The health of humans and animals is closely intertwined, particularly in rural areas. And livestock farmers experience particular threats to their wellbeing, says the **Nigel Calvert**, lead for FPH's Animal and Human Health Special Interest Group

LOOKING through the health stories featured by the media in recent years it is clear that from Avian flu to Zika, zoonotic infections (diseases that can be transmitted to humans from animals) have had their fair share of the limelight. Zoonoses have been recognised for centuries, and more than 200 – caused by all types of pathogen, from bacteria, parasites and fungi though to viruses and prions – have been recorded.

However, one thing I have learned from working in a rural public health department is that, when considering animal and human health, it is important to remember that the issues extend far beyond infectious diseases.

We do have high rates of many gastrointestinal infections in our region but – as in many rural parts of the UK – there are other important public health considerations for those who make a living from working with animals. These include the physical hazards of working with large animals and potentially dangerous machinery.

Agricultural work environments also pose significant public health threats. Farming has long been known as a suicide-prone occupation, and it is thought that financial pressures, isolation and relatively easy access to potentially fatal machinery, chemicals and weapons lie behind this.

The Health and Safety Executive (HSE) has looked at the agricultural sector in Great Britain and estimated that in 2015-16 there were around 16,000 cases of work-related illness and 15,000 non-fatal workplace injuries. There were also 27 fatalities. Despite this significant burden of ill health, in 2012, when I was fortunate enough to attend an international conference in Sweden on agricultural health, I was one of the very few delegates from the UK.

In our region, public health colleagues have been working to address some of these issues. We have worked with the HSE to run events for farmers at which we covered quad-bike safety, basic risk assessment and lone working. We have also run outreach events in conjunction with the National Farmers' Union and with several local Young Farmers' Clubs.

> **When considering animal and human health, it is important to remember that the issues extend far beyond infectious diseases**

The health board has also attended a number of rural shows in recent years and these events have provided opportunities to engage with rural communities on a number of health issues. A recent survey of local farmers and their families found that the main stressors were difficult market conditions for selling stock and the consequent business pressures, isolation, having to use dangerous machinery and – predictably in south west Scotland – the weather.

These local initiatives are a start, but more could be done across the UK to tackle these health issues in a coordinated fashion. I was pleased to be offered the opportunity to lead the Faculty of Public Health's (FPH) Special Interest Group (SIG) on Human and Animal Health. These SIGs develop and advocate policies and programmes that support delivery of the FPH's strategic plan and act as an expert resource to FPH.

They aim to support best practice and to provide a focal point for members with common interests to exchange ideas, knowledge and information.

I recently attended a workshop for SIG leaders and was impressed by the enthusiasm expressed by those present. I hope we can develop a vibrant SIG to look at this exciting area of public health, and I would be glad to hear from any FPH colleague who is interested in joining us.

Nigel Calvert
Consultant in Public Health Medicine
NHS Dumfries and Galloway

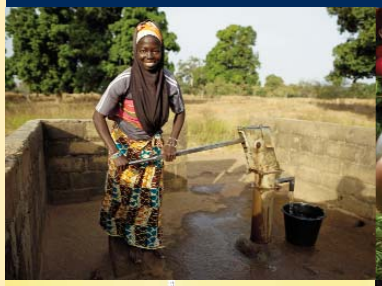
nigel.calvert@nhs.net

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

December 2016

In this issue

Public Health Today









What has public health ever done for us?

OK, apart from clean water, immunisation, no smoking, contraception, fluoridation, air bags, food labelling, seatbelts...



Information

ISSN – 2043-6580

Editor in chief
Alan Maryon-Davis

Commissioning editor
Chris Mahony

Production editor
Richard Allen

Public Health Today **is distributed to over 3,400 public health specialists. To advertise please contact Richard Allen at richardallen@fph.org.uk**

Editorial board
Andy Beckingham
Stella Botchway
Matthew Day
David Dickinson
Rachel Johns
Frances MacGuire
Helen McAuslane
Sally Millership
Thara Raj
Leonora Weil

Contact us
Email: news@fph.org.uk
Policy & Advocacy: 0203 696 1455
Professional Standards: 0203 696 1481
Business Services: 0203 696 1469

Join the Faculty of Public Health and receive *Public Health Today*
Go to www.fph.org.uk/membership
or call 0203 696 1483

Address
Faculty of Public Health
4 St Andrews Place
London NW1 4LB
www.fph.org.uk

Submissions
If you have an idea for an article please submit a 50-word proposal and suggested authors to news@fph.org.uk. Themes for 2017 include accidents, the early years and alcohol harms.

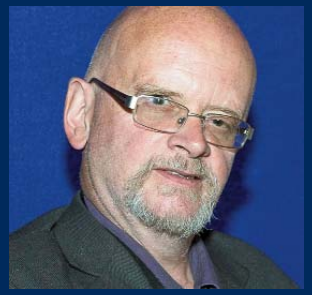
Public Health Today
The magazine of the
UK Faculty of Public Health
www.fph.org.uk

December 2016

Contents

Cover images: top left © WaterAid / Layton Thompson, second row down, centre © Wellcome Library, London

Welcome



WHAT works for the public's health?
Freedom from violence. A meaningful role in society. Clean drinking water, sewers. Handwashing. Better housing. Better nutrition. Universal education. Rewarding, meaningful, fairly paid work. Safer working conditions. The minimum wage. Working families tax credit. Surestart maternity grant. Environmental, air, soil, food and water regulations. Family planning and contraception, reducing teenage pregnancy, increasing birth spacing. Maternal education/literacy. Preconception folate, good antenatal care, smoking-free pregnancy and smoke-free partners. Antenatal screening for syphilis and sickle cell, neonatal hearing tests, screens for phenylketonuria, hypothyroidism, cystic fibrosis. Breastfeeding. Early-years education and family support. Home visits to prevent non-accidental injury. Back-to-sleep and smoking reductions by parents to prevent cot death. Multidisciplinary assessments for children with developmental delay. Bookstart – book distribution to parents of very young children, reading to young children by volunteers. Parenting-skills training for those whose child has behaviour disturbance. Home-safety equipment for child accident prevention, child-proof tablet containers. Fluoridation to prevent dental caries. Immunisation for childhood infections. Youth mentoring, personal social and health education including peer education. Traffic-light food labelling, advert bans for highly processed food, sugar tax. Brief interventions for alcohol problems, Last Drink Survey reports to influence licensing, alcohol minimum pricing, increases in duty on alcohol. GP advice, nicotine replacement therapy, smoking ban in public places, smoking advert bans, increases in tobacco duty, control on tobacco smuggling. 20mph zones, 'living streets', active travel, anything that gets people walking and cycling. Random breath testing for drink-driving, seat belts, child restraints, car design and materials improvements, air bags, laminated glass, anti-lock brakes, speed restrictors. A universal national health service, free at the point of need and funded from general taxation. Hypertension screening and treatment. Fitness and weight management. Diabetes detection and control. Cardiovascular disease (CVD) risk detection and reduction. Systematic management in primary care of CVD, chronic obstructive pulmonary disease, diabetes, osteoporosis, epilepsy, anxiety and depression, leg ulceration and common skin disorders. Stroke units, thrombolysis, emergency percutaneous coronary intervention for coronaries. CPR training for the public. CVD rehabilitation programmes. Folic acid in bread flour preventing coronary heart disease (CHD) adverse outcomes in older people. Vitamin D for preventing CHD adverse effects and excess winter deaths. Exercise, tai chi, home safety schemes, eye tests, medication reviews for falls and fracture prevention. Vitamin D high dose for fracture prevention +/- calcium. Care in the community for people with learning and physical disabilities. Depot medication for people with enduring mental illnesses. Tuberculosis T-spot testing and contact tracing, control. Infection surveillance. Healthcare-acquired infection control. Early treatment of sexually transmitted disease (STD) to reduce spread, contact tracing for STD including AIDS/HIV. Streetlighting to reduce violent crime. Drug methadone and heroin maintenance programmes, harm-reduction including safe injecting for blood-borne virus prevention. Cognitive behaviour therapy for offender management, domestic violence and many forms of anxiety/depressive illness. Affordable warmth. Flu vaccine for reducing winter deaths.

