In this issue

> Camila Batmanghelidjh on the summer riots
> Zoe Williams avoids cycling past lots of plate glass
> International Red Cross: on the frontline

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

December 2011

Public Health Today

Building for the future
How to design wellbeing into our environment

Public Health Today
The magazine of the
UK Faculty of Public Health
December 2011

Contents

Up Front 3

Interview with Panu Sarristo 4

Special Feature – The Built Environment 6

Red light for greens 6

The transfer to local authorities can lead us to healthier places 7

Planning as a vehicle for better health 7

Debate: Can we be sure that green space promotes mental health? 8

Stairways to health 9

Moving to improved health in the US 10

Let's champion benefits of inclusive design 10

Quick! Slow down! 11

The waist land 12

Finding the remote in the Scottish Highlands 13

The worst crisis since the Great Smog of 1952 13

What exactly is high-quality green space? 14

Guide through the regulatory landscape 14

Books & Publications 15

Endnotes 16

Noticeboard 19

The Final Word 20

Lindsey Davies image © Jonathan Perugia

Cover image: Melbourne – the World's Most Liveable City 2011 (Economist Intelligence Unit)

Welcome

THE importance of the built environment to health and wellbeing has been recognised for centuries, from huts to sewers to inspiring architecture. Wordsworth captures the essence of a cityscape's ability to uplift in his wonderful poem *Upon Westminster Bridge*: "Dull would he be of soul who could pass by a sight so touching in its majesty... silent, bare, ships, towers, domes, theatres and temples lie open unto the fields and to the sky..." but the poem offers no recognition of the tension between that glorious vision and the hovels lining the streets between the domes. That tension was well known to 19th century public health pioneers and philanthropists; and many medical officers of health (MOHs) were relentless – and remarkably effective – in their pursuit of better housing and improved sanitation for their populations.

One of the MOH's most powerful levers was the ability to speak out, in public, on health matters. This capacity is a cornerstone of any successful public health system: the public must be confident that health advice and information is accurate and appropriate – and has not been influenced by conflicts of personal or political interest. There are, of course, exceptions and not every public health professional is able to speak directly to the public in this way. In the UK civil service, for example, the primary duty of officials is, quite rightly, to serve ministers. Those public health professionals who choose to work in that environment have made a conscious choice to influence from within, relinquishing their ability to make personal comments in public on government policy. This is not always comfortable, but it is an accepted and important component of the essential trust between members of the government and those whose job it is to help them develop and implement policy. In practice, even outside the civil service, no officer of any organisation can be entirely 'independent'. The normal rules of corporate governance and courtesy apply, even to the most committed and determined director of public health – but the capacity to speak out must be enshrined somewhere in the system and DPHs must be able to alert the public to health issues when they need to.

As I write this, in November 2011, I have serious concerns about the prospects for free speech for public health in England. Why? Two reasons. Firstly, I have been told that some NHS public health specialists (none of whom are civil servants), who have raised concerns about the NHS reforms, have been warned that their stance could have a potentially negative effect on their pay and/or career prospects. Secondly, Public Health England (the body which will lead English public health, play a major role in health protection and be a 'one-stop shop' for information on the population's health needs, risks and remedies) will be an executive agency of the Department of Health and part of the civil service. Unless some innovative way to secure freedom of expression is designed into its conditions of service, its staff will be bound by the civil service code of conduct and any public information PHE produces will have to be approved by ministers.

In this new context it will be more important than ever that DPHs, in their new bases in local authorities, are able to be at least as confident as the MOHs were that they can speak freely when they need to.

It's a difficult time – and although the timescale for getting things changed is now very tight, we at FPH are still doing everything we can, through our lobbying in Parliament and our work with the Department of Health, local government and the media, to reduce the risks and get a safe and sensible system in place. Your FPH officers continue to lobby with all their energies on behalf of public health professionals, professional standards and for the public's health.

Lindsey Davies

Bandage for a banned age – support for the invisible children

I WATCHED a young man biting his arm who believed that, as a bird, he was pulling out feathers. There was no parent to care for him; for a long time he had coped alone. Let me evidence the invisibility of children like him who, at best, survive on leftovers of other people's care and, at worst, shut down hope to avoid disappointment.

Kids Company supports 17,000 children and young people with psychosocial care. Recently, our work with 668 disadvantaged 16- to 23-year-olds highlighted dark statistics. Just under 560 were not registered or connected with a GP; 411 required mental health interventions; 87% had experienced multiple trauma; 394 required housing; 365 needed sexual-health interventions; 436 had to be registered with a dentist; 363 required an optician's assessment. These are citizens of the under-belly whose needs remain invisible and unmet. Young people have little faith in civil society's ability to reach out to them. As one put it: "The government hates us."

> Young people have little faith in civil society's ability to reach out to them

Young people believe this because the narrative emanating from politicians is often unwittingly derogatory. Tuition fees have increased, the EMA grant has been stopped, housing benefits have been cut. No-one will rent a room to a young man for fear that he may trash their house, and yet he cannot live in his own flat or bedsit, because £70 a week is the maximum allowance for his rent. During the summer riots the TV cameras didn't follow all those children who stole food. Instead they focused on those who took plasma TVs and trainers. Forty-two per cent of the young people brought before the courts were in receipt of free school meals. But we are too frightened to see need. Instead, we see greed.

So what brought these desperate young people to such extremes of rage? Don't go looking for big answers. The truth resides somewhere smaller: in that insidious space where human dignity is systematically eroded. The kids describe it as "stress": the door of possibility slamming in their faces. They're told to have aspirations, but no-one will pay their college fees. They're told to get fit, but no-one will give them money for the gym. They're told to eat well, but they have no more than £10 a week to buy food while on benefits. They're told to see their doctors but don't have enough phone credit or patience for the booking queue.

With 1.1 million children and young people having mental health difficulties in the UK, you'd be forgiven for thinking we were organising a nationwide famine in therapeutic support. Children need an integrated approach to wellbeing, taking into account their range of psychosocial needs in the context of sustained care relationships – not this lucky-dipping for healthcare. Proximity would yield mutual solutions – healing the wounds of the banned age with a bandage. Bandages support, hold and promote self-recovery. If a piece of cloth can do it, why can't we?

Camila Batmanghelidjh
Founder and Director
Kids Company

SHUT OUT: Coverage of the riots only focused on those who took TVs and trainers, says Camila Batmanghelidjh

News in brief

Five-year plan for NHS in Wales
Health and social services minister Lesley Griffiths has unveiled her five-year plan for the NHS in Wales. The vision is based around community services with patients at the centre, and places prevention, quality and transparency at the heart of healthcare. Further details can be found at wales.gov.uk/topics/health/publications/health/reports/together/?lang=en

Mental illness among quitting smokers
Dr Lisa McNally and Chloe Todd have published the first study to examine the prevalence of mental health conditions among those accessing community-based NHS Stop Smoking Services in the *BMC Health Services Research* journal. The study also looks at the impact of the new AIMS screening procedure.

Chicken liver pate food poisoning rise
Official figures from the Health Protection Agency show the number of outbreaks of Campylobacter food poisoning caused by eating undercooked liver pate has risen from three in 2008 to 14 last year. A fashion for undercooking chicken livers to retain flavour has been blamed.

WHO issues Europe measles alert
European countries need to act to tackle measles outbreaks, the World Health Organization warned. There were over 26,000 measles cases in 36 European countries from January to October 2011. In England and Wales, there were nearly 1,000 confirmed measles cases in that period, compared with just 374 in the whole of 2010.

Liver disease epidemic warning
Hospital admissions for alcoholic liver disease among people in their early 30s in north-east England have increased by more than 400% over eight years. The figures from health campaign group Balance reveal 189 hospital admissions for 30 to 34-year-olds in 2010 compared with 37 in 2002.

