Traffic, home entertainment and fear of strangers have turned our streets into no-go zones for children and that is very unhealthy, says **Lucy Saunders**. So she has developed the 'healthy streets' approach to transport planning

OUR efforts to tackle childhood obesity have focused on modifying diet, but the other side of the 'energy in/energy out' equation deserves careful consideration for the many co-benefits it can bring.

A study by Mackett and Paskins (2004) assessed children's energy expenditure during different activities and found that children burned the most calories when playing outdoors unsupervised or travelling actively. Neither activity is a routine use of time for the majority of children in the UK. Unlike past generations, most children in the UK do not spend several hours a day drifting around the streets looking for adventure and opportunity. Instead a car ride to organised activities, playing computer games and watching TV are more common.

There is good reason for this. Over recent decades cars have filled our streets in ever increasing numbers. Now more affordable, convenient, comfortable and faster than ever, their ubiquity means we don't think to question their right to line our streets when parked and take precedence over other uses and users of the streets when they are moving. As a result, many parents are reluctant to let their children walk to school, the park, the community centre or the library, and the sight of a child kicking a ball around in the street is rare. While many children living in urban areas live within walking distance of parks, their ability to access them is constrained by the availability of an adult to accompany them. If we are to address inactivity amongst children, then this is the issue we must face head on: how do we create street environments that are safe enough for children to use on foot or by bike unsupervised?

**10 indicators of a healthy street:**

- Pedestrians from all walks of life
- Easy to cross
- Shade and shelter
- Places to stop
- People choose to walk and cycle
- Not too noisy
- People feel safe
- Things to see and do
- People feel relaxed
- Clean air

Achieving this goal will deliver many wider health benefits. Streets in which car use is constrained (both in volume and speed) reduce road danger to all of us, improve air quality, reduce noise and are more accessible to the most vulnerable groups: older people and those living with illness and disabilities. These streets become welcoming spaces for everyone to walk, cycle and spend time in, helping us all to build some much-needed activity into our daily routine and connect with our neighbours and communities. More eyes on the street help reduce the fear of strangers that can further restrict children's independent mobility.

To deliver these outcomes, I have developed the 'healthy streets' approach. There are 10 indicators of a healthy street (see box); all are evidence-based to improve health, reduce inequalities and promote active travel. These indicators help focus transport policy and decision-making on what really matters: the human experience. The healthy-streets approach moves us away from the passive acceptance of the dominance of motor traffic. We must consciously act to restrain motorised traffic through measures such as enforcing speed limits, ensuring pedestrian priority at crossings, reducing the convenience of driving short distances for trips that could be done on foot or by bicycle and installing cycling infrastructure that parents would be happy for their children to use unsupervised. Only through measures such as these, delivered at scale in villages, towns and cities across the country, can we provide an environment in which we can grow up and grow old healthy.

**Lucy Saunders**
*Consultant in Public Health*
*Transport for London*


## Information

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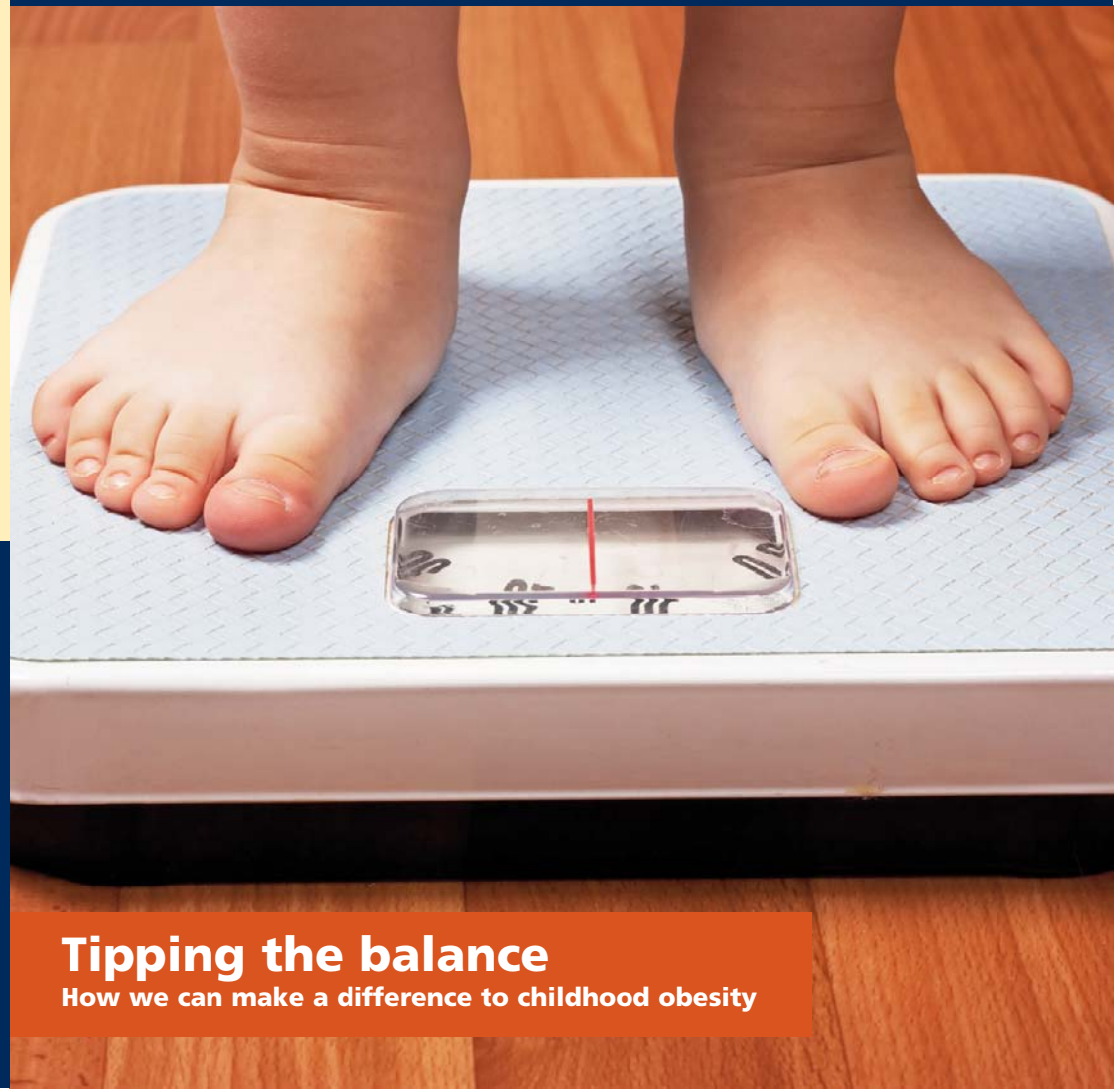
**Spring 2017**

In this issue
> **Interview with top public health nurse Helen Donovan**
> **Plan to prevent suicides 'too little, too late'**
> **The 'healthy streets' approach to transport planning**

# Public Health Today



## Tipping the balance
**How we can make a difference to childhood obesity**

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

**Spring 2017**

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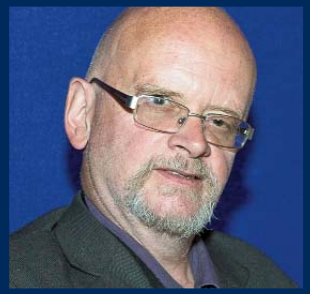
# Welcome



A FEW years ago, several our eminent members contributed to the landmark TV documentary series, *The Men Who Made Us Fat*. I am of the generation of children educated by those fat ad men. I know that a "Mars a day helps you work, rest and play", Maltesers have the "less fattening centres" and Milky Ways are "the sweet you can eat between meals without ruining your appetite".

At medical school, I learned the counter-maxims of the famous paediatrician, Illingworth, that "sweets are calories in the nude" and "fat children make fat adults" and... "if the baby cries it's my fault". By then it was too late. Hunger had become an abnormal state, confined to history by marketing. The multinational fat machine was already accelerating down the hill.

I have always tried to be pragmatic about public health intervention. In relation to obesity, I don't hold with either the 'it's all diet' or the 'it's all exercise' view. You can't outrun a bad diet and exercise only makes you hungry. But at least while you are exercising you tend not to be eating. Children stuck in front of computer games can easily get through a pack of biscuits and a couple of litres of cola. A habit, or an addiction, is formed.

I have also always resisted the 'national is everything' versus the 'local is everything' view of where to intervene. Local services can be a sop – keeping national politicians comfortable and their electors quiet: "We are doing something." But local interventions can create a groundswell of demand for tougher national action; the story of tobacco control is a clear example.

Community service developments in healthy eating and exercise create local community advocates for the services they provide and the things they know they can't change. So, we can use our local intel to demand national action – on policy, regulation and taxation.

The public health community was united in its outcry against the inadequacies of the childhood obesity strategy launched in August. The evidence of the need to cut marketing of highly processed foods was clear in the Public Health England evidence review and the Government chose to ignore it. The Government ostensibly felt obliged to protect jobs in marketing and the food industry. But history tells us that marketing adapted after tobacco advertising and sponsorship were stopped. There are more jobs in healthier food production and a fairer deal for farmers in a food system built on health and environmental objectives. We do not need to be wedded to high fat, high sugar, highly processed, highly profitable foods.

My mum cut up a Mars bar which we shared once every few weeks as a treat in the innocent early-sixties. Tune into any commercial satellite children's TV station and understand just how much we are grooming our children for a lifetime of overconsumption: of highly processed food, of fashion and fantasy, of plastic toys, cosmetics and clothes, of TV, computer and Gameboy-bound inactivity. Yes, sugar is the new tobacco; yes, sugar is the alcohol for children. We are growing our children on a panoply of insidious addictions. The multinational manufacturers, the advertisers, the packagers in turn are addicted to the profits they make. It is shortening the lives of our children, and of our planet.

"Don't forget the fruit gums, Mum." It is the 'Men' who are making us fat, and if the baby cries, it is our fault…

**John Middleton**



# Plan to prevent suicides 'too little, too late'

THE current rate of suicide is "unacceptable and likely to under-represent the true scale", according to a report by the House of Commons Health Committee.

The report warns that the Government's provision of suicide-prevention funding will be too little, and too late, to implement its suicide prevention strategy effectively.

While it is welcome that 95 per cent of local authorities now have a suicide prevention plan in place, the report makes clear that an effective quality assurance process and implementation at local and national level is needed to ensure the strategy is realised.

It calls for a joined-up approach to coordinate voluntary and non-clinical sector activity. Local authority plans must embed strategies for reaching those unlikely to access traditional services – particularly men. Government, it concludes, should ensure all patients discharged from inpatient care receive follow up support within three days – requiring action to address NHS staff shortfalls.

Finally, the committee calls on the Government and the medical colleges to promote the Consensus Statement on information sharing – recognising that many who commit suicide are at known risk, and this must be communicated effectively. The quality and consistency of suicide recording must also be improved to establish the most effective preventive measures.

Read FPH's inquiry response at http://bit.ly/2okqxM1

**Mark Weiss**
*Senior Policy Officer*
*Faculty of Public Health*

# Lords call for reversal of funding cuts

A MAJOR House of Lords inquiry report has warned that a "culture of short-termism" has fuelled a crisis in the NHS and led the adult social care system to "the brink of collapse". It calls for the reversal of "short-sighted and counter-productive" cuts in public health funding which are likely to lead to a greater burden of disease and strain on services.

