# An Atlas to the North West: Navigating the future


**FEATURED INSIDE:**



**By Ian Ashworth**

**Chair for the North West StR Group**

We are delighted to bring you this month's edition of pH1 and for the first time from the North West. As we are fast approaching the handover of snagging lists to our new hosts, this edition will be looking at the transition and how our public health work has varied because of this.

The North West enjoys a very diverse population and geography. With a population of 6.9million, it is the third greatest among the regions of England and countries of the UK with only London and South East larger.

Training wise we have three zones, each with their own individuality and specific public health challenges. Starting in Cumbria and Lancashire, with the natural beauty and rural back drop of the Lake District through to the bright lights and the alcohol related 'attractions' faced in Blackpool.

Moving south down to Cheshire and Merseyside brings both coastal and environmental health challenges. Taking a ferry across the Mersey and viewing the world heritage sites of the Liverpool waterfront we uncover very complex urban public health problems in both housing and poverty. What can we do to mitigate this when the gap between those that have and those that have not gets bigger with welfare reforms and significant public sector 'savings' being made?

Passing through Cheshire and the multiple COMAH sites that can be found in Runcorn, we reach Greater Manchester. This is home to 10 Local Authorities, NICE offices, an international airport and three universities to name just a few settings that can shape our training.

This edition is structured by providing a snapshot of the work being completed in each zone.

The North West also has a privileged history of producing key public health leaders, movers and shakers, originally starting in 1847 with Dr William Henry Duncan in Liverpool-the country's first Medical Officer for Health.

We ask our current leaders about the challenges of the transition and how StRs can best make use of their training.

We speak with Dr Janet Atherton on the role of ADPH, Dominic Harrison for his DPH perspective from Blackburn with Darwen, we consider the role of academic public health with Professor Simon Capewell and Professor Iain Buchan from their respective Universities of Liverpool and Manchester. We also look at International Public Health and the People's University.

Finally we are delighted to bring you a message from your new FPH President Elect Professor John Ashton and his vision for the future of our profession.

We hope the atlas directs you to some of the great work being undertaken by StRs in the north west, the impact of the transition on training and an insight to the varied public health challenges that we face up North.

# Professor John Ashton- A vision for public health after April 1st

According to Cicero 'The health of the people is the highest law'. This dictat is reproduced above the doorway of the former mother and baby clinic in Walworth Road, near to the Department of Health at the Elephant and Castle. It is a reminder of the higher nature of our calling to protect and improve health. It should be tattooed on the forehead of all incoming Secretaries of State for Health.

When I was starting out on my public health career I studied for the Masters in Social Medicine at the London School of Hygiene and Tropical Medicine. The year group that I was in was typical of the time and of recruits into public health in the mid 1970's.Our motivations were mixed. There were political radicals like myself, those motivated by religious belief, two officers sent by the Royal Army Medical core, some who had worked as local medical officers in developing countries and seen the limitations of clinical interventions and a handful who were turned on by the prospect of management. The battle for the soul of public health had yet to begin, it was unfashionable and sometimes, sadly the last resting place for those who had failed to make it in other branches of medicine. At that time entry was restricted to medics and the one student in my year group without medical qualifications was denied the 'social medicine' tag and instead became a Master of Philosophy. Nevertheless in those early days after 1974, when the medical officer of health was put to death and replacement 'community physicians' were banished to health authorities bereft of resources and with little credibility, our mission was clear. It was the transformation of health services into public health organisations and to carry the torch of public health into all the nooks and crannies of communities, to wherever we could find a willing ear.

Over time, we began to have an impact and often well beyond the NHS. We had to respond to new threats and plagues that were unknown to our local authority predecessors. With challenges such as the heroin epidemic that followed mass youth unemployment in the 80's and the related spread of HIV/Aids, we had to persuade reluctant politicians to take risks and introduce large scale syringe exchange programmes. We were at our best when we were most imaginative as with the Healthy Citizens Project and all

# Professor John Ashton- A vision for public health after April 1st

the work on settings that followed in its train.

Yet lurking in the wings was the growing influence of technicolor-managerialism based on a target culture imported from north America. Steadily transaction, not transformation, became the fashion. Making the beds run on time and ticking ever longer lists of boxes became the criteria by which careers were made or broken, not the ability to make a difference to the people's health. At times it seemed that the only expertise that mattered in Richmond house was the ability to carry through yet another reorganisation. Moving furniture round and round in ever diminishing circles. This madness has culminated in the scandal of mid Staffordshire hospital and of similar scandals around the country. The remarkable thing is that the so called leaders, responsible for 25 years heading into a Cul de sac, claim to have the expertise to find a solution.

So what is a new recruit into public health in 2013 to make of this? Surely it is a stupid choice of career! I would argue to the contrary. To paraphrase Charles Dickens I would say that 'It is the worst of times, it is the best of times'. Public health and the NHS are in crisis. They are facing the twin problems of demoralisation and fragmentation at the same time as there is no money. However, the Chinese have always recognised that every crisis is an opportunity. John McKnight has taught us with Asset Based Community Development, that our community of health professionals and activists is half full not half empty, that we should look to see what is in the back yard to see what we have there before going to the shops. In our backyard we have 3000 members of the Faculty of Public Health whose skills in all aspects of the determinants of health are to be found in abundance. Our recruits are of the highest calibre and are now drawn from a wide range of disciplines and backgrounds. We have the opportunity to go forward with a transformational agenda in which leadership should be seen as something that we can all demonstrate each and every day in partnership with citizens who are restless for change.

As your president it will be my intention to map and mobilise all the talents of our members and supporters and public health activists. It is my intention that the Faculty of Public Health and each of its members should come to be seen as major resources for health, not solely as technocrats but as visionary leaders, as motivators, coaches and allies in the journey to honour the memory of Cicero's wisdom so many years ago

**John Ashton C.B.E.**

**President Elect Faculty of Public Health of The Royal Colleges of Physicians.**

**9th February 2013**

# Cheshire & Merseyside Training Zone

Cheshire and Merseyside is currently home to eight PCTs that will result in local public health teams moving into nine different local authorities serving a population of approximately 2.7million.

The training zone is coterminous with the current Health Protection Unit (HPU) that from April 2013, becomes one of three new Public Health England Centres in the North West.

We also have three  public health networks across the North West. Cheshire and Merseyside's is known as CHaMPs and enables StR training placements and projects to be undertaken. (www.champspublichealth.com)

The training programme also has strong academic links with University of Liverpool via the MPH programme, Part A and Part B preparation courses and Clinical Lecturer training posts. The regional public health observatory is also located within Liverpool John Moores University.

This pH1 edition explores these academic links with an interview with Professor Simon Capewell, we look at an example of work undertaken by an StR in CHaMPs, we consider the impact of the welfare reform and the unprecedented measles outbreak that Cheshire & Merseyside HPU had to tackle throughout 2012.

Finally we conduct an interview with Sefton DPH and President for the Association for DsPH, Dr Janet Atherton.

# Reducing the burden of mental illness: The role of DPHs

**By Dr Elspeth Anwar, ST4**

**Reducing the burden of mental illness: The key role of Directors of Public Health and their departments**

Nationally mental health has risen up the policy agenda. The higher priority afforded to mental illness is demonstrated by the Government's commitment that physical and mental health are given equal priority. This is enshrined within the Health and Social Care Bill which places an explicit duty upon the Secretary of State for Health to promote parity of esteem between mental and physical health care.

I recently had the opportunity to become involved in a regional project through CHaMPs. In order to scope the capacity and current activity within public health departments in Cheshire and Merseyside to reduce the burden of mental illness, interviews were undertaken with mental health leads, health intelligence leads and mental health commissioners across the region. Recommendations will be presented back to DPH in order to shape public health activity in this area.

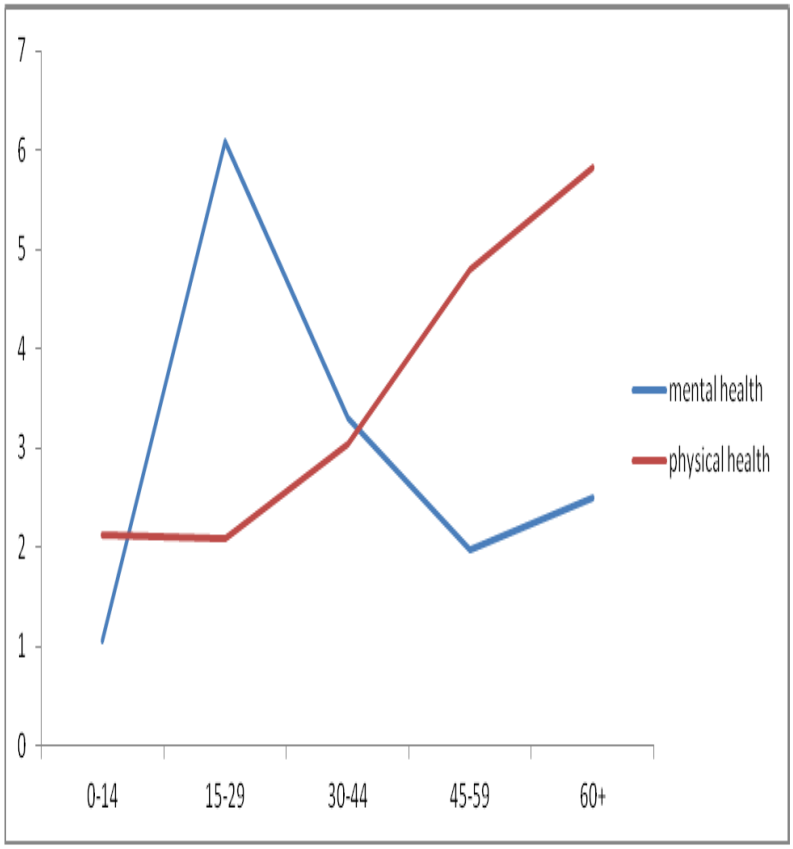
**The scale of the burden of mental illness**

Mental illness is common. In England, one in six adults and one in ten children will experience a mental illness at any one time. This compares to one in ten people with cardiovascular disease and one in twenty with diabetes.

This means that in 2012 across Cheshire and Merseyside an estimated 236,609 adults suffered from a common mental disorder and just under 6,000 people had a psychotic disorder.

Unlike other health problems such as cardiovascular disease or many cancers mental illness begins early in life and persists over the life course. Among people under 65, nearly half of all ill health is due to mental illness, see Figure 1.

**Figure 1: Rate of morbidity from mental and physical illness by age group (equivalent life years lost per 100 people)**




Mental illness is also costly. Mental health services are the largest area of NHS spending (spending on mental health services accounts for 11 per cent of the NHS secondary health care budget, more than spending on either cardiovascular disease or cancer services). The full cost to the NHS and society goes well beyond this figure which does not include costs to primary care or the wider economic impact of mental health problems.

# Reducing the burden of mental illness– The role of DPHs

**The role of directors of public health and their departments**

Historically, public health strategies and activity have concentrated on physical health and overlooked the importance of mental health and illness. More recently there has been recognition of the importance of public mental health to promote health and wellbeing and prevent mental illness, with a subsequent increase in public health activity within this area. The move of public health to the local authority means that there is a danger that public health activity related to reducing the burden of mental illness is neglected. The NHS transition and the formation of Health and Wellbeing boards and clinical commissioning groups provides public health with an opportunity to reduce the burden of mental illness within their localities.

Public health can provide support to reduce the burden of mental illness through:

- Working with the Health and Wellbeing board to lead the development of a specific plan to reduce the burden of mental illness in their locality
- Identify and make use of appropriate mental health data, indicators and measures to drive change locally
- Measure progress towards the achievement of outcomes related to mental illness
- Support evidence based public health commissioning
- Ensure services consider the specific needs of people with a mental illness

It is the duty of Directors of Public Health to follow the national lead and ensure that mental health and illness are given equal priority to physical health.