Afghans living longer and fewer infants die
Afghans are living longer, fewer infants are dying and more women are surviving childbirth because healthcare has dramatically improved in the past decade, according to a national survey. Increased access to healthcare, more hospitals and clinics and more trained healthcare workers and doctors have significantly contributed to an overall improvement in the health of most Afghans, the survey says. See http://moph.gov.af/en/documents?DID=516

Panu Sarristo is a health emergency coordinator with the International Federation of Red Cross and Red Crescent Societies. Born in Finland, he trained as a nurse anaesthetist and worked in Sweden and Norway before taking a master's degree in Disaster Relief Healthcare at the University of Ulster. He spoke to *Public Health Today* about his work

'We are already

Local knowledge key to Red Cross success

Why did you decide to work in disaster relief healthcare?
It was the international aspect of it that appealed to me, and the fact that people have to be very professional and well trained. Even when I was doing my master's, I knew I wanted to work for the International Red Cross. I took a basic training course with the Norwegian Red Cross and, because I speak some Russian and am clinically trained, I thought I would be sent to work in a hospital in Chechnya. That didn't happen. I was offered a place as a trainee delegate in disaster management in Panama. It was an interesting challenge that brought me onto the public health track. During that time, I developed an understanding of what's needed in an emergency; it's not just about disasters but also applying primary healthcare principles.

How does the International Red Cross gain the trust of local people?
We are a membership organisation, and that makes us fundamentally different from international NGOs because we have national societies. That means our members are very often the first to help their own people, and our local and national counterparts are at the core of our response. We are still there when the TV camera crews have gone. Sometimes people ask: "Is the Red Cross going to go to such and such a country?" But we don't have to go anywhere. We are everywhere. We have 187 national societies in almost every country in the world.

When do you and your colleagues get involved in an emergency?
If our International Federation has a local delegation they contact us. In somewhere like Haiti, it was very obvious in the first few hours after the earthquake. People were launching an appeal for funding. Our emergency response units have the hardware and trained units to supply water, sanitation and healthcare. In Haiti, we had 21 emergency response units, the same number we had in the [entire] tsunami region.

How do you deal with the risks of working in dangerous places?
It's a question of preparedness, training and planning. Because we have this strong local/national/international approach, people know who we are, and we are not new to their community. We don't just show up when there is a disaster. That helps us to reduce our risk. Our prior training means we are solid professionals with the character and maturity to work in very stressful situations.

> 'We are not new to their community. We don't just show up when there is a disaster. That helps us to reduce our risk'

How is emergency healthcare different from other forms of public health?
In emergency settings, everything shifts so violently on so many levels that we have to refocus our thinking. We have to keep focused on the longer-term needs and link them to recovery. It's a concept that helps us and national societies to focus on the right areas.

everywhere’

Centre of Port-au-Prince after the earthquake in 2010

How could public health professionals working at a national level benefit from this international perspective?
National public health might benefit from having greater community involvement in programmes, focusing on the resilience of communities to bounce back from crises, and not just focus on delivering services. It’s also important to take a holistic view of health and take the psychosocial approach. Communities are not just a village. They can be any group of people, such as a school or senior citizens. They each have their own needs and coping mechanisms.

What motivates you to keep going when you are working in such difficult circumstances?
At first sight, it can seem as if the challenges we face, such as the Millennium Goals, are just too big. To take the example of Haiti, we had to make very difficult decisions about priorities and the only way to do that was in a very structured way. My background in anaesthesia helps with this. The first step was search and rescue – to get people out of the rubble. We can’t help people if they are buried under a metre of rubble. The second step was to provide water, and then to arrange shelter. Then, people want to be with their loved ones. If loved ones are dead, people want to bury them. If the disasters keep coming, we need to refocus the public health work and think of risk reduction. Certain types of natural disasters can be prevented. For example, in Haiti we put in mobile text systems to send the general public messages in Haitian Creole and French about safe water or vaccinations. Some people questioned whether this was a good idea, but lots of people have mobiles, or know someone who does. This [text system] has become a permanent part of the Haitian Red Cross’s work. It means we can target users who live in a particular region and might be hit by a tropical storm.

> ‘In emergency settings, everything shifts so violently on so many levels that we have to refocus our thinking’

Where will your work take you next?
I travel to Nepal tonight to facilitate ‘field school’ training in water and sanitation with the staff of national societies and international delegates getting refresher training. We won’t just be sitting in classrooms – people will be working in the field with local Red Cross volunteers to produce plans of action.

Is there any particular piece of work you are most proud of?
After the earthquake in Haiti, the media reported that Haitians were “paralysed” and “waiting for help”. Nothing could have been more wrong. In very difficult circumstances – the central headquarters had been destroyed – Red Cross volunteers were applying their training. They dragged people from the rubble and applied first aid. We can deploy any field hospital, and that’s important, but without linking it to national volunteers it won’t perform as it is meant to. I am proud every time I see Red Cross volunteers working in the early aftermath of a disaster.

Panu Sarristo was talking to Liz Nightingale

Red light for greens

As *Public Health Today* focuses on the built environment, a relaxation of planning laws theatens environmental gains, says Alan Maryon-Davis

WE COULDN'T have timed it better. Here we are, focusing on the built environment, just as the mother of all rows has broken out between the government and the environmental lobby over the relaxation of planning restrictions in England.

The proposed National Planning Policy Framework (NPPF) sweeps away a thousand pages of "bureaucratic red tape", condensing it down to just 52 pages of streamlined policy intended to remove "unnecessary" barriers to planning and development. But, from a public health point of view, the NPPF can hardly be described as holistic, as it makes scant reference to the wellbeing of communities and provides no quantified assessment of its impact on health, habitats or the environment. Many environmentalists see the NPPF as little more than a charter for rampant erosion of the countryside and green spaces, heralding a tidal wave of new estates, hypermarkets and business parks, threatening biodiversity and increasing the carbon footprint.

As if to add fuel to the fire, the Chancellor of the Exchequer made it very clear in his Autumn Statement that, in these tough times, he doesn't want to see green policies getting in the way of business and economic growth. Forget all that husky-hugging before the election – the green agenda is facing the red light.

> **The Chancellor doesn't want to see green policies getting in the way of business and economic growth**

The other huge new policy driver impacting the built environment is the far-reaching 2011 Localism Act, described as the most fundamental change to the planning system in England for over 60 years. The intention is to devolve much more decision-making to local level, empowering communities to engage in and challenge planning proposals through a range of mechanisms including local referenda. Among many new freedoms, the act allows "communities" (aka businesses) to propose developments and push them through with much less risk of rejection providing they conform to new, less restrictive, planning guidelines.

All this provides an interesting backdrop to our theme of the built environment. We have contributions from planners, architects and policy analysts as well as public health specialists, and a debate on the strength of evidence linking green space with mental health and wellbeing.

Just to add my own pennyworth: it's worth looking at a recent document from the Scottish Government, *Green Infrastructure: Design and Placemaking*, which, although aimed at planners, architects and developers in Scotland, also makes useful reading for public health people moving into local government in England (http://www.scotland.gov.uk/Publications/2011/11/04140525/0). And I would also recommend the Department of Health's recent report, *Healthy Towns – Early Learning*, which looks at initial lessons from the 'whole-town' approach to tackling obesity in local areas (http://tinyurl.com/7q6hccw).

Alan Maryon-Davis
Editor in Chief

The transfer to local authorities can lead us to healthier places

THE proposed transfer of responsibility for public health to local authorities has resulted in a renewed focus on what it can achieve, and on the opportunities for greater synergy between public health and other local authority roles and responsibilities. One such opportunity is to bring health and planning closer together.

The 21st century has brought with it a different set of health-related problems: rising obesity levels (particularly in children), other life-limiting conditions, the ageing population with its implications for care needs, and the seemingly intractable nature of health inequalities. The rising cost of care is a very real concern with these trends. They also go to the heart of how we can create healthier places that support the lives people and communities want to lead.

The London Healthy Urban Development Unit (HUDU) was set up in 2004 to help foster closer working relationships and alignment of agendas between the health sector, PCTs in particular, and planning authorities in the context of significant population growth and change in London. Funded by all the London PCTs, HUDU works to ensure health is better integrated into planning policy and the health impacts of development proposals are assessed. Where new facilities and services are required as a result of developments, appropriate developer contributions are sought. Ensuring timely and effective engagement between PCTs and planners is a key ingredient in the process.

There has been a growing recognition that achieving the wider aspiration of healthier people, places and communities and reducing health inequalities requires coordinated action. Public health and planning both have a key role to play, working alongside other professions, to raise awareness, change behaviour and influence the wider environment needed to create and sustain healthier people, places and communities. Housing, social care, transport, architecture, sports and leisure, environmental health and education professionals all have a role to play in facilitating and supporting healthy lifestyles. For example, much can be achieved through the provision of safe open space, recreational areas and facilities and children's play areas. Encouraging

more walking and cycling, and getting communities more involved in health and planning using the new mechanisms and structures under the Localism Act also help.