The report by the Select Committee on the Long-term Sustainability of the NHS recommends a new, national, long-term, political consensus on the future of health and social care and cautions that "we can no longer defer action on prevention".

The Faculty of Public Health (FPH) welcomes the recommendation that ring-fenced public health budgets should be maintained for at least 10 years so local authorities can implement sustainable public health measures. In turn, FPH supports the recommendation that long-and short-term service transformation and national funding increases are needed for social care, against a backdrop of chronic underfunding.

Alarmingly, the inquiry reports the absence of a long-term strategy to secure an appropriately skilled, trained and committed workforce. Public health specialist cuts have meant loss of experts who can help ensure efficient use of NHS resources.

> **Public health specialist cuts have meant loss of experts who can help ensure efficient use of NHS resources**

Finally, while recognition of the impact of the obesity crisis and calls for a nationwide obesity campaign are welcome, focus on individual responsibility must not detract from strong, upstream action.

Read FPH's inquiry response at http://bit.ly/2okfxhs.

**Mark Weiss**

# News in brief

**NHS Scotland to fund Prep HIV drug**
A "game-changing" drug which dramatically reduces the chances of being infected with HIV is to be made available on the NHS in Scotland. The Scottish Medicines Consortium has agreed to approve the treatment, known as Prep. Scotland will be the first place in the UK to routinely offer Prep to eligible patients.

**Smoke alarms 'fail to wake children'**
Forensic scientists and fire investigators have warned that smoke alarms may not wake children. Research by Dundee University and Derbyshire Fire and Rescue found that of 34 children tested, 27 repeatedly slept through smoke detector alarms. They have developed an alarm with a lower pitch and a woman's voice.

**France bans unlimited drink refills**
Restaurants and other spaces catering to the public in France have been banned from offering unlimited sugary drinks in an effort to reduce obesity. It is now illegal to sell unlimited soft drinks at a fixed price or offer them unlimited for free.

**Teen pregnancies at record low**
Fewer teenagers are getting pregnant than ever before in England and Wales. Among under-18s, the conception rate has halved in eight years, to 21 per 1,000 women in 2015, data from the Office for National Statistics shows.

**We value your views on *Public Health Today***
We would very much value your input on what's good about *Public Health Today* and how it can be improved. If you haven't already received our online questionnaire by email and completed it, please go to https://www.surveymonkey.co.uk/r/XYYH3 3K The survey will take about 10 minutes to complete.

**Correction**
In the December 2016 edition of *Public Health Today* we published an article headlined 'We have a duty to share what we know' as part of the debate on page 8 with the byline Jo Dunne. We would like to make it clear that it was in fact written by Kevin Fenton, Director of Health and Wellbeing, and Sheila Mitchell, Director of Marketing, Public Health England. Apologies.

INTERVIEW

Helen Donovan is the Royal College of Nursing (RCN) Professional Leader for Public Health. She has had a wide breadth of experience including general nursing, midwifery, practice nursing, health visiting and specialist health protection. Here she tells *Public Health Today* how nurses are able to spot how health needs impact on all areas of life

UNIQUE: Nurse Swan on duty for the West Sussex County Nursing Association, 1931 © RCN Archive

# ‘Let’s make every contact count’

## And then let’s measure it, says Helen

**How does public health nursing differ from other kinds of nursing?**
In some ways there is no difference. All nursing should be about improving the health of the population. In my role, I support nurses in very specific, specialist areas of public health, for example occupational health, sexual health, tuberculosis, immunisation and health protection, but my role is also about reminding all nurses of their responsibility in improving health, so that they are making every contact count. So for example, if you’ve got somebody who is pregnant and they smoke, how do you help them stop smoking? It’s about using those opportunities to have the more classical public health conversation.

**How did you get into public health nursing?**
My career has been quite varied and I suppose that’s one of the reasons why I came into it. When I first qualified as a nurse I was very interested in the health promotion angle rather than any specific disease area. That was what tempted me to think about becoming a health visitor. In the late 1980s, it was still seen that it was better to do midwifery first, and then go into health visiting which is what I did. I then spent a bit of time as a practice nurse, but I always felt, through all of those roles, that public health came into it – health promotion and supporting people to adopt a healthier lifestyle as well as immunisation.

**What are the biggest challenges currently facing public health nursing?**
For me I think there are two things. The first is the way services are delivered. While the move in England to local authorities has opened up an awful lot of opportunities to think about the bigger picture, for a nurse working in drug and alcohol, sexual health, smoking cessation services, and so on, it’s not always clear where your supervision and clinical governance comes from. There’s also a sense for nurses working in those areas that they don’t have the necessary professional support and they could lose their professional identity.

The other challenge is being able to justify the cost spend. At the moment we are facing huge pressures in acute services and A&E, so the prevention agenda, while it makes perfect sense, becomes very difficult because the question is: How is that going to be paid for? Most of us would agree that, if we could do it, it probably would save money, but these savings would be quite a long way down the line.

**How can FPH members help with those challenges?**
One thing that might work in the future would be better alignment of public health nursing qualifications with public health practitioner and specialist qualifications – how a public health nurse can use those skills to move up to become a specialist. The Public Health Skills and Knowledge Framework may help, but I don’t think we’re quite there yet. I feel that public health nursing has developed almost in parallel to other public health disciplines.. So I’d like to see directors of public health and consultants see the values in the workforce that they’ve got and maybe have placements for nurses within public health teams in the same way medical training does. What’s the USP of being a nurse? It’s being able to deliver high quality evidence-based care to individuals or to populations. They are not the only professional healthcare group that can do that but they are the biggest. They are also unique in having a good overall knowledge of how different services align and link, so it’s about recognising those skills when services are being set up.

**What achievements are you most proud of?**
At the RCN, I was very proud of last year’s report *Nurses 4 public health. The value and contribution of nursing to public health in the UK*. It helped put public health nursing on the map and gave a real entity to it. I’m also very proud of the public health nursing exhibition [*A Healthful Form of Work: The history of public health nursing*]. I worked in Haringey as immunisation lead and worked across north central London and managed to improve the rates of immunisation reported which was very satisfying. I’m still involved in training and education for immunisation, developing with colleagues at Public Health England a revised e-learning resource.

> **We measure satisfaction – people say they value the service – but do they actually change the way they behave?**

**Tell us more about the history of public health nursing exhibition**
It came about really as an adjunct to the report *Nurses 4 public health*. It is about the value and contribution of nursing to public health in the UK. Chief Medical Officer Sally Davies wrote an article about the waves of public health – healthy water and sanitation, vaccines and antibiotics, the Beveridge Report and improving peoples lot, then moving to the fifth wave, the social movement for health, place-based approaches – all of those things resonated with me in designing this exhibition and seeing how nursing has developed over those areas. We have a big nursing archive at the RCN, and we were able to relate those elements to various fields of nursing. So, it is about how healthcare changes, and how nurses in particular have often got the skills to see a person as a whole and see how they fit within their society rather than just as an isolated health need or problem; it’s how that health need impacts on other areas of life, and how those other areas of life need to be managed in order for them to cope.

**What has been the biggest single challenge of your own professional life?**
When I think back over my career, particularly as a health visitor, I think, “I wished we’d measured better.” I was involved after a particular vaccine-scare incident; it was around MMR where quality and safety issues came to light with one of the services providing single vaccines. As a team we had to ring people and give them advice. It took 10-15 minutes of my time to listen to people’s fears and give them advice, and they would say, “I wish someone had told me that at before.” But we really didn’t measure how many contacts we made and how many people were reassured to have the MMR vaccine. Another example was a piece of work I did with some travellers – improving access and giving some good basic health promotion advice – and again we didn’t really measure the outputs. I know I’m not alone in that; we measure satisfaction – people say they value the service – but do they actually change the way they behave? Do they change their exercise routine? Even if we’d been able to say that, over a six-month period, they’d exercised more, bought more fruit and vegetables or lost weight , it would have been very useful. If we’d been better at collating data 30 years ago, we’d have more data now to prove the value.

**Is there anything that keeps you awake at night?**
At the moment it’s the problem of getting the prevention agenda into the debate about real cost saving and stopping people using hospital services.

**Interview by Richard Allen**

*A Healthful Form of Work will be at the RCN Edinburgh from May 3*

*RCN members can now join the Faculty of Public Health as Practitioner members at a reduced rate. For more information, go to www.fph.org.uk/fph_practitioners*

# Rising or turning?

Childhood obesity is one of the most challenging issues facing us today – but there are signs that things are improving, says Alan Maryon-Davis

"CHILDREN'S sugar intake equals five doughnuts a day." Recent headline in the *Guardian*. Similar splashes in other papers. Great coverage for the Obesity Health Alliance, a pressure group which includes our faculty. Helping to keep childhood obesity at the top of the public health agenda.

In England about one child in three is now overweight or obese – for Year 6 children up by over eight per cent since 2006/07. Faced with this rising tide the government has moved its deckchair further up the beach. Last August it eased back its ambition from "reversing the upward trend by 2020" to "significantly reduce the rate of England's childhood obesity within the next ten years".

There does seem to be a glimmer of hope. The upward trend does show signs of slowing, and among younger children the rate has been more or less flat-lining in recent years, but the overall problem is stubbornly persistent despite huge efforts, particularly by the public health community.

The toughest nut to crack is the stark divide between the haves and have-nots – an issue highlighted in this magazine's centre-page infographic. Broadly speaking, children from the most deprived households are about twice as likely to be overweight or obese as the least deprived children. And, crucially, this deprivation gap is steadily widening.

> **The toughest nut to crack is the stark divide between the haves and have-nots**

Much of the blame can be directed at the food industry with its heavy marketing of high-fat, high-sugar snacks and sweets, sugary drinks, ready meals and deep-fried takeaways. Wall-to-wall cheap calories – instant childhood chubbiness. And the prime target is young low-income families.

To counteract this onslaught, much hope was pinned on the government's long-awaited national childhood obesity strategy – which finally landed last August as a somewhat truncated *Plan for Action*. It reiterated the Chancellor of the Exchequer's promise of a levy on sugary drinks. It reaffirmed the voluntary programme for the food industry to cut sugar content by 20 per cent by 2020. It talked about more financial support for schemes encouraging physical activity in schools and the community. But, as one of our articles describes, the big stick the health lobby had confidently expected – a ban on junk food-and-drink TV ads before the 9pm watershed to protect the millions of children watching such shows as *The X Factor* and *The Voice* – was crushingly absent.

Nevertheless, lots of good things are happening – as you'll find in the following pages – and there are encouraging signs that the landscape really is changing. The levy on sugary drinks kicks in next April. There's a new voluntary code of restrictions on online junk food marketing through social media. And here's another recent headline to savour – this one from BBC News: "Kit Kat sugar content to be cut by 10%, says Nestle."

Sweet!

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





## Burden of obesity costs UK more than £27 billion per year

THE UK is rapidly reaching a crisis, with one in three children and two in three adults affected by obesity or overweight. The prevalence of obesity has increased steeply since the 1980s, first in the USA then in the UK and Europe.

Obesity generates a huge burden of premature death, disease, disability and reduced economic productivity. It increases the risk of acquiring many conditions, including Type 2 diabetes, heart disease, strokes, dementia and several cancers. This burden to society, especially deprived groups, costs the UK more than £27 billion per year. The UK government has now prioritised obesity, aiming to "significantly reduce England's rate of childhood obesity within the next ten years".

