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Changes to Examinations and Training

In the last edition of *ph.com* the President set out the reasons for changes to the Faculty's current system of examination and membership. This article provides an update on developments and sets out a provisional timetable for change.

Exams
Since the last update it has been decided that the current Part II examination will, from end 2005, no longer be a requirement for placement on either the GMC Specialist Register or the Voluntary Register. However, membership of the Faculty will still be required — but the means of obtaining it will change. The membership examination will still consist of two parts. The Chair of Part I Examiners explains the new Part A on p.4 (see *Diploma and Part I Exam*). From early 2006, candidates must pass the new Part B examination, in the form of an Objective Structured Public Health Examination (OSPHE