Many local authorities across the country either have now or are close to adopting, their Local Development Framework Core Strategy which sets the broad spatial planning aspirations and policies for their area. One challenge is to make better use of the strategies, plans and evidence-based material that all professions have – not least the planning profession in support of the local plan-making process. Another is to be clearer about the scale and nature of physical and demographic change in an area over time, and the opportunities this could create to improve health and wellbeing more generally. Again, this should be at the heart of the plan-making process. The requirement to establish Health and Wellbeing Boards and to use Joint Strategic Needs Assessments to provide the evidence-base for strategy and action by the new boards means there is a good place to start the process of bringing together information in a way that better reflects the need for coordinated action.

Vernon Herbert
Interim Head
Healthy Urban Development Unit

Planning as a vehicle for better health

Local authorities' new lead responsibilities for public health give the planning system increased opportunities to improve health and address health inequalities. However, the draft national planning policy raises many questions about how health issues would be considered. Its aim is to promote "strong, vibrant and healthy communities", but "emphasis should be given to economic growth". What weight will be given to health objectives within the sustainable development framework?

Despite uncertainties about the reforms, there are many examples of local collaboration between public health and local planning authorities and developers, and 'healthy' plans, particularly transport, residential and retail developments, access to public services and open space.

The reviews of evidence undertaken by NICE on spatial planning and health, in collaboration with the University of the West of England, show that there are key points within the planning system for ensuring health is properly considered with related sustainable development goals. The report, *Steps to Healthy Planning*, prepared by the independent Spatial Planning and Health Group, draws on this evidence.

Health and wellbeing boards and directors of public health will need to consider how their work can effectively align with the planning system to:

- Ensure that the analyses and priorities defined in joint strategic needs assessments and health and wellbeing plans are incorporated in local development documents, including the core strategy and supplementary planning documents on fast-food outlets and public open spaces.
- Promote healthy design standards on issues of mix-of-land uses, street layout and connectivity, access to public services, open and green space and transport.
- Encourage health impact to be recognised as a 'material' consideration.
- Ensure the scoping of plans and proposals for their health impact. Where this is likely to be significant, integrate a full health-impact assessment into sustainability appraisals or environment impact assessments.
- Ensure scrutiny committees agree a protocol for integrated scrutiny of planning and health issues.

Dr Amanda Killoran
Public health analyst
NICE

DEBATE: Can we be sure that green space promotes mental health? Rosella Saulle and Giuseppe La Torre say we can't, while Damian Basher says the research is good enough

If you look for it, the evidence is there

THERE is growing evidence for the public health benefits of natural environments. The recently published UK National Ecosystem Assessment estimates that they provide a range of 'services' worth billions of pounds a year. These include economic (such as tourism), public health, social and community benefits, as well as biodiversity and adaptation to climate change.

Many reviews highlight the wide range of public health benefits of using, viewing and being in proximity to natural environments, citing sources from programme evaluations to experimental studies. Often, appropriate research is not commissioned, and the existing evidence base is spread across a range of health and non-health disciplines, including social and community development, environmental science and economics, as well as public health.

Not all studies show conclusive effects – but overall the evidence base suggests that green spaces provide a wide range of social and public health benefits. These benefits can interact through improving mental wellbeing, contributing to 'active transport' infrastructures, increasing biodiversity, and providing resources to adapt to climate change.

High-quality 'gold standard' research should always be the goal. Yet, pragmatically, best-available evidence is often used in policy and resource allocation. Even in clinical areas, NICE often uses lower levels of evidence in their guidance. National policy often uses best-available evidence to meet immediate challenges or policy needs. For example, there is no RCT-quality evidence base for the effectiveness of GP commissioning.

YES

This has implications for fully understanding the importance and relevance of natural environments. New models for evaluating public health benefits are being proposed to address the deficiencies in current models and to tackle new challenges such as sustainability, inequalities and general wellbeing. More appropriate research to harness the breadth of quantitative and qualitative evidence relating to green spaces could support these new, integrated models.

Green spaces are not a solution to all public health problems and their benefits should not be overstated. However, they can provide a range of public health, socio-economic, educational and climate-change resources. The challenge is how to make those benefits sustainable and available to everyone, improving the public's health and wellbeing, tackling inequalities and adapting to climate change.

Damian Basher
Former public health consultant
Department of Health

The science is unreliable and unconvincing

ALTHOUGH several scientific literature reviews have reported statistical associations between physical activity, physical and mental health, and 'open green spaces' – including reduced risk of mortality and the prevention of chronic diseases – less is known about the strength of these links, and they remain unclear.

Questions such as "Are open green spaces a resource in promoting public health?" and "How strong is the evidence for public health benefits of urban open green spaces?" need to be more fully assessed. Researchers have shown a real interest in quantifying these links, but traditional research approaches have not succeeded in developing a reliable and convincing evidence base. Theoretical and methodological limitations are present in much of the existing literature.

Many of the studies lack the methodology to measure complex effects on urban health outcomes and are very limited by differences in the ways exposure to green spaces and health outcomes are assessed.There are multiple, complex and reciprocal pathways between health outcomes and their vast range of determinants.

Future research conducted from a complex perspective might explore how these components work individually and together. Measuring the impact of physical activity is limited by reliance on self-reporting. The consequences of bias in the links between lowering stress and greenness complicate their interpretation. High-quality, robust and objective measures of both population health and green-space coverage are needed to have realistic and comparable data.

NO

We need a comprehensive set of research instruments, including qualitative and quantitative approaches, to generate the data that would answer our questions. New technologies use self-reported and objective data as well as detailed outcome measurements through geographic information systems, accelerometers and specific questionnaires. Although empirical studies have been conducted with both tools, the findings continue to be heterogeneous, with differing environmental measures, study populations or geographical settings.

Additionally, many studies are cross-sectional in design and therefore unable to prove a causal relationship between exposure to urban green spaces, physical activity and mental health. Full evaluation will require longitudinal studies and multi-level analyses over time and ideally examine the effects of large-scale environmental interventions, such as the construction of a park, on health outcomes in whole populations. The science is not there yet.

Rosella Saulle, Giuseppe La Torre
Department of Public Health and Infectious Diseases
Sapienza University of Rome

Stairways to health

Obesity doesn't have to be designed into the way we live – it's just a matter of making sure that the healthy choice is not the harder choice, says Colin Haylock

AS A planner and an architect I am well practised in reconciling the demands of both professions whilst meeting the aspirations of local people who have to live, work and use the places that I help design. With 30 years' experience I can say with confidence that for too long we have made it easier for people to make unhealthy choices rather than healthy choices about how they live their lives.

When you enter a building for the first time, do the stairs naturally draw your attention, inviting you to walk up a floor, or is the lift just that bit easier to take? In a neighbourhood, is it easier to walk children to school or to drop them off by car? If you are lucky enough to have cycle paths that are safe, is there somewhere you can lock your bike up when you get to where you want to go? I am afraid that we are all somewhat guilty of unconsciously designing obesity into the way that we live.

> **For too long we have made it easier for people to make unhealthy choices rather than healthy choices**

But it does not have to be that way. In popular parlance, I do not believe we need to nudge people to make the 'right' choice. We just need to make sure that the healthy choice is not harder than the unhealthy choice. And many of the planning provisions in the Localism Bill make this rebalancing possible, if planners and public health professionals are prepared to work with local communities.

Local communities will shortly have the statutory ability to shape the look and feel of future development in their area. Far from a nimby's charter, the provisions have the potential to allow communities to grow – but more on their terms rather than have them imposed by others. Public health professionals need to get their heads around neighbourhood planning quickly and make sure that their voice is heard loud and clear in the debates that are happening up and down the country amongst communities about the future of their neighbourhoods.

Whilst readers of *Public Health Today* may see things in a different light, there is a feeling amongst some in the planning sector that public health professionals have been relatively muted in arguing their case when it comes to place shaping. The creation of the health and wellbeing boards is potentially very significant in this respect, and I will be encouraging RTPI members to get involved with them. I hope that public health professionals will welcome this, and that we can work together to reduce local public health inequalities. The challenge I put to those in the public health sector is to not leave it to planners, community leaders or even architects to work out how to allow people to make healthy choices but to get involved in localism and work with us non-health professionals in helping communities think about and build healthy approaches to life into their plans.