It is vital to provide adequate resources for treatments including behavioural and pharmacological approaches, multicomponent interventions and bariatric surgery. However, we only perform some 6,000 bariatric surgery procedures each year, yet more than one million people in the UK have a body mass index over 40. This population-wide obesity burden is thus likely to continue to worsen unless much more effective prevention strategies are rapidly implemented.

The existing evidence base is skewed towards the more easily evaluated individual-level interventions and says much less about more upstream responses, perpetuating the likelihood of what has been described as 'lifestyle drift' – we know we need to act at population level, but all too often we respond at individual level.

Furthermore, the 2007 UK government Foresight report emphasised the complexity of the problem of obesity and the importance of the 'obesogenic environment' – the wide availability of cheap, unhealthy food and the widespread obstacles to routine physical activity.

Happily, academics, government, charities, celebrities and the wider public are now increasingly contributing to the debate and supporting initiatives to promote healthier diets and regular physical activity. This debate is further fuelled by the international momentum generated by successful sugar-sweetened drinks taxes in many countries, and leadership from the World Health Organization on the importance of tackling industrial determinants of ill health.

The past decade has seen a number of UK policy initiatives, ranging from the Change4Life campaign to the Responsibility Deal with industry. However, despite these efforts the problem is getting worse, and more effective action is urgently needed. Furthermore, local councils attempting to tackle obesity are faced with unprecedented fiscal challenges.

We thus need a whole-system response which recognises the complex nature of obesity, incorporates upstream actions across society as well as targeted measures in schools, workplaces, and elsewhere, and pursues 'proportionate universalism' to address widespread social inequalities.

The recent evidence-based recommendations from the Parliamentary Health Committee include a sugary drinks tax, a junk-food marketing ban, reformulation, and decreases in portion size and promotions, plus support for local authorities and the wider public sector. The National Institute for Health and Care Excellence likewise recommends comprehensive pathways to obesity prevention and treatment extending from pre-school interventions, through bariatric surgery, to local environmental interventions.

The purveyors of unhealthy food impose their external costs on society. At the same time there is also a growing crisis of poor air quality on many of our streets. Tackling these and other problems jointly by addressing market failures within the food system and environmental failures within the transport system allows us to maximise health and environmental co-benefits, leading to a rebalancing in favour of healthier diets and safer, more appealing environments for physical activity. With these and other measures, at national, regional local and NHS levels, we can work together successfully to tackle this major public health challenge.

**Harry Rutter**
*Senior Clinical Research Fellow*
*London School of Hygiene & Tropical Medicine*
**Simon Capewell**
*Vice President for Policy*
*Faculty of Public Health*

## This is not just a developed-world problem

FOR the first time ever, the world's leaders gathered at the United Nations to discuss the challenge of non-communicable diseases (NCDs) in 2011. Among the risk factors for NCDs of particular concern was the rapid rise in prevalence of obesity in infants, children and adolescents.

Worldwide, the prevalence of overweight and obesity combined rose by 47.1 per cent for children between 1980 and 2013, and the problem is not confined to high-income countries. Three-quarters of the 41 million children under five who are overweight or obese live in Asia and Africa. If current trends continue, overweight or obese infants and children globally will number around 70 million by 2025.

Children with obesity may face immediate health problems, poorer educational attainment and lower quality of life. They are likely to remain obese as adults and are at risk of premature onset of illnesses, including diabetes and heart disease. In India, the 'diabesity epidemic' highlights that the issue is no longer just of fat children but of increasing rates of diabetes.

Despite the staggering increase in global prevalence, there is a lack of awareness of the challenges, especially in those developing countries also facing the burden of undernutrition. Chubby children in India are often referred to as healthy because they are not malnourished. And research suggests that China's burden of diabetes is probably exacerbated by its one-child policy, which translates into approximately 100 million first-borns whose status may be linked to an increased risk of obesity.

Increasing urbanisation has emerged as a key determinant by creating conditions for children to be less physically active and consume more unhealthy foods. The dietary changes are evident at any income level.

Tackling childhood obesity requires a whole-system and whole-society approach from encouraging breastfeeding to healthy urban planning that gives priority to the child. The 2016 report of the World Health Organization's Commission on Ending Childhood Obesity rightly reminds us of our obligation to act now to improve the health of future generations.

**Mala Rao**
*Professor & Senior Clinical Fellow*
*Department of Primary Care and Public Health*
*Imperial College London*

DEBATE: Is the 'fat letter' a useful way of combating obesity? Eustace De Sousa says most parents find it helpful, while Raheelah Ahmad and Fiona Sim say it is often confusing

## Parents need help seeing new reality

WITH childhood obesity rates in England reaching alarming rates, it's no surprise that overweight and obese have become the 'new normal.' This makes visually assessing a child's weight more difficult – which is why an objective measure like the National Child Measurement Programme (NCMP) is so helpful.

Through the NCMP, Reception (age 4-5 years) and Year-6 (age 10-11 years) children across England have their height and weight measured in all state schools, with over a million children participating every year.

The information allows us to know the levels of childhood obesity and what the trends are, so we can monitor changes and progress.

But many local authorities and schools also use the results to prompt action to tackle childhood obesity.

Results are shared with parents to signal that their child's weight requires attention and crucially also offer guidance for how to take some positive steps. For many, this will be the first time they have received independent information about their child's weight.

We're not hiding the fact that talking about a child's weight is a sensitive issue. However, it's this important information and the fact that there is a

**YES**

lot parents can do to support their child to achieve a healthy weight that makes the feedback so vital.

And we're not the only ones that see the benefit of the letters. Based on independent research, the majority (87%) of parents find the feedback helpful. Nearly three-quarters of parents also reported an intention to change lifestyle behaviours following the feedback.

The NCMP presents an opportunity to support health messages to children and parents and spur action towards a healthier lifestyle. Depending on which weight category the child falls into, the letters include information about the relevant associated health risks.

The NCMP result is a point in time – a useful 'check point' that also allows parents to monitor their child's growth via the NHS Healthy Weight Calculator.

A new web page on the Change4Life website has also been developed to allow parents and pupils to take charge of their own health and take action, which parents are directed to via the feedback letter.

We all know that obesity is difficult to reverse, so early identification and action will help us to create a healthier future for our children and wider society.

**Eustace De Sousa**
*National Lead for Children, Young People and Families*
*Public Health England*

## Making parents guilty or angry will not help

PROVIDING parents with information about their child's weight should be one step towards creating a better-informed public. But it is often received negatively by parents if they are sent unfamiliar graphical or technical information and told that their child's weight is outside the healthy range for their age. If their child is very overweight they may be signposted to local weight management interventions. Generating adversarial feelings of guilt or anger among parents is unlikely to be helpful in tackling the problem.

Through our training programme at Imperial College, CHALK (Creating Healthy Active Local Kids), together with research, we know that even professionals (health and non-health such as teachers) who work daily with children and families are often not fully aware of the relevance of the information that is shared with parents. Most do not have a clear understanding of how to interpret data about body mass index (BMI) in children and, for example, need to be informed that BMI is applied very differently in children compared to adults.

We found that health and other professionals are often ill-equipped to raise this sensitive issue with families and, without training, feel unable to deliver focused, brief intervention advice within their busy working schedules. Trying to make sense of

**NO**

the plethora of information and guidelines in the public domain is a burdensome task for even the most highly motivated.

While there are some examples of good practice with integrated services supporting the measurement programme, the Royal Society for Public Health found that only one in five parents said the information they received on their child's weight was useful. Surrounding media coverage is frequently unhelpful, supporting the misconception that parents can somehow 'tell by looking' if a child is overweight. When one in three 11-year-olds are overweight or obese, this belief risks creating a new and unhealthy norm.

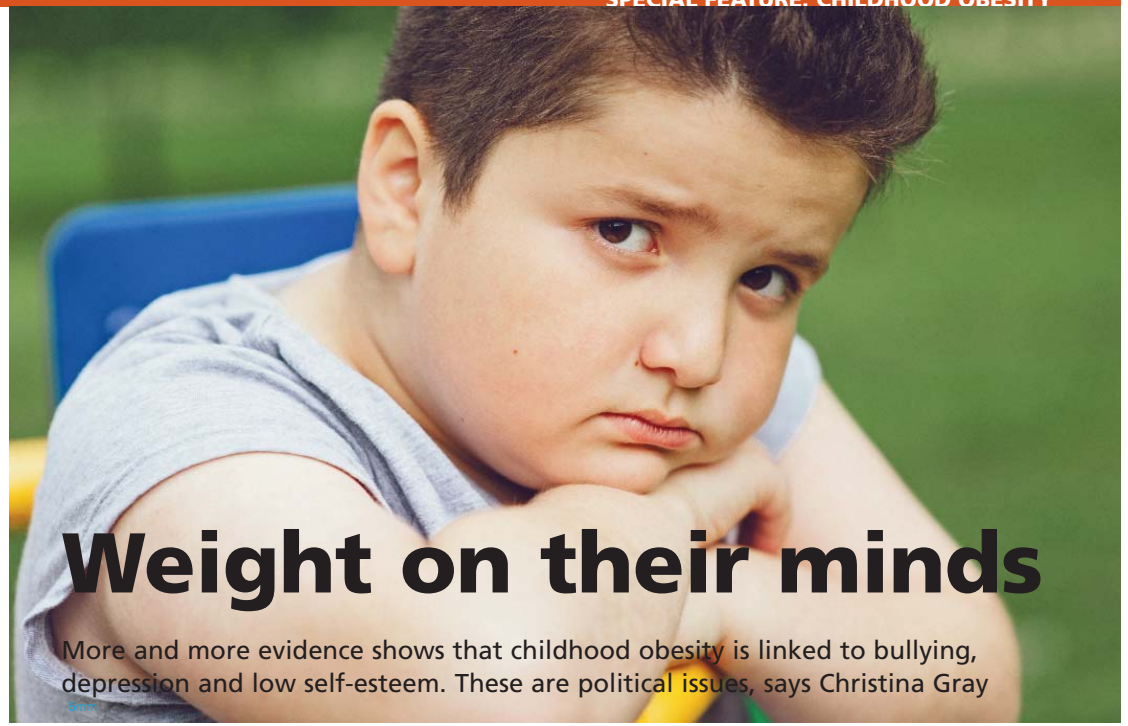
We note that the results of the National Child Measurement Programme (NCMP) are not integrated routinely with local health information systems; GPs have told us that they would benefit from having this information linked to their GP IT systems via local authorities. This would act as a prompt to raise the issue opportunistically.

Revisiting the so-called 'fat letter' with parental engagement and an evidence-based approach, joining up more smartly with national initiatives such as Change4Life, as well as ensuring that professionals who interact daily with families and children are equipped and resourced to offer effective brief interventions, are steps that could be taken without delay.

**Raheelah Ahmad**
*Programme Director*
*CHALK*
**Fiona Sim**
*Honorary Senior Lecturer*
*London School of Hygiene and Tropical Medicine*







# Weight on their minds

More and more evidence shows that childhood obesity is linked to bullying, depression and low self-esteem. These are political issues, says Christina Gray

SO, WE have an obesity 'epidemic' – a well-rehearsed public health problem defined as the spread of disease affecting many individuals at the same time. There are also loud whisperings of a 'mental health' epidemic, with around three children in every class estimated to be suffering from a mental health problem and an increase in incidence of self-harm. Enough evidence for Prime Minister Theresa May to champion the issue and public money to be allocated particularly for eating disorders. Coincidence?