Public health is by definition a collective venture. Not everything in this list is therefore done by or led by public health practitioners. But the totality is a body of activity that protects and improves the public's health. But do challenge. Do add. We will put the list on the website and it can grow…

John Middleton

Making history – a pictorial approach to showing what we do

IT STARTED on Twitter. The Chartered Institute of Environmental Health tweeted its poster demonstrating what environmental health had done for us. This poster captured the range of functions and responsibilities of the profession. The Association of Directors of Public Health tweeted: "Wouldn't it be good if there was something similar for public health?"

The UK Public Health Network began a project to capture 'what public health has done for me'. The aim is to create a set of graphics to encourage consistency in public health messages and present a coordinated feel to the UK's public health function.

Content needs to reflect the evidence base, the domains of public health and the different situations in England, Scotland, Wales and Northern Ireland. Proposed graphics include:

- A public health alphabet, based on "A is for Amy who fell down the stairs"
- Cradle-to-grave illustrations of health protection and health improvements
- The spectrum of inequality umbrella
- An historical timeline of achievements and life-expectancy increases since 1834.

Additional images such as a house depicting health protection and improvement impacts in every room could also be included.

Although a common suite of materials would be a valuable communication tool, distilling public health into easily understood and commonly agreed messages is challenging. It is proving difficult to agree on issues that are reflective of both national and local needs.

With this edition of *Public Health Today* taking up the subject of the profession's historical legacy, the network is hoping to move the project forward. Would you welcome these resources? Could they work across the whole UK? Your thoughts would be welcome. If you are interested in pursuing this with me, I will be delighted to hear from you.

The UK Public Health Network brings together the statutory public health agencies in England, Wales, Scotland and Northern Ireland and the non-governmental bodies with a generic remit for public health. The network shares learning and knowledge, focusing on the strategic issues of importance in protecting and improving the health and wellbeing of the public. Further information is at www.ukpublichealthnetwork.org.uk

Heather Lodge
Coordinator
UK Public Health Network
heather.lodge@ukhealthforum.org.uk

GETTING THE MESSAGE: A draft poster for the UK Public Health Network's campaign

News in brief

HIV vaccine: Clinical trial begins
A vaccine against HIV is being tested in South Africa in the first large study of an HIV vaccine's effectiveness since 2009. The study aims to enrol 5,400 sexually active young men and women. Experts hope the vaccine will be "the final nail in the coffin" for HIV.

Five-a-day advice 'unrealistic'
Two portions of fruit and vegetables a day, rather than five, is more realistic advice to give families, says the new chair of the Royal College of GPs, Dr Helen Stokes-Lampard. She told the BBC many children were being brought up in a culture of not eating any fresh fruit and vegetables at all.

Breast cancer 'more often advanced' in black women
Black women in England are almost twice as likely to be diagnosed with advanced breast cancer as white women, according to analysis by Cancer Research UK and Public Health England. Experts say low awareness of symptoms and screening are partly to blame.

Scouts and guides provide 'mental health boost for life'
People who were in the scouts or guides are 15% less likely than other adults to suffer anxiety or mood disorders at the age of 50. Researchers from Edinburgh and Glasgow universities believe lessons in resilience and resolve have a lasting positive impact.

Sore throat sufferers urged to take pharmacy test
People with soar throats will be encouraged to visit their pharmacist instead of their GP for an on-the-spot test to see if they need antibiotics. The walk-in Sore Throat Test and Treat service is aimed at reducing doctor appointments and over-use of antibiotics, NHS England said. But pharmacies say cuts in funding to the sector could jeopardise the scheme.

Pubic hair grooming linked to STIs
Women and men who regularly trim or remove their pubic hair run a greater risk of contracting sexually transmitted infections (STIs) than those who do not, according to a survey of more than 7,500 American adults published in *Sexually Transmitted Infections*. Doctors say small tears in the skin could be to blame.

INTERVIEW

Frank Atherton became the Chief Medical Officer for Wales and Medical Director of NHS Wales this year after returning from four years as Deputy Chief Medical Officer in Nova Scotia, Canada. He is a former Director of Public Health in North Lancashire and was President of the Association of Directors of Public Health from 2008 to 2012

Colwyn Bay town centre

Talking about the next generation

Put wellbeing at the centre, says Atherton

What particular public health challenges does Wales face compared to other parts of the UK?
I'd say that the challenges are pretty similar to those in other parts of the UK in most respects, but I realise that on some health outcomes we do lag behind; for example, childhood obesity rates are higher in Wales than in England. There is the challenge that comes from deprivation and these are pretty difficult economic times.

How do you see yourself balancing the strange mix of your population health role and medical director role?
Strange is an excellent word for it, but it makes it an interesting role. It gives me great insight into the workings of the NHS and I can help make sure that public health and the NHS are working together. We're not seeing cuts to the public health budgets in Wales that are taking place in England – we're continuing to invest in public health.

Since April a range of statutory organisations have had to take into account the impact of their actions on current and future citizens under the Wellbeing of Future Generations Act. How do you aim to make best use of the legislation in improving health and wellbeing in Wales?
The legislation was one of the reasons I was keen to come to Wales. It is a very progressive health-in-all-policies approach. Here in Wales, it is part of making sure that health and wellbeing are at the centre of government decisions and decisions by local authorities and other public bodies. It is attracting a lot of international attention, but the challenge will be to take the enabling language and turn it into a reality.

To do that, we have a future generations commissioner and I want to make sure that public health is working with her.

The enhanced focus on the next generation will be based on a public health approach and will focus on the first 1,000 days of life and childhood experiences. We have done a lot of work with Public Health Wales to understand the impact of early years and build that into work with public health services and the NHS.

What first attracted you to public health as a career?
I worked in Africa for a decade as a young man. I trained as a GP, but I was district medical officer in Malawi. I saw there the consequences of lack of education and the lack of gender equity – such as high maternal mortality rates. I realised then that it was important to work with the upstream determinants of healthcare rather than rely just on the rescue services delivered in hospitals.

> The enhanced focus on the next generation will be based on a public health approach and will focus on the first 1,000 days of life

You were president of the Association of Directors of Public Health (ADPH) for four years. What achievements under your leadership do you feel most proud of?
By 2008 it was an organisation that was in need of renewal. We built up strong processes for developing a consensus on public health around a swathe of issues. It was a very difficult time with the passing of the Health and Social Care Act, but I think we developed a consensus response for ministers and the health select committee. I'm very pleased to see that the ADPH is continuing to lead on that with the Faculty of Public Health.

At the time, there was a very strong feeling that, as so many determinants of health lie in local government, that was a natural home for public health. However, we did identify problems around implementation and the protection of public health budgets that we are beginning to see.

The arrangements that were put in place are not as robust as they could have been, but that is not to say that things would have been any better if public health budgets were still determined in the NHS. The ability of public health to influence local authority decisions in many areas is a very strong aspect of UK public health.

Why did you go to work in Nova Scotia and will that experience be useful in your current job?
I always felt it was important in public health to have experience from elsewhere. I had been in north Lancashire for 10 years and had experienced a couple of reorganisations – and I had just finished my term as president of the ADPH. I had to make the decision whether to carry on in Lancashire or go to Canada. I had some contacts there, and you always learn things from different structures and health systems.

It is two or three times the size of Wales but has only one-third of the population, so the big question is how to provide health services to sparse, rural populations. One way that happens is to change service models from hospital-based to collaborative care centres where paramedics and nurses deliver immediate emergency care 24/7, but they link into higher-tier services and invest in transport systems. Health professionals other than doctors are involved in delivering more services such as vaccinations.

> In Africa I saw the consequences of lack of education and the lack of gender equity – such as high maternal mortality rates

The system leadership was also interesting with a strong belief in consensus-building processes with health professionals and the public to avoid conflict.

What would you say has been the single biggest challenge in your professional life?
Building population health into all aspects of health service planning and delivery.

Is there anything that keeps you awake at night?
The American presidential election and the spectre of what that might lead to.

How do you like to relax?
I do all my thinking when I am out running. In Nova Scotia that meant trail-running when the temperature was minus 29.