> **Public health professionals need to get their heads around neighbourhood planning quickly**

Colin Haylock
Senior Vice President and President Elect
Royal Town Planning Institute

Moving to improved health in the US

ONE of the striking features of modern urban life in many developed countries is how neighbourhoods are segregated by race, ethnicity and economic status. The correlation between neighbourhood segregation and life outcomes, including health, is equally striking. These sorts of disparities have generated long-standing concern that living in high-poverty neighbourhoods might harm people's health. This is an important question because a range of social policies affect the geographic concentration of poverty.

There are several hypotheses for how neighbourhoods affect health, including access to healthy foods and opportunities for physical activity. Empirically isolating the causal effects of neighbourhood environments on health has been challenging because most families have some choice over where they live. Differences in health outcomes for people living in different neighbourhoods could be due to hard-to-measure individual attributes associated with health and location.

My colleagues and I recently published a paper in the *New England Journal of Medicine* that provides the first test from a randomised experiment of how social and physical environments affect health outcomes. Drawing on data from the US Department of Housing and Urban Development's Moving to Opportunity (MTO) experiment, we found that giving low-income women the opportunity to move from high to lower poverty urban neighbourhoods was associated with about a one-fifth reduction in extreme obesity and diabetes rates.

> **'Our research could help policymakers use housing policy to improve life for low-income Americans'**

Our study suggests that long-term investments in improving neighbourhood environments may be an important complement to medical care, preventing obesity and diabetes as well as improving poor families' health outcomes.

In comparing the MTO impacts to other studies, it is important to remember that studies differ in the types of people they enrol and their exact outcome measures. With this in mind, we saw health effects in MTO that are comparable to the long-term impact on diabetes that can result from targeted lifestyle interventions.

Our research may also shed light on why the US prevalence of obesity and diabetes has doubled since about 1980. We're not yet certain how well our findings generalise to other populations, but these results suggest that growth in the number of Americans living in distressed neighbourhoods could be one reason why obesity and diabetes have increased.

Jens Ludwig
McCormick Foundation Professor of Social Service Administration, Law and Public Policy
University of Chicago

Let's champion benefits of inclusive design

THE influence of public health expertise on the design of the built environment is less than it should be. This limits our ability to calculate the cost-benefits of inclusive design.

Inclusive design embraces all aspects of the built environment. Its potential contribution to health and wellbeing through the accessible design of public buildings, spaces and transport is generally acknowledged.

The first UK legislation to acknowledge a link between the built environment and disabled peoples' lives was in 1971. Designers were encouraged to incorporate accessible building features that we now routinely expect. Since 1985 building regulations have required that all public buildings are accessible to disabled people. Many local authorities now require new housing to be accessible for the ageing population, and there are requirements for accessible public transport. However, we have no agreed method of calculating the cost-benefits of these improvements.

Most of the task remains with our older buildings, existing streets and public spaces. The considerable cost of improving these will be borne by local authorities who will need to justify the financial benefits, especially to the government. Our increasingly older and disabled population, with considerable collective spending power, has ensured political interest in inclusive design. Improved sales figures readily justify it for retailers.

Regrettably our public health professionals do not yet make full use of a similar cost-benefit approach. Imagine a director of public health demanding improved access to local streets or parks. Intuitively we know that an accessible built environment is good. It will help older and more vulnerable people to take responsibility for their lives and better engage with the community. But we do not have the close collaboration needed to calculate potential savings and seek changes to plans.

The government is looking at dismantling inclusive-design regulations, arguing that they inhibit development and increase costs. This could undo the advances of the past four decades. Health professionals can counter this by articulating the benefits of inclusive design so that local authorities and the government, like Sainsbury's and Tesco, can spend confidently and wisely.

David Bonnett RIBA
Principal
David Bonnett Associates

Quick! Slow down!

The movement of public health professionals into local authorities is a golden opportunity to push for lower residential speed limits, says Phil Insall

AS PUBLIC health teams move into local authorities, new opportunities arise to work with colleagues in other disciplines for major public health gains. Traffic speed reduction should be high on the list.

In 2008, the Faculty of Public Health and Sustrans were among the authors of *Take Action on Active Travel*, now signed by 120 national and local bodies from the fields of transport, public health and communities. It calls for "20mph or lower speed limits [as] the norm for residential streets and those used by shoppers, tourists and others, close to schools or public buildings, or important for walking and cycling or children's play".

Recent work by the North West Public Health Observatory modelled the road safety impact of reducing the speed limit in built-up areas from 30 to 20mph. Over a timeframe of 2004-08, an average of 140 children each year, killed or injured in real life, could have been saved by this simple measure in the North West alone*.

Sustrans has used a similar methodology to estimate the impact at Great Britain level and finds that up to 580 child deaths and serious injuries could be prevented each year. By any measure, bringing speed limits down would be a hugely important public health intervention.

Of course the public health benefits should not be measured in road casualties alone, but also in physical activity. As the National Heart Forum says: "Areas with slower vehicle speeds are associated with increased opportunities for walking and cycling."

There are no practical obstacles to bringing speed limits down. Since the 1970s, continental European cities have successfully implemented widespread 30kph (19mph) urban speed limits, and early adopters in the UK, such as Hull and Portsmouth, have already achieved remarkable results. Hull, for example, reduced child pedestrian crashes by 74%. In the whole town of Kirkcaldy, where Sustrans and Fife Council are working jointly to increase levels of walking and cycling, residential streets now have a 20mph limit. In Edinburgh, Sustrans and City of Edinburgh Council are working together to deliver a 20mph zone for the south side of the city, one element in an overall plan for a 15% modal share for cycling by 2020. Meanwhile, the Westminster government's determination to remove 'red tape' has made it much easier for English highway authorities to move to a 20mph limit.

> **As many as 580 child deaths and serious injuries could be prevented each year**

Lancashire County Council is now taking the next step: all residential roads in the county will have a 20mph speed limit by 2013. Councillor Tim Ashton, portfolio holder for transport, says, "I hope within a generation we will change hearts and minds. We must make people aware it's not right to speed in residential areas."

Traffic speed restraint does have its opponents. When Cardiff proposed area-wide 20mph limits, the Institute of Advanced Motorists called the reduction of speed limits across the UK a "creeping disease". However, the extremist nature of such comment is in conflict with local public opinion – communities see speeding as the number-one anti-social behaviour according to the British Crime Survey, and the Department for Transport found 71% of those surveyed favouring 20mph limits in residential streets.

So, for public health professionals, 20mph is a potential quick win. Please lobby your transport colleagues now.

Philip Insall
Director, Health
Sustrans

* *See http://www.nwpho.org.uk/rtcs_nw/*

The waist land

The human environment is becoming increasingly 'obesogenic' – and that's how most people want it to be. But planning law can force a change, says Andy Jones

THE latest figures show that a quarter of English adults and more than one in 10 children are now obese. If current trends continue, estimates suggest that 60% of men, 50% of women and 25% of children will be obese by 2050. But what is causing these alarming trends? They can't be driven by genetics as our DNA doesn't change so quickly. Perhaps changes to the environment are key?

Obesity is related to an imbalance between 'energy in' from food and 'energy burnt' from physical activity. The term 'obesogenic environment' has been coined to describe external influences or environments that encourage inactivity or make it difficult to be active, or that make unhealthier food choices the easier option. Attention has focussed on the role of factors such as urban design on the ease and safety of walking or cycling around cities, and the availability of amenities such as parks that can be used for recreation. In terms of food, evidence has been produced to show how fast-food outlets tend to cluster in poorer areas, often where there is a significant health burden from obesity-associated conditions. Intuitively, it seems sensible that the environment will influence our ability to maintain a normal weight. However, few studies have found anything but weak associations between environmental features and the drivers of bodyweight.

The lack of strong findings may partly stem from difficulties in research-study design. However, although our genes are not changing, perhaps they do hold the answer. We are hard-wired for an environment where physical activity is necessary to survive and food is scarce. Indeed we have faced this over millions of years of human evolution, right up until the last few decades. This means most of us will intuitively choose to conserve energy by resting rather than be physically active. When a variety of foodstuffs are on offer, we're most tempted by the energy-dense option. Indeed, multi-billion-pound industries have been built around these desires – the motor trade and the confectionery and fast-food industries being prime examples. The motor industry wants people to drive, and driving is a sedentary activity. Although 70% of trips in the UK are less than five-miles long, more than half are made by car. Only around 2% of trips are made by bicycle.