**Links:**

*London School of Economics (2012). How mental illness loses out in the NHS. Available from: http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf*

*Public mental health focuses on wider prevention of mental illness and promotion of mental health across the life course. For further details see: Royal college of psychiatrists (2010) No health without public mental health http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf*

# Interview with Professor Simon Capewell

**By Rebecca Mason ST3**

**Simon's Background:**
I qualified from Newcastle University and subsequently trained in clinical medicine (general, respiratory and cardiovascular) in Edinburgh, Cardiff and Oxford. I discovered Public Health in Edinburgh, then moved to Glasgow University before becoming the first Professor of Clinical Epidemiology at the University of Liverpool in 1999.

I manage a research programme focussing on the epidemiology and prevention of cardiovascular disease (mainly heart disease and stroke), and on food policy. I enjoy writing papers and grant applications, managing research projects and mentoring colleagues.

Personal outputs thus far include over 250 peer-reviewed papers and more than £20 million joint funding (over £5m as Principal Investigator).

My recent MRC/EU/NIHR/BHF funded research work includes:

a) an IMPACT programme examining why have cardiovascular disease (CVD) mortality rates recently plummeted in the UK, the USA and other high income countries (how much is due to population-wide risk factor improvements as opposed to modern cardiological treatments?); and

b) conversely, why are CVD mortality rates rapidly increasing in China, the Middle East (including Tunisia and Syria) and in other low and middle income countries?

c) developing effective and cost-saving national CVD prevention strategies in the UK (using policy analyses, empirical evidence and quantitative modelling); including supporting our Heart of Mersey regional CVD primary prevention programme;

d) determining how best to help policy makers and planners develop effective non-communicable disease prevention strategies in low, middle and high- income countries.

I am thus valued as a public health "generalist", with expertise that spans the clinical, health service, population and policy aspects of health and disease, notably CVD.

I contribute to policy development and service work locally, nationally and internationally, including recently chairing, vice-chairing or supporting committees at the Academy of Medical Royal Colleges, the British Heart Foundation, the European Society of Cardiology, the National Heart Forum, NICE, the UK Faculty of Public Health, and WHO.

***What would you be doing if you weren't working in public health?***

An architect, a tree surgeon or a retired ski instructor!

***Why did you choose academia over other areas of public health?***

The variety of work and the freedom to challenge keeps it interesting.

***Can you tell us about your route into academia from the training scheme?***

Long, circuitous & atypical.

***What do you see as the main strengths of academic advisory support and how would the training programme be best to develop and capitalise on this?***

Strengths: academia offers the opportunity to advise outside of usual LA/NHS setting. Secondly, experts are networked to other experts, meaning that we have a very broad network of experts to draw on for any particular public health issue.

# Interview with Professor Simon Capewell

Finally, academia provides a different angle to counterbalance the expediency & pragmatic approach of service based public health.

Limitations: sometimes academia has a much more narrow perspective than other areas of public health, and is often short of time.

***What do you see as the biggest gaps between academic public health and public health in practice following this transition?***

There is often a tension between academic perfection & service need for context-based rapid answers. Also, academic idealism vs. political constraints of local public health teams.

***What are the biggest challenges you think we will face in the next 10 years?***

NHS: privatisation, fragmentation, & cuts.
Public Health: increasing fights with corporate interests marketing healthcare, hamburgers, alcohol & sugary drinks.

***What is your position on the transition and the future of public health?***

I am concerned about the increasing corporatism of public health, with the increasing power that the Government are giving to private corporations with regard to health policy (see Mindell et al, 2012, BMJ for further information).

***What opportunities are there for improving training, how can we improve the availability and uncertainty about future placements?***

I think there should be more opportunities for academic placements.

***What advice would you give StRs towards their training and careers knowing what you know now?***

A Public Health career can provide amazing highs and lows within any working day; it is rarely boring!

***Finally if you could have one super power what would it be and why?***

Immense wealth, and the courage to use it for public health, like Michael Bloomberg (Mayor of NYC).

Note:

Michael Bloomberg is the Mayor of NYC and one of the wealthiest men in the USA, with a reported personal fortune of around $20 Billion. During his time as Mayor, he has passed a number of laws to improve the health of New Yorkers, often in the face of staunch opposition:

- Banned smoking in all restaurants and bars
- Banned the use of “trans-fats” in restaurant food
- Required restaurants with more than 15 outlets to display calorie information on menus
- Banned the sale of 16oz sweetened drinks in restaurants, cinemas and other leisure outlets
- Supported schools to administer emergency contraception to girls as young as 14, without parental consent

# Homelessness: austerity, recession and welfare reform

**By Rachael Musgrave ST4**

The social and policy environment that influence the social determinants of health is in overdrive. Global recession; welfare, housing and other social policy reforms combined with public expenditure austerity measures conspire to exacerbate health inequalities. For many, homelessness is the apex of the economic crisis. Since the economic downturn there have been sustained increases in levels of homelessness and it is anticipated that the impending welfare reform programme will further escalate the problem.


The impact of homelessness is profound. People who are homeless are amongst the most socially excluded, vulnerable and disadvantaged groups within society. They are exposed to a range of social and health inequalities and as a result experience serious and chronic morbidity and have a significantly reduced life expectancy. Indeed the mere threat of homelessness has a negative impact on health, increasing both stress and anxiety.

The spectrum of homelessness is however multifaceted; ranging from those who live for a short time in temporary accommodation to those who are regularly rough sleeping. The associated health need reflects this diversity. Those officially classified as homeless tend to be young families, headed by a lone female, whose health problems are of a general health and mental health nature. The 'unofficial homeless' tend to be older males who are more likely to be rough sleeping or living in a hostel and are the most vulnerable in terms of health need and outcomes. Estimates suggest that half of all rough sleepers have an alcohol problem, three fifths report a drug problem, a third have physical health problems and over half a mental health issue.

The national rough sleeper count rose by 23% between Autumn 2010 and Autumn 2011 and during 2011/2012 the number of statutory homelessness acceptances in England increased by 14%, following a 10% rise in 2010/2011. Temporary accommodation placements have also risen, with Bed and Breakfast hotel placements almost doubling over the past two years and in many cases for periods more than 6 weeks. In particular there has been a significant rise in the numbers of households with children in Bed and Breakfast hotels, from 630 in March 2010 to 1,660 in March 2012. Studies show that adults and children in B&B hotels have higher than expected rates of A&E use and emergency admissions. Burns/scalds and infections are also more common in children living in B&B accommodation.

# Homelessness: austerity, recession and welfare reform

A further indication of this burgeoning problem is the increasing number of families struggling to meet housing costs and the rising number of repossessions and evictions particularly in the rental market. One third of people report that they are finding it difficult to meet housing costs often resorting to payday loans to manage their finances and the number of landlord possession claims, the first stage in the eviction process, rose by over 42% last year.

The prolonged economic downturn, stagnant or falling wages, high and rising rents combined with the increasing cost of living are seen by many as the backdrop for increases in homelessness of all forms.

The imminent welfare reform programme which is due to be implemented this year is anticipated to compound the problem further. Under the reform programme, benefits will be rationalised into a single household allowance merging several previously separate benefits into one. Crucially this will change the way people receive money, necessitating household budgeting in order to manage a lump sum payment on a monthly basis. In addition proposals to remove housing benefit entitlement for those aged under 25 may aggravate many of the other social and policy conditions adversely affecting young people including unemployment and existing benefit reductions.

These trajectories represent significant pressures for health services, and local authorities as well as the community and voluntary sector particularly in urban areas and/or those with high cost accommodation markets. In the context of major organisational change and local authority budget reductions public health will need to ensure that the needs of this often hidden and under represented group are addressed. Health needs assessment; partnership with housing providers, local authority housing departments, CCGs, community and voluntary sectors organisations in particular credit unions will be vital to minimise the potential adverse health impact of evolving housing need.

# Outbreak! A true story about measles, Merseyside and me….oh, and mountains….

**By Siobhan Farmer ST4**

It was just a normal morning in late January in the Cheshire and Merseyside Health Protection Unit. I can't remember but I imagine that, as invariably is the case in our Liverpool office, the wind was blowing up and down over Lime Street Station and I was enjoying the normal hubbub of activity that is the 'Duty Desk' in our Unit, where our admin team diligently receive all enquiries from professionals and the public and enter them on the case management system, HPZone.

I was 'first on' the Duty Desk that day, which meant I was responsible for responding to and prioritising all new enquiries that came in. I had been at the HPU for just under a year, as I had elected to do a longer term placement in Health Protection, so I felt like I knew the ropes by then. I was confident that the possible measles case passed to me from our Public Health On Call Practitioner would be like the tens of cases I had dealt with before, where a phone call to the GP to clarify a few details would be all that was necessary before we agreed that measles sounded unlikely and our admin team would issue a salivary test kit to the parents.

As I reviewed the documentation, I saw that the notifying Dr had agreed with the On Call practitioner that measles was unlikely: the symptoms were consistent (cough, cold, temperature for a couple of days, red eyes), but there was no epidemiological link to another case, no recent travel, and there had been no individuals with confirmed measles in the Merseyside area for over a year. However, as I was finishing off my administration of the case, I received a call from one of our local hospitals. The clinician informed me that this same child had presented at hospital overnight, and a profuse maculopapular rash starting behind his ears and spreading down his body had developed. His parents could not recall being in contact with anyone with a rash, but the clinician said that he believed this was a true measles case. I quickly alerted our Duty Consultant in Communicable Disease Control (CCDC) and discussed what we would do next. What followed over the next few hours was the start of an outbreak that would consume the time of every staff member of our Unit over the next days, weeks and months.

Over the next few days, one of the CCDCs assumed the lead for the situation, and called an Outbreak Control Team meeting. When two cases were confirmed, an outbreak was declared and we moved very quickly to contact tracing and control measures. By the time one week had passed, further cases were being notified. There had clearly been community spread and the outbreak was building. By week 3, the call volume and workload became so great that it was necessary to open the HPU at the weekend to handle the management of the outbreak.

To illustrate the work level, we serve a population of just under 2.5 million people and our average "in hours" call volume varies, but is normally around 100 new enquiries per working week. At the time, we had 16 full time staff, consisting of CCDCs, nurse practitioners, administrative staff, a surveillance officer and an emergency planner, plus me. We had no other Registrars or F2 doctors on short term placements at that time. In February 2011, there were approximately 280 enquiries recorded on HPZone, but in February 2012, this had quadrupled to just under 900 new enquiries in the same period, and we received nearly double this in March (1700 new calls, not including returns of call and ongoing case management). By this point, we had developed new local guidance which was issued to GPs to help manage the notification process and better evaluate the likelihood of new measles cases in Merseyside.

# Outbreak! A true story about measles, Merseyside and me….oh, and mountains….

I am not going to go into the epidemiology of the outbreak, as we have covered this elsewhere (http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20226) but to give an indication of the size of the workload we experienced, in 2012, we received over 2000 notifications of measles compared to just over 200 in 2011. Of these, we received laboratory confirmation of just under 600 cases of measles compared to 25 in 2011 (of which the majority were a family cluster in a different part of our patch). The vast majority of cases in 2012 were of one strain type, B3 although it is worth noting we had a few cases that were confirmed as strain type D8, which we know were linked to a national travelling community outbreak. Although rates have fallen in recent months, the Merseyside outbreak has still not officially been closed. It has been the largest outbreak of measles locally since the MMR vaccination was introduced in 1988.