Interview by Chris Mahony

From John to Jamie

The list of people who made a real difference to the health of the human race is long and varied. But they all have three things in common, says Alan Maryon-Davis

A QUICK quiz for the holiday…

Who has done most for the UK public's health? Is it (a) John Snow (b) Marie Stopes (c) Aneurin Bevan (d) Jamie Oliver?

Hmmm. Difficult one. They've each made a massive contribution in their own way. And there are dozens of other names I could have thrown in.

The theme for this issue is public health successes and, unsurprisingly, John Snow and the Broad Street pump crop up a few times. Snow was the only public health professional in this illustrious clutch of heroes (although primarily a clinician), but there's a common factor to all of them: they each had the vision and dedication to really push the boundaries and make change happen. Drive is a crucial ingredient for public health success.

Another is collaboration. Nearly all the great successes have been achieved through collective action. The main reason why the smoke-free legislation got through – which I see as one of the biggest advances in public health in the UK since the launch of the NHS – is because years of advocacy, lobbying and media framing by a broad alliance of activist individuals and organisations shifted public opinion so much that the politicians finally had to go along with it.

> **Nearly all the great successes have been achieved through collective action**

And a third key ingredient is opportunism or serendipity; that is, being in the right place at the right time and grabbing the zeitgeist by the horns. This is how Aneurin Bevan caught the national post-war mood and spearheaded the jewel in the welfare state's crown. Ditto Jamie Oliver – some nameless TV producer plucked him out of a kitchen to front a series on school food, and he seized the opportunity.

So, we've got articles here on a smattering of successes – from the global triumphs of vaccination and communicable disease control to the huge fall in teenage pregnancies in the UK, and from victories in the battle against smoking to the great gains from screening programmes and reductions in road accidents.

Where will be the successes of tomorrow? Jeanelle de Gruchy and Justin Varney offer their thoughts on this. I have a hunch that genetic profiling of disease susceptibilities combined with individually tailored behavioural interventions could have a massive impact. But is that public health? Certainly we can provide the evidence of what works best.

As in the past, policy breakthroughs are likely to be most impactful. Hopefully, if we ever get minimum unit pricing for alcohol, we will consider it as a major success. Same perhaps with the sugar tax. We might even look back on e-cigarettes as a great public health breakthrough (Discuss).

Ultimately, our hope must surely be that some future government will bring in a series of policies around education, employment, housing and environment, as well as health and social care, that together create a more equitable and just society.

Now that really would be a public health success story.

Alan Maryon-Davis
Editor in Chief

SPECIAL FEATURE: WHAT HAS PUBLIC HEALTH EVER DONE FOR US?

How we escaped the miasma and saw the light on lifestyles

CHANGE over time is key to understanding public health. How did we get to where we are today and what were the challenges in the 19th century compared to the 21st?

The environment and sanitation were central to public health in mid-Victorian times. Rapid economic growth and mass urbanisation coincided with high mortality from infectious diseases such as cholera and typhus. Dominant beliefs about the transmission of disease through miasma (foul air) were wrong, but they brought an environmental focus on sewers and drains. There was opposition to government intervention – the precursor of later 'nanny state' arguments. It was not until the 1875 Public Health Act that a new cadre of public health officials, the Medical Officers of Health, developed widely at the local level.

By then, public health had entered a new phase. From the 1860s, when Louis Pasteur formulated germ theory, bacteriology had opened up a new view of public health. Vaccines and therapies for specific diseases became possible, with safe food and water and infant feeding practices also coming on to the agenda. Public health's focus began to shift from collective management of the environment to interventions targeted at the individual in the home.

Concern shifted away from infectious diseases in general to what were termed the 'racial poisons' – tuberculosis, alcoholism and venereal disease. Anxiety over population quantity and quality stimulated interest in maternal and child welfare with infant welfare clinics, school inspection and home visiting on the public health agenda.

In the inter-war years in the UK, the 1920s and 1930s, public health in the UK attained its peak influence, running a widening portfolio of services within local government. Public health doctors could find themselves in charge of the local hospital, running a range of clinical services as well as the public health portfolio. Public health's record at this local level is a matter of debate. Recent research has given a more nuanced picture, emphasising the integration of preventive and curative services in this proto NHS.

The arrival of the NHS left public health struggling. The epidemiologic transition pointed to another new stage, stressing the diseases of behaviour, or 'lifestyle'. New investigative techniques, chronic disease epidemiology, emphasised 'risk' and 'risk factors' for disease. Smoking was the issue which epitomised the new approach. The work of Doll and Hill in the UK, and Wynder and Graham in the US, first brought the issue to the fore. This new way of looking at public health issues also encompassed heart disease, food and diet. In the US, the Framingham study of heart disease was the first to use the term "risk factor".


Death on the polluted Thames, 1854

Increasingly, public health became an international and then a global enterprise. HIV/AIDS in the 1980s emphasised the interdependence of local, national and international responses. The new approaches within public health – from 'new public health' to 'health promotion' – were elaborated internationally.

Where now? The environment and the individual are now both part of public health. Climate change and air pollution on the one hand, preventive drug treatment and self-monitoring on the other. Antimicrobial resistance could herald a return to infectious disease, while the rise of non-communicable diseases is now of concern across the globe. How will these trends pan out? It would be a brave historian who stated with certainty what the next stage of public health will bring.

Virginia Berridge
Professor of History and Director
Centre for History in Public Health
London School of Hygiene and Tropical Medicine

Virginia Berridge's book, 'Public Health: A Very Short Introduction' (OUP), is out now

Priority setting is much in evidence

ALL healthcare systems are facing increasing demands against a backdrop of limited resources. Most countries are introducing systems to assess 'value for money' in order to gain legitimacy with their constituents. Collectively these are referred to as healthcare priority setting underpinned by health technology assessment.

But these emerging evidence-based approaches face legal, political, methodological, philosophical and ethical challenges – particularly when 'tragic choices' have to be made. Healthcare priority setting is not a purely technical exercise but involves considerations of societal or social values. Measuring health gain, determining cost-effectiveness and setting priorities all presuppose values such as fairness, non-discrimination and responsiveness to need, and obligations of accountability and transparency.

Yet, there is still much work to be done on how values are to be incorporated into routine day-to-day decision-making. Public health practitioners have been at the heart of this new international research and policy movement to address the challenges of delivering efficient and equitable healthcare.

Bringing together colleagues from diverse backgrounds, such as law, ethics, philosophy and patient and public involvement, they are undertaking research and policy analysis to improve the overall health of the public in developing as well as developed countries. It is taking evidence-based medicine one step further. It can work at an individual citizen level as well as influence governments and national policy.

> **It is taking evidence-based medicine one step further**

By understanding and including the hopes and fears of the main players, including the general public, this work is identifying the best way for evidence to inform policy and practice in healthcare.

Peter Littlejohns
Professor of Public Health
King's College London

DEBATE: Are mass media health campaigns worth the money? Geof Rayner says they get lost in the cultural noise while Jo Dunne says the evidence that they save lives is strong

They are either compromised or outgunned

"COUGHS and sneezes spread diseases" proclaimed a health education campaign in 1945. The accompanying film depicted the best way to use a handkerchief. You can see the film at the electronic National Archives which itself states that the campaign was "far more to do with fighting absenteeism than concern about people catching a cold".

Things are never quite what they seem. The biggest health education campaign in the USA between 2002-2006, called VERB, aimed to get young people to be more physically active. Costing $339 million, it was silently constrained by political considerations – placing food or car culture 'off-limits'. Its organiser was "pleasantly surprised" it achieved any results. Whether it even deflected the USA's appalling child obesity statistics is a matter of debate.

In contrast, the success of National Non-Smoking Day was down to targeted, cost-effective activism in a world being gradually reshaped in opposition to tobacco.

But how can you fight the deluge of money in food and drink marketing? The combined marketing spend of Pepsi and Coca Cola exceeds the entire budget of the World Health Organization.

Change4Life may have developed a good profile (I declare an interest, as former expert advisor to the Department of Health on

NO

obesity), but it was a soft approach when we need many strands of activity. Some of these are tough and regulatory, eg. closing down the marketing of unhealthy foods. The food industry has powerfully influenced the current government's obesity strategy. Harm awareness campaigns for gambling and alcohol are industry-financed – more or less a fig leaf covering burgeoning, poorly-regulated product advertising.