> **We are hard-wired for an environment where physical activity is necessary to survive and food is scarce**

So, it is true. Environments are becoming more obesogenic. The problem is that the majority of people are perfectly happy with this situation. For many, an evening on the sofa is a far more attractive proposition than taking a long walk. Who would cycle to work when there is a comfortable air-conditioned car sitting on the drive?

What can we do about the situation? Maybe we just need to force society to change. Excluding traffic from city centres, radically increasing parking charges, forcing employees to walk at least part of the way to work by removing workplace car parks, and taxing high-fat foods may be politically difficult pills to swallow but will undoubtedly have an effect. We must also develop ways of making good behaviours easier – for example, building a comprehensive traffic-free cycle network like that of the Netherlands. We might then find that being physically active and making healthy food choices become the obvious and even the most desirable options. With true political will, we could consign the term 'obesogenic environment' to the history books.

Professor Andy Jones
School of Environmental Sciences
University of East Anglia

Finding the remote in the Scottish Highlands

"IF I SEE someone I haven't seen for a while, I'll stop them and say, 'Let's have a chat.' Of course, I then do all the follow-up as well – the smoking cessation, alcohol brief intervention and so on, but then I'm the only one around!"

This was the practice nurse in one of our North West Sutherland practices, where we have been running cardiovascular health checks as part of the national Keep Well programme. Her comments are echoed by many of our remote practices – hers has a list size of around 600 and patients may need to drive for over an hour to get there. Staff are often shared between practices separated by considerable distance and poor road connections.

NHS Highland serves a population of just over 300,000 living anywhere from Campbeltown on the Mull of Kintyre to Thurso and Wick in Caithness, or numerous inhabited islands. Around half the population, however, lives in the inner Moray Firth area, within an hour's drive of Inverness and all the usual services. For our geographically remote communities, reaching services on the mainland may mean a ferry journey followed by several hours by car or bus. Using telehealth and telecare to provide information and specialist advice has proved very successful in some areas, but is not yet uniformly available.

Two-thirds of people living in Highland rate it as a very good place to live, but over 50,000 people are living in poverty according to Scottish Government figures. There is also a financial premium for living in a rural area: a single adult needs to earn up to £18,600 a year to maintain the same standard of living as someone earning £14,400 in an urban setting. It is not surprising that extreme fuel poverty (spending more than 20% of household income on fuel) is experienced by around 16,000 of the Highland population. Employment outside the public sector is often seasonal and low paid, and many people in remote areas have several jobs.

> **You have to ask about whisky separately, otherwise it's not counted as alcohol**

Against this background, recognisable to most remote areas, the major public health issues are the same as the rest of the UK: an ageing population, a smoking prevalence that is still over 20% and rising levels of obesity and chronic conditions. We have an inequalities gap, with life expectancy in our most deprived wards similar to the poorest areas of Glasgow. Alcohol misuse is a very specific and deep-rooted problem in Highland – alcohol-related mortality and hospital admissions are among the highest in Scotland, and there is a lack of recognition of the issue by both the public and professionals. While there is concern over dependent drinking and the visible signs of social disorder and violence, regularly drinking well over recommended limits is not seen as a problem. As a GP told me: "You have to ask about whisky separately, otherwise it's not counted as alcohol."

Highland has strong fiercely, independent local communities. Building a coherent partnership approach to working with them is both rewarding and challenging.

Dr Margaret Somerville
Director of Public Health
NHS Highland

The worst crisis since the Great Smog of 1952

AIR pollution in London is much worse than most of us have realised. Near the capital's busiest roads, it is well over twice World Health Organization guidelines and legal limits.

We face the worst public health crisis for nearly 60 years. The Mayor has estimated 4,267 premature deaths in London in 2008 were attributable to long-term exposure to dangerous airborne particles, at an average reduction in lifespan of 11.5 years. This is more than the 4,075 people who died due to short-term exposure during the Great Smog of 1952, when we knew nothing of the long-term impacts.

Road traffic is responsible for some 80% of the most harmful emissions in London, with diesel fumes being the worst. Clean Air in London (CAL) recently discovered that 1,100 schools were near roads carrying, on average, more than 10,000 vehicles per day. Scientific research suggests living or going to school near such roads could be responsible for 15-30% of all new cases of asthma in children.

With people spending up to 90% of their time indoors, CAL is encouraging people to ask their employers whether their ventilation system includes regularly maintained air filters that comply with European guideline EN 13779. CAL is also pressing for full and sustainable compliance with air-quality laws.

There is a great opportunity for the Olympic city to show the world in 2012 how air pollution and sustainability issues can be tackled successfully through a mixture of political will, technology and behavioural change. Let's do it!

Simon Birkett
Founder and Director
Clean Air in London

What exactly is high-quality green space?

IN EXAMINING the evidence on green spaces and health and wellbeing, the discussion usually revolves around research quality and rigour. From a built environment perspective, there are more important considerations. Built-environment 'interventions' are rarely instigated solely for health purposes. Buildings and places are constantly being created and adapted, usually with little thought for health and virtually no use of evidence. Architects are taught to be creative, inventive and original – not to rely on research. With this in mind, my view is that any evidence is better than none.

For me, the issue is not the quality of the evidence but its lack of usefulness in practice. There is a lack of sophistication in the definition and measurement of 'green spaces'; measures are often subjective, not objective, evaluations of quality. If we know, for example, that only 'high-quality' green spaces are beneficial, how does the designer interpret this?

Where objective measures are used, they are often crude measures of overall footprint or proximity to residents. There is a focus on quantity, when it may be the quality of the spaces that matters most – factors such as the demarcation of public and private space, boundaries and enclosure, overlooking from surrounding buildings, accommodation of routes from one place to another, inclusion of seating, sculptures and paths, the formality or wildness of the space and the type of planting (trees, lawn, shrubs or flowers).

> **Increasing the amount of green space in an urban area necessarily reduces density, which over a certain level may have negative health consequences**

Measuring the individual design elements of green spaces would allow the investigation of relationships that might not exist for quantity alone. We need to identify the characteristics of green spaces that are most beneficial for health and wellbeing. We also need to know if there are thresholds: increasing the amount of green space in an urban area necessarily reduces density, which over a certain level may have negative health consequences, such as the inability to walk to nearby facilities.

So far, research on green spaces has concentrated on dedicated open spaces in urban areas. But there are many different types of green space in a city, from window boxes to gardens and roof terraces to grass verges. Some research points to the value of green spaces for the views they provide from inside buildings rather

than the outdoor activities they support. A recent study we completed suggests that outdoor space is generally less green in today's housing developments than ever before. Perhaps it is more worthwhile to address this deficit rather than insist on huge swathes of open space which may fail to deliver benefits if not well designed. Greenery can be accommodated successfully even within an urban environment.

Built environments are designed to meet a whole range of requirements. Evidence on design to support health should be balanced against evidence on other objectives. Some aspects of design may benefit certain sectors of society but not others. As a designer, how do I decide whose needs to prioritise? And how can we measure the impacts?

Generating evidence in this field is challenging and complex. Flaws in research design are inevitable. To truly make a difference, we need evidence that is not only robust but also useful to the people who are designing, adapting and delivering urban environments.

Elizabeth Burton
Professor of Sustainable Building Design and Wellbeing
Founder director of the Wellbeing in Sustainable Environments Research Unit
University of Warwick

Guide through the regulatory landscape

THERE is a growing body of evidence that demonstrates that the built environment is one of a range of important factors that influences people's physical activity, consumption of healthy food and social interaction. The National Heart Forum has recently launched an online resource, *Healthy Places*, focused on how the regulatory environment can provide opportunities to promote healthy living in communities, through the built environment.

Based on research by the British Heart Foundation's Health Promotion Research Group at the University of Oxford, *Healthy Places* is a resource to help planners, local authorities and public health practitioners navigate the regulatory environment, especially as it relates to the impact of the built and physical environment on health.

Through easy-to-use explanations of legal areas, case studies and links to further guidance, *Healthy Places* is a practical, web-based resource that showcases particular opportunities to promote physical activity and healthy eating through enabling active travel, access to healthy food and promoting active communities.