So, in truly reflective Specialty Registrar style, what have I learned from this experience? Well, firstly I sat in on and contributed to Outbreak Control meetings and observed the dynamics, pressures and changing information that need to be carefully balanced in an outbreak. I better understand Infection Control issues specifically related to measles, which is one of the most communicable diseases we know, and the impact that this has on organisations. I understand better Silver Command and Control processes and have contributed to a report on how things might operate in the "new world" of Public Health. I led the management of an extremely busy and pressurised duty desk, in which other StRs, PCT staff, Environmental Health Officers, Health Visitors and other Community Nurses were enlisted to help, some of whom had little previous Health Protection experience. I can probably quote the national guidance on Human Normal Immunoglobulin (HNIG) administration after measles exposure, and I can recite the symptoms of measles in my sleep. I learned how I manage pressure: nothing else in Public Health is quite like an outbreak where you can be juggling 8 phone calls, a room of staff, 64 open enquiries, HNIG ordering, HPZone entry and managing to fit in your lunch. I was assertive enough to make a persuasive plea, alongside other colleagues, for maintaining data entry on HPZone which, although labour intensive, helped us manage the vast volume of notifications more easily. I had a chance to practice media skills and watch how the local press coverage unfolded throughout the outbreak. Incidentally, the lead CCDC became a local celebrity, as he began to appear on every news bulletin on local radio and TV, and he was quoted in the Liverpool Echo. This appears to be one way to get your 'hits' up on Google….

As the outbreak has wound down, I have had the opportunity to be involved in the write up of the epidemiology, contribute to a case-control study protocol, support the planning of a qualitative retrospective 'diary' investigation led by another Registrar, and contribute to a costings study examining the economic impact of the outbreak.

But this is merely a list of what I have done, and any Educational Supervisor worth their salt would now be asking me, "so what?". So…. I did some things well in the outbreak, and I did some things not so well (which I won't bore you with here). I have been able to reflect on these fully and work out where I need to invest my time trying to improve certain skills and put plans in place to do this, and understand where I am already functioning at Consultant level. Most importantly, I have an appreciation of how quickly outbreaks can escalate, and finally, those many happy hours of reciting outbreak control team pathways and protocols finally makes sense….

For the future, I worry that the pathways and policies are not yet established in the "new world" that would ensure that every agency knew what their roles would be in an outbreak. I am concerned that

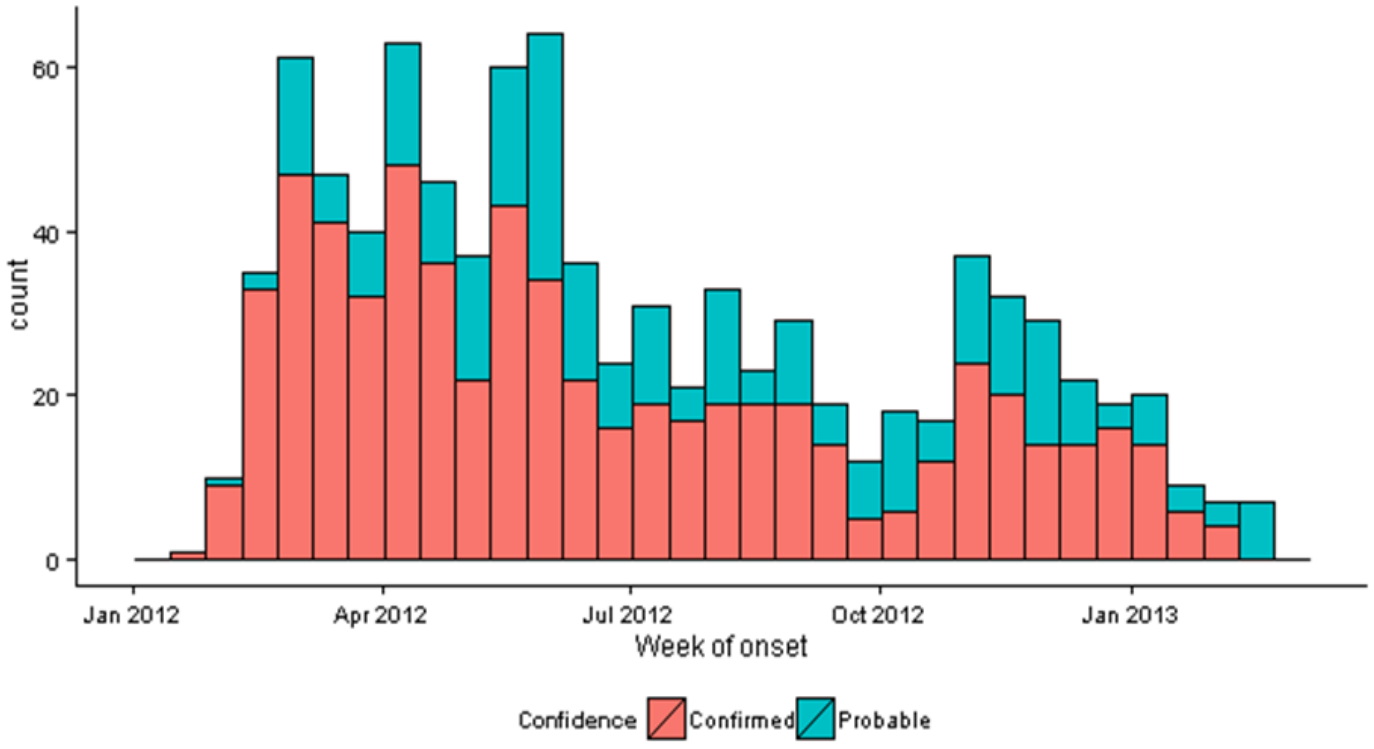
# Outbreak! A true story about measles, Merseyside and me….oh, and mountains….

we clearly still have a long way to go to help the public arrive at the decision that vaccinating children on schedule is the best way to protect them from disease. I am a bit anxious that the changes in the NHS will cloud the real role we have to protect the public and improve health. But, I also am hopeful that the dedication I saw from all staff involved in the Merseyside Measles Outbreak will continue as we move into the new health system post April 2013. I know that the people I work with care about their job, and want to reassure and help the population they serve.

In this outbreak, we have had no deaths due to measles and, although hospitalisation was relatively high (around 25%), we are unaware of anyone with long term complications. Was this due to our efforts to control the outbreak, or better medical care, or down to luck alone? I suppose, as with most public health interventions, we will never be sure of our effect: how many cases did we prevent? But, I am sure that we did prevent some cases, and, because our Unit supported a lot of GPs, Hospitals, local communities, parents, schools last year at the time of a lot of people being concerned about catching an infectious disease with rare but potentially fatal complications, we made a valuable contribution to managing the outbreak locally. And surely, that is what Health Protection is all about?

**Epidemic Curve of the Merseyside Measles Outbreak (Jan 2012 – Mar 2013)**

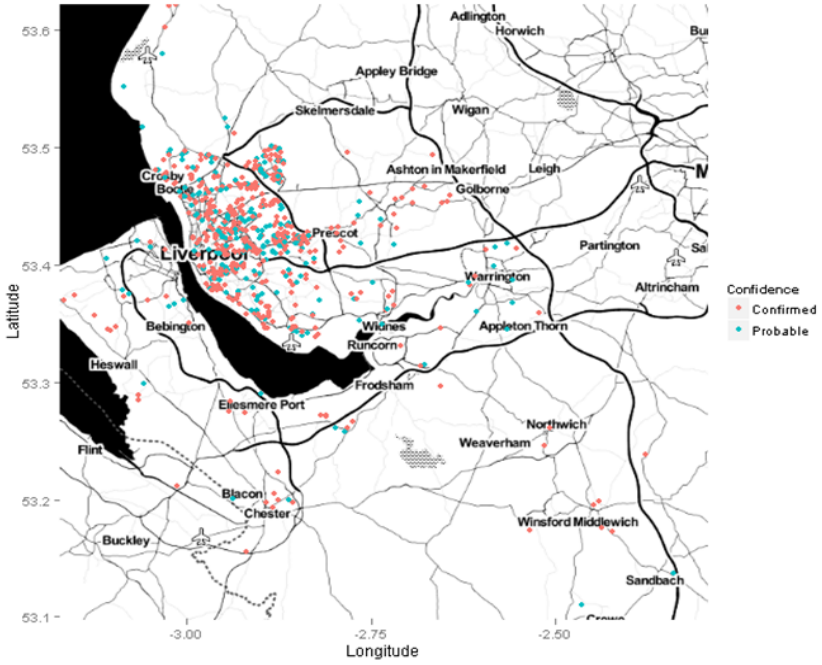
Reproduced with the kind permission of Dr R Vivancos, HPA North West Regional Epidemiology and CMHPU.



# Outbreak! A true story about measles, Merseyside and me….oh, and mountains….

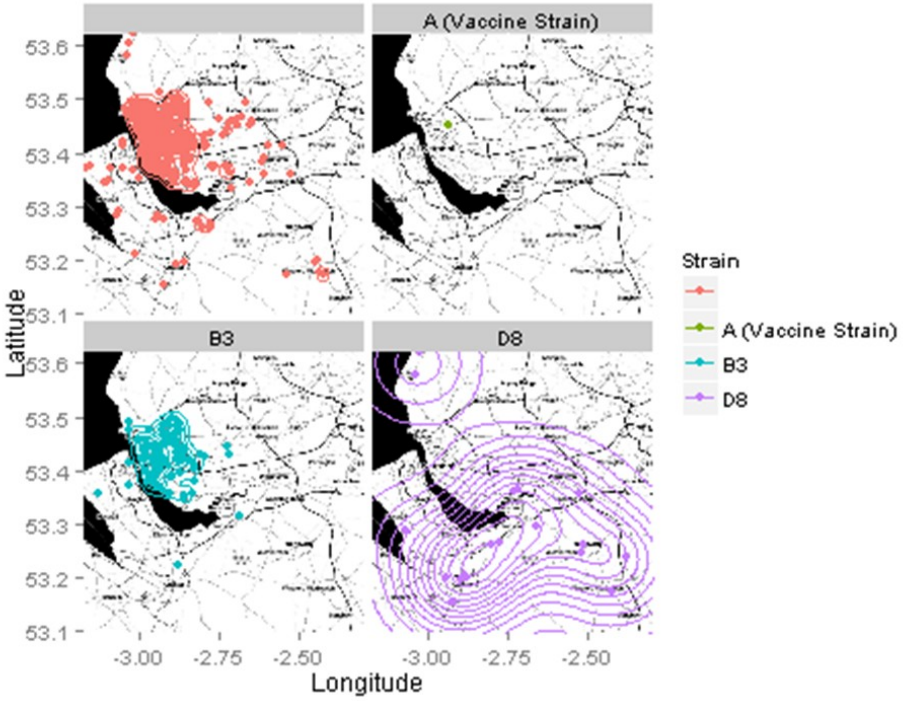
## Map of all cases of measles in Merseyside (Jan 2012 – Mar 2013)

Reproduced with the kind permission of Dr R Vivancos, HPA North West Regional Epidemiology and CMHPU. This map shows how the cases are concentrated in Liverpool and the immediate surrounding area. Many of the cases in Cheshire were shown to be strain type D8 i.e. not the same strain type as the cases of measles in Merseyside.




## Maps of strain types of measles cases in Merseyside (Jan 2012 – Mar 2013)

Reproduced with the kind permission of Dr R Vivancos, HPA North West Regional Epidemiology and CMHPU. This map shows how the cases are concentrated in Liverpool and the immediate surrounding area. Many of the cases in Cheshire were shown to be strain type D8 i.e. not the same strain type as the cases of measles in Merseyside. The closer the contours, the more confirmed cases in that area (hence, Liverpool looks like it has a small but steep 'mountain' of measles, and Cheshire, a small but wide hill…



# Dr Janet Atherton- Association of DPHs

**By Dr Katie Smith ST1**

**Dr Janet Atherton is the Director of Public Health at NHS Sefton and the President of the Association of Directors of Public Health. She kindly agreed to answer a few questions about training, transition, and teleportation.**

***What inspires you about public health?***

It's a really interesting career, with lots of variety. It feels like you're doing something which is actually quite important. Improving people's health, tackling inequalities, I've got a real thing about social justice, that's what I'm about. I came into public health in the first place because through my clinical roles, there was a real sense of doing too little too late. I could see there were things around the system that needed changing, but you couldn't do that from a position as a junior doctor, and you couldn't see that in a career as a consultant in a hospital, or a as GP that you could do it. I think you could do some if it now, from a position in General Practice particularly, but you couldn't at the point at which I joined.