Mass-media health campaigns are either compromised or outgunned. Culture is shifting fast, as commercial marketers know. The intensity of cultural 'noise', they say, hampers getting the message across. The US elections and the Brexit vote show that major cultural disruptions are occurring. Perhaps this is why TV cancer-prevention advertising or the various campaigns funded by Public Health England seem banal.

Not having money forces you to think. The critical issue is what is to be achieved: short-term profile or long-term results? In many cases the balance tips against media health campaigns. In the case of 'flu vaccination, well-timed and integrated media campaigns might be useful. The old advertiser's saying still holds: only 50% of advertising works, but which 50% is unclear!

Geof Rayner
Honorary Research Fellow
Department of Sociology
City University of London

Geof Rayner is co-author, with Tim Lang, of 'Ecological Public Health: Reshaping the Conditions for Good Health', Routledge

We have a duty to share what we know

PEOPLE do frequently question the value of mass-media public health advertising campaigns. They are not always as expensive as people imagine, but as they are very visible they get talked about. And that's fine: taxpayers have a right to know how we spend public money, and colleagues should be confident that we apply the same rigour to marketing as to any other public health intervention.

When lives are at risk, people expect their government to warn them. Past public information campaigns have effectively communicated that smoking kills, driven uptake of seatbelts and shifted the societal norm away from drink-driving. Who would turn back the clock?

As we learn more, we have a responsibility to share what we know, for example about how to spot the early signs of cancer or sepsis. While public health professionals read the academic literature, ordinary people do not. Some may not read a newspaper or watch the news, but most watch television. We can reach 93% of the population with a TV advertising campaign in just one week.

Mass media, such as advertising, might be the most visible elements of our campaigns, but these are often just the 'front end', directing people to an increasingly sophisticated range of tools that help them make changes to their lifestyles. Examples include our

YES

Change4Life Sugar Smart app, which has been downloaded over two million times and lets parents see how much sugar is hidden in the food they buy.

The evidence that marketing can save lives, improve quality of life and save the NHS money is strong. For example, econometric modelling of our Act FAST campaign estimates that, over the past six years, it resulted in 47,804 more people arriving at hospital within three hours of having a stroke, saving 12,200 Quality Adjusted Life Years. This has generated an economic return of £411 million, equating to £28 for every £1 of public money spent.

While these results are impressive, we can be more efficient. Our Stoptober campaign spend, including television advertising, has fallen from £4 million to £1 million by using highly targeted social media advertising to reach smokers for a fraction of the price. Increasingly, our advertising spend is matched by partners such as Asda, Weight Watchers or the Disney Corporation, ensuring our investment leverages additional funds.

And we keep innovating. We will soon publish our marketing strategy for the next three years, outlining how we will tackle new health challenges such as antimicrobial resistance. As always in public health, there is much to do, but there is a strengthening evidence-base for how to do it well.

Jo Dunne
Head of Directorate Office (Health and Wellbeing)
Public Health England

Smoke signals

A cycle of increasing awareness, shifting attitudes and strong legislation has led to a significant decline in cigarette smoking since the 1970s, says Amanda Sandford

ADULT smoking has more than halved since the early 1970s when 51% of men and 41% of women were cigarette smokers. Just as importantly, youth smoking has also declined sharply with 18% of children in 2014 reporting that they had ever smoked, compared to half in 1982.

So what has led to this significant decline? The answer lies in a combination of legislation, shifting public attitudes and greater awareness of the hazards.

One of the most important interventions was the landmark smokefree legislation implemented a decade ago which brought instant health protection to the millions of people who previously worked and socialised in smoke-laden venues. Significant health benefits were achieved quickly, as shown by marked reductions in emergency hospital admissions for heart disease and asthma.

But that legislation followed a shift in public attitudes to smoking in public places. Support for the 'right' to smoke in indoor public places was displaced by greater support for the right to breathe air free from tobacco pollution. The proportion of adults favouring smokefree workplaces rose from 51% in spring 2004 to 66% by December 2005. The smokefree law also prompted a rise in quit attempts and there is some evidence that it has deterred some teenagers from starting. This behavioural change has also strengthened attitudes, as demonstrated by the continuing rise in support for the smokefree legislation.

Building cross-party parliamentary support is essential to the passage of good public health law and was particularly important in getting the smokefree legislation through Parliament. Since then there has been a growing consensus of support for a raft of tobacco-control measures. The primary legislation banning smoking in cars carrying children was approved on a free vote by 376 to 107, a larger majority than even that for the 2007 smokefree public places law.

The smokefree law is a good example of how population-wide regulations are key to changing attitudes and behaviour compared to education alone. But the turning point came a decade earlier with the launch of the first government strategy on tobacco control which recognised the need for a comprehensive approach. The 1998 *Smoking Kills* policy document resulted in the ban on tobacco advertising, successive rises in tobacco taxation and the establishment of the stop-smoking services.

EU legislation also played a key role in securing measures such as pictorial health warnings on tobacco packaging. Meanwhile, international agreements have driven action against the illicit trade in tobacco which can undermine tobacco control policy.

However, much more needs to be done to reduce the harm caused by smoking, particularly among socially disadvantaged groups where smoking rates are typically more than double the rates of the general population. In her first speech as Prime Minister, Theresa May promised to fight "against the burning injustice that, if you're born poor, you will die on average nine years earlier than others". Although she did not specifically refer to tobacco use, the Government has acknowledged that smoking is responsible for half the gap in life expectancy between rich and poor in the UK. But will this acknowledgement translate into action?

Despite assurances from Health Minister Nicola Blackwood that tobacco control remains a "top priority" and that the Government is committed to publishing a new tobacco control plan to replace the one that expired in December 2015, we still await a publication date.

We urgently need a new strategy to reduce health inequalities and the thousands of premature deaths that smoking still causes.

Amanda Sandford
Information Manager
Action on Smoking and Health

A history of tackling accidents head on

A HUNDRED years ago this year, restricted street lighting in London due to air raids led to what was described as "an alarming increase" in road traffic accidents. As the year closed, a public meeting near Westminster decided to elect a London

Safety First Council – a precursor to the Royal Society for the Prevention of Accidents (RoSPA) – to address the issue. The group's campaign encouraging people to walk on the side facing oncoming traffic led to a significant drop in fatal accidents caused by pedestrians stepping into the path of vehicles.

Over the past 100 years many more such challenges have been tackled in a similar way. These include campaigns to introduce compulsory wearing of seatbelts and legislation banning the use of mobile phones behind the wheel – not just on the road but also in the workplace.

It was not RoSPA alone that tackled the challenge of life-changing accidents. Decades of investment by the Government and employers in education, enforcement and engineering on the roads and in the workplace have seen significant and systematic reductions in casualties, so that the UK is now a world leader in road and workplace accident prevention. There has been a tremendous return on investment in terms of the huge reduction in fatalities and serious injury.

But there is a problem. Relative to these huge strides, there have been constant setbacks in our efforts to reduce home and leisure accidents. In the decade after the Department of Trade and Industry (now Business, Energy and Industrial Strategy) stopped collecting injury causation data, hospital A&E attendances rates grew by 65 per cent. Without this crucial data, product designers, politicians, civil servants, companies and accident prevention practitioners have struggled to prioritise, evaluate and justify investment in accident prevention programmes. As a result, home and leisure accidents have been largely neglected, leading to a long-term and increasingly unsustainable rise in A&E attendances and a steady increase in fatalities. Accidents are now the principle cause of preventable, premature death for most of our lives – one in 40 of us will have a fatal accident unless we do something different.

One hundred years on from its inception, RoSPA and its partners are working hard to make accident prevention a public health priority, just as it was when the London Safety First Council was formed. We need to put the issue back on the map of public awareness, because accidents don't have to happen.

Errol Taylor
Deputy Chief Executive
The Royal Society for the Prevention of Accidents

Hard to target and assess – but life-saving

THERE are 5,000 fewer cases of cervical cancer every year as a result of screening. This is one of 11 national NHS screening programmes that detect disease or risk factors early, reduce disability and save lives.

Last year, the programmes carried out 20 million screening tests in England for more than 30 conditions and referred 450,000 people for diagnosis and possible treatment.