The regulatory options on the site are new, often not fully understood or not sufficiently recognised as having a potential impact on health in a local area. Case studies demonstrate practical, real-world examples of these legal areas, showing how communities have used regulations to promote physical activity or healthy eating in their areas.

Hannah Graff
Senior Policy Researcher
British Heart Forum

Visit www.healthyplaces.org.uk

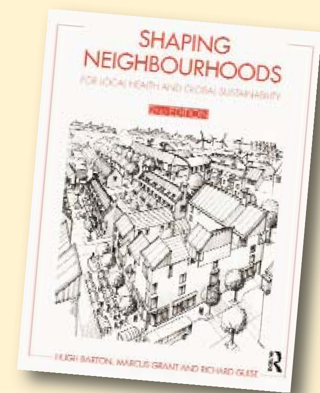
How sustainable development applies to health

THIS book is intended as a practical manual for planners, designers, developers and community groups to support strategies for sustainable development at a neighbourhood level. It focuses on the planning, design and management of the physical environment of neighbourhoods and the relationship to health. In particular it shows how the principle of sustainable development can be applied to address issues relating to obesity, mental illness and social exclusion.

Although public health practitioners are not the prime audience, the manual provides a very useful resource for working with planners on regeneration, greenfield developments, urban extensions and master planning. The term "neighbourhoods" covers small towns, districts of a large city, villages, parishes and residential, environmental and catchment areas, with populations ranging from about 12,000 to 40,000.

The first chapter sets out the policies and principles relating to sustainable development and spatial planning. The key characteristics of a sustainable neighbourhood are defined. Chapter two outlines the neighbourhood planning process: how to work with planners, investors and local communities to develop a strategy, spatial framework and implementation programme (for regeneration, urban extensions or other changes). This includes use of community profiles, mapping techniques and health appraisal methods. The specific topics of housing, enterprise, facilities, movement, food and resources are covered in chapters three and four. The fifth chapter on neighbourhood design is particularly valuable as it brings together the principles and ideas covered in the previous chapters. It shows how a focus on four key elements – land use, density, networks and green space – allows a coherent and integrated approach towards sustainable development.

Each chapter contains helpful checklists. Case studies from the UK and other European countries demonstrate how the approach of neighbourhood planning applies to different types of urban context and particular issues. The final chapter provides two detailed comprehensive checklists. The "community checklist" is a test of the health of a neighbourhood and the "development checklist" provides criteria for assessing the local impact of development proposals.



Amanda Killoran

Shaping Neighbourhoods: For Local Health and Global Sustainability (Second edition)
Hugh Barton, Marcus Grant and Richard Guise

Published by Routledge
ISBN 9780415495486
RRP: £95

Concise account of the hidden child killer

IT IS the single biggest killer of children and young people in the developed world. It causes some of the widest health inequalities between the haves and the have-nots, hitting the poorest hardest. And yet childhood injury is something of a Cinderella subject in public health, swamped by such issues as obesity and asthma.

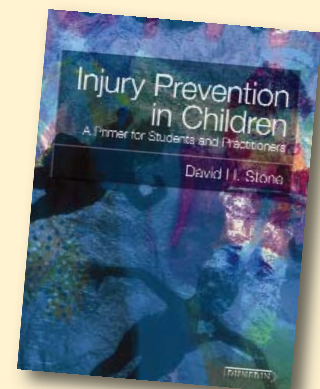
But this is changing. We now have excellent data and analyses concerning the causes and impacts of injuries on young lives and their families and communities. We have plenty of new evidence of what works best for prevention. Today's and tomorrow's policymakers, professionals and local partnerships need a thorough understanding in order to make properly informed decisions for their populations.

David H Stone, Professor of Paediatric Epidemiology at the University of Glasgow, has put together this crisp introductory text summarising the key principles of child injury prevention and looking at how these can be most effectively translated into practice. Chapters cover concepts and definitions, epidemiological methods, preventive approaches, evaluation and ethical issues. Intentional as well as unintentional injuries are considered, and there's a chapter on the international dimension and another looking to the future with a focus on messaging and the new media.

The style is accessible and jargon-light, yet authoritative, and the text is liberally sprinkled with "learning points" (key messages) and "practice nuggets" giving practical examples of injury prevention in action. Each chapter begins with learning objectives and ends with summary notes, and there are useful charts, tables and diagrams throughout.

Every now and then there's a featured "heated debate" on such issues as targeted versus universal prevention or the need for cause-of-injury data in A&E. Surprisingly, no heated debate in the chapter on ethics – what about issues of intrusion in safeguarding children or the pros and cons of regulation versus personal liberty in accident prevention?

All in all, a concise textbook packed with thoughtful insights about how fundamental principles translate into practical action in this expanding field.



Alan Maryon-Davis

Injury Prevention in Children: A Primer for Students and Practitioners
David H Stone

Published by Dunedin Academic Press
ISBN 9781906716257
RRP: £25

From the CEO

AS WE approach the end of another year it is time to look back and reflect. In many ways this has been a particularly challenging year for FPH. The wholesale changes that the specialty is facing due to the Health Bill have meant that much of our time has been spent on trying to gain clarity and influence the development of a new public health system. FPH has been working hard to change elements of the bill to ensure that we have a public health system that is fit for purpose. The recent membership survey has enabled us to get a clear steer from you on what are the main issues that you wish us to focus on. This is powerful and helpful information that we are already using to push forward the changes that we would like to see. The President and officers have worked tirelessly to highlight your concerns where and whenever possible. This work is often unseen, frustrating and time-consuming. We have made considerable progress when you look at where we started from – but there is still a long way to go.

Internally we have restructured the organisation and I am pleased to report that we achieved all of the objectives of the review and are now in a sustainable position to move forward. It's been a tough year for staff at the Faculty, with uncertainty about their future, some colleagues leaving and others changing roles – but the level of professionalism in coping with an increased work load has been tremendous, and I thank them all, together with the officers, for their support during a difficult year. I would

> **We are now in a sustainable position to move forward**

also like to thank all members for their understanding and patience whilst we made these changes over the past 12 months.

I am sure that 2012 will bring with it a new set of challenges and your support as members is invaluable as we work towards shared goals and aims. We are always seeking new ways for you to engage with FPH – so please get in touch if you want to help – there is always plenty to do.

I look forward to working with you in 2012 and take this opportunity to wish you all a peaceful and relaxing break over the festive period and a healthy and happy 2012.

Paul Scourfield
Chief Executive Officer

FPH in Scotland Annual Conference

THIS year's Faculty of Public Health Scottish Conference was attended by 270 delegates in the autumnal sunshine in Aviemore. At a time when unprecedented public-sector austerity, in some parts of the UK, is creating an uncertain and inward-looking context, questions over whether local authorities represent a safe pair of hands for public health were raised. However, we were urged not to get bogged down in issues of structure and governance or let our energies be drained by issues of power and hierarchy. As Professor David Hunter said, "culture eats structure for breakfast". This inspired delegates to put uncertainty to one side and return to fundamental matters.

Quality was the theme of this year's conference, and we were reminded that it was vital to ensure the maintenance of public health in difficult times. We were urged to follow core personal instincts and to realise that if we were to confront such problems of modernity as inequalities, climate change and excessive consumerism, then a more radical approach was required than tackling lifestyle issues. We needed to stand up for social and political reform, put the public before our profession and work for a better future. We needed to nurture leaders with the core humanitarian values of altruism, compassion, courage, commitment and integrity to inspire trust in public health. The call was indeed for quality, but quality with a genuine foundation in our core values.

The ministerial address, by Michael Matheson, Minister for Public Health Scottish Government, recognised significant recent achievements in public health. He pledged to continue to address tobacco control by implementing legislation to ban displays and vending machines. He pledged to tackle alcohol issues by introducing a minimum price and to address the complex cultural challenge of obesity. During the 'Dragons' Den' forum, alcohol was described as a "weapon of mass destruction" and the Scottish Government proposed that minimum pricing legislation should be whole-heartedly supported as a "no-brainer". Could similar 'shove' rather than 'nudge' legislative measures be employed on the food industry to tackle obesity? Radical suggestions from conference included a new temperance movement, a fat tax and even "rationing".