***What would you be doing if you weren't in public health?***

What else would I do? The teashop keeps coming up! I had a brief spell as acting Chief Executive for the PCT and I feel it was better because I did it from that public health perspective of understanding strategy, the needs of the population, trying to focus on what we do to prevent things rather than spending all of the money downstream. I think we can use our skills in all sorts of different roles; it doesn't have to have public health in the title. Sometimes we constrain ourselves by thinking like that. There's been Directors of Public Health in chief executive jobs, accountable officer roles, Medical Directors in trusts, all sorts of different routes, even specialities within public health such as health care or health protection. I think being Director of Public Health has the benefit of being able to do a little bit of all of those, while having a real oversight of it all. Whatever I end up doing, there will be public health in it somewhere!

***Can you tell us what the Association Directors of Public Health role is and how this fits in with the transition?***

The ADPH is the association that brings together all of the Directors of Public Health across the UK, and we have three main roles.

One is providing a peer support network for the DPHs. That's been particularly important over the last two years as people have been going through the transition process.

Secondly, being a collective voice, so that we can influence and work with other key bodies like Public Health England, Department of Health, Local Government Associations, to make sure that whatever public health system we have over time actually works – that's been really important.

Third is a role around advocacy for general public health policy. We've been working on areas like the plain packets, minimum unit pricing, and we're going to be doing more work around inequalities and the impact of things like welfare reform.

We've got a small, core, officer team including president, vice-president, chief executive, policy officer, project management post, so we're really

## Dr Janet Atherton- Association of DPHs

heavily reliant on our regional network – 2 executive representatives for each region who feed in the views of DPHs from across the country. Around the whole of the transition we've been the ones people have gone to for input about things which have been concerning members, such as how health protection is going to work. We've had Directors of Public Health in working groups contributing a public health view into policy. When you see fact-sheets around intelligence, or CCGs, those things have had some ADPH input, although the final products don't.

***Are there any specific areas you feel the training programme should be developing given the reform?***

I think one of the things about working in Public Health is that it is constantly changing. I can remember being in the midst of a reorganisation when I was a registrar, and have been in the midst of various reorganisations since. We should be able to adapt our core competencies to whatever situation we find ourselves in and operate effectively. Organisations do change over time, and if you're not flexible and can only work in one given way I think anybody in public health would really struggle. Being able to adapt to change is absolutely fundamental. It's about stretching you; the training programme needs to reflect the different settings that people may well find themselves in when they reach the end of their training. I think it needs to constantly adapt, so to look for where are there niches that people might be moving into in the future and that kind of thing. Muir Gray uses the term – "covert operations", people using public health skills in areas you might not expect.

***What advice would you give StRs towards their training and careers knowing what you know now?***

Stick with it and look for what opportunities there are at any given time. The more you just go out and grasp what's there and make the most of it, the more likely you are to get what you want in the longer term. Whilst you're training you're relatively protected – I can clearly remember going through a change, people around me going through things like applying for their own jobs, it does impact on the way people go about doing their jobs – there's no doubt about it. At the end of the day, what we are supposed to be about is doing the best for the local communities, so whatever system we're in, we need to keep that as the basis of our practice.

***Finally if you could have one super power what would it be and why?***

There is something about being able to be where you need to be at any particular time. Popping up at the right moment – a teleporter would be good, because there are so many different places that you could be influencing, and knowing how to get into the right places at the right time is a real skill, as well as actually physically being able to do it. A machine that would identify where you need to be: "there is a health promotion opportunity over there – if only you could get to it". I think some of the biggest things that have been achieved have often been through a very chance conversation actually, just being in the right place at the right time. You can do lots of very detailed analytical work, and you always need to be sure that you're on very firm ground about the evidence, but sometimes having a soundbite that actually works with a particular individual at a certain point in time can move something on, and they can take it on and do it.

# Greater Manchester Training Zone

Local public health teams in Greater Manchester will be moving into ten different local authorities, that serves an approximate population of 2.68million.

These Local Authorities are made up from both City and Metropolitan Borough Councils and are represented regionally by the Association of Greater Manchester Local Authorities (AGMA).

From AGMA and the GM Public Health network, a National Commissioning Board Local Area Team and the Public Health England Centre will create further opportunities for training.

The area is also home to multiple specialist training placements including health protection, acute posts within Stockport Stepping Hill Hospital, the North West Cancer Intelligence Service and a 'National Treasure' placement in the National Institute of Health and Clinical Excellence (NICE).

The following section includes an interview with Professor Iain Buchan on how the Institute of Public Health is developing in Manchester.

Some local Clinical Commissioning Groups (CCGs) have already established joint Consultant in Public Health posts in place, strengthening primary care and wider public health services.

The Greater Manchester training network also has StR posts in University of Manchester and strong public health links with Manchester Metropolitan and Salford Universities.

We also unearth some of the real public health challenges faced in an urban and multicultural society- from the burden of alcohol related disease , working with diverse communities and partners to improve circumcision practices and improving screening programmes for people with learning difficulties.

# Innovative Public Health for a Controversial Problem

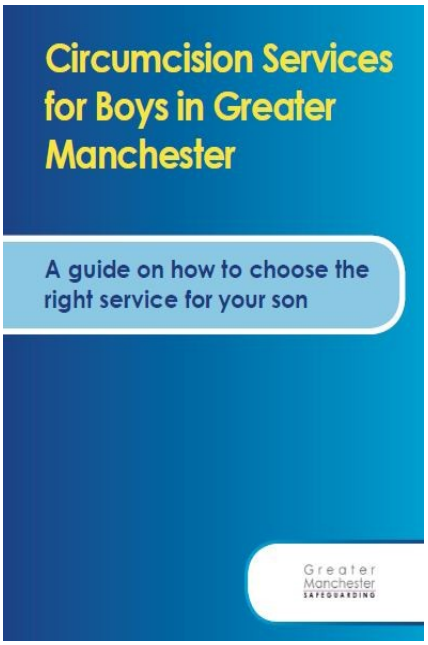
**By Helen Gollins ST4 & Dr Paula Whittaker ST4**

Greater Manchester presents some challenging public health issues. In the UK, the debate about non-therapeutic infant male circumcision has reached stalemate.

We are two StRs who had placements at Public Health Manchester; we worked together to improve outcomes from non-therapeutic infant male circumcisions.

Many baby boys are circumcised every year for cultural or religious reasons, but until recently there has been little information for parents to help them choose quality services to perform the circumcision. In Greater Manchester non-therapeutic circumcisions are not provided by the NHS and families have to find a provider to undertake the procedure. Although legal in the UK, providers are not regulated.

The overarching aim of the project is to reduce the risk of harm for boys by improving access to good quality providers. Acute, primary care, midwifery, health visiting, third sector groups, circumcision providers, community and faith groups have been involved in shaping the process.




The aim is achieved by supporting parent choice and improving understanding and aftercare through the promotion of an information leaflet that explains the procedure.

The leaflet is available in seven languages and as audio downloads from www.gmsafeguardingchildren.co.uk The leaflet is also included in the Child Health Record (red book) and is distributed by midwives and health visitors.

The project also focused on improving providers' standards through a voluntary annual audit and expert quality review. The contact details of the quality assured providers are displayed on the Greater Manchester Safeguarding Children Website. Both successful and unsuccessful applicants are provided with feedback with the aim of positively changing practice.

The process has been in development since 2010. Four providers were quality assured in March 2012 and were added to the website in April 2012. The leaflet has being distributed by maternity units, health visitors, primary care, and community and faith groups since June 2012. The 2013 process is underway with providers' names expected to be published from March 2013.

The project has been cost minimal; the expert quality panel gave their time for free as did many of those who translated the resources. Using networks and meaningfully engaging with stakeholders has strengthened the implementation of the project. Promoting the parent information leaflet, list of providers and audio downloads via the website, means that people can easily access the information whether they are parents, health and social care professionals or community groups.

For us as Specialty Registrars this has been a fantastic learning opportunity, navigating the tricky path of finding the most effective solution to safeguard boys whilst keeping on board groups of people with passionately held, polar opposite opinions, on this very emotive subject. We have developed relationships across many different community groups and organisations, and learnt the art of engagement, which at times was the most difficult part of the project.

Public Health Manchester is managing this project throughout the period of reorganisation. Due to the low costs it is sustainable and could be replicated elsewhere.

# A beverage or two...(many?)

**By Ian Ashworth ST4**

Our relationship with alcohol is a major public health issue for us all in the UK.....sadly in the North West we face the biggest challenge.

Blackpool, Liverpool, Manchester and Salford continue to rank as areas with greatest alcohol related harm. This is shown through rates of alcohol related mortality, hospital admissions, crime and liver disease. Hospital admissions due to alcohol continue to rise with over 1.2million recorded during 2010/11 and it is estimated that alcohol related harm costs our society £21 billion annually.

Not only are we ranking at the wrong end of the scale for alcohol related harm in England but also in Europe. Work undertaken by the European Urban Health Indicator system (EURO- URHIS) which is hosted by University of Manchester surveyed drinking habits in adults and young people across Europe. Graph 1 below shows how adults in Merseyside and Greater Manchester are binge drinking at greater levels than our European neighbours.

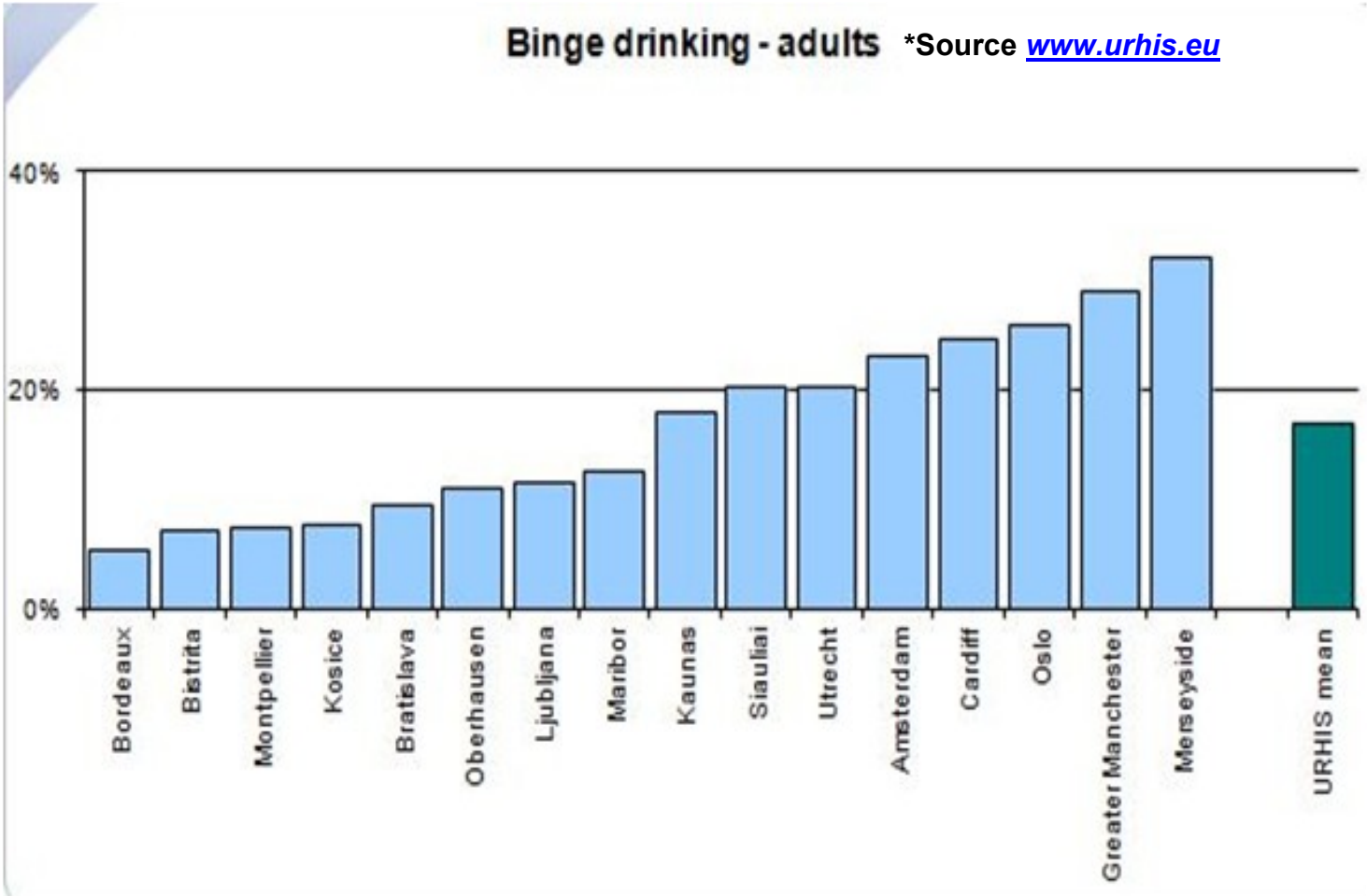
**So what are we doing about this?**

The Government launched their alcohol strategy last year and the consultation on minimum unit pricing (MUP) and multi-buy promotions has just ended.