Continuous efforts are being made to consider new screening programmes as well as improve the current set. There are ethical concerns in offering millions of essentially well people tests that may bring harm. There are also real technical challenges in managing and quality-assuring programmes of this size. Major changes are proposed in some of our largest programmes.

Following ministerial approval, faecal immunochemical testing (FIT) will replace the guaiac faecal occult blood test for bowel cancer. Not only is FIT a more accurate test, research shows it could increase uptake by around 10% – meaning 200,000 more people tested each year. The aim is to start sending FIT tests out in April 2018.

Ministers have also approved *Human papillomavirus* rather than liquid-based cytology as a primary screen in the cervical programme. This, combined with the fact that immunised women are now entering the programme, promises to completely change cervical screening.

We know how public health colleagues feel about the lack of regular local data, including the ability to assess efforts to improve uptake. We have been publishing regular key performance indicators on the antenatal, newborn, diabetic eye and abdominal aortic aneurysm programmes for years. We have just started sharing management information on breast and cervical cancer ahead of official publication.

There is increasing focus on uptake and inequalities. Breast and cervical screening statistics show a decline in uptake and coverage. We have commissioned and published a review of evidence in this area and will be including evidence-based actions in the screening service specifications..

Finally, please visit our screening blog for updates on our work and examples of good practice across England: https://phescreening.blog.gov.uk/

Anne Mackie
Director of Programmes
UK National Screening Committee

Out of season

The success of the campaign to reduce salt intake shows how evidence and lobbying can make a difference, say Chris Kypridemos and Simon Capewell

MOST public health victories reflect a fairly consistent pathway beginning with the scientific evidence and leading eventually to effective public health regulation.

One clear success is the campaign to reduce salt in people's diets. Every year in the UK around 12,000 cardiovascular deaths are attributable to excess intake of dietary salt. Excess salt consumption also increases the risk of stomach cancer and kidney disease.

Consensus Action on Salt and Health (CASH) was formed in the 1990s to raise awareness of the ill effects of excess salt consumption. CASH was very successful in providing scientific evidence, leadership and advocacy including organising media campaigns and lobbying MPs. This eventually led to salt being prioritised by the Government and the Food Standards Agency (FSA).

The UK Scientific Advisory Committee on Nutrition reported on *Salt and Health* in 2003. The Government then set a salt reduction target of 6g of salt a day by 2010 as a challenging but achievable goal, which would bring measurable improvements in health. The FSA salt reduction programme implemented from 2004 involved media campaigns (Sid the Slug), clearer labelling of salt content in food and, most importantly, reformulation of processed food.

In 2003, about 80% of population salt intake came from processed food. The FSA developed salt content targets for a wide range of food groups, and then worked closely with industry to make it happen. This process was not entirely voluntary – substantial political pressure was applied steadily by successive ministers of public health, and both CASH and the FSA threatened to name and shame non-compliant manufacturers.

This worked. Between 2001 and 2011, the mean salt consumption in the UK

> **CASH and the FSA threatened to name and shame non-compliant manufacturers**

dropped from 9.5g/day to 8.1g/day per person, representing a 15% reduction. This translated into approximately 10,000 fewer deaths each year and recurrent annual savings of approximately £1.5 billion.

This UK progress slowed after 2010, when ministerial pressure was replaced by the Responsibility Deal, a voluntary scheme generally agreed to be ineffective. By one estimation, this relaxation of pressure on the industry resulted in approximately 6,000 completely avoidable deaths.

Studies have consistently suggested that mandatory reformulation can be far more effective than voluntary schemes and also more equitable. Mandatory reformulation of processed foods and other legislative initiatives have already been adopted successfully in Argentina, South Africa, Portugal, Hungary and elsewhere, emphasising their political and technical feasibility. Achieving the UK national salt target of 6g/day will most likely require the adoption of similar legislative changes. Welcome support may come from the Public Health England (PHE) sugar reformulation programme; PHE is scheduled to address salt in 2017.

Scientific research, then campaigning and lobbying by public health professionals, charities and the wider public have substantially reduced average UK salt intake. However, it is still 8g/day, far above the maximum levels recommended by the FSA (6g/day) or the World Health Organisation (5g/day). There is a long way still to go. Good intentions may need to be bolstered by mandatory reformulation.

Chris Kypridemos
PhD student in public health modelling
Simon Capewell
Professor of Clinical Epidemiology
Department of Public Health & Policy
University of Liverpool

Critical jabs

The figures prove that vaccination has been a spectacular success, but we must continue to broadcast its immense value, says Catherine Heffernan

Edward Jenner vaccinating a boy © Wellcome Library, London

THERE'S a much-cited phrase in Master of Public Health programmes that "next to clean running water, vaccinations are the most successful public health intervention". It's a phrase students use to introduce essays and with which specialists open presentations. It's much accepted yet little questioned.

Before the diphtheria vaccine was introduced in 1942, there had been 50,809 cases in the UK in 1941. In 2014 there was just one. In the year before measles vaccine in 1968, there had been 460,407 notified cases. In 2014 there were 130. With meningococcal C vaccine in 1999, there had been 883 notified cases. In 2014 there were 28.

In the past three years, I've seen for myself the huge drop in hospital admissions in infants due to the introduction of Rotavirus vaccine in 2013. Within a year hospitalisations had dropped from 1,214 to 424 cases in infants under the age of one year. Clearly vaccines have an impact – but how, and for how long?

There are currently 17 national immunisation programmes in the UK, known collectively as the Section 7a immunisation programmes. The criteria for deciding upon an immunisation programme is not quite as clear-cut as those for population-based screening programmes, but they are usually based on direct and/or indirect protection. 'Direct' means the person receiving the vaccine is directly protected from infection (eg. rubella) or progression to severe disease (as in the case of neonatal BCG or adult shingles vaccine). 'Indirect' protection relates to interrupting the spread of disease, referred to as herd immunity.

Indirect protection can also refer to reduction of carriage of meningococci in predominant carriers (eg. Men ACWY in adolescents), thereby protecting the most vulnerable from invasive disease.

> **There is much work to do in explaining the scientific evidence of vaccines in the face of populist rhetoric**

Influenza vaccine provides both direct and indirect protection – individuals most at risk are vaccinated to protect themselves against the main strains while healthy children are vaccinated with Fluenz, as they are the main carriers of flu. By vaccinating them, we reduce the transmission of flu.

And therein lies the problem. Because vaccines such as flu vaccine interrupt transmission, they reduce the level of disease in the population resulting in people becoming complacent about vaccines. People can falsely assume that the diseases are no longer around and are not as convinced of the benefits of vaccinations. Instead they focus on the side effects.

We have certainly seen our controversies around vaccinations in recent years – Wakefield and MMR being one notable example and the recent media uproar on HPV and the erroneous link to development of chronic illnesses being another. While vaccines are scientific developments and constantly improving, they are very much concerned with patient safety. A vaccine only comes to the market after years of development and vaccine trials.

In the wake of 2016's populism, there is much work to do in explaining the scientific evidence of vaccines in the face of populist rhetoric. While the UK has one of the highest uptakes of vaccinations in the world, our immunity for many diseases will be solely vaccine-induced.

That means we will need our herd immunity more than ever to prevent communicable diseases.

Catherine Heffernan
Principal Adviser for Commissioning Early Years, Immunisations and Vaccination Services
Public Health England

A success story – but we need to keep it up

"CHILDREN by choice not chance" was one of many slogans informing the UK's sexual and reproductive health services in the 1920s. Easier access to contraception has been key to helping women and men avoid unplanned pregnancies.

There were 23 conceptions per 1,000 15-17 year-old girls in England in 2014, compared to a high of 55 in 1971. This has been a great public health success story, but sustained action is needed to ensure this downward trend continues.

Continued investment in sexual and reproductive health services has led to significant reductions in unplanned pregnancies in under-18s, especially in places like Bristol, one of the UK's teenage-pregnancy hotspots. Repeat abortions in under-25s have fallen sharply in Bristol in the past two years compared to the England average.

Jackie Haskins, a nurse specialist in Bristol helping vulnerable women avoid repeat pregnancies, says: "Much of my work is facilitating young women to make healthy choices, which will enable them to enjoy relationships free from abuse and exploitation, when they have previously had difficulty accessing advice and services.