To reverse the obesity epidemic, the focus has been on food intake and exercise. Oh, yes, and measurement. We can now hear from over the horizon, the gathering thunder of 'treatments' for childhood emotional trauma, alongside the development of (long overdue) metrics and measures for mental health.

In this disease-ridden discourse, might we have lost our way just a little in our tried and trusted disease models of measure, hypothesise, test, and re-test – seeking to understand the pathology and ultimately identify a 'cure' for these 21st century ills?

It is undeniably the case that unhealthy weight is associated with increased risks of type 2 diabetes, cardiovascular disease and cancer. It is also the case that poor mental health is strongly associated with long-term physical health conditions and lower life expectancy.

However, healthy weight, like healthy mind, is also a social issue. There is increasing evidence linking low self-esteem, bullying and depression in children with obesity, body image and size. The social gradients for both healthy weight and healthy minds tell us that these are also political issues. The National Obesity Observatory (now part of Public Health England) reports that obesity prevalence of

> **'In this disease-ridden discourse, might we have lost our way just a little?'**

the most deprived 10% of the population is approximately twice that of the least deprived 10%. At the same time, 72% of children in care are estimated to have behavioural or emotional problems and 95% of imprisoned young offenders at least one mental health disorder.

The precise nature of the relationships between the social, psychological and behavioural aspects of obesity and mental health are not yet well understood. However, resilience (defined as the process of coping positively with adversity and change) has been found to be a protective factor for both mental health and obesity. So why are we persisting in an individual, behavioural approach which by its very nature blames, shames and undermines our children, young people and parents? Not intentionally, not directly, but implicitly – ably supported by all the images of perfect people and perfect lives which surround children every minute of every day. Tricky stuff.

For inspiration, go and watch Dawn French in her new one-woman show. Here, as she has done before, she talks openly about her weight, how the love of her family, and in particular her father, set the foundation for her positive sense of self in the world. How his unexpected death by suicide tested her personal resilience beyond imagining and finally, how an understanding of the serious health implications of her adult weight led to her recent planned weight loss. Dawn French embraces herself and her body in a glorious celebration of humour, honesty and healthy self-reflection.

What a wonderful public health aspiration that would be.

**Christina Gray**
*Chair*
*Public Mental Health Special Interest Group*
*Faculty of Public Health*


# The world is watching UK change its recipe

CHILDHOOD obesity is major public health problem in the UK, which is almost entirely due to the food environment. Sugar is being consumed in excessive amounts and this is leading to obesity.

Current intakes of sugar exceed recommendations in all age groups, but particularly in children and teenagers. Sugar reformulation has been recommended by Public Health England (PHE), the House of Commons Health Select Committee, the Obesity Health Alliance and Action on Sugar as one of the most cost-effective solutions to obesity, similar to the successful UK salt reduction programme. The latter worked by setting targets to achieve a 40% reduction of salt in the nation's diets, gradually, with small incremental reductions of 5-15% every 2-3 years. Targets were set based on what was technically achievable by category, meaning some targets were much lower than others. Salt intakes fell by 15% from 2000 to 2011, with a predicted saving of almost 9,000 lives a year from strokes and heart attacks and £1.5 billion in healthcare costs every year.

A similar programme for sugar is predicted to work just as well. The government published *Childhood Obesity: A Plan For Action* in August 2016 and asked manufacturers to reduce sugar by 20% by 2020 in each of the nine categories that contribute the most sugar in children's diets. This was to be done through reformulation and also by reducing portion size and promoting the lower-sugar options. Product research by Action on Sugar shows that reductions of at least 30% can be made without technical issues and that manufacturers should gradually work towards a reduction of at least 20%. The sugar reduction programme will exclude soft drinks, since they are covered by the Soft Drinks Industry Levy.

> **The challenge will be the resistance from manufacturers who do not engage with government-led programmes**

The challenge will be the resistance from manufacturers who do not engage with government-led programmes. Unlike the levy, this is voluntary. There is no major disincentive for manufacturers who choose not to participate in the programme. In the absence of a level playing field, many retailers have called for regulation. PHE hopes to overcome this shortfall by monitoring and reporting on progress every six months.

The UK is leading the world by setting these targets across such a wide range of categories. Many countries will be looking to follow our example, so it is vital we succeed. The cost savings and the impact on children's health and wellbeing from a successful sugar reduction programme will be immense.

**Kawther Hashem**
*Registered Nutritionist*
*Action on Sugar*

# Welsh study highlights physical activity

AS PART of my specialty training I undertook a study using the Welsh Health Survey data from 2008 to 2013 to determine which risk factors were associated with childhood obesity.

The analysis used a large data set of 11,279 children aged 4-15. Variables were considered in two groups: socio-demographic/socio-economic factors (limited ability to change these factors) and lifestyle variables (potential to change these factors). The socio-demographic and socio-economic factors included sex, age, Welsh Index of Multiple Deprivation quintile, National Statistics Socio-Economic Classification and housing tenure. The lifestyle variables considered as potential risk factors for obesity included consumption of sugar-sweetened beverages daily, unhealthy food consumption (ie. eating crisps, chips, sweets or chocolate daily) and meeting the physical activity guideline of an hour of physical activity daily. In addition, the child's health status was considered (number of currently treated illnesses).

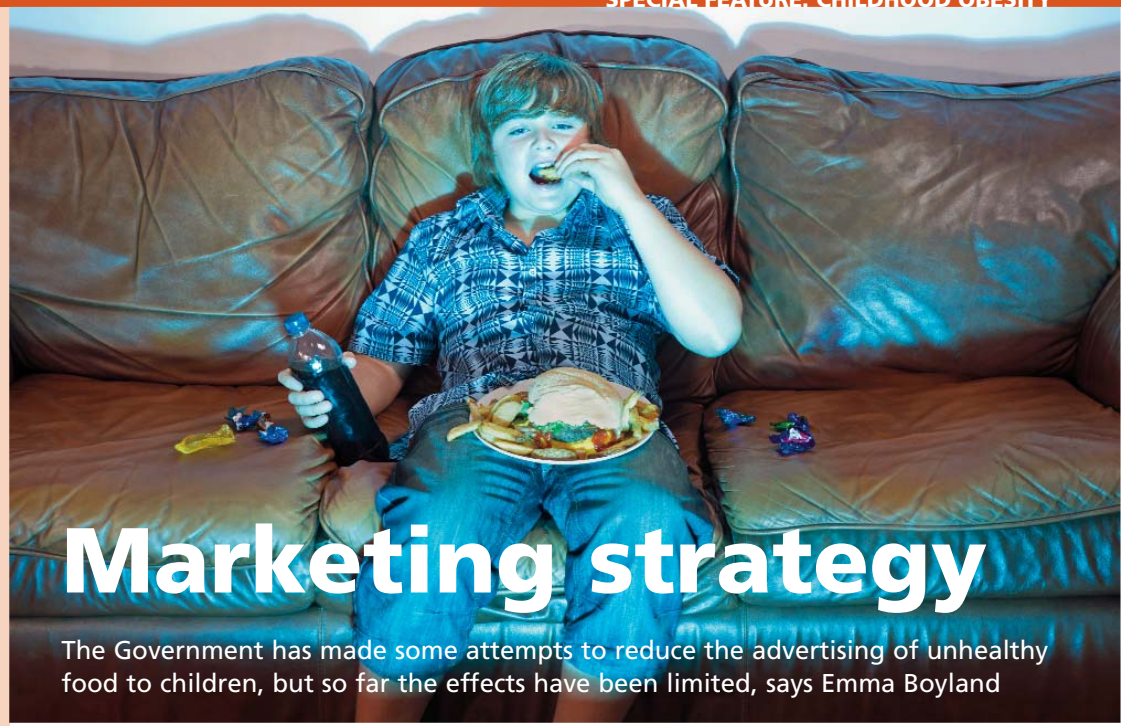
A total of 1,582 children (19.6%) were obese. The most important modifiable risk factor was physical activity. There was a 33% increased risk of obesity for children who did not meet the physical activity recommendation of an hour's activity per day. There is a strong evidence base that being physically active protects against obesity, and this study helps to reiterate the importance of every child meeting the physical activity recommendations. Public Health Specialists and Practitioners involved with commissioning and planning physical activity for children should recognise that this is essential to addressing the preventive agenda and reducing obesity in the future.

The study also found an association with a currently treated illness: 20% increase in risk of obesity for children with one treated illness, and 50% increase in risk of obesity for children with two or more treated illnesses. So another recommendation from this study is that children with an illness should receive a holistic care plan that not only addresses the illness but also helps children prevent or manage obesity.

To see the *Lancet* abstract go to https://tinyurl.com/j4yfrf6

**Claire Beynon**
*Specialty Registrar*
*Public Health Wales*





# Marketing strategy

The Government has made some attempts to reduce the advertising of unhealthy food to children, but so far the effects have been limited, says Emma Boyland

AN INCREASING body of scientific evidence exists to demonstrate the effects of exposure to food advertising on children's food preferences, brand preferences, product requests, food consumption, overall caloric intake, reduced intake of fruits and vegetables over time, and higher rates of obesity.

There is high-level political commitment from the World Health Organization and others towards taking action on this issue. Accordingly, a number of regulatory approaches to tackling the marketing of foods and drinks high in fat, sugar and sodium (HFSS) to young people have been attempted across Europe, including statutory regulation and industry self-regulation (such as the EU Pledge), but overall policy progress has been slow and of questionable effectiveness.

In 2007, the UK brought in statutory legislation specifically to address food marketing to children, with the stated aim of "limiting the exposure of children to HFSS advertising on television, as a means of reducing opportunities to persuade children to demand and consume HFSS products". HFSS advertising was banned in and around programmes of particular appeal to children under 16 years. Ofcom, the UK broadcast regulator, reported that children saw 34% less HFSS advertising following the regulations. However, academic evaluations suggest that reductions in exposure are limited to dedicated children's programming (where children actually spend a small minority of their viewing time) or have not occurred at all; one study found that relative exposure to HFSS advertising had actually increased post-regulation.

A government inquiry into childhood obesity last year recommended strengthened controls on the marketing of unhealthy foods and beverages to children, specifically suggesting a 9pm watershed. However, this recommendation did not then feature in the Government's subsequent Childhood Obesity Plan, which repeatedly referred to "economic realities" – code words for industry lobbying, perhaps. Nevertheless, the UK's Committee on Advertising Practice announced new rules late last year that are intended to bring the regulations regarding HFSS marketing within non-broadcast media more in line with those that govern television advertising.

One issue that undermines both of these regulatory approaches is the use of audience thresholds. This way, a programme with an audience that is 20% children can be exempt from the regulations – yet for popular Saturday night entertainment shows, websites or blogs this can still mean five million children being exposed to HFSS food marketing. Furthermore, even with the television regulations in place, fast food advertising has not reduced; it now simply increasingly depicts healthier items (eg. a bottle of water and a bag of fruit alongside the main item, instead of French fries and a soft drink). This kind of advertising has been shown to increase desire for fast food, rather than drive healthier choices.

Government and industry bodies maintain that further policy action is not necessary as they deem there to be a lack of data to demonstrate a direct link between HFSS marketing exposure and unhealthy changes in childhood body weight. But the literature to date suggests that rather than a simple, direct link between food marketing exposure and obesity, there exists a logical sequence or 'hierarchy of effects' linking food promotion exposure to individual-level weight outcomes that will not be picked up in the kind of experimental trials that are possible. An abundance of evidence already supports strengthening of regulations to reduce this unhealthy influence on children's eating behaviours and long-term health. What is lacking is the political will to act on it.