The North West amongst others have been pushing for 50p MUP, however the consultation asks where the minimum price should be set, at the median of 45p and not the upper limit of 50p, which is shown to be the most effective level in reducing alcohol related harm.

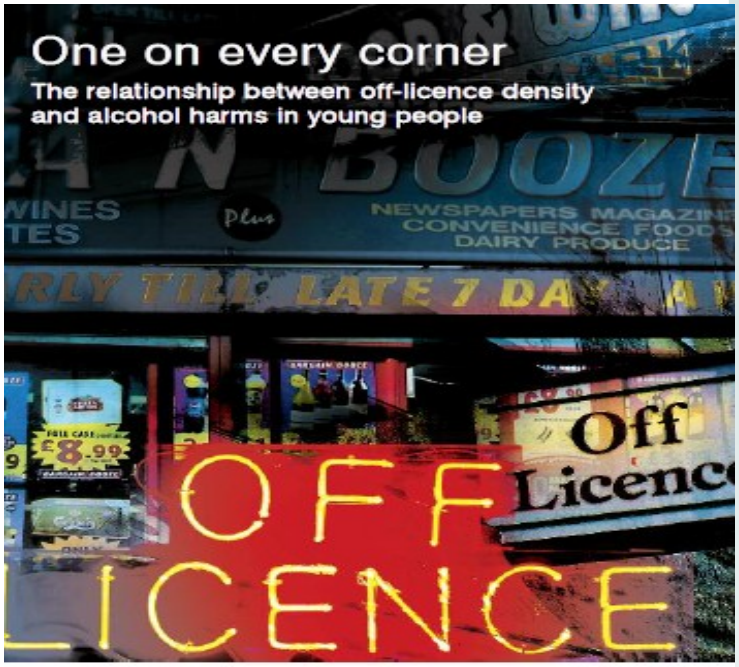
Choosing this median 45p price attempts to balance the reduction in harm against the costs to business with the research suggesting a MUP of 50p would reduce consumption of low risk drinkers by 3.5%.

Other aspects of the strategy will help support Local Authorities in tackling harmful drinking



# A beverage or two...(many?)

through MUP, multi buy promotions, licensing conditions, health as a licensing objective for cumulative impact and reducing burden of regulation on responsible businesses.




The move from public health to councils has created an increased opportunity to reduce alcohol related harm.

Having completed a recent Alcohol Equity Audit in Salford we were able to utilise data from specialist drug and alcohol services, trading standards, police crime systems and secondary care and combine with GIS mapping software.

The results of this helped to identify areas to improve our services and also develop intelligence to support council licensing decisions, given Salford has the highest density of off licenses in England (apart from London).

Tackling the availability of alcohol is just one part of this difficult challenge. Empowering Local Authorities and guided by their public health teams, may just improve our relationship with alcohol that is very much 'on the rocks'.

**Links:**

*1-Burden of Liver Disease and Inequalities in the North West of England www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317136121097*
*2-www.lape.org.uk/*
*3-European Urban Health Indicator system (EURO- HIS). www.urhis.eu*

# The Future Challenges of Offender Health

**By Jon Hobday ST3**

Last autumn I was given the opportunity to carry out a health needs assessment of Her Majesty's Prison (HMP) Manchester. This turned out to be both a fantastic experience and a huge challenge. Having never visited a prison prior to this work I found the environment to be intense, claustrophobic and somewhat intimidating. The levels of security were phenomenal – the sheer numbers of fences, doors, keys and locks was staggering. However, even though I only spent a short time there it was amazing how quickly I became desensitised to the environment.

Having limited prior knowledge around offender health the huge issues which offenders face quickly became apparent. Mental health problems, self-harm, drug addiction, alcohol dependency and poor oral health were just a few of the overtly apparent challenges. There was also the additional issue of the changing population of the prison. There had been year on year increases in older people and non-foreign nationals coming into the prison over the last 10 years. These groups had differing health needs and demands meaning that the health services had to be constantly evolving to cater for these. The difficulty for the prison was that they had to design and provide services which were responsive to these changing demands, while providing healthcare in a secure environment. There was a constant battle between health and security needs, and it was almost impossible to provide one fully without compromising the other.

A significant proportion of the needs assessment looked at current healthcare provision and delivery. In addition the levels and impact of non-communicable disease, infectious disease, mental health, suicide, self-care and medication were also investigated in detail.

On the whole I found that HMP Manchester had an extremely proactive prison health service. They regularly reviewed their systems and constantly adapt their delivery methods. This ensured appropriate provision and best use of resources was achieved. They also took a whole prison approach and linked closely with the education and prison officer staff. This resulted in prevention and health promotion being delivered at every opportunity.

While the needs assessment covered the majority of in house health and healthcare challenges it did not cover the challenges faced following the release of prisoners. Reoffending levels are currently at around 27% (Ministry of Justice, 2012) and the risk of ex-prisoners of slipping back into drug use, unemployment and homelessness are extremely high. The health and life challenges of those leaving prison are complex and it is clear without the appropriate support the likelihood of a positive outcome is low.

# The Future Challenges of Offender Health

The plans during the reforms are that the NHS National Commissioning Board (NCB) will be responsible for health services and public health in prisons and those with other custodial sentences. Clinical Commissioning Groups (CCGs) will be responsible for adults and young offenders serving community sentences and those on parole – which will be delivered through public health in local authority.

However, the responsibility for those formally released from prison is not currently specified. This could result in a particularly vulnerable group being missed. Without appropriate support this may well lead to poorer health outcomes and higher levels of reoffending.

In conclusion, the potential impact of the public health reforms on offender health is still unclear. There are risks that the commissioning board and the CCG will stick rigidly to the areas they are required to cover leaving a distinct lack of provision for those released. While the areas the NHS CB are designated to cover are key aspects, the appropriate support of those being released is also essential. This is a vital transition period which we have to support individuals through if we want them to thrive. Personally I believe that the future challenges within public health are to support released offenders locally and to ensure the wider determinants of health are addressed once released.

There is the possibility that by public health being placed in the local authority it improves the support released prisoners can obtain. The internal links within local authority may result in improved access to housing, benefits, training, education and employment. If this is the case it may well contribute to improved health. However, this is very much dependant on how the public health service is developed within local authorities.

The transition will certainly be an interesting time for offender health, let us hope it's for the better.

# Think Positive Public Health

**By Dr Ashley Sharp ST1**

The provision of mental health services for common mental health problems is complex and varied, and is shared between multiple organisations in the public, private and voluntary sectors. With the government reforms, it will be predominantly CCGs who will take on the public commissioning of mental health services, with public health teams in Local Authorities responsible for mental health promotion and prevention.


Not so, however, in Bolton, where a unique model has been developed which combines mental health promotion with a strategic, population based provision of treatment for the most pervasive mental health problems. With the development of the government's IAPT initiative (Improving Access to Psychological Therapies), there has been slowly increasing provision of NICE recommended talking therapies, in recognition of a vast unmet need.

In Bolton, the 'Think Positive' pilot has been commissioned by the public health team, to provide services for people with sub-clinical/mild-moderate depression and anxiety. This service offers high-volume, low-intensity treatments, meaning it has a high capacity and can help many people to avoid the need for more intensive services.

What is unique about Bolton's approach is that, because the service is strategically led by the public health team, it is delivered in-line with broader public health priorities and values. There is an emphasis on access, particularly where the need is greatest. Patients are able to self refer to the service and it is provided at multiple venues in the community, both health and non-health, and even over the phone. The aim is to both de-medicalise anxiety and depression and also to de-stigmatise them. Bolton hopes to raise awareness of mental health problems and build capacity in the community to recognise problems and sign-post to support. The service is designed using local intelligence from needs assessment and survey work in order to target areas of greatest need.

Mental wellbeing is one of the greatest challenges for public health. Mental health problems cause a great deal of suffering, much of which goes unreported, therefore this needs to be a priority for public health nationally. The wide variation in the provision of mental health services suggests there is great opportunity for learning. Bolton aims to provide NICE recommended therapy, not in isolation, or as part of the established health system, but as a social programme, itself housed within a developing integrated Wellness Service.

Think Positive is a brand new programme and whether it will meet its aims remains to be seen, but perhaps lessons will be learnt which could apply to other localities as the IAPT initiative is rolled out further.

# Learning Disabilities and Cancer Screening

**By Jen Connolly ST2**

There are a number of particular challenges to ensuring effective health promotion for adults with learning disabilities. These include providing the extra support needed for people with learning disabilities to make informed health choices, and developing appropriate health and lifestyle education. Moreover, there is strong evidence that the uptake of preventative services such as immunisation and screening is less among people with learning disabilities. A number of studies have reported low uptake of health promotion or screening activities among people with learning disabilities including cervical smear tests, and breast self- examinations and mammography.

This is a particular concern when we consider the increasing demand for cancer screening services for this population, as the life expectancy of people with learning disabilities is increasing. In the 1930s average life expectancy was estimated to be less than 20 years of age. Today, mean life expectancy is now estimated to be 74, 67 and 58 for those with mild, moderate and severe learning disabilities respectively.

I recently undertook a systematic review of qualitative and quantitative literature, looking at barriers to access and ways to improve uptake of cancer screening services for people with learning disabilities. The findings were limited, as only one quantitative and six qualitative papers met the inclusion criteria. The key themes from the literature were summarised in to three key areas: lack of information; fear of medical intervention; and embarrassment. These issues need to be addressed in an intervention that seeks to improve uptake of cancer screening services for people with learning disabilities.

Salford's Learning Difficulties team are already finding ways to address these issues, improving the likelihood of a person with learning disabilities to access appropriate screening for cancer. Their work includes working with people with learning disabilities directly, with their carers and with GPs. As an example, the easy read guides are designed to provide information about screening in a way that is understandable for people with learning disabilities.

***Fig 1: Sample page-Easy Read Guide to Breast & Cervical Cancer Screening***


You can decide if you want to have cervical screening.

In summary, the evidence for interventions to reduce the barriers to access to cancer screening for people with learning disabilities is very weak. The evidence that barriers do exist, is much better, and those barriers were identified through this review as embarrassment; fear of medical intervention; and lack of information. Interventions to tackle these barriers need to be developed and evaluated to contribute to the evidence base on this area. It is important that steps are taken to improve the services available for people with learning disabilities as life expectancy and therefore cancer risk increases.

# An Interview with Iain Buchan, Professor In Public Health Informatics

***By Helen Gollins ST4***

**Why did you choose Public Health?**

"Principally because I felt I could help more people than I could as an individual clinician. I got hooked on statistics at medical school. It became more than a hobby as people (would) ask me to help make sense of their data. At the same time there was the PC revolution. It was very clear that medicine was going to have a tsunami of data over the next 20 years and that it was ill equipped to use the data understand population health."