"Since 2008 we have individually targeted and supported teenagers who have already had a pregnancy. They are referred to us via local maternity services and also the termination service. We contact or meet face-to-face during their pregnancy or prior to their termination and keep in touch for six months or longer. The uptake of long-acting reversible contraception [LARC] methods in this group has increased by more than 80%, as has knowledge about safer sex. The young people have text access to the outreach nurses for as long as they wish and sometimes this is for a number of years.

"We work closely with other professionals including Family Nurse Partnership, GPs, social workers and colleagues in education."

Using innovative public health approaches to tackle repeat pregnancies is what has drawn talented trainees like Susanna Hall to work with Jackie. Susanna, who is doing her final year training in community sexual and reproductive healthcare, one of the most competitive specialty training schemes for medics, explains why public health is so important.

"Looking at sexual health services through a new lens of screening and prevention is eye-opening," she says. "I look after vulnerable women and help them with a range of issues, including domestic violence, not just their sexual health outcomes."

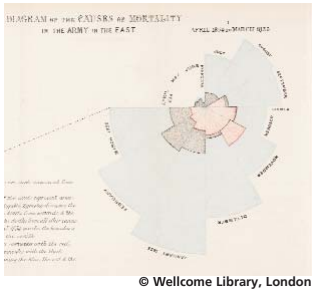
Bristol remains part of the Office of Sexual Health for the South West, set up by Gabriel Scally when he led the South West Regional Public Health Group. The office supports local authority public health teams to commission quality sexual health services – a vital leadership role when commissioning responsibilities are so fragmented.

The National Institute for Health and Care Excellence has told us for 10 years that LARC is a cost-effective life saver. The challenge is getting all women of child-bearing age who do not wish to have a baby to use it – with condoms for protection against transmissible diseases.

Councils in England need to work hard to make sure that these vital services are grown when funding is under threat.

Thara Raj
Consultant in Public Health
Joint appointment Bristol City Council and Public Health England

Graphic images to show our key challenges



© Wellcome Library, London

THE Faculty of Public Health (FPH) has begun an exciting collaboration with the London College of Communication (LCC), challenging its graphic design students to put across public health messages in fresh and original ways. The results will appear in future issues of *Public Health Today*.

Information graphics and the practice of public health have a long relationship. Dr John Snow was using data visualisation in his famous 1854 'cholera map' of London's Soho, allowing him to close the Broad Street pump at the centre of the outbreak. Florence Nightingale invented complex 'rose' or 'coxcomb' charts (above), showing causes of death among soldiers in the Crimean War, and how they changed over time (Mortality of the British Army, 1858).

FPH has asked the final year LCC students to follow in these considerable footsteps. Students chose from four topics: early years and infant mortality, childhood obesity, road traffic accidents and alcohol harms.

The projects are designed for publication in *Public Health Today*, with digital equivalents. The students were given defined datasets and have been hard at work. Members of our editorial board have been briefing and giving feedback, as part of the 'industry practice' module – simulating a real-life design brief.

At the time of writing, the designers are still designing. The work judged to have best met the brief for each topic will be printed in the centre pages of *Public Health Today* during 2017, and we have plans to include more of the projects on the FPH website and at next year's conference in Telford.

Public health messages of the future are in talented hands.

David Dickinson
Editorial Board member
Public Health Today

We must make ourselves the people's experts

OUR lengthening lifespan will see us move from a past when very few survived beyond their 60s to a world, by 2050, in which one-in-five people is over 60.

This great achievement raises the challenge of how we live our extra years to the full – and how we tackle rising inequalities in healthy life expectancy.

Rapid demographic change has been matched by economic, political and social change. The hope at the turn of the century, with the fall of the Berlin Wall and Nelson Mandela's release from prison, has been battered by 9/11, the Iraq war and the rise of Isis. The complexity of globalisation and the effects on local economies of off-shoring, multinationals and mass movements of capital and workers are being met with efforts to wrest back control which too often have xenophobic overtones and involve calls to build walls and take countries back to their racist, misogynist and imperialist glory days.

It's a "people... have had enough of experts" postmodern world in which there is seemingly no such thing as objective truth. And it's unclear how things will play out. In these uncertain times many more people will experience hardship. And through all this, our experience is recorded and shaped by the revealing omnipresence of social media – our personal, professional and political lives intersect.

Great medical and public health advances have driven increases in life expectancy. Yet over-medicalisation prevails

> **Devolution promises a shift from a highly centralised state (and NHS) to the release of local energies**

and global warming continues apace, unleashing extreme weather and potentially new – or re-emergent – communicable diseases, mainly affecting vulnerable populations.

And, with the new epidemic of non-communicable disease, the commercial determinants of health have never been so important. While the UK successfully controls tobacco consumption, globally it rises 4% a year. The UK has barely started to tackle obesity; the recent national strategy is evidence of the ongoing conflict between the 'national interest' of the junk-food industry and the health of our nation's children.

While much needs to be done to tackle big issues at scale nationally, devolution promises a shift from a highly centralised state (and NHS) to the release of local energies, partnerships and innovation for the benefit of residents. It's about public sector reform, where there is less prescription about the way we deliver services and more focus on the outcomes achieved – although this transformation coincides with budget cuts. Will we really see a shift from funding expensive interventions to a "radical upgrade in prevention" (*NHS Five Year Forward View*).

So what for public health in the 21st century? What measures do we need and

Smoking-cessation poster, Nepal

how do we organise ourselves to articulate and deliver a public health model for our contemporary socio-political and ecological context?

We can start by reclaiming the term 'expert' while ensuring we remain closely connected to the lives of those we serve. The challenge for those of us in local government is to shape our core purpose as "independent advocate[s] for the health of the population and system leadership for its improvement and protection" (Association of Directors of Public Health).

We need to continue to chart and challenge the iniquity of inequality and mitigate harm, to exploit the opportunities presented by public sector reform and the integration of health and social care, and to galvanise efforts to shift resources to prevention. Our vision must be for a society where all can enjoy fulfilling, healthy lives and relationships.

Jeanelle de Gruchy
Vice-President
Association of Directors of Public Health
Director of Public Health
London Borough of Haringey

Here come the plugged-in centenarians

FORESIGHT is rarely celebrated because the impact of something that doesn't happen is usually invisible. People seldom see how much worse things could be if mitigating steps hadn't been taken.

Technological advancement means society is evolving at an unprecedented rate. If a device can be plugged in and switched on then it's collecting data. About 90% of operational data is unused. As tech integrates into our lives through our phones, watches and even our kitchen appliances, public health can mobilise this rich stream of intelligence for surveillance and behaviour change. Social entrepreneurs are developing software to make your mobile phone an early-warning system for your mental health. It knows a lot about your sleep patterns, levels of inactivity and social connectedness.

Life expectancy is rising quickly. Around a third of children aged five today can expect to see their 100th birthday – double the proportion of their parents and triple that of their grandparents. This is a great success for public health but comes at a cost. More of us are living longer but with a greater proportion of our lives affected by illness and impairment. Living to 100 with a reasonable quality of life and independence requires investment in personal health and wellbeing as well as financial resources.

The traditional three-stage life – education, employment, retirement – is unlikely to be sustainable. People will probably have several careers with multiple periods of training and 'retirement'. There are opportunities here to rethink our approach to careers and professions.

We know from market research that the attitudes and beliefs of the baby-boom generation are different from those of the millennial generation. In around 2030 the millennials will start to move into senior management positions and become the predominant influencing generation. Their digital world will shape system-wide public health approaches and the experience of health and social care.

We are, at heart, a specialism of futurologists, but we rarely take the time to celebrate this part of the art of public health. Emerging opportunities to use the full breadth of our skills will be ours to take.

Justin Varney
National Lead for Adult Health and Wellbeing
Public Health England

Addressed to kill and guess who's dying

THERE'S been no shortage of books on health inequalities – from the famously suppressed 1980 'Black Report', through Margaret Whitehead's follow-up *The Health Divide* and Kate Pickett and Richard Wilkinson's celebrated *The Spirit Level*, to last year's *The Health Gap* by Michael Marmot. Health inequalities is a crowded field, and the challenge for any author is to find a niche.