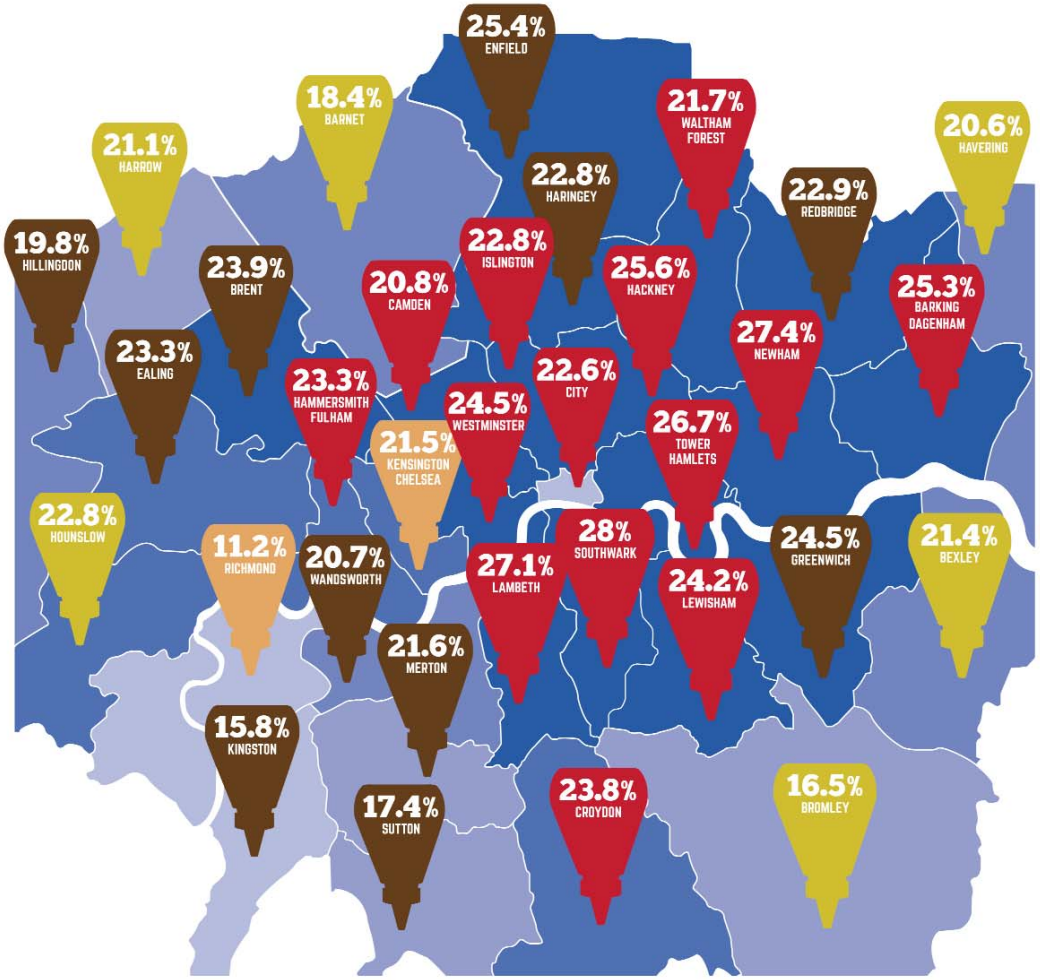
**Emma Boyland**
*Lecturer in Appetite and Obesity*
*University of Liverpool*

# FAST FED CHILDREN

ual: london college of communication

Designed by Lauren Vaughan
BA (Hons) Graphic and Media Design

FACULTY OF PUBLIC HEALTH




This map of London shows the rates of obesity among children in Year 6 (aged 10/11) together with the density of fast food outlets and the relative levels of income deprivation in each borough. There appears to be a correlation between income deprivation and the density of fast food outlets in line with national data shown in the scatter plot opposite. The boroughs with the more severe income deprivation tend to have a higher density of fast food outlets. The map also supports the well-established link between relative deprivation and levels of childhood obesity.

**Percentage of obese children in year 6 (2014/15)**

BOROUGH

www.phe.gov.uk

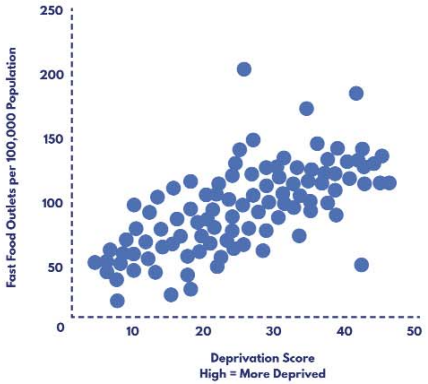
**Fast Food Outlets per 100,000 population**


www.phe.gov.uk

**Income Deprivation Affecting Children 2015**


www.dclg.gov.uk

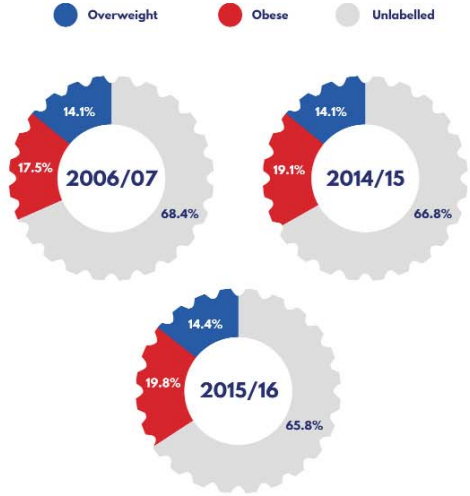
## Fast food outlets and deprivation




In deprived areas, it can be extremely easy for children to access fast food outlets as not only are they ubiquitous, they are affordable, appetizing and energy-dense. This scatter plot illustrates the strong correlation between deprivation and fast food outlet density across England (2014). Fast-food outlets include three categories combined: fast food and takeaway outlets, fast food delivery services and fish and chip shops.

www.phe.gov.uk

## Prevalence of overweight and obesity among Year 6 children in England

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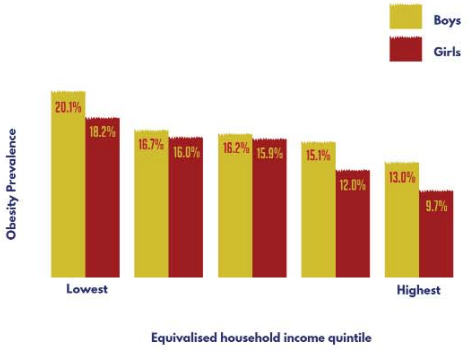
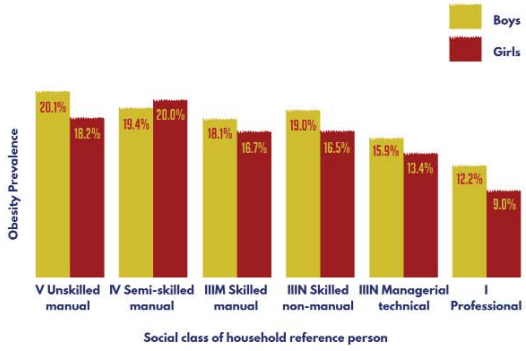
## Obesity among children 2-15 years by household income (2008-11)



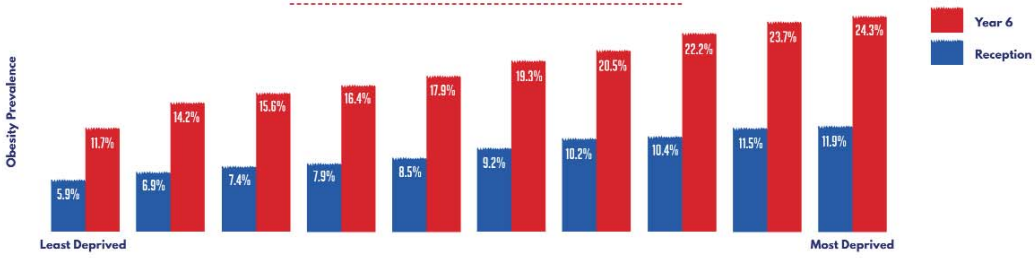

Health Survey for England

## Obesity among children 2-15 years by social class (2005-09)




Health Survey for England

## Prevalence of obesity in children by school year, by income deprivation affecting children 2010




www.dclg.gov.uk
www.phe.gov.uk

# Street wise

Children who can walk, cycle or play in the street have better development, so they need protection from traffic, say Shaun Scholes and Jenny Mindell

OBESITY reflects the combination of excessive intake of calories and insufficient activity. Regular physical activity for children is critical for reduced body fat, as well as improved bone and muscle strength, motor development, psychosocial health and cardiometabolic health. It can also instil lifelong healthy habits.

Only 9% of children aged two to four have at least three hours per day of reported activity (although questionnaires substantially under-report physical activity in young children). Only 22% of children aged five to 15 were moderately active for at least one hour every day. Accelerometer data collected within the UK National Diet and Nutrition Survey showed that boys were more active than girls and that activity levels fell with age, particularly among girls.

The obesogenic environment in the UK, where children are exposed to marketing and sales of large portions of energy-dense, high calorie foods and drinks while streets remain designed primarily for cars, militates against children consuming a healthy diet or being active in their daily life. Active travel represents an important potential source of periodic physical activity for children and is generally considered fun. However, only three in four children aged two to 15 attending school or pre-school activities in England had walked there or back on at least one day in the last week; only 3% had cycled at least once. Bikeability training can reduce ethnic and socio-economic inequalities in cycling.

Active play is an important type of informal physical activity, especially among pre-school and primary school children. An increasing number of national and local organisations exist to promote active play.

Children's cognitive development, mental health and awareness of their local environment is closely related to their travel mode and their 'freedoms'. Children who are allowed to walk, cycle or play in the street have better development; these activities are more likely where the local infrastructure protects children from exposure to large volumes of fast traffic. It is important that the urban environment is designed to allow this, with a focus on 'liveable streets', 'complete streets', or 'healthy streets'. Homezones are 10mph areas where social use of the street takes priority over through traffic. They allow active play outside, associated with lower obesity risk. Slower speed limits in residential streets, Safe Routes to School, segregated cycle lanes, and enforcement of speed limits can all help create an environment in which children are allowed to be independent and active.

> **Children's cognitive development is closely related to their travel mode**

In the longer term, land use planning must embrace mixed use, with more potential destinations being within walking or cycling distance. Inverting the traditional hierarchy, so that infrastructure provision and maintenance for pedestrians is foremost, followed by cyclists, with private motor vehicles at the bottom of the hierarchy, could enhance the public's health overall as well as improving children's physical and mental health.

Public transport is also increasingly included as 'active travel', as most people walk (or cycle) at one or both ends of the journey. Investing in public transport rather than subsidising car drivers (whose impacts on the environment and population health outweigh the taxes contributed) is another strand of a comprehensive strategy to tackle childhood obesity and reduce inequalities.

**Shaun Scholes**
*Research Associate*
**Jenny Mindell**
*Reader in Public Health*
*Research Department of Epidemiology and Public Health*
*University College London*





# We may need help to fight our own biology

THE study of human genetics has illuminated the biological component of obesity in the past few years and clearly shows that it's a lot more complicated than simply choosing to eat less and move more. This role for genetics may seem surprising given that our genetic makeup has not changed much in the past 50 years. However, there's a large amount of evidence that genetic factors have a strong role to play in determining where you lie on the body mass index (BMI) scale in the modern environment.