The take-home message from Aviemore was that public health should focus on quality founded on firm core values. Chief Medical Officer for Scotland, Sir Harry Burns, closed conference by inspiring us to focus on an asset-building approach. He urged us to use the internal capacities and resources of individuals and communities to create a sense of self-determination and social cohesion. It is clear that public health in Scotland has not lost its values. This is what gives us the inspiration and resilience to see through the difficult challenges ahead. The quality and variety of posters and parallel sessions presented at the conference demonstrated that the distraction of financial austerity is not enough to divert us from our values or distract us from debating and addressing the issues at the heart of public health.

Lucy Denvir
StR Public Health
NHS Dumfries and Galloway

Policy updates

NHS reforms

As the Health and Social Care Bill makes its way through the committee stage at the House of Lords, FPH continues to actively engage with members, key stakeholders, and parliamentarians, as well as through its representation on strategic working groups and wider media work.

With Lord Patel taking a lead on FPH's amendments, we are maintaining a focus on statutory regulation, the qualifications and accountability of directors of public health, the organisational independence of Public Health England, public health expertise in the new NHS Commissioning Board and employment conditions for public health professionals at parity with the NHS.

FPH is also working with other health and public health organisations through our chairing of the PHMCC task group, and active engagement with local government colleagues. We have representatives on key strategic groups, including the Workforce Advisory Group and have taken an active involvement in the NHS Future Forum Process.

Public health specialists' views

We were asked by some members to survey the entire FPH membership on the Health and Social Care bill. Over 3,000 people were contacted, and we had responses from 973 people (30.4%).

A clear message from the results is that there is significant concern about the future – both of the specialty itself and the health and wellbeing of the public. There were three main areas of concern:

- The overall functioning of the NHS post-reform and the potential effects on inequalities and other vital health areas.
- How to ensure strong, safe and effective input in all areas of public health to the NHS after the proposed changes to local and national structures.
- How to ensure proper public health staffing and training including those of Public Health England and directors of public health in local authorities.

Call for a comprehensive EU alcohol policy strategy

FPH is one of 84 health and social NGOs from across Europe that have joined forces to call on European governments and the European Commission to develop an alcohol strategy for the EU before the current initiative ends next year. An apparent lack of political will at European-level raised fears alcohol prevention would fall off the EU political agenda. FPH endorsed a letter by the EU Alcohol Health Forum calling on the European Health Ministers to acknowledge the need for a comprehensive policy framework.

And the letter proved successful: at a meeting of the Committee on National Alcohol Policy and Action on 17 November, delegates all supported a new strategy.

Mark Weiss
Policy Officer

Message from the CPD Director

THE Faculty of Public Health (FPH) has an excellent and well regarded CPD programme. We are among very few Royal Colleges or faculties to have pretty much universal implementation of an agreed policy. We are also among the few to have regular audit of the quality of CPD returns.

The underpinning value of the programme is that individuals should set their own learning requirements and reflect on their effectiveness and value to them as individual practitioners. Was it good, was it worth it, what did I learn, what else do I need to do/know?

This might argue for a completely unsupervised, trusting approach to CPD, but we live in increasingly regulated times. Each of us needs to demonstrate continued competence to practice, and many of us will need to be revalidated. This implies a regime of writing things down and using them as evidence of our continuing development and ability to do our jobs, whatever the environment may bring!

To this end FPH has developed a set of standards (so we can measure ourselves against them and demonstrate that we're doing as much as the next man) and consistent ways of evidencing activity. So we have:

- Standards for number of hours (50).
- A signed PDP for the year to which CPD relates.
- An expectation that much (the majority) of the CPD will be in some way related to the PDP.
- Reflective notes.

It is against these standards that we audit 20% of CPD returns a year. We have noticed a significant improvement in every area. The notes seem genuinely reflective, the PDPs are clear and much of the CPD relates to their content.

So far so good, but we are aware that what we are auditing is the quality of the return not the quality and relevance of the learning. That is simply not possible at such a scale or distance. It is only when the professional is with someone who knows them reasonably well and knows what sorts of skills and attitudes are required for the job that a learning plan that is relevant for them in their own context can be developed. And it is only then that an assessment of whether they were the right activities and whether the professional is better equipped to do their job can be ascertained. Hence there is an increasing focus on appraisal as the link between potentially formulaic CPD returns and actual learning related to the job and the skills, aptitudes and attitudes of the professional.

Revalidation is due to commence its first five-year cycle at the end of 2012. Public Health Specialists will need to maintain a portfolio of supporting information drawn from their practice which demonstrates how they are continuing to meet the principles and values set out in the GMC's Good Medical Practice Framework for appraisal and revalidation. The vital components of the revalidation process are CPD, PDP, annual appraisals and 360-degree feedback. During the annual appraisal meeting your appraiser will review your practice based on the portfolio of supporting information by the Responsible Officer of the doctor's designated body.

A key component of annual appraisal is a requirement for evidence of CPD. FPH therefore runs a CPD scheme with:

- An online diary of CPD for members and fellows to use.
- A system of checks to validate fellows' CPD records.

For those specialists who fall outside of the main designated bodies (NHS, deaneries, locum agencies, armed forces, and local authorities are likely to be added to this group) FPH is developing a revalidation process to ensure independent specialists have access to an appraiser, 360-degree feedback, a Responsible Officer and an electronic portfolio for uploading and storing their supporting information. For further information on revalidation, please go to the FPH website: http://www.fph.org.uk/revalidation

The UK Public Health Register (UKPHR) will introduce mandatory revalidation for all specialist registrants who intend to remain in active practice.

Dr Anne Mackie
CPD Director

Public Health Careers for the 21st Century

MORE than 250 delegates gathered at the Examinations Schools in Oxford on Tuesday 20 September to discuss the future of careers in public health in the UK.

The conference, organised by the Oxford School of Public Health (OSPH), Solutions for Public Health (SPH) and the Faculty of Public Health (FPH), brought together those interested in public health – specialists, practitioners and students from a wide range of disciplines at various stages of their careers, including more than 60 public health registrars from all over the UK.

They came to listen to the views of key policy-makers, specialists, practitioners and academics on the future of public health careers, particularly arising out of the changes to the NHS, and to debate long-term opportunities and challenges to the public health workforce.

The keynote addresses were given by FPH president Professor Lindsey Davies (pictured below) and Dr Michael McBride, Chief Medical Officer, Northern Ireland. They outlined the need for both public health leadership and sound scientific evidence to inform health policy at a time of unprecedented changes in the NHS and continuing public health challenges for our wider society.

Others who spoke at the conference included Andrew Jones, Director of Public Health Wales, Sir Muir Gray and Professor Sian Griffiths, Director of the School of Public Health and Primary Care at the Chinese University of Hong Kong, who recalled their careers in public health, shared their experiences and gave practical advice about being a successful public health specialist or practitioner. They also reiterated the continuing need for a skilled workforce to meet the public health challenges in the UK and increasingly abroad.

In addition to the speakers there were several workshops throughout the day covering careers in traditional domains of public health such as health protection, health promotion and commissioning, as well as newer and more novel opportunities that are opening up for those with public health training, including those in independent- and third-sector organisations.

Delegates at the conference commented that they found the event "warm", "friendly" and "inspirational" with many saying that it had re-energised their passion for public health.

A follow-up report and video interviews with key speakers and other contributors will be available shortly, following the launch of the Oxford School of Public Health website (www.oxsph.org) or by contacting Hannah Musson, email: hannah.musson@oxfordshirepct.nhs.uk, tel 01865 289426.

Uy Hoang, Hannah Musson, Premila Webster and Sucharita Yarlagadda

In memoriam

Sir John Stuart Pepys Rawlins KBE FFPH
1922 – 2011

Born into an Army family, John read medicine at Oxford and did his clinical training at Barts before choosing the Navy for his post-war National Service, discovering a lasting love of deep-sea diving. Continuing as a career Navy doctor, his practical experience and knowledge of different types of pressure valve in breathing apparatus led to an attachment to the RAF Institute of Aviation Medicine where he made improvements to aircrew's pressurised G-suits preventing G-force blackouts. In the late 1950s he helped to develop a system for the crew of ditched planes to eject underwater – automatically if unconscious. In the mid-1960s he became medical officer to the Ark Royal and was then seconded to the US Navy to design thermal suits for submariners. Back in the UK he was appointed Director of Health and Research (Naval) from 1973 to 1975, Dean of the Institute of Naval Medicine (1975-77) and Medical Director General of the Navy (1977-80). After retirement he was much sought after as a consultant in underwater technology.