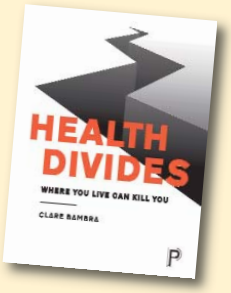
What makes Clare Bambra's *Health Divides* stand out is the way she explores the subject through the lens of place. Fittingly for a public health geographer she sees health status and life chances as being closely linked to where people are born, raised, learn, live, work and play.

After a historical scene-setting, inevitably starting with John Snow and the Broad Street pump, she goes on to conduct a forensic examination of place in terms of compositional factors (who lives there) and contextual factors (what kind of place it is). She illustrates this approach largely through the use of four case studies – the 'health divides' of the title – namely the US 'health disadvantage', the 'Scottish health effect', the English 'north-south divide' and local health inequalities in Stockton-on Tees.

But it's in chapters five and six, when Bambra throws off her geographical chains and dives right into the mire of politics, that the book, for me, really comes to life, and her passion for fairness and social justice shines through her objectively balanced assemblage of facts and figures. Again, she uses the four case studies to show how health is indivisible from politics, how it is a fundamental human right, how 'the organised efforts of society' can make or break the public's health. It's political epidemiology red in tooth and claw.

This is a fascinating and very readable analysis, ranging across the US, Europe and the UK, from the aftermath of the Second World War to the present day. It will appeal to anyone seeking a deeper understanding of the causes of the causes of health inequalities in the developed world. I particularly enjoyed the section on the effects of German re-unification and the chapter picking over the entrails of Thatcherism, New Labour and the Coalition.

There are lots of lessons to be learned, and ultimately, Bambra concludes, it all



comes down to political will and strategic choice.

Where you live need not be a matter of life and death.

Alan Maryon-Davis

Health divides: Where you live can kill you
Clare Bambra

Published by Policy Press
ISBN 978-1447330356
RRP: £12.99

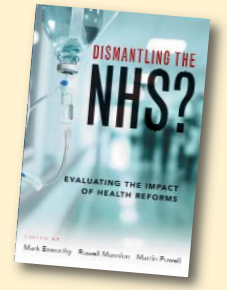
A triumph of ideology over evidence

THIS book provides a wide array of contributors' analyses of the impacts of the Coalition Government's 'reforms' of the NHS. Their examinations, which cover finances, productivity, workforce, healthy equity, effectiveness of health and social care integration, public health, public involvement, quality and safety of care, searched for evidence of both positive and negative impacts. The results largely do not challenge the popular view that the reforms were a huge gamble, based on market ideology rather than evidence.

The contributors struggle to find impacts or mechanisms driven by the policy changes that look as though they might do some good. Given the complexity of the NHS, the evidence is itself complex, of course. There may have been increases in productivity, but there are doubts about their sustainability. The section on public health is positive, but lukewarm: "While there is much to welcome in these changes within public health... it may be a case of the right policy at the wrong time..." (when there are swingeing cuts to public services).

The New Zealand contributors contrast the White Paper's stated intention to create "an environment where staff and organisations enjoy greater freedom and clearer incentives to flourish" while imposing more rules and constraints on managers and cutting budgets. They cite research showing managers are more pressured than ever, constantly trying to balance making cuts with maintaining services and patient safety, complying with endless government-imposed demands for information, and being themselves targets for cuts. Another chapter suggests that while NHS staffing remains crucial to the success of reforms, their accumulated effect over years has created a perpetual crisis in managing the NHS, and economic imperatives under the reformed system have come to overshadow ethics of care, with profound effects for patients. The 'success' in reducing management costs has been at the price of workplace stress, redundancy, agency costs and gaps in service provision.

The chapter on equity finds a more difficult environment for reallocating resources effectively, and little likelihood that clinical commissioning groups (CCGs) will make more progress than primary care trusts in that respect. They found little evidence of health and wellbeing boards being able to cooperate enough with



CCGs to address inequities, given "the stagnant NHS budget since 2010".

Empty political rhetoric, exposed.

Andy Beckingham

Dismantling the NHS? Evaluating the impact of health reforms
Editors: Mark Exworthy, Russell Mannion, Martin Powell

Published by Policy Press
ISBN 978-1447330233
RRP: £26.99

From the CEO

IN THIS issue we reflect on some of the key achievements of public health across the past two centuries. This historical perspective is important – but let us note Aldous Huxley's concern: "That men do not learn very much from the lessons of history is the most important of all the lessons of history."

So, are we able to learn these lessons and apply them to the future – and if so, how?

Many of you will already be aware of Professor Dame Anne Johnson's report *Improving the health of the public by 2040*, (http://bit.ly/1LDoWoO) setting out a number of recommendations for action: improving co-ordination of research, harnessing digital technologies, aligning approaches between clinical and public health practice, working with all sectors of society and engaging globally.

In a not dissimilar vein, FPH President John Middleton has flagged a number of future challenges for the sector in an article in the *European Journal of Public Health* (http://bit.ly/2g0PklF). John cites terrorism, food shortages and a lack of antibiotics as public health challenges already upon us – and asks us to think about where we will need to learn new skills, make new alliances and be more effective.

FPH, its staff and members, must pick up these challenges and ask how they influence how we develop our curriculum and enhance the skills of the profession. What are the critical alliances we should develop – not just among the public health sector and across other professional disciplines, but across the third sector, civil society and with the public?

FPH is already building on existing partnerships in the UK and internationally, but this needs to accelerate. Our connectivity and capacity to act collaboratively – based on existing and emerging evidence – needs strong leadership and clear voices. FPH, as individuals and as a membership organisation, does and must continue to play a key role in the "organised efforts of society".

Our special interest groups are developing at pace and provide a fantastic opportunity to drive forward this agenda – but we can't afford to hang around. If you aren't already, please get involved. The future needs you.

"The value of history is, indeed, not scientific but moral: by liberalizing the mind, by deepening the sympathies, by fortifying the will, it enables us to control, not society, but ourselves – a much more important thing; it prepares us to live more humanely in the present and to meet rather than to foretell the future"
– Carl Becker, 1873-1945, US historian

David Allen

FPH elections

FACULTY OF PUBLIC HEALTH

Registrar

Peter Sheridan will be standing down as Registrar on the Faculty of Public Health (FPH) achieving incorporation as a charitable company, which it hopes to achieve during the first half of 2017. In addition, Meradin Peachey will complete her term as Vice President for Standards at the AGM in 2017 and, in accordance with the governance arrangements for the new incorporated FPH, this post is to be stood down and the role subsumed within that of Registrar. The new Registrar will therefore play a key role in both undertaking the functions of company secretary and in leading FPH's work on public health standards.

Nominations are currently open for the election of a new Registrar and will close on **31 January 2017**. The post is open to all FPH Fellows.

Local Board Members

Nominations will open on 6 February 2017, and close on **6 March 2017**, for the election of Local Board Members for the following constituencies: North East, East of England, London, South Central, South East Coast, South West and Wales. The posts are open to all FPH members.

Nomination papers for all roles, including post descriptions, are available on the FPH online members' area or from carolinewren@fph.org.uk, tel. 020 3696 1464.

In memoriam

Peter Draper FFPH
1933 – 2016

PETER Draper single-handedly invented the study of health policy in the UK and for many of us was the most important UK public health practitioner in the second half of the 20th century.

Early 1970s public health had a settled, environmental focus with no awareness of what we now call the social determinants of health. The 1974 NHS reorganisation replaced local authority public health advocacy with technocratic NHS community medicine. In this stifling climate, the launch of Peter's Unit for the Study of Health Policy (USHP) at Guy's Hospital Medical School in 1975 was a breath of fresh air. Peter brought together practitioners of epidemiology, sociology, health economics, statistics and public health to challenge predominant approaches that emphasised individualistic 'victim-blaming' policy solutions. That we now routinely consider causes of ill health as diverse as macroeconomic policy, fuel poverty, unhealthy work, unemployment, agricultural policy and the arms trade owes much to Peter's contribution.

The output from USHP's decade of existence represents an unrivalled body of critical public health scholarship. Some papers, such as the 1977 *Journal of the Royal Society of Health* 'Health and wealth' – an analysis of the health impacts of market ideology and economics – remain in the vanguard of knowledge.