Twin studies consistently show that the BMIs of identical twins are more similar than the BMIs of same-sex non-identical twins. For example, a contemporary study of more than 5,000 UK twins showed that at the age of nine the estimated genetic component to variation in BMI was 77%. The BMIs of sibling pairs that share 60% of their genomes are more similar than the BMIs of sibling pairs that share 40% of their genomes. Siblings share 50% of their parental DNA code on average, but by chance some of us share more and some less of our parental DNA with our brothers and sisters. Genetic assays that measure a large proportion of variation across the genome can quantify the amount of parental DNA we share with our siblings, and it is then a simple task to correlate that percentage with the BMI difference. These studies have estimated the heritable component to BMI at 40%, although there are wide confidence intervals on this estimate.

In rare cases, a specific DNA change can cause very early onset overeating and severe obesity. Mutations in genes affecting satiety, including the MCR4, leptin and POMC genes, all cause severe forms of obesity and have highlighted the role of the hypothalamus in the control of satiety.

Whole-genome studies of 250,000 people have identified 97 variants in our DNA code associated with BMI. These effects are subtle, but provide definitive evidence that genetic variation influences BMI. Studies of the genetics of body fat distribution show that obesity and its adverse health effects are not just about extra fat, but where you put it. Some common DNA changes (alleles) are associated with higher fat percentage but a lower risk of type-2 diabetes, hypertension and blood pressure. These alleles preferentially place the extra fat in the lower body or subcutaneously (under the skin) rather than viscerally.

What does this increased understanding of obesity biology mean for UK children? Possibly the most important point is the message it will send to policy-makers: there is a strong biological component to where people lie on the BMI scale, and it's not all down to better education and conscious decision-making. The world around us is inadvertently designed to make us fatter, and some people's biology will mean they will put on weight at a greater rate than others.

This biological component means tackling the obesogenic environment is likely to be crucial. If a bar of chocolate is sold in the same-size packaging but has fewer calories – as has recently been done with Toblerone – it may help by reducing the need to consciously fight our biology.

**Tim Frayling**
*Professor of Human Genetics*
*University of Exeter Medical School*

# How Brighton started to tax its sweet tooth

SUGAR Smart Brighton & Hove started as a city-wide public health debate in 2015. We were keen to raise awareness of the fact that we are all consuming too much sugary food and drink, and to ask residents, food outlets and schools whether we should be taking action and, if so, what. Sugar Smart commitments that cafes, restaurants, takeaways and other food outlets could choose to take up ranged from offering water as an alternative to sugary drinks, changing menus, recipes and price promotions, to introducing a voluntary sugary drinks tax.

When first discussing a specific question to debate we had considered asking residents whether we should introduce a sugar tax or levy, but this was considered too sensitive politically. We decided to contact Jamie Oliver to see if he would be interested in raising the profile of a local and very low-budget debate and were delighted that his Food Foundation were keen to go into partnership with us whilst they campaigned nationally for a sugar tax.

Our debate and voluntary tax introduction helped generate a lot of discussion locally and nationally. More than 1,100 residents and 130 food businesses responded to a survey with more than 80% saying we should be taking action and providing more detailed feedback on what we should do and how.

But nothing got everyone talking about sugar more than the sugar-tax issue. How did it work in the city? A few independent smaller businesses, a few chains, the University of Brighton and Sussex Cricket Club chose to introduce a levy. Meanwhile, we carried on with our work in primary schools, leisure centres, hospitals, at events and across the city.

In March 2016 the budget announcement that a national sugary drinks tax would be introduced surprised us all, and even before the end of 2016 some of our popular drinks brands were being reformulated with reduced sugar.

The sugar tax question gave our debate a reach we could never have dreamed of, or paid for. And, 15 months on, Sugar Smart Brighton & Hove is still evolving with new work in secondary schools on the horizon.

**Katie Cuming**
*Consultant in Public Health*
*Brighton & Hove City Council*

# Many hands are making lite work

IN 2015, 17 health-focused organisations came together to discuss how they could work together more closely to prevent obesity. Just 18 months later, 38 organisations representing more than a million members are involved in this collaboration.

The Obesity Health Alliance (OHA) is led by a central steering group of nine organisations including the Faculty of Public Health. The alliance's strategy, once agreed, is implemented by three specialist sub-groups focusing on evidence-based policy, public affairs and communications (led by Diabetes UK). A dedicated manager coordinates activity across the steering group and members.

OHA members collectively agreed on 10 key interventions for tackling obesity and then prioritised three for initial action: a sugary drinks tax; reformulation of everyday foods to reduce sugar, salt and saturated fat; and restrictions to protect children from junk-food marketing. We have subsequently seen progress on all three.

First advocated by Action on Sugar in 2014, OHA and its members, including Jamie Oliver and his Food Foundation, pushed this evidence-based intervention hard with policy makers, journalists and the wider public. In March 2016, the Chancellor of the Exchequer announced the Sugary Drinks Industry Levy, a charge on sugar content which was designed to encourage soft drinks manufacturers to reformulate their products. This was a major step forward. Several high-profile drinks companies announced immediate reductions in the sugar content of their products, well before the levy commences in 2018. The estimated £500 million revenue raised will be invested in school sports and breakfast clubs.

> **Food marketing powerfully influences children's food preferences, purchasing behaviour, and consumption**

Public Health England (PHE) is working with industry to substantially reduce the sugar content across nine categories of foods commonly eaten by children (see accompanying article by Alison Tedstone). The challenging yet achievable target is to reduce sugar content by 20% in five years. It is early days for the programme. OHA and its members will therefore be carefully scrutinising and commenting on the data to be released regularly by PHE, in order to champion progress made by industry leaders and identify laggards.

Food marketing powerfully influences children's food preferences, purchasing behaviour, and consumption. Current Ofcom regulations already apply to children's TV programmes, banning adverts for unhealthy food and drinks. However, children are still heavily exposed because more than 60% of their total TV viewing takes place in adult airtime, peaking between 7 and 8pm. Despite strong campaigning from OHA and its members,

this loophole was not addressed in the 2016 Child Obesity Plan.

Children are also deluged by adverts for sweets, sugary drinks and fat-laden foods online, on packaging, in cinemas and in street advertising. After years of campaigning by numerous groups including OHA, in December 2016 the Committee on Advertising Practice announced a ban on adverts for high fat, sugar, salt products targeting children in the non-broadcast media. This progress brings non-broadcast advertising in line with the rules for TV and represents a good start. But it does not go far enough. Many loopholes remain, and this will be targeted by OHA and members in 2017.

OHA can now be counted with the Smokefree Action Coalition, Alcohol Health Alliance and the UK Health Alliance on Climate Change as a further example of collective action successfully improving the current and future health of our families and wider communities.

**Caroline Cerny**
*Policy Manager*
*Obesity Health Alliance*
**Simon Capewell**
*Vice President for Policy*
*Faculty of Public Health*

# Working to cut a fifth of sugar from kids' food

WITH more than one in five children starting primary school overweight or obese, and more than a third by the time they leave, the urgent need to tackle childhood obesity is no longer up for debate.

What is worse is that these figures are a sad predictor of what is to come. Unlike any other major global health risks, the prevalence of obesity is not decreasing and obesity in childhood is a robust predictor of obesity in adulthood.

Fuelling the problem is the abundance of cheap, easily accessible food when out and about. Our National Diet and Nutrition Survey shows that 18% of meals were eaten out of the home in 2015, up 5% on 2014. The fact that more than a fifth of adults (21.1%) and children (21.0%) eat take-away meals at home at least once a week makes for even worse reading.

A British Social Attitudes survey on obesity found 91% believed cheap fast food is too readily available. The same survey found 49% believed unhealthy snacks should be made smaller, compared to 28% who opposed this and 23% who had no view.

Public Health England is working with all sectors of the food and drink industry to meet the challenge of taking out 20% of sugar in everyday products by 2020, as outlined in the government's *Childhood Obesity Plan*.

The programme will initially focus on the nine categories that make the largest contributions to children's sugar intakes: breakfast cereals, yoghurts, biscuits, cakes, confectionery, morning goods (for example, pastries), puddings, ice cream and sweet spreads.

While still in the early stages of the programme, we have already held more than 40 individual meetings and nine product category meetings with industry. We will be publishing proposed targets alongside benchmarks for each product category. And we will be ensuring that the programme is closely and transparently monitored and that progress is openly reported.

But it is important that we're all playing our part in this. Creating demand for lower-sugar products is one thing we all can do. Are you demanding healthy food procurement and catering standards for your organisation?

**Alison Tedstone**
*Chief Nutritionist*
*Public Health England*





# How not to make a drama out of a crisis

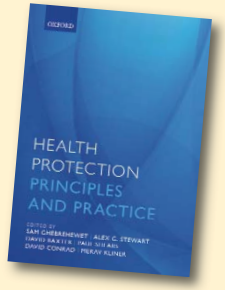
LONDON, late afternoon, Friday. As health protection lead, you take the call: terrorists disguised as marmots have set fire to a warehouse containing asbestos, acrylonitrile and rubber Donald Trump masks, and toxic smoke drifts towards a blues harmonica concert on the South Bank. Simultaneously, an outbreak of explosive d&v has struck 300 attendees at an international congress on fruit bat neurophysiology, many of whom are now reeling back to their hotels via the Central Line. You also have urgent briefings to finish for your local authority on meningitis and multi-resistant infections.

Many would quail. You, however, casually mix an alcohol-free vodka martini, adopt a smug expression and pick up the 'phone...

How so cool in the face of health threats and unpronounceable diseases? It is simple: you have this book. It is a comprehensive, clear guide to everything you need to know and do, across dozens of health protection scenarios. It starts with key principles and practice. Then brief guides: who does what, what it involves, and diagrams to show integrated responses. The section on the basics of infection microbiology is clear, with lots of helpful tables and a useful summary of action areas. Then there are the chapters on individual infectious disease control scenarios from E coli 0157 to TB, each following a really practical format: overview, terms, background, clinical symptoms, epidemiology, risk factors for the infection, tools of the trade, what immediate action would you take? This is exactly what you need when you quickly have to respond. And it's thorough, so it's ideal not just for formulating your response, but excellent as a check list, to avoid forgetting something important. There are sections on emergency preparedness and response, fire, flooding, business continuity, and chapters on new and emerging threats, and sustainability.

This book was really well thought out. To an impressive degree, because many textbooks are dense, wordy, appealing to an enthusiast for the subject, but a slog for non-experts. By contrast, this one seems designed precisely to meet all the needs of someone on their first day in a health protection job, worried they will be faced with a really difficult scenario. Not only is it utterly practical, with single-page summaries for dozens of topics, but for every major health issue come bonus answers to well-anticipated questions such as "How would you respond to a media enquiry?" and "What if the case had been infectious whilst on the plane?"

Five sars. Sorry, stars.




**Andy Beckingham**

**Health Protection: Principles and Practice**
Samuel Ghebrehewet, Alex G Stewart, David Baxter, Paul Shears, David Conrad and Merav Kliner

Published by Oxford University Press
ISBN 9780198745471
RRP: £34.99

# Finding himself on the right side of history

THIS is a wonderful historical novel which is essential reading for the public health community but whose appeal will stretch way beyond that. Katherine Tansley weaves a rich and colourful narrative around a fascinating period of history which saw the beginnings of a paradigm shift in the medical profession. We enter Victorian London via the world of a fictional doctor, Frank Roberts, friend to Dr John Snow and doctor for the Broad Street area of Soho, an extremely effective way of chronicling the impact of cholera on the occupants as well as the battles Snow has to be taken seriously. Roberts, a man very aware of his lowly start in life, simply does not question authority and struggles to accept his friend's well-researched hypothesis that the sudden increase in deaths amongst the poor has nothing to do with their particular susceptibility to bad odours but is the result of contaminated water.