**Why did you choose academia over conventional public health?**

"I'm not a conventional one discipline academic. I see my chair as an ideal position from which to benefit the public health by developing the interface between Public Health and Health Informatics. I (have) dedicated my career to a data intensive approach to supporting decisions for the public health, i.e. to turn big data into big sense making, for the maximum health benefit for the maximum number.

Academia is also a wonderfully neutral territory, this University is a charity and my job as a professor here is to maximise the number and quality of interactions and as I sit at the junction between LAs, the NHS, industry, patients and the public, many different types of scientist, what I need to do is get the maximum interplay between those different groups to build this new interdisciplinary area. There isn't currently a professional career route in the UK for health informatics. In the USA doctors can now sub-specialise in health informatics. So the UK needs to build the profession, and public health is a great parent for health informatics. The university is nurturing the knowledge and skill base for this nascent discipline."

**What is the vision for the Institute of Public Health at the University of Manchester?**

"To make sense of the large scale data we need to bring together different disciplines such as epidemiology, health informatics, biostatics and computer science. The Institute is designed to both assemble people and help them think outside the box, for example by seeding a new application of an analytical method from one area to another.

"The Institute hosts a MPH but we are also developing CPD courses in health informatics with a very strong public health flavour. We have public health informatics here which is the only focus in the UK for these skills. Our aim is to feed great material into the established courses and to train a new cadre of people able to navigate data intensive problem-solving in public health. We try to avoid labels though, as we want to maximise the interdisciplinary multiplication of effort. Contributing to education, learning and research is a joint mission here so it isn't just a research group. We work across structures to get on with the job; this is typical of Manchester University".

**Iain Buchan** is Clinical Professor in Public Health Informatics and leads the Centre for Health Informatics at the University of Manchester. He pioneered the development of "e-Labs" in health science and directs the new MRC/RCUK Health eResearch Centre (HeRC) across North England. He is an honorary Public Health Physician and Chief Scientific Officer for North West e-Health. He holds qualifications in clinical medicine, pharmacology, public health and computational statistics, and runs a multi-disciplinary research team bridging health sciences, computer science, statistics, social science, and management science. Iain's work centres on understanding and improving population health and healthcare through large scale participation in making sense of health data.

Iain completed his training at the Eastern Deanery and received his CCT in 2002. He has worked at the University of Manchester for 10 years and became an academic supervisor for the Greater Manchester zone in 2007.

# An Interview with Iain Buchan

**What do you see as the key strength of academic advisory support and how can the training programme best capitalise on this?**

"I don't know if you've heard of disruptive innovation, it is a principle by which many of the high tech industries in the world have described success i.e. when you get too comfortable and set in your ways you'll go out of date quickly. If you are prepared to be a little bit uncomfortable or disrupted then strong new ideas will surface – in a similar way academic advice can be the grit in the oyster. So I see my role as a disruptive innovator. To be a great change agent, a public health professional needs to be prepared to be a disruptive innovator, to unfreeze the convention – attracting attention to neglected problems and leveraging networks of effort to solve them".

**Following the transition what do you see as the biggest gaps between academic public health and public health in practice? What are the biggest challenges we face in the next ten years?**

"The greatest challenge for the public health profession in the next ten years is to embrace a new type of organised effort of society, which is more from the bottom up than the top down. Public health has been tuning its skills, influencing legislation, enforcing regulation, acting as officers in multidisciplinary teams in localities that make population level decisions from the top down. There's been some work in community development but those communities are now interacting in different ways because of socially networked technologies and society is able to rapidly self-organise. The nature of business is changing, they spring up much more quickly to adapt to a community's needs. Communities consume resources and interact with Local Authorities in different ways, so there is much more use of data that governs day to day distribution of resources. Transactions are recorded and people interact on a larger scale which is a digital society. Public health needs to be in at the heart of that self-organisation to maximise the opportunities for society, to maximise health. At the same time healthcare is facing an ageing population, increasing technologies, decreasing resources, cost constraints and chronic diseases with increased longevity, and need to participate more in a digital society to manage these challenges.

One more thing is that Public Health must keep up with industry. I suspect that the wellbeing sector will grow quite quickly, the danger there is that this will widen health inequalities as those with more disposable income will use up more of the wellbeing resource. Thus we must look to ways of working with industry to reduce the price of such commodities so they are affordable for everybody. This might be an alien role to many current Public Health professionals. However we need to support industry to see how their products could be used in a variety of settings, maximising public health benefits and revenues alike.

If you think of a healthy city in the future, wouldn't it be nice if the transport system in that city rewarded you for taking more physical activity – interacting via your smart phone with your social networks, movement patterns and transport uses.

Good Public Health is like good parenting, you need to know when to let go. Wellbeing interventions will probably only be truly effective when they are consumer-driven, with attractive brands that are fun and fashionable, not associated with sickness or seen as 'nanny state'. If we are clever we can sow public health seeds that germinate, but we can't run a nursery of those seedlings we need to persuade others to propagate them".

# Professor Iain Buchan continued

**What is your position on the transition and the future of public health?**

"Indirectly I've been involved with the organisations going through transition, I've often been ask about data supply and how this can work with LAs. So my position on the transition is that it is essential and exciting. It is, however, bound to be painful, just like disruptive innovation. At the same time we must-n't throw the baby out with the bath water, i.e. the positive role of public health in influencing the health service towards equity and excellence. Some of the NHS-connected work falls into the realm of Public Health, some Primary Care – they overlap, but the definitive population view is held by Public Health so it needs to learn to influence whether it sits in the local authority or it sits in the NHS, it's got to keep that influence over the NHS. Where there's a will there's a way".

**What opportunities are there, how can we improve the availability and uncertainty about future placements?**

"It is essential to put resource aside for training people to come together and bridge change – the service needs to have the courage to invest in people and their capabilities, their numbers and their interconnectedness, in terms of multidisciplinary training and the opportunities for coming together. To address those fundamental challenges I mentioned before, for public health embracing a more connected and self-organising society. We don't have that full capability yet, I would urge the service and those who benefit from the service to invest in the capability".

**If you had one super-power, what would it be and why?**

"I'd like to be able to stop people fearing one another, fearing false foes is the most wasteful human occupation. Hopefully it would fuel a meritocracy flooded with goodwill".

# Cumbria and Lancashire Training Zone

Cumbria and Lancashire serves an approximate population of 1.5million. Public health teams in this region have faced a slightly more complicated transition process compared to their counterparts in Cheshire and Merseyside and Greater Manchester, given the presence of Lancashire County Council to consider within their plans.

In Lancashire there are three local authorities that will take on Public Health responsibilities.

- Lancashire County Council - which covers the existing PCT areas of NHS Central Lancashire, NHS North Lancashire and NHS East Lancashire.
- Blackpool Council - a unitary authority which covers the existing area of NHS Blackpool.
- Blackburn with Darwen Council - a unitary authority which covers the existing areas of NHS Blackburn with Darwen.

In the Lancashire County Council area, the project for moving Public Health responsibilities into the County Council is called Public Health Lancashire.

Cumbria and Lancashire will also have a Public Health England Centre and a National Commissioning Board Local Area Team that will create new training opportunities.

It also has strong academic links with Lancaster University and the University of Central Lancashire (UCLAN) and a regional public health network ( www.clph.net )

As the 5th wave of public health progresses, the transition provides us with clear opportunities to work more closely with our local communities. In this section we provide an overview of asset building and examples of this in practice.

We also speak with Dominic Harrison DPH of Blackburn with Darwen on his thoughts on the challenges ahead and look at some of the wider work our StRs have been involved in.

Two new ST1s give us their thoughts on starting the training scheme and if it is what they expected.

Finally we look at the contribution StRs from the region have made to wider public health projects including how you can get involved with the People's Uni.


# Involving children and young people in strategy development

**By Heather Catt ST1**

A well-established view is that any intervention will be most acceptable and successful when designed with residents. A health and wellbeing strategy is no exception and in Blackburn with Darwen it was decided to ask children and young people what was important to give them the best start in life.

I am an advocate of asset based approaches and this would be appropriate for engaging children and young people. Rather than asking for their priorities for health and wellbeing (a question which most adults would struggle with) we discussed what keeps them healthy and happy.

**The approach**

I used the five ways to wellbeing as a frame of reference for thinking about health and wellbeing: at the mention of "health" people will parrot back healthy lifestyle messages – all important but too narrow a definition. I also kept it visual – I met a range of young people including offenders and carers, and young children so it needed to be accessible . I developed the following method:

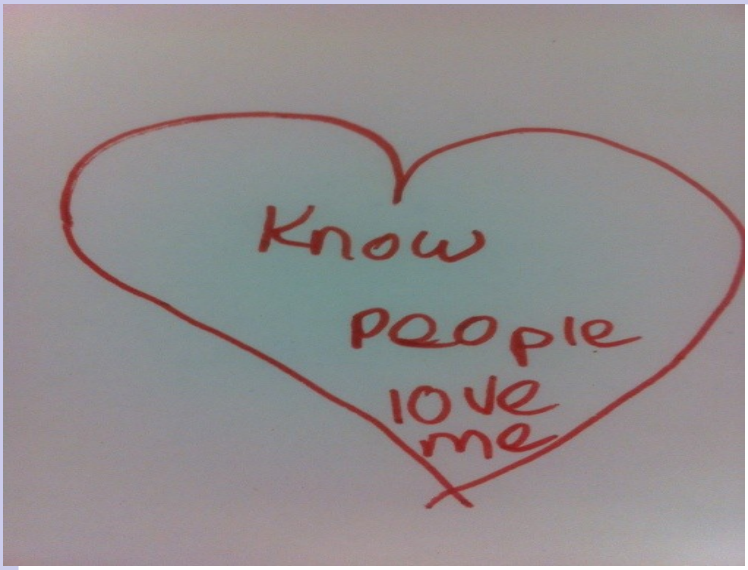
Image slide show representing each way to wellbeing and discussion about what they represent and how they might make them healthy and happy.

Show and talk through the Dahlgren and Whitehead diagram including an adapted younger version.

**Dahlgren and Whitehead for kids!**

Each young person writes the three most important factors for their health and happiness, then feeds back what they have written and why.

# Involving children and young people in strategy development





The notes are grouped and they reach consensus on the most important for their health and wellbeing.

**The outcome**

The children and young people all truly engaged in the topic. The feedback has been favourable from both the young people and the staff involved. Most importantly, the discussions highlighted issues to be tackled that we hadn't previously considered, which means that the strategy and action plan have been improved, which is surely the best possible outcome, apart from successful delivery!

**Challenges and lessons learned**

A number of challenges arose from this work:

Firstly, the short notice – the consultation period on the strategy had already started, which meant I had to be pragmatic and see what groups were available. For the review I will start the process well in advance and be systematic in involving children and young people.

Secondly, capturing the views of children – young people had more experience of life and their own individual needs so it was easier to directly include their views. The priorities of the children reinforced, rather than challenging, the content of the strategy. I will review the approach taken with younger children to make it more effective – maybe involving parents?

Thirdly, balancing evidence – the JSNA had informed the strategy, providing the evidence of need. The children and young people identified their areas of need. Which should take precedence? Striking a balance is important and the pragmatic approach was to add to the strategy and action plan where there were clear lines of complementarity and hold for review issues where further evidence is needed

Finally, language - children and young people do not talk in a way that lends itself to strategies and action plans but interpretation can distort meaning. In the sessions I reflected back to the groups their priorities with a strategy interpretation so that I could maintain meaning. This seemed to work but the proof in the pudding will be whether they recognise the changes when I feedback to them.

Engaging communities in strategies is important, and needn't be painful - I found this experience enjoyable. The children and young people were bright, knowledgeable and clear on what they wanted. The process was challenging and I didn't get it all right, but I'm not sure that it's possible to ever get it right. The important point is to keep engaging and involving people, and to learn from each experience to make it better next time.

# Assets - how can we put it on the health radar?

*By Dr Debs Thompson ST5 &*

*Heather Catt ST1*

**Changing the way we measure 'health'**

"A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses." Antony Morgan, associate director, National Institute for Health and Clinical Excellence (NICE), 2009.