Peter took on vested interests with courage and relish – equally prepared to attack Big Pharma for exaggerated claims and prices or his own medical colleagues for using scarce NHS resources to promote early UK heart transplants; he enjoyed a *Daily Mail* front page headline, 'Top Doc Slams Heart Swops', which followed a USHP press release.

After funding problems caused the closure of USHP in 1984, Peter remained a prolific writer, consultant and activist. In 1986 a *Health Service Journal* article 'Whatever happened to public health?' which Peter and I wrote, led directly to the founding of the Public Health Alliance, later the UK Public Health Association.

In 1991 he edited *Health Through Public Policy: The Greening of Public Health* which brought together his thinking about the broad scope of healthy public policy – another now-familiar term.

Peter was born in Blackburn; he studied medicine at Magdalene College, Cambridge and trained in Manchester hospitals. He lived with and wrote extensively about bipolar disease; he was also a prominent humanist.

Alex Scott-Samuel

Stuart Paynter FFPH
1969 – 2015

IN HIS tragically short life Stuart Paynter had already made important contributions to our understanding of maternal and infant health and disease in low-income tropical countries. Much of his research

centred on factors involved in viral transmission, notably respiratory syncytial virus, and Stuart's main contribution was in mathematical modelling of various causative factors, with a series of influential papers.

Graduating with an MSc in Public Health from the London School of Hygiene & Tropical Medicine, Stuart worked for the World Health Organisation, the Health Protection Agency and the NHS before moving back to Australia to take up a public health consultant post with Queensland Health. He then switched to academe, gaining his doctorate with a thesis on the environmental drivers of seasonal lower respiratory tract infections in infants in the tropics.

Stuart held a number of academic posts in Queensland and Perth before being appointed senior lecturer in epidemiology at the University of Queensland. Along with his research he was a dedicated teacher, much appreciated by his students. He had a gift for bringing statistics and mathematical modelling to life. Described by his friends as unassuming, well-informed, passionate, Stuart was loved for his brilliance, his frankness, his wicked wit, his geekiness and his perennial ability to laugh at himself.

Fiona Tolley FFPH
1949 – 2016

FIONA Tolley was one of the first non-medical public health consultants in the country and one of the very first non-medical directors of public health (DPHs). She originally trained and worked as a physiotherapist before moving into NHS management and then public health. She was awarded her MPH from Cardiff University.

Fiona was DPH for Torbay in Devon from 2002 to 2008 and one of the first to become a DPH when primary care trusts were created. She set up the public health team in Torbay, secured additional funding and instigated programmes to improve lifestyles, from 'bay walks' to an enhanced drugs and alcohol service.

The DPH role required extensive partnership working within the NHS and with other statutory agencies and Fiona excelled at this. Her personality and sense of style were always remarked on; anyone who knew her will remember her trademark earrings and wicked sense of humour.

Working for Fiona was a pleasure but did come with challenges. She had high standards for herself and high expectations of others. Many of us who started our careers in public health with her in Torbay consider ourselves very lucky to have benefited from her expertise, example and guidance. After Fiona retired she was kind enough to continue to mentor a number of us and was a very dear friend.

Debbie Stark

Deceased members

The following members have also passed away:

John Clarke MFPH
Charles Simpson MFPH

Correction: In the Autumn 2016 issue we mistakenly reported the death of David Simpson OBE, former director of ASH and tireless campaigner for tobacco control. We are delighted to say that David is very much alive and active in the world of tobacco and health. We sincerely apologise for any distress we may have caused.

Making sure the right people get the senior jobs

THE Advisory Appointments Committee (AAC) is a widely recognised, tried-and-tested method of recruiting to senior public health appointments. The Faculty of Public Health (FPH) endeavours to send an independent assessor to sit on every AAC senior public health specialist interview panel. AACs provide a quality-assured appointments system to any employer and minimise the risks to them by ensuring that only those who are qualified for specialist posts are considered for appointment.

Failing to appoint a properly qualified specialist increases the risk of an employer being drawn to a candidate who is not on the specialist register, not capable of meeting the necessary job requirements and therefore not capable of doing the job. This can harm the public and needs to be avoided at all costs.

A faculty adviser deals directly with the employer in signing off the job description, person specification and advertisement, including relevant information based on the FPH templates for each post; these might be consultant, director of public health (DPH) or any other specialist post. Once this has been approved, the faculty adviser will provide an approval letter to the employer who can then approach the FPH office (aac@fph.org.uk) for a list of assessors to sit on the panel. Full details of panel compositions are available on the website at www.fph.org.uk/senior_public_health_appointments

The faculty assessor will take part in the shortlisting and interview process for an AAC to ensure that the candidate meets the relevant criteria. The faculty assessor will then let the FPH office know the outcome of the AAC.

Each FPH region, including: East of England, East Midlands, London, Northern Ireland, North East, North West, South Central, South East Coast, South West, Public Health England, Wales, Yorkshire and Humber, and Scotland, has a faculty adviser.

Our assessors are made up of consultants, academics, consultants in communicable disease control, DPHs and assistant DPHs who assist with AACs per year; they are provided with training once a year and need to have attended a training course within the previous four years to be able to represent FPH at an interview.

There are approximately 150 files opened each year and assessors are required to sit on a minimum of two panels per year. Most of the posts are consultant posts, but FPH also covers DPH and academic posts and other niche specialist roles.

It is vitally important that each employer, FPH assessor and FPH adviser lets the FPH office know of the outcome of each interview panel so that we can gain a clear picture of all of the appointments made across the year.

The appointments process would not be possible without our 257 assessors, and we would like to thank all of them for the work they do on our behalf.

Hannah Westoby
FPH Appointments & Workforce Co-ordinator

Win an award for your work

NOTICE OF ENTRY DEADLINES FOR 2017 AWARDS

COCHRANE PRIZE
Awarded to an undergraduate to support educational activity in public health. The winner will receive a certificate and an award of up to £250 at the annual Faculty of Public Health (FPH) awards ceremony.

JUNE AND SIDNEY CROWN AWARD
Open to all FPH members in good standing and under the age of 35. To support the cost of travel to gain experience or further training outside the UK. The winner will receive a certificate and award of up to £150 at the annual FPH awards ceremony.

SIAN GRIFFITHS INTERNATIONAL AWARD
Awarded to FPH members with the aim of promoting the development of public health capacity by helping those working within the specialty to gain international public health experience either whilst in training or as a part of continuing professional development. The prize will consist of a certificate and cheque up to a maximum of £500 and shall be awarded at the annual FPH awards ceremony.

SAM RAMAIAH AWARD
Awarded to the best piece of work on a public health topic, seeking to improve the health of black and minority ethnic communities or reduce health inequalities in the UK. The winner will receive a certificate and award of up to £250 at the annual FPH awards ceremony.

BACP TRAVELLING FELLOWSHIP
Awarded biennially to assist FPH members in training to undertake educational travel, normally outside the UK. The winner will receive a letter and cheque by post; and the decision will be announced at the annual FPH awards ceremony.

SIR JOHN BROTHERSTON PRIZE
Awarded to the best essay or research on a public health topic by a student or young graduate. The winner will receive a certificate and a cheque of £100 at the annual FPH awards ceremony.

To view the regulations for these prizes, please go to the FPH website at http://www.fph.org.uk/facultyprizes or contact the Education and Training Department on 020 3696 1451 or by email at educ@fph.org.uk

DEADLINE FOR ENTRIES: 1 FEBRUARY 2017

SIGs of the best

THE Faculty of Public Health's (FPH's) Special Interest Groups (SIGs) have gone from strength to strength over the past 12 months. Their reach and outputs have made them a constant and valuable mechanism for FPH to advocate for and influence public health for the benefit of populations nationally and internationally.

FPH is now looking to expand its SIGs, using public health themes advocated for by the World Congress on Public Health and beyond:

- Maternal Health
- Devolution and Regional Health
- Genomics
- Lesbian, Gay, Bisexual and Transgender Health
- Alcohol
- Child Health
- Human and Animal Health
- Libraries and Health
- Health Promotion
- Equality and Diversity
- Oral Health
- Ocular Health
- Health in All Policies.

If you are interested in being part of or establishing a SIG based on these or any other topic, please contact Femi Biyibi, FPH Policy Officer, at femibiyibi@fph.org.uk