Michael Charles Latham FFPH
1928 – 2011

Born in Tanganyika (now Tanzania), Michael studied medicine at Trinity College Dublin, the London School of Hygiene & Tropical Medicine and in the US before returning to Tanganyika as a rural doctor. He developed a keen interest in prevention and more specifically in nutrition, publishing several articles on the practicalities of infant nutrition for subsistence-level communities. He was a fervent champion of breastfeeding and against the heavy marketing of formula milk in the developing world, becoming one of the first public health scientists to sound a warning. In the mid-1960s he took up a teaching post at Harvard and then Cornell where he directed the Program in International Nutrition for 25 years. He was a consultant to the WHO and FAO and in 1991 helped found the World Alliance for Breastfeeding Action.

Marion Elizabeth Jepson MBE FFPH
1921 – 2011

Trained at Manchester medical school, Marion began her career as a pathologist but then moved into the still emerging specialty of community medicine. She rose to the position of senior community physician with Sheffield Area Health Authority at the same time as gaining an honorary doctorate at Sheffield Hallam University. She received her MBE in 1982. In her spare time Marion was a tireless charity worker, much of which was linked to her local church. In the 2000s she took part in the Sheffield Employment Bond, a scheme through which interest free loans were provided for projects in support of the city's long-term unemployed.

Deceased members

The following member has also passed away:

Mairead Mary Lilliott MFPH

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to FPH between September 2011 and November 2011

Fellows
Michael Baker
Simon Bryant
Julia Burrows
Delphine Grynszpan
Hazel Henderson
Caroline Hird
Mary Kiddy
Maria Lang
Helen Lewis-Parmar
Ayoola Oyinloye
Nora Pashayan
Murad Ruf
Emma Seria-Walker
David Sugden
Malti Varshney
Ian Wake
Jacqui Wiltshchinsky
Fiona Wright

Members
David Conrad
Anna Dhar
Allison Duggal
Maya Gobin
Jharna Kumbang
Rishma Maini
Gemma Morgan
Mary O'Brien
Catherine Quarini
Rosalind Reilly
Leonie Roberts
Katherine Russell
Sarah Stevens

New diplomate members
Marina Buswell
Kirsty Anne Hewitt
Clare Humphreys
Marjorie Johnston
Jennifer Leslie
Kirsty Little
Rachel Mearkle
Suzanne Meredith
Tolulope Osoba
Rebecca Somerville
Miranda Sutters
Dean Wallace
Sarah Weld
Rachel Wigglesworth
Claire Winslade
Pang Fei Yen

Trainee member
Amrita Jesurasa

FPH assessors

The Faculty of Public Health (FPH) is seeking to expand its pool of assessors for senior public health appointments.

FPH has a statutory role in the appointment of senior public health consultants. Assessors play an integral role in quality assuring and ensuring standards in public health by assisting in short-listing candidates, sitting on AAC panels and ensuring that only appropriately qualified individuals are appointed to public health consultant posts.

All applications are welcome. However, we would particularly welcome applicants from backgrounds other than medicine.

Criteria for appointment:

- Fellow, Member or Honorary Member of FPH 'in good standing', including meeting FPH's minimum CPD standards.
- Full specialist registration via either the GMC Specialist Register, the GDC Specialist List in dental public health or the UK Public Health Register.
- Working for a minimum of five years in public health posts and currently working in an NHS/government/public health post (or honorary NHS public health post) as a consultant or as a consultant in a related specialty (for example CCDC, CHP, consultant epidemiologist, etc) in the UK.
- Trained in fair and non-discriminatory interviewing and selection techniques and to have received appropriate training in the application of equal opportunities legislation to appointment procedures.

For further information on the role of an Assessor visit the FPH website at: www.fph.org.uk/faculty_guidance

Interested members should email aac@fph.org.uk

New public health specialists

Congratulations to the following on achieving Public Health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Helen Raison
Nicola Jayne Lomax
Emma De Zoete
Simon Bryant
Rachel Gosling

Defined specialist portfolio route
Nevila Kallfa
Catherine Mackereth
Penny Greenwood
Christina Gray

GENERAL MEDICAL COUNCIL REGISTER

Maya Gobin
Dominik Zenner

CPD update

Members are reminded that in April 2012 the CPD year is changing from a January-December cycle to an April-March cycle. This means that you will have an extra three months to complete your 50 credits of CPD in the year 2011/2012. The 2011 CPD 'year' runs from 1 January 2011 to 31 March 2012 and your CPD return for 2011 (or applications for exemption) must be submitted to FPH by 30 June 2012.

Please also note that the final version of the updated CPD policy is now available on the FPH website. Thankyou to all who sent us comments on the draft policy.

CPD is a key component of revalidation. The international, national and regional CPD co-ordinators are committed to helping you get the most out of the scheme. They have huge experience in CPD and make sure the changes we make to policy and implementation are practical for participants. For further details please visit www.fph.org.uk/faculty_advisers

You may not be Bradley Wiggins, but you can still overtake a £60,000 4x4. And, writes Zoe Williams, as your mood lifts with every pedal rotation, the four-wheel driver might just think: 'That looks like fun...'

IT WAS the first properly cold day of the year when I cycled to Liverpool Street on my way to Essex, having forgotten the wherewithal to pay for a train ticket, and had to cycle straight back home again in the full knowledge that there was no better way back to the station than cycling a third time.

This is not a great start: an 18-mile trip, in the fog, and, if I were a man, right now I'd also tell you that I had a bit of a sore throat. But these adverse conditions just underlined how great the whole business is, even when all the normal reasons for its greatness – like it's fast and it's easy – have by circumstance been countermanded. The repetitive route sent me into a gentle reverie of love. And that's something I'll pass on before I go anywhere else: don't go into a reverie – even when you've done the journey many times that day, you still have to look where you're going. All the other traffic is new. It's not Groundhog Day.

I always used to feel a bit guilty, while under-taking or even overtaking a 4x4, about my self-righteous triumphalism, which I think is probably visible from my posture. You see, inside I'm thinking: "Eat that! You spent 60 grand trying to outpace the world, and you're going at three miles an hour. Whereas I, humble and fuelless, am going at, what, maybe eight miles an hour!" It's not an attractive aspect of a cyclist's personality, this. However, it struck me today that, from within their (usually tinted-windowed) driving prison, they might not be able to tell how obnoxious I am. They might just look at my bike and think it looks fun. I could be a positive role model for them. It might not matter whether I intend to be or not – it might just happen.

> **It struck me that, from within their (usually tinted-windowed) driving prison, they might not be able to tell how obnoxious I am**

There comes a point in your life when, however cool you feel, you no longer look that cool. You now look like one of those straggle-haired hippies that make driving instructors say: "Look out for that cyclist – she looks a bit funny." The upside is that you perpetually forget that you've reached that point and set out thinking you look like a young, female Bradley Wiggins. Avoid cycling past large areas of plate glass.

Unlike all other transport, and I think I can even include walking here, the longer you cycle for, the better your mood becomes. By the time I was on the third unnecessary leg of my Liverpool Street odyssey, I was on top of the world. Whereas imagine: if I'd had to go backwards and forwards on the tube, after an hour, my mood would have corroded steel. That's the kind of public health I'm talking about. Speaking only for myself, cycling does not make me that fit. There was a reason they invented the wheel, and that was to make life easier. But it brightens my psychic landscape, and that's good enough for me.

Zoe Williams
Columnist
The Guardian

Information

ISSN – 2043-6580

Editor in chief
Alan Maryon-Davis

Managing editor
Lindsey Stewart

Commissioning editor
Liz Nightingale

Production editor
Richard Allen

Contact us:
news@fph.org.uk

Editorial board
Matthew Day
David Dickinson
Andrew Furber
Catherine Heffernan
Amanda Killoran
Ashish Paul
Premila Webster

Address:
Faculty of Public Health
4 St Andrews Place
London
NW1 4LB

Switchboard: 0207 935 0243
Education: 0207 224 0642
Policy & Communications: 0207 935 3115
www.fph.org.uk

FPH closes at midday on 23 December 2011 and opens on 3 January 2012

Submissions
If you have an idea or a suggestion for an article for the next issue, please submit a 50 word proposal and suggested author to: **news@fph.org.uk**

Advertising inquiries to Richard Allen at richardallen@fph.org.uk

All articles are the opinion of the author and not those of the Faculty of Public Health as an organisation