"I had great respect for John, but I was struggling… Surely the whole medical establishment couldn't be wrong? I bit my tongue."

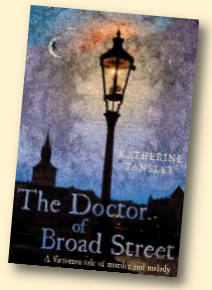
The tragedy of course was the time taken to acknowledge Snow's findings and that Snow himself, like many others, did not live to see the eventual impact of his work.

The book is rich in character, colour and detail, giving the impression of being meticulously researched. It is a superb reminder of the difficulties faced in challenging entrenched views but is largely positive, constantly hinting at the progress we have since seen; there is a wonderful moment when some "ladies of the night" mock Snow and Roberts' closeness, telling them there are "laws against it". Later, Snow avoids a smoky bar as he believes tobacco to be injurious to health.

We are aware of the presence of Florence Nightingale, busily opening windows in the hospital to let the air in, as well as Sir Edwin Chadwick, in a highly entertaining and entirely fictional account of a crucial debate with Snow. However, medicine and the medical profession are the backdrop for this novel. Centre stage is taken by the struggles for survival of some of the hundreds of working class families wiped out by the disease on the streets of Soho in the stinking hot summer of 1854, living in squalor in London, alongside the rich, the wealthy and the privileged.

Public health types and fans of historical fiction alike will adore this book, as I did.

More please, Dr Tansley.




**Jenny Hacker**

**The Doctor of Broad Street: A Victorian tale of murder and malady**
Katherine Tansley

Published by Troubador
ISBN 9781785892103
RRP: £8.99

## From the CEO

IT HAS been a strange start to 2017. The inauguration of President Donald Trump has seen executive orders issued and statements made which are potentially devastating to numerous public health initiatives.

At a simple level, Trump's support for the Keystone XL and Dakota Access Project oil pipelines, banning federal money going in to support abortion, committing to a $12bn wall with Mexico, withholding funding from 'sanctuary cities' who protect undocumented migrants – all represent a serious enough list. Add to this Trump's support for water-boarding, his proposals to suspend the Syrian refugee programme and refuse visa applications from a number of Muslim-majority countries, and the implications of cutting regulations for US-based businesses by 75 per cent – it doesn't look good.

And so the world order is changing: the Prime Minister is discussing the post-Brexit trade deal. We will soon see what price the 'special relationship' comes at.

But more importantly, what is this saying to our communities and those of other countries around the world? That racial and religious discrimination is acceptable, that women's rights don't matter, that climate change is a hoax, that the employer matters more than the employee, that power is to be protected and not shared. And how will these individuals, communities and governments react? Will they accept the "alternative facts" on offer?

Much of this was foretold by Martin McKee and David Stuckler in a packed, late-breaking session at the European Public Health Association (EUPHA) conference in Vienna (http://bit.ly/2oQLU8X) which coincided with the US election results and which had many shaking their heads in dazed wonderment at how this could have happened.

But happen it has, and, without doubt, there is more to come on both the US agenda and how the rest of the world reacts. The UK's public health community needs to respond to this emerging agenda positively, courageously and with evidence. We know the price of many of these policy shifts will be paid out in years to come with reduced longevity and increased morbidity, unless we find creative and innovative ways to influence the agenda and bring the public with us. More than ever, we can see the benefits of a global approach to health, and we must both support and learn from our colleagues in America in engaging in this new political landscape – to lessen the damage done and get health and wealth taken as seriously as each other.

**David Allen**



## FPH Annual General Meeting

**Tuesday 20 June 2017, Telford**

The 45th Annual General Meeting (AGM) of the Faculty of Public Health will be held on 20 June 2017 at 6pm at the International Centre, Telford.

The AGM will note the admittance of new Members and Fellows to distinction and honorary grades of membership, prize and award winners, election results and the composition of the FPH Board for 2017-18.

It will receive the FPH annual report and accounts for 2016 and reports from the officers on the first half of 2017.





# In memoriam

**Donald Ainslie Henderson FFPH**
**1928 – 2016**

Donald Henderson – or 'DA' as he was universally known – was one of the giants of modern public health. He led the global effort to successfully eradicate smallpox in the mid-1970s, and later spearheaded the USA's public health preparedness against bioterrorism.

Born in Lakeland, Ohio, DA gained his MD at Rochester in 1954 and MPH at Johns Hopkins in 1960 before joining the Epidemic Intelligence Service of the Communicable Disease Center, now the Centers for Disease Control & Prevention (CDC) in Atlanta. There he set up a five-year USAID programme to eliminate smallpox and control measles in 18 countries of west and central Africa.

In the mid-1960s, smallpox was afflicting 11 million people worldwide and killing two million every year. In 1966 Henderson moved to Geneva to direct the World Health Organization's drive to completely eradicate the disease. He and his team coordinated the work of some 73 countries in a painstaking process of surveillance and containment. This vast effort, as we all know, was ultimately successful – the last case occurring in Somalia in October 1977.

That same year DA was appointed Dean of Johns Hopkins School of Public Health – a position he held until 1990 when he became an advisor to the White House and later the Department of Health and Human Services on matters of biosecurity. In 2001, following the attack on the World Trade Center, DA, at the age of 73, was asked to head up the newly established Office of Public Health Preparedness against the heightened threat of bioterrorism.

In addition to his many other accolades, DA Henderson was awarded the London School of Hygiene & Tropical Medicine's prestigious George Donald Medal in 1975 and the US Presidential Medal of Freedom in 2002.

**Robert (Bob) Logan FFPH**
**1917 – 2016**

Bob Logan was one of the pioneers of what is now known as healthcare public health. His main contribution was in developing methodologies for analysing the demand for inpatient and outpatient hospital care in the 1960s.

Born in Bangor, Northern Ireland, Bob graduated from Queen's Belfast and, after medical service in Liverpool in the Second World War, won a Nuffield Fellowship in industrial medicine based at the Medical Research Council's Social Medicine Unit in London. In 1950 he was appointed a lecturer in industrial medicine at Manchester University and in 1962 became Director of the University's Medical Care Research Unit.

A burning question for the NHS at that time was how many district general hospital beds were needed per head of population. Nobody quite knew how to go about answering it. How do you link usage with demand? And demand with need? Where do you set the thresholds? Who are the gatekeepers? Funded by the Nuffield Provincial Hospitals Trust (now the Nuffield

Trust), Bob, with his non-medical colleague Gordon Forsythe, undertook pioneering work in the Liverpool area looking at trends and variations in a wide range of routine metrics and comparing them with figures for other regions in England, Sweden and the US. To these supply-side analyses they added innovative studies of demand, including population surveys of symptomatology, inpatient surveys of treatment satisfaction and surveys of doctors' perceptions of policy and practice. The resulting rich compendium of cross-cutting studies provided an internationally recognised model for assessing need, demand and appropriateness – and the basis of much of today's standard approach.

Later, together with Jerry Morris, Bob co-founded the two-year MSc in Social Medicine at the London School of Hygiene & Tropical Medicine – the incubator of many an illustrious career in public health.

Bob was a dedicated teacher and, long after his retirement from the London School in 1982, continued to act as an advisor and mentor to alumni across the globe.

**Paul Castle**
**1945 – 2016**

When Paul Castle, of Castle Communications, died suddenly in September, the public health community lost an extremely hard working, intelligent and talented member.

After gaining a degree in history at Oxford University, Paul started his career as a reporter for the *Liverpool Post and Echo*, moved on to work in public relations in the NHS and finally, headed up his own PR consultancy.

He made major contributions in the West Midlands and the North West to the promotion of smoking cessation and water fluoridation and was able to apply his talents to practically any theme. He could turn a dry factual document into one guaranteed to grab attention, often to the amazement of the original author who had thought that the topic would never get a hearing. His courage enabled him to push boundaries to get a message across. On one memorable occasion, in the space of six weeks, he turned a one-off under-spend (those were the days!) into a poster campaign promoting condoms to prevent the spread of HIV/AIDS, resulting in most roads into central Birmingham being plastered with "Don't go too far without one". This may have caused surprise amongst Department of Health officials visiting the city at the time but the message got home.

Paul's many colleagues and friends in the field of public health will sorely miss him for the energy, common sense and humour he brought to every task he undertook.

**Rosalind Hamburger**

## Deceased members

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

**John Beal FFPH**
**Peter Briggs FFPH**
**Jonathan Hildebrand FFPH**


# Sharing the future

The health service in Pakistan is at a turning point, so this is a huge opportunity for us to offer our expertise in teaching, research and field work, says Zafar Iqbal

ACTION PLAN: The PHE/FPH delegation at the HSA conference

THERE is huge potential for collaboration between health professionals in the UK and Pakistan, helping Pakistan to achieve its Sustainable Development Goals (SDGs), improve healthcare and move towards universal health coverage. Pakistan and the UK have over one million shared citizens – a huge mutual interest in the future. While there are profound differences, there are also shared challenges. We can and must learn from each other.

With this in mind, in early December last year five members of the Faculty of Public Health (FPH) Pakistan Special Interest Group (SIG) accompanied a delegation from Public Health England (PHE), led by PHE Chief Executive Duncan Selbie, to Islamabad to take part in the Pakistan Health Services Academy (HSA) 7th Annual Public Health Scientific Conference on the theme of 'Sustainable Development Goals for Health: Collaborating for Prosperity'.

More than 800 delegates took part in a series of sessions and scientific workshops tackling the considerable challenges faced by Pakistan in achieving its SDGs, in part by profoundly restructuring its health service in line with the National Health Vision 2025.

In a fascinating week, we discussed the recent provincial devolution of the health services to provide more equitable health coverage. Pakistan tested a pilot free health insurance programme involving 100,000 people and last year extended this to cover the poorest 10 million people across the whole population. This is expected to expand to 20 million next year.

In some ways this scheme goes further than the NHS, covering not only hospital care costs but also the cost of transport to hospital. This comes with a rise in budget allocation from 0.6 to 3 per cent of GDP (compared to around 7 per cent in the UK) and raises major challenges which demand a comprehensive review of the issues relating to systems, planning and delivery of health services.

Currently 70-80 per cent of services are delivered by the private sector, even in the poorest areas, with little regulation and accountability. Meanwhile, the military provide healthcare not only to their own members but also to parents and children of military personnel, reaching around eight million people.

Pakistan's National Health Vision 2025 requires a high-quality public health workforce and the UK delegation were asked to focus on enhancing education, recruitment and retention. Mr Selbie and Dr Assad Hafeez, Executive Director of the HSA, co-chaired a half-day session that covered the role that FPH could play in helping develop joint programmes between the government of Pakistan and PHE.

The main workforce issues raised were the need for support for the HSA students and FPH in teaching, research and particularly field work. There were many cases of excellent work but limited work at grass-roots level to explore and learn from primary research. Another key challenge highlighted was the fragmentation and lack of co-ordination of services, described by one delegate as "all the right notes in the wrong order".

The Pakistan health service is at a turning point with significant federalisation and devolution underway. There are talented people at work already in the system, so now is the time to add our weight to this enterprise, sharing our public health experiences and knowledge in order to maintain the trajectory towards the light.

The FPH Pakistan SIG aims to take the issues raised at the conference and formulate an action plan with PHE following local discussion and dialogue with the HSA.

**Zafar Iqbal**
*Chair*
*FPH Pakistan Special Interest Group*

*Interested in joining the Pakistan SIG? Contact policy@fph.org.uk*





# The top 10 most downloaded articles from the Journal in 2016

AUSTERITY matters for public health; our readers realise that and want to know the details. That's the message we draw from the fact that a study of the UK's 'bedroom tax' was downloaded four times as often as almost any other article from the *Journal of Public Health*'s website in 2016.

The top 10 list reflects the diversity of problems confronting today's public health practitioners and policy makers. It also shows readers have a special concern for vulnerable populations, such as those within our borders who are at risk from tuberculosis, and those outside them who have been driven to seek asylum by conflicts at home. The health of children and adolescents is likewise a special concern, as shown by the presence of articles on teenage pregnancy and school physical education.

If there is one theme that runs throughout the list, it is the tilt towards pragmatic, real-world problems. Our audience downloads material that offers practical help in gearing public health efforts. And this, we feel, is our USP – not so much dry curiosity about disease and populations, but practical action to improve wellbeing and health through policy.

We have been encouraged by responses to the journal over the past year; we encourage readers of *Public Health Today* to rely on it as a resource and to provide feedback and suggestions (and, of course, to submit their research).

**Eugene Milne**
**Ted Schrecker**
*Co-editors*
*Journal of Public Health*


| Title | Authors | DOI | Downloads |
|---|---|---|---|
| A qualitative study of the impact of the UK 'bedroom tax' | Moffatt S, Lawson S, Patterson R, Holding E, Dennison A, Sowden S et al. | 10.1093/pubmed/fdv031 | 377 |
| Truancy and teenage pregnancy in English adolescent girls: can we identify those at risk? | Zhou Y, Puradiredja DI, Abel G. | 10.1093/pubmed/fdv029 | 219 |
| Nudging healthy food choices: a field experiment at the train station | Kroese FM, Marchiori DR, de Ridder DTD. | 10.1093/pubmed/fdv096 | 94 |
| Who are the obese? A cluster analysis exploring subgroups of the obese | Green MA, Strong M, Razak F, Subramanian SV, Relton C, Bissell P. | 10.1093/pubmed/fdv040 | 53 |
| Charging migrants for health care could compromise public health and increase costs for the NHS | Britz JB, McKee M. | 10.1093/pubmed/fdv043 | 51 |
| Ethnic inequalities in dental caries among adults in East London | Delgado-Angulo EK, Bernabé, Marcenes W. | 10.1093/pubmed/fdv097 | 41 |
| Tuberculosis in South Asian communities in the UK: a systematic review of the literature | Offer C, Lee A, Humphreys C. | 10.1093/pubmed/fdv034 | 40 |
| 'I'm not trusted in the kitchen': food environments and food behaviours of young people attending school and college | Tyrrell RL, Townshend TG, Adamson, Lake AA. | 10.1093/pubmed/fdv030 | 38 |
| Health profile and disease determinants among asylum seekers: a cross-sectional retrospective study from an Italian reception centre | Russo G, Vita S, Miglietta A, Terrazzini N, Sannella A, Vullo V. | 10.1093/pubmed/fdv049 | 37 |
| Factors affecting school physical education provision in England: a cross-sectional analysis | Greenfield JRF, Almond M, Clarke GP, Edwards KL. | 10.1093/pubmed/fdv032 | 37 |

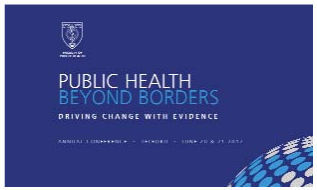
# Where shared ideas are much in evidence

THE days are getting longer and equinox has passed. That can mean only one thing – the annual conference is coming. This year we will be in Telford, and we are just putting the finishing touches to the programme.

We have a wide range of talks, papers, discussions and workshops covering all aspects of public health work. Following the academic theme of last year, we are looking at how we can put evidence into practice this year. We are also looking at wider aspects of health on a planetary basis – how do we interact with the world we live in? How do we use resources such as water and food as the United Nations declares the first famine in a decade? What about other natural resources, climate, novel infections and indeed the size of the human population itself? All topics of interest to public health.

We aren't forgetting other parts of everyday work in the UK. We are excited that a number of papers on health protection will be presented. Alongside these we will also have talks on mental health, child health, sexual health and identifying and developing good laws.

Our working environment is also important to successful delivery of public health, and we will have sessions on the places we work, the teams we work with, and the organisations we work for in order




to help the populations we serve. Alongside this we are also looking at the public health workforce: without trained colleagues it becomes an uphill struggle to make the improvements we strive for and to maintain those improvements.

You can also find out about the Special Interest Groups as they evolve. A number will be running discussions and workshops about their work. So come and find out more about what they are doing – and perhaps get involved.

We are also building on last year's successful exhibition, with a large area dedicated to partners, associations and organisations that work alongside us in public health. There was a wonderful range of stands in Brighton with some interesting and surprising ideas about what can and is being done. This year promises to be bigger and better.

We also have a social programme to balance all this hard work. Come and meet friends new and old at the conference party or join in with exercise in the local park. Telford is one of the birthplaces of the industrial revolution where mass-produced iron was used to build the world we now know, so there will be opportunities to learn more about local history and the world it created.

The conference is a chance to talk with others about our work, to share knowledge and pass on information about what has worked (and what hasn't). Together we can make public health work even when austerity is all around. Come and see what ideas you can get this year.

We look forward to seeing you in June.

**David Williams**
*Member*
*FPH Conference Planning Committee*

# New public health specialists

Congratulations to the following on achieving public health specialty registration:

**UK PUBLIC HEALTH REGISTER**

**Training and examination route**
Sarah Perman
Dana Sumilo
Katrina Stephens
Shade Agboola
Russell Vincent
Rachael Leslie

**Defined specialist portfolio route**
Alison Patey
Helen Harrison
Corinne Harvey
Frances Hughes

**Practitioners**
Rachael Davis
Judith MacMorran
Claire Fauvel
Sarah Johns
Gilles Bergeron
Mary Shek
Samantha Hibberd
Sophie Krousti
Tracey Hellyar
Zoe Kelly
Helen Cheney
Natalie Barrow
Rachel McIlvenna
Muhammed Meah
Holli Dalgliesh
Sheila Rundle
Rebecca Laider
Ramji Tiwari
Jacqueline Nixon
Aine Lyng
Katie Wilson
Susan Carmichael

**GENERAL MEDICAL COUNCIL REGISTER**

Charlotte Stansfield
Charlotte Warren-Gash
Michael Edelstein
Tamasin Knight
Melanie Roche
Katherine Russell
Simon Howard
Jane Bray
David McAllister

# A celebration of the life of Peter Draper

**Date:** 10 May 2017
**Venue:** Brockway Room, Conway Hall, 25 Red Lion Square, London WC1R 4RL
**Speakers include:** FPH President John Middleton; Rupert Morris and Andrew Copson, British Humanist Association; Jenny Griffiths, Research Assistant, Unit for the Study of Health Policy; Alex Scott-Samuel, Chair, Socialist Health Association; Tom Davidson, friend and fellow political activist.





# Welcome to new FPH members

We would like to congratulate and welcome the following members who were admitted to FPH between September 2016 and March 2017

**Fellows**
Andrea Fallon
Andrea Sanabria
Andrew Rixom
Andy Beckingham
Angela Tinkler
Anita Bell
Anna Miller
Anne Graney
Anthony Hill
Catherine Gregson
Charlotte Warren-Gash
Dana Sumilo
David McConalogue
Declan Bradley
Diane Halton
Erlend Aasheim
Fiona Bragg
Gary Fuller
Graham Watkinson
Jacqueline Gray
James Smith
Jennifer Darnborough
Jeremy Wight
Jialin Chen
John Toby
Julian Mallinson
Katherine Russell
Katrina Stephens
Kirsteen Watson
Lindsay Forbes
Louise Sigfrid
Malcolm Ward
Mercy Vergis
Michael Soljak
Nishamali Jayatilleke
Olaf Horstick
Olatokunbo Sangowawa
Paula Jackson
Rachel Clark
Rachel Wells
Robert Clarke
Roland Salmon
Sarah Stevens
Sarah Weld
Shade Agboola
Shirley Brierley
Valerie Little
Veena de Souza
Yung Cheung

**Members**
Adeola Agbebiyi
Alison Patey
Allan Reid
Alyson Smith
Andrea Clement
Andrew James Fox
Andrew Scott-Clark
Ann Robins
Anna Jones
Anna Lyon
Ashley Sharp
Catherine John
Cherry Jones
Claire Bayntun
Clare Ebberson
Cynthia Carlson
Damani Goldstein
Elizabeth Dubois
Ellen Pringle
Gerald Tompkins
Greg Hartwell
Hayley Teshome Tesfaye
Heidi Douglas
Helen King
Helen Ross
Ian Diley
James Morris
Jane Kenyon
Janet Thompson
Joanne Newton
John Ford
Jonas Thompson-McCormick
Karen Wright
Katharine Cole
Katherine Pearce
Kathryn Cobain
Katy Harker
Keith Allan
Laura Shallcross
Louise Flanagan
Lynn Gibbons Martin
Lynne Kennedy
Margaret Komashie
Mark Pietroni
Martine Usdin
Mary Black
Mary Hall
Mattea Clarke
Matthew Fung
Matthew Saunders
Matthew Tyrer
Nicholas Bundle
Orsolina Martino
Paul Brotherton
Paul Southworth
Peter Baker
Rachel Scantlebury
Rebecca Nunn
Ruth Robertson
Sally Haw
Samantha Bennett
Sangeeta Rana
Sarah Rayfield
Sharon Hutchinson
Stuart Keeble
Support Trillium
Susan Levi
Suzanne Bartington
Wajiha Doulton
Yoga Nathan Velupillai

**Specialty Registrars**
Aideen Dunne
Alexa Gainsbury
Alexander Allen
Alexandra Smith
Alice Puchades
Amir Kirolos
Andrew Turner
Angela Cartwright
Anna McKeever
Anna Trelfa
Anne Whittington
Antiopi Ntouva
Carol Wilson
Catherine Flanigan
Catherine Stafford
Claire Neill
Daniel Stewart
Dino Motti
Eleanor Powers
Eleanor Turner-Moss
Elizabeth Marchant
Elizabeth Stratford
Emily Parry-Harries
Emma Howard-Drake
Fran Bury
Frances Butcher
Gabrielle Woolf
Grace Norman
Hasna Dulfeker
Hayley Coleman
Heather Catt
Helen Johnston
Helena Posnett
James Adamson
James Moore
James Paweleck
Jill Harland
Jonathan Currie
Kate Bisset
Kathryn Hamilton
Laura French
Liam Crosby
Logan Manikam
Lucy Devapal
Mahiben Maruthappu
Matilda Allen
Matthias Rohe
Megan Harris
Melissa Brown
Nadeem Hasan
Nicola Ainsworth
Rachael Marsh
Rebecca Willans
Robert Hayward
Sally MacVinish
Sarah Gentry
Sarah Milligan
Selina Rajan
Steven Senior
Wendi Ann Shepherd
Wikum Jayatunga

**Practitioners**
Annabel Gipp
Catherine Scott