An asset approach starts by asking questions and reflecting on what is already present:

- What makes us strong?
- What makes us healthy?
- What factors make us more able to cope in times of stress?
- What makes this a good place to be?
- What does the community do to improve health?

**An asset is only an asset when viewed from the perspective of the use**r – organisationally driven lists, whilst a start, do not constitute 'an asset approach'. Ultimately, no one definition is satisfactory, but may include:

- The practical skills, capacity and knowledge of local residents
- The passions and interests of local residents that give them energy for change
- The networks and connections – known as 'social capital' – in a community, including friendships and neighbourliness
- The effectiveness of local community and voluntary associations
- The resources of public, private and third sector organisations that are available to support a community
- The physical and economic resources of a place that enhance well-being.

**How do we begin to collect info on assets?**

NHS North West has published a toolkit (A glass half full) advising commissioners about how they can start to measure assets using different approaches, including:

- Asset Mapping
- Asset Based Community Development (ABCD)
- Appreciative Inquiry
- Participatory Appraisal
- Open Space Technology

Positive assets are not routinely collected or available at ward/district/county/region level but are a determinant and outcome of health. One of the challenges of providing a broader picture of assets to inform decision making, is that the asset definition will vary widely dependent upon the community and context in question eg 'assets' for diabetes management may differ than those for 'alcohol harm reduction'. In Lancashire, public health staff are working with NHS and Local Authority commissioners to understand how to best generate and utilise asset intelligence to support decision making by using a number of methods:

1. speaking to commissioners to understand what intelligence they need and in what format.
2. identifying a series of generic asset data indicators (e.g. civic participation, educational achievement etc), which can be overlaid on a map across Lancashire.
3. investigating the production of a publicly available online interactive map using intelligence from asset maps already produced across Lancashire.
4. exploring the use of asset intelligence for an identified strategic priority, such as loneliness in older people in the Health and Wellbeing Strategy.

An anticipated challenge is that given the local nature of this work, the intelligence gathered may quickly be out of date and will therefore require continued update. This is no small task and it is to public health to decide whether the improvements in decision making and commissioning justify the resources required.

# Assets - how can we put it on the health radar?

**Examples of Lancashire taking an asset approach to health**

**Healthy Streets** – Debs Thompson talks about her role in the project as a PH registrar:

In 2010, the Lancashire Health Partnership prioritised 'healthy streets' as one of its 'Big Ticket Issues'. This focus on the structural environment, reflects the evidence on physical activity which shows that informal play and walking/ cycling to school, feeling safe in the local area ,and satisfaction with the quality of the local environment is associated with physical activity in children and adults.

'Healthy streets' is a three year Lancashire pilot designed to make outdoor spaces safer and healthier so that residents can be more physically and socially active. This pilot is taking an asset approach by asking residents what they value about where they live (asset mapping) and for their ideas about how they want to make the best use of these assets so residents can be more active, play, and connect with neighbours.

My role was to work with the council neighbourhood team and other voluntary organisations in the pilot area to ensure the community pilot maintained an assets approach. Close partnership with a local Academy school at the early stage, helped to identify asset approaches that had worked well in the area. The Stand Out In Darwen pilot used a touring living room to ask people what they like about where they live. People were then invited to share their ideas at a 'turning ideas into action' event. Residents were asked to share existing resources (time, skills, equipment etc) to realise their ideas. This model had worked well across the town, and our aim was to duplicate the living room approach in a targeted ward.

One of the challenges in achieving an asset approach, with all residents valued as an equal partner, was the involvement of different partners with differing power. Towards the later stages of the pilot the local councillors were pressured to achieve measurable outcomes and to spend the budget, which led to a power-imbalance between partners and the formation of a core group of decision-makers.

On reflection, it helped me appreciate that partnership requires regular and honest communication. This process takes time and can be a challenge for statutory organisations that are required to spend a budget/demonstrate outcomes within the financial year.

**Preston City Council**: Heather Catt talks about her role as a local resident:

The ABCD approach was used by neighbourhood management to develop neighbourhood action plans, all of which identified health as a priority. Residents from across the borough joined together in a Preston Health Action Group. The group adopted an asset approach and developed a number of models including the good neighbour scheme where individuals are supported to take an active role in their neighbourhood. Due to the success in the health action group, the asset approaches and models are now being mainstreamed across all work programmes at Preston City Council (click to read more about the programmes).

From a resident perspective, the move to an asset approach revitalised community activism. Before using an asset approach, the neighbourhood management partnership had started to struggle, as funding was cut and residents were unsure of the role of the group if it could no longer fund improved landscapes or community safety schemes. Service providers strangely also become less committed! It wasn't easy and it took a long, long time to get residents out of the mind set of looking for problems in an area to be "fixed" (asset mapping in the early days tended to focus on speeding cars and dog fouling). However, once it changed, the momentum built quickly - more residents became involved once they discovered that the focus was on them rather than on board papers.

From a professional perspective, chairing the neighbourhood management partnership seemed appropriate as at the time I was working in regeneration – it was the perfect opportunity to experience regeneration from the community level and provided benefits on both sides: I got to develop my leadership skills and become more informed about the practicalities of community

# Assets - how can we put it on the health radar?

development in deprived areas, which helped to introduce realism to my regeneration (and subsequent public health) practice; and the partnership was able to benefit from my research and strategy skills. The role was challenging for many reasons: finding the motivation to attend (and chair!) partnership meetings following a full day at work; dealing with interesting and often challenging characters; and fighting the constant battle of dwindling volunteer interest, to name a few. Being a community activist is an important role and something that I would argue that registrars should be doing – walking the walk as well as talking the talk. I'm not saying all registrars must go out now and get active, but if an opportunity should fall across your path, grab it as the benefits far outweigh the costs.

***FURTHER READING:***

- *NHS North West: The Development of a Method for Asset Based Working*

  *Discusses a vision for a new way of commissioning whereby Neighbourhoods are given budgets to commission solutions that recognise and build on strengths, skills and resources and what's working well for whom, where and how. Empowering people and providing professions on tap to service the communities rather than the top down approach.*

- *Living Well Across Local Communities – The Asset Approach to Living Well*

  *Discusses prioritising well-being to reduce inequalities.*

- *The Glass Half Full – How an asset approach can improve community health and well-being. Improvement and Development Agency 2010*

# Interview with Dominic Harrison

Dominic Harrison is the Joint Director of Public Health for Blackburn with Darwen Borough Council and Blackburn with Darwen Care Trust Plus.

***By Dr Debs Thompson ST5***

***What challenges do you see over the coming years for Public Health in local government? and how can these be overcome?***

I think people working in Public Health in local government are going to have to acquire a new skills set. One of the core differences is that we have been brought up in a culture where the primary accountability is professional. In local government the primary accountability is to the community. A practical example will be deciding when to discuss an issue with an elected member to get a policy decision or when it's sufficient to discuss it with other officers? It seems to me from the experience I've had in the last 6 months from the inside that those very subtle judgements are very nuanced and we need to learn them.

Of course we're going in with very difficult issues. One on the agenda at the moment is the fact that Local Authorities have been outed because of their investment in tobacco companies through their pension funds. This is a key public health issue that we need to raise with senior officers and politicians.

One of the opportunities is for us to develop a direct relationship with the public that I don't think we have done in the past as Public Health Directors. A lot of us have acquired a professional style where we're constantly on broadcast – 'do this, do that', 'this is right, that's wrong'. I'm not sure we've ever been on 'receive' – and we're certainly not yet good at being in a 'dialogue' which is more interactive. I think there's a number of things that will force us into that. One is elected members saying 'You might say that heart disease is the biggest killer in my ward, but actually the people that live in my ward think that *isolation* is the biggest issue. Because we operate on a statistical, epidemiological, scientific rationale and elected members operate on a democratic, engaged, 'hearts and minds' model – it's a very different place. Neither one is right or wrong. Who is to say what's most important?

***How can we develop our Public Health skills for working with local councillors/partners/ local authority?***

Up to a point you can acquire them through training, for example by talking through scenarios. But in the end, I don't think there's any substitution for being in the institution from the inside and experiencing the judgements that are made, the subtle shifts in opinion. It's about being aware that you can gain wisdom and insight from other senior officers in the council. I would say actually, one of the biggest challenges will not be for the trainees, but for those of us that have been working for many years.

I think we have to have an honest dialogue. One of the famous writers of health services said when health managers get into discussing health priorities, what's really going on is what he called 'pluralistic bargaining'. So how do you say 'one coronary artery bypass graft' is more important than '3 smoking cessation sessions'? Or how do you say that a 'cancer screening programme' is more or less important than a 'mental health intervention'. They're not the same thing, and actually if our aim is to try and get a currency of each, for example QALYs, we have to reflect if that relates to what the public would value.

# Interview with Dominic Harrison

Very often the public are wiser than we are. I'll give you an example of the work we've done on our Health and Well-being Strategy (in Blackburn with Darwen). So if you look at what the epidemiological defined needs of older people are, you come up with a long list including dementia, CVD etc. The thing the 50+ group came up with (which is almost universally non professionals) is the single most important thing to improve health and well-being is to 'reduce social isolation'. Actually if you look at admission to care for people over 50, we've assumed it's a clinical need – usually a long term condition which exacerbates or is poorly managed. But actually there's some really interesting research that shows that it's not the severity of the condition which shows the likelihood of crisis, it's actually whether you've got the social support at home, whether you have family and friends around you that visit, which can help you cope with all sorts of exacerbations.

You look at the outcome frameworks for Public Health, adult social care and NHS – most of them are clinically or service orientated - with an epidemiological framing and medical model - and actually reducing social isolation isn't very prominent. One of the things that drives our framing of problems and solutions is the evidence base. One of the problems with the current public health evidence base and associated NICE recommendations, is that there's a research bias. The only research that is of sufficient quality to end up in an effectiveness review is funded with a pre-established model – predominantly from a clinical bio-medical perspective. If you look at the evidence base for communities and families reducing the social isolation of older people as an intervention to reduce admissions to secondary care for long-term conditions you'd struggle to find it.

***How do you think Public Health registrars can be effective advocates for Public Health locally or nationally?***

Engage with NICE and work collaboratively to generate the evidence base. One of the things we've been poor at is researching our own practice as Public Health professionals. One of the ironies is that if you look at the data on spend per head there's an inverse relationship between Public Health spend and the health of the population. We need to research our own practice more. We spend £112 per head, but are we being allocatively efficient in the way that we spend it? We're spending it largely against disease-based programmes and so we have to try and change that culture to advocate for a non medical model.

Directors of Public Health have traditionally been allowed to say what they think they need to and it hasn't yet been tested in the local government setting. The guidance from the DH is very clear that we have an independent right to speak to the public and a duty to write the Public Health report. In reality whilst that's true we are going to face more political pressure than we have done in the past, because there's all sorts of subtle ways in which you can be dissuaded from saying things perhaps that are uncomfortable for your employers. The solution for that is that we need to create different spaces for that voice to be heard. A practical example in Lancashire is that we've created a website for Public Health in Lancashire which is an independent professionally based forum where we can post material, not as employed staff but as a professional group. We will use it for giving a Lancashire wide view on controversial issues like fracking, tobacco investment, alcohol policies and proactively campaigning about sugar.

Realistically within 10 years, almost all the communication we will do will be digital. We need to become visible and be heard in non-traditional settings such as writing to the guardian, blogs, newspapers internet sites and twitter, facebook

# Interview with Dominic Harrison

etc. We need to look at innovative ways to have a professional voice that isn't even attributable to an individual, but rather to a professional group, and will open up interesting possibilities.

***What's your experience of the interplay between local and national Public Health policy? how do you think this is changing with the Public Health transition?***

Increasingly we are getting more and more stakeholders that realise they are part of public health, that are not professionally Public Health aligned. I think where national policy in non-health sectors is health damaging, we're going to see a much stronger alliance between local Public Health professionals and advocates at a national level. Take the example of 20mph speed limits, where lobbying by DPHs alongside other stakeholders has put pressure on the Department of Transport to change their opinion. You're also getting work going the other way, where you've got communities advocating for 20mph in their area. Public Health can play an important role as a partner, a leader or as an advocate that says here is the evidence base – why are you killing children?

# The Power of the Written Word

**By Dr Tamasin Knight ST3**

Since the invention of the printing press, community controlled publications have enabled the voices of those with little power in society to be heard.

In mental health, the powerful voices are the pharmaceutical industry and the psychiatric profession, and it can be very difficult for other voices to be heard, particularly if they challenge the status quo and the interests of those with power. People who are diagnosed with mental illness but reject the psychiatric way of conceptualising, and treating, their experiences can find their perspectives ignored. As can those mental health professionals who question the dominance of medication in mental health care.

Asylum magazine for democratic psychiatry, psychology and community development, is a community-run magazine which provides a place where these alternative voices can be listened to, and in doing so, it challenges us all to question what promotes mental health. Asylum magazine started in 1986 and is published 4 times a year. The magazine is not-for-profit and is run by a Collective of unpaid volunteers.


A year ago I was invited to join the Collective of Asylum magazine and it was a role I gladly accepted. Asylum magazine is unique in several ways and this has enhanced my experience of being involved. The role of the Collective is wider than a conventional editorial board and also includes promoting the magazine, encouraging participation from a wide range of individuals and groups, and linking with others working for social change. Since being involved I have used my public health knowledge and experience to develop the magazine in a number of ways. I have also used the public health networks I am part of to find opportunities for linking the concerns of Asylum magazine with wider issues of social inequality and injustice. For example, in January 2012, members of the Asylum magazine Collective (including myself) went to speak at Tent City University at the Occupy camp outside St Paul's Cathedral.

The ethos of the Asylum magazine Collective is 'working in a spirit of equality' and making decisions collectively. The experience of working in this way along with being in contact with co-operatively run organisations linked to Asylum magazine has been very beneficial to me. It has shown me that there are alternatives to hierarchical organisational structures.

This has been particularly noticeable during the time of the 'public health transition' when during my regular public health job I have been sent numerous proposed organisational structures, all hierarchy based.

Knowing that this is just one way of structuring organisations has given me a new perspective on the future.

*Asylum magazine website*: http://www.asylumonline.net/

# ST1 Perspectives

**Six months into the training scheme, two new recruits offer their perspective on starting as ST1s in Cumbria and Lancashire.**

Sara Southall ST1

I'm not going to lie to you. Moving from West Wales has been a wrench. Granted, living there or thereabouts for 32 years means that I should have suspected as much. Sitting in the induction watching the weather turn over the Mersey, I'll admit to a distinct sense of foreboding.
It's been bracing.

For a start, there is a definite temperature difference. It's cold. Added to this is the down-the-rabbit hole sensation of starting a new job. Compared to clinical medicine, the language is different, the structure at work is different, the training scheme is different. There's a lot to take in at first. Even for the people already in the job, the landscape is shifting. In essence, we are not in Kansas anymore.

Despite this, I was not last seen disappearing back over the border, screaming wildly. Mainly because it's really nice here. Lancashire (Heather will kill me for letting this out of the bag) is beautiful. Liverpool is cool. And for all the uncertainties and queries, they're outnumbered by people who have been there before and are genuinely nice enough to spend their time talking you through it. Because they like what they do and they're proud of it. Which is, when you think about it, a pretty special thing.

*Heather Catt ST1*

Well, I've gone and done it, given myself to the dark side – I've taken the big step of giving up a job I loved in local government to move into the NHS. I'm going to experience working in "health". And for my first placement...I'll be with the NHS but in a local authority? Public health (well, parts of it) will be in local authority in the future? Ok then, not such a big move after all.

I'm working in a familiar area, in a familiar organisation and regularly coming across people I'm already familiar with. So it might seem like this is going to be easy. Wrong. It's still been a shock to the system. There's been trying to understand the interesting processes of expenses or annual leave or getting my contract. Then there's the worry; the constant anxiety about the deadlines for the MPH modules, or the looming dissertation, the fact I still haven't got on the e-Portfolio, or sitting the Part A and Part B exams. I'm already wishing away the next two to three years so that's all done with.

Having said this, I feel honoured to be on the programme, and to be able to work in the County where I was born and bred. Maybe I'm idealistic (or a bit simple) but I relish the opportunity to put a little something back, to repay some of the life chances that I have had.

Between us we cover a spectrum of experience, showing change can be challenging no matter who you are or what background you're from.

What stands out is the strength of, and continued need for, the public health registrar links, networks and support.

# The People's-Uni

**By Dr Debs Thompson ST5 & Dr Charlotte Simpson ST3**

The People's Open Access Education Initiative is helping to build international Public Health capacity using internet-based e-learning. Peoples-uni was set up as a charity in 2007, fuelled by Professor Dick Heller's drive to provide affordable public health education to people in low and middle-income countries. A combination of freely available resources on the internet and an international volunteer faculty allows learning modules to be developed and delivered at a very low cost. If you're interested in reading more about Professor Heller's passion for global health education then read his interview on BMJ careers.

Since the courses began in 2007, 45 students have achieved a peoples-uni diploma, and in June 2013 we will have our first graduates awarded a Masters of Public Health in partnership between Peoples-uni and Manchester Metropolitan University. Ezra is one of the MPH students with a desire to cascade her learning:

*"As is the case with most Africans, with an average monthly pay saddled with loads of chain of family responsibilities on a regular basis I knew a foreign online MPH degree was rather out of reach for me; so the initiative of P-u to be a low cost degree was just awesome and a welcomed development. P-u has greatly improved my skills and knowledge and I encourage all who desire to see the developing world reduce the burden of diseases to contribute to sustaining this noble "project". We owe it to P-u to return as tutors! That's the least we can do."*

Ezra Yakubu Yarima, Nigeria

People's Open Access Education Initiative

http://peoples-uni.org

**Student experiences of on-line learning**

*"As students we have been actively involved in discussion forums that help us develop multidisciplinary and collaborative strategies for solving health-related problems. The discussion forums involve students from a variety of settings all over the world where we share our experiences and contribute to the learning process".*

Johnstone Kuya, Kenya

Our students tell us that the knowledge and skills gained from P-u has improved their ability to think critically, analyse data and think about the public health perspective when planning and managing health programmes.

# The People's-Uni

Jerome Akeneck Ambanibe is a mental health nurse that has been visiting prisons in Cameroon for years. Now that he has completed a module in epidemiology he is able to prepare reports for the District Health Office that describe the health needs of prisoners, and he is more confident analysing the prison health data. Studying with P-u can also open up further international training opportunities - In this interview a masters student Kenji Obadiah Mfuh discusses how his P-u studies enabled him to apply for an international PHD scholarship in Tropical Diseases. Read about more student experiences on our website.

**Volunteering with Peoples-uni - perspectives from North West PH registrars (past and present!)**

Public health registrars around the UK have been showing support for Peoples-uni by developing courses, facilitating and/or reviewing modules and marking assignments. Here, two North West registrars talk about their experience:

**Debs Thompson:** Being part of Peoples-uni offers great training opportunities and opens up avenues for international volunteering from the comforts of your home computer! Being a mother-to-be I imagine it will be several years before I can live and work again in a low-income country. So Peoples-uni gives me the chance to connect with the international health community, keep up to date with global health issues, and share my public health skills and knowledge (bearing in mind it's a two way learning process).

It's great to be part of such a diverse community of students and volunteers – students come from over 30 different countries, and there is a growing team of academics, education and PH professionals. As a Peoples-uni volunteer you're given the support and encouragement to be innovative and help to shape the future of the charity. It's great working with an organisation that doesn't have the hierarchy and the bureaucracy that can sometimes bog you down when working in the UK.

**Charlotte Simpson:** Taking part in the opportunities that Peoples-uni has to offer has given me some useful experience of facilitating learning within an online community, something which I think is becoming of increasing importance.

I am a tutor on the 'Public Health Concepts for Policy Makers' module and I would have to say that it's been really valuable and interesting to hear about the students' experience of public health within their own country. It's fascinating to compare and contrast these perspectives with my own.

It's also fantastic that as a fairly junior public health professional I have access to the wealth of knowledge and experience available in public health via the network of people involved. I love how there is the support there to allow you to develop ideas you may have about how to develop the course. During the transition and increased day-to-day work commitments, I think it is crucial that we make time to support initiatives like Peoples-uni which have important public health principles at their heart. I have found involvement to be very flexible and so it can easily fit in with other commitments and would strongly encourage other registrars to make use of the opportunities it presents.

# The People's-Uni

**Fiona Reynolds:** Fiona Reynolds is a Public Health consultant at NHS Salford.

In this interview, available online, she discusses her role as a volunteer in Peoples-uni and talks about the challenges and opportunities for global health education through on-line learning

( http://www.peoples-uni.org/content/becoming-tutor

**How you can get involved.**

- Why not become a Peoples-uni module reviewer or design a new module so you can offer your expertise on global health issues?
- Or volunteer to be a module facilitator, assignment marker or dissertation supervisor so you stay connected with international health issues and share your skills with the public health work-force in low/middle income countries
- A Volunteer survey of PH registrars in 2010 found that registrars have used their different P-u roles to contributes towards CPD, ARCP outcomes and to develop their leadership and teaching skills.
- Link your research with alumni group

**For more information or applications:**

See the web site at http://peoples-uni.org (you can contact us through this site).

For a list of modules and a demonstration module, see http://courses.peoples-uni.org

# Places to go and things to do in the North West.....

Whether you're training in the North West or not, here's just a taster of some fantastic public health contacts you might want to make, plus our national treasure training placements in case you fancy staying '*Up North'* with us for a bit….

NHS
National Institute for Health and Clinical Excellence

**NICE Office Central Manchester**

National treasure placements are available for periods of at least six months. Consider if you are in phase three and interested in research interpretation and synthesis, health service quality, health policy and planning.

Paula Whittaker was based at the NICE Manchester office for one year and highly recommends the experience:

"It's a very business-like output driven organisation, but also very democratic, you'll be highly valued as a public health registrar and given plenty of leadership opportunity".

Interested? Contact educational supervisor Judith Richardson Judith.richardson@nice.org.uk or Paula paula.whittaker@nhs.net to hear more about her experience.

**Liverpool School of Tropical Medicine**

Opportunities are available in the International Health Group in research synthesis – assessing the benefits and harms of clinical and public health interventions, with a focus on interventions in malaria, TB, and health systems in low and middle income settings, and the Cochrane Infectious Diseases Group

**North of England EU Health Partnership (NEEHP)**

In January 2013, the North West Health Brussels Office became the North of England EU Health Partnership (NEEHP) and will now represent the health service community across the whole north of England in Brussels.

http://www.northofenglandeuhealth.eu/

NORTH OF ENGLAND EU HEALTH PARTNERSHIP

# Places to go and things to do in the North West.....

**Field Epidemiology Training Programme, HPA North West, Liverpool**

A competency based 2-year specialist postgraduate training programme. The programme is aimed at Specialty Registrars whose future career may involve working in a field epidemiology post involving field investigation, epidemiology and applied research, and who want to further enhance their specialist epidemiology skills.

**North West Cancer Intelligence Service**

Set up in 2006 NWCIS covers three cancer networks (Greater Manchester & Cheshire, Lancashire & South Cumbria and Merseyside & Cheshire). The unit collaborates with public health to produce cancer mapping, analysis of incidence and survival trends to inform decisions on prevention and treatment. From 1st April 2013 it will become part of Public Health England.

NHS
North West Cancer Intelligence Service
Hosted by The Christie NHS Foundation Trust

**North West PH1 StR Editorial Team**

Ian Ashworth

Jen Connolly

Siobhan Farmer

Helen Gollins

Rebecca Mason

Charlotte Simpson

Katie Smith

Debs Thompson

Paula Whittaker

For more information on public health training in the North West please visit the Mersey Deanery website:

www.merseydeanery.nhs.uk/phhome