaded with risk**

Evidence suggests that women want to be asked about domestic violence, but it is clear that for many women disclosure can be loaded with risk. Fear of the abuser and the potential repercussions can deter women unless there is real trust between a woman and her named midwife. Trust can only be established where there has been continuity of care that is compassionate, knowledgeable and has time for advice and support when appropriate. Maintaining midwifery continuity throughout the pregnancy is crucial to ensuring all women who are suffering domestic violence feel empowered to speak up.

Following disclosure to her midwife, the priority is the safety of the pregnant

woman and any other children. Many community midwives are trained to understand the legal framework around domestic abuse and also how to practically support vulnerable women in accessing the support they need. Midwives deploy a zero-tolerance approach to violence, but this can cause conflict when vulnerable women are trapped in a cycle of abuse and are often desperate to hold their families together. Referral pathways can vary and the in-depth knowledge of these as well as awareness of any changes or adaptations should be a priority for all maternity services.

Midwives have a crucial role in facilitating the disclosure of domestic violence and the ongoing safety of the woman and her family. Pregnancy is a high-risk time, and it's an area where midwives need to be skilled at delivering a package of care that addresses – not avoids – the issue and skilfully signposts victims to services that will most fulfil their needs.

Sarah Fox
Professional Policy Advisor
Royal College of Midwives

Facing up to the impact of disfigurement

"IT'S not always easy, for me or for some people. I have two children, and while they don't seem to notice, I can see that it's difficult for the other mothers at the playgroup to come up to me."

Accidents and injuries can cause disfigurement, meaning any condition, mark or scar that affects the appearance of a person's face, hands or body. Around 1,345,000 people in the UK have significant disfigurement to the face and body and around 66,000 have disfigurements from accidents such as burns and facial scars.

People with disfigurements have to learn to live with their disfigurement in a society that prizes 'good looks' and makes negative assumptions about what looking different must be like. A person's adjustment is found to have more to do with psychosocial variables, many of which can be modified, rather than appearance-specific effects which may be harder to change.

The crucial insight from research is that the extent or severity of a disfigurement does not correlate with the amount of emotional and social distress it can cause. It is a serious and lifelong psychosocial challenge for many which health and social care professionals can do much to make less daunting.

Quality standards should reflect the need for psychosocial interventions, and health and social care professionals and commissioners should be aware of the psychosocial impact of disfigurements. Changing Faces offers online training and resources and training days. To provide effective support and to enable people with disfigurements to live in today's culture, it is essential for professionals to routinely assess and address patients' psychosocial needs in the service they receive both pre-discharge, at follow-up and as-and-when necessary, and include it in patients' care plans. This will help reduce health inequalities and really make a difference to people's quality of life.

For more information on resources, strategies and training programmes visit the health resources pages at: www.changingfaces.org.uk

Ivon van Heugten
Policy Advisor in Health
Changing Faces

The crippling effect of vanity and ambition

AS THE introduction says, the story of polio "is a great story, with a powerful storyline, a rich cast of heroes and villains and a nail-biting final chapter that really deserves to resolve into a happy ending".

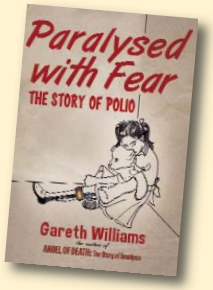
The book can be viewed on several levels. It is an entertaining read, if some of the explanations of disease pathology are a little long for those with knowledge of the subject. It is also a detailed history of the rise of a relatively 'new' disease first described in the medical literature in the 18th century and the US struggle to find a cure or means of prevention. Research on the latter was funded by a highly successful public campaign based on keeping fear of the disease in the public consciousness.

However, for me the most frightening part was not the disease itself, which as Dr Williams points out, was never one of the great killers, but the damage 'eminence-based' medicine does to patients and scientific progress. Leeches, cupping, smacking the limbs with a wet towel and even applying a red hot poker to the spine were meted out as 'treatment'.

As late as 1908 many authorities did not consider polio an infection. Although confirmation that a filterable agent was involved occurred at this time, papers refuting the existence of the polio virus continued to appear in respectable journals until 1954 by which time it had been seen under the electron microscope. Furthermore, it took 25 years for the discovery that the virus was present in the gut to be confirmed, largely because one eminent scientist wanted to protect his theory that polio entered the body via the olfactory nerve – and also the reputation of his institution.

The attitude of this same scientist did much to delay further work on vaccines for over a decade. When research resumed it was in an atmosphere of intense competition bordering on hatred between the various scientists involved.

The story of polio is almost over after 25 years and $10 billion, but some bizarre incidents have delayed final extermination. In South Africa a mother who took her children for vaccination was beaten to death by her husband, a member of the Johanne Marange Apostolic Church, for doing so. Then there was a hypothesis that an early live vaccine had been contaminated with HIV when given to



children in the Belgian Congo. The final twist was the killing of Osama Bin Laden by a doctor claiming to run a team vaccinating against hepatitis. The response of the Taliban was to target genuine vaccinators involved in the polio campaign.

Sally Millership

Paralysed with Fear: The Story of Polio
Gareth Williams

Published by Palgrave Macmillan
ISBN 9781137299758
RRP: £22

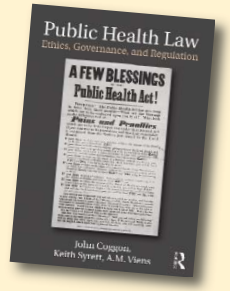
Taking the law into our own hands

PUBLIC health activity, and the state's public health responsibilities to assure the conditions in which people can be healthy, can only be achieved through different means of social coordination. This places law and regulation at the heart of public health. They are fundamental both to methods of achieving public health goals and to constraints that may be put on public health activity. Therefore public health trainees, practitioners and leaders in public health need to understand the importance and nature of legal and regulatory approaches and the place of ethics in public health.

Public Health Law: Ethics, Governance, and Regulation is by three leading scholars in public health ethics and law, John Coggon, Keith Syrett, and Adrian Viens, who succinctly define and examine this crucial area of study and practice and provide a key resource for scholars, practitioners and leaders working in public health. While many people consider such issues as often full of technical jargon and heavy reading, the authors demonstrate the fundamental importance of the issue to practice, and clearly highlight the various key issues and concepts and implications for action.

John Middleton, President of the UK Faculty of Public Health, says: "Trainees and practitioners will benefit significantly from this accessible introduction to the field of public health law, broadly conceived and clearly explained. It explains how ethics impacts on public health practice, the history of public health regulation in the UK, and the many different ways that contemporary laws can both serve and constrain public health. After 30 years in public health, I thought I had heard all this, argued about it, considered it a talk-shop subject. But this book brought it alive and new and fresh to me. Public health ethics and law is live, vital and kicking! I commend this book to everyone in public health – young and old, specialist practitioner or interested enthusiast. The public needs to be interested and concerned about public health ethics and law. This is a good place to start."

There has been a tendency to forget that public health is not merely a technical specialty but is grounded in moral norms and values that are key to our behaviours, decision-making and practice as public health practitioners and policy makers. This



book provides a timely tool for learning and for systematically reflecting on such issues in order to meet the growing public health challenges around us and get public health ethics into practice.

Farhang Tahzib

Public Health Law: Ethics, Governance, and Regulation
John Coggon, Keith Syrett, and AM Viens

Published by Routledge
ISBN 9781138790780
RRP: £31.99 (paperback)

In memoriam

Jonathan Hildebrand FFPH
1961 – 2016

Jonathan Hildebrand, Director of Public Health (DPH) for the Royal Borough of Kingston upon Thames, died suddenly last November aged 55 at the height of his career. Cherished and admired by colleagues, Jonathan was a quintessential public health practitioner, teacher and mentor. His particular passions were mental health and wellbeing and sexual health – at the time of his death he chaired the London strategic partnership for alcohol and drugs, was co-lead DPH for sexual and reproductive health in London and represented London on the Association of Directors of Public Health Council.

Jonathan qualified in medicine at Charing Cross in 1984 and, while in general practice, became increasingly interested in the social and psychological factors linked to ill-health. His passion for holistic approaches and influencing the wider 'upstream' determinants of health and illness soon led to a career shift into public health.

Gaining his MFPH in 1997, Jonathan started his public health career in Portsmouth and East Hampshire Health Authority, working as a consultant there from 1998 to 2000, before taking on various increasingly senior positions in Surrey as the NHS went through successive reorganisations, then joining Kingston in 2006 as Joint DPH for NHS Kingston and Kingston Council. He also stepped up to become the DPH for the NHS South West London cluster from 2011 to 2013. In April 2013, with the implementation of the NHS Health & Social Care Act, he took up his final post.

Jonathan's whole-hearted commitment to education and training, and his dedication to mentoring, was hugely valued by colleagues. He was by all accounts a delight to work with: supportive, kind and quietly full of humour, displaying the best of public health leadership and working from strongly held values.

Myrtle Summerly FFPH
1930 – 2017

Myrtle Summerly (nee White) graduated MB, ChB from the University of Birmingham in 1955. After a post in radiotherapy she entered the Public Health Department of the City of Stoke on Trent. Her experience with the School Health Service working in a deprived post-industrial community inspired her interest in public health.

After the 1974 NHS reorganisation she was the driving force behind the new Department of Public Health in North Staffordshire and after the dissolution of Area Health Authorities was appointed Director of Public Health in 1984 and held that post until retirement in 1994. In that position her charm, tact, humour, diplomacy and networking abilities, as well as her boundless energy, served her well.

Myrtle maintained a good relationship with her clinical colleagues and staff from other authorities and sectors. She was perceptive in developing a relationship with Post Graduate Medicine, Keele University. An early initiative was organising ongoing education for the community health doctors. She contributed to *The Potteries* (edited by ADM Phillips for the BAAS visit). Later she was a major contributor to the health promotion component of the then new Certificate of Health Education.

Within public health she was supportive as a trainer and had an ability to spot and encourage talent.

Myrtle loved classical music and gardening. As a colleague said of her: "She was such a happy person. It was a joy seeing her at work each day."

Angela Davies

John Lock Hon MFPH
1954 – 2016

John Lock was a shining example of someone totally dedicated to serving their local community in many ways, over many years. A resident of the London Borough of Newham since 1979, John stood successfully for election as a Newham councillor in 1986, holding office until 1994.

During that time, he led a major programme to redevelop the borough's leisure services and libraries and served on a wide range of committees including policy and resources, education, police and community safety, race equality, and community affairs. He represented Newham on the Association of London Authorities, the Local Government Information Unit and the Greater London Arts Council.

John had over 30 years' experience in the fields of health, education, arts, urban regeneration, sport, technology, third sector, social enterprise, volunteering and business development. He led the University of East London's (UEL) involvement in the 2012 Olympic legacy, reshaping their volunteering programme and transforming their approach to sports development. He played a huge part in gaining funding for UEL's iconic Docklands campus.

John was a founder member of the Stratford Renaissance Partnership, spear-heading the development of new businesses, and was instrumental in the creation of Stratford's cultural quarter, now home to Birkbeck University and UEL. He championed the development of Stratford Circus performing arts centre and was for 10 years a director of Theatre Royal Stratford East.

At Newham Primary Care Trust he defined the concept of community ownership of health. He chaired the board of the Sir Ludwig Guttmann Health and Wellbeing Centre on Queen Elizabeth Olympic Park and ensured that there was a significant academic component to its work.

In 2014 John was awarded Honorary Membership of the Faculty of Public Health and last year was given Freedom of the Borough of Newham in recognition of his extraordinary contribution.

Deceased members

The following members have also passed away:

Sunil Shah FFPH
Basil Slater FFPH

Welcome to new FPH members

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

Honorary Fellows
Anthony David Harries
David Nabarro
Donald Irvine
James O'Neill
Michael Rawlins
Paul Lincoln
Richard Horton
Roderic Griffiths
Stephen Townley Holgate

Fellows
Abina Varadarajan
Anthony Sudell
Aroop Mozumder
Balvinder Kaur
Catherine Morris
Catherine Pritchard
Charlie Foster
Charlotte Simpson
Christian David Mallen
Elizabeth Ollerhead
Emma Hall-Scullin
Emma Plugge
Emmanuel Okpo
Harish Nair
Haroon Khan
Hon Yee Constance Chan
Iain Kennedy
Jessica Stokes
Joanna Peden
Justine Womack
Lit Man Leo Poon
Marta Busana
Martin Hawkings
Mohannad Al-Nsour
Muhammad Moazzam
Ronan Lyons
Sally Bradshaw
Stewart Mercer
Tahir Manzoor
Theodore Tulchinsky
Thomas Ferris

Honorary Members
Abeer Al Teneiji
Alasdair Walker
Andrew Carson-Stevens
Asiya Odugleh-Kolev
Izzi Seccombe
Jenny Edwards
John Coggon
Karen Wheeler
Martin Birley
Moira Angel
Robert Steele
Sheila Duffy
Valerie Saunders

Members
Ahmed Mohammed Kheir
Amy McCullough
Andrew Attfield
Caroline Rumble
Catherine Carmichael
Clare Turnbull
Diane Bolton-Maggs
Diane Kirkland
Emilia Holland
Guy Kilminster
Ho Fai Thomas Tsang
Jack Bedeman
Jenny Osborne
Joanne Morgan
Jonathan West
Joshna Mavji
Katherine Sinka
Louise Woolway
Mohammed Ibrahim
Mzwandile Mabhala
Paul Sheehan
Paul Southon
Rebecca Pickup
Robert Sookoo
Sanjay Pooran
Steven Maddern
Yasmin Ahmed-Little
Yitka Graham

Diplomate Members
Camilla Parikh
Catherine Jeffery
Emily Dobell
Lynsey Patterson
Michelle Black
Sara Dunling-Hall
Shannon Katiyo

Specialty Registrars
Antiopi Ntouva
Ellen Bloomer
Lois Murray
Rebekka Shenfine
Selina Rajan

Practitioners
David Stacey
Maaike McCloskey
Martin Knight
Sam Rowell

International Practitioners
Anoop Ivan Benjamin
Bashir Aden
Kester Maniaul
Lindsay Lowe
Pankaja Raghav
Preetam Mahajan
Sayed Himatt
Surajudeen Abdulrahman

Student Members
Abdul Mohammed
Alice Ogbodo
Amy Woodward
Andrea Lambell
Bethuel Mbaramah
Bridget Mutuma
Cathy Baldwin
Ciceley Scarborough
Ellinora Ndege
Elliot Clissold
Emily Bebbington
Fiona Ellwood
Hannah Abadoo-Brew
Henson Kuuya
Jacqueline Mukankwandi
Jemima Kola-Abodunde
Jenny Bakkali
Johanna Bannis
Minjoung Monica Koo
Niall McDougall
Olalekan Sanusi
Olusegun Ajao
Patronella Ganza
Philip Harley
Reshma Janmohamed
Rory Wilson
Samiat Ajayi
Sheku Koroma
Shifa Sarica
Siham Dahir
Uzma Ahsanullah
Victoria Bola-Okerinde
Violet Mukangarambe
Wayne Rebello

Associates
Ademola Olaiya
Aisan Ghaemian
Alice Stonham
David Scott
Eleanor Barry
Fatima Ndanusa
Fiona Thomson
Helen Castledine
Jane Jobarteh
Kathryn Loxton
Kingsley Oturu
Laura Taylor-Green
Mairead Harding
Martha Earley
Mohammad Anisul Haque
Rachel Clark
Rachel Cullum
Theresa Carswell

GMC REGISTER

Congratulations to the following on achieving General Medical Council registration:

James Crick
Sinead McGuiness
Laura Shallcross
Carol Chatt
Janice Lo
Eszter Vamos
Claire Bayntun

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Rachael Leslie
Russell Carter
Allan Reid
David McConalogue
Eleanor Garnett-Bentley
Helen Buttivant
Lynn Gibbons-Martin
Claire King
Jessica Stokes
Amy McCullough
Charlotte Matthews
Claire Currie
Sarah Ogilvie

Defined specialist portfolio route
Corinne Harvey
Frances Hughes
Helen Harrison
Rachel Spencer-Henshall
Tony Mercer
Victoria Ononeze
Donna Sager
Steven Maddern

Practitioners
Aine Lyng
Helen Cheney
Holli Dalgliesh
Jacqueline Nixon
Katie Wilson
Muhammed Meah
Natalie Barrow
Rachel McIlvenna
Ramji Tiwari
Rebecca Laidler
Sheila Rundle
Catherine Hutchinson
Jennifer Smith
Amit Gaokar
Cindy Dickson
David Stacey
Emma Dillner
Gina Zelent
Helen Aston
Jannette Smith
Kirsten Mueller
Lesley Morison
Maaike McCloskey
Rachel Davies
Ravi Jaipaul
Susan Carmichael
Agnes Munday
Clare Burgess
Florence Mpofu
Karen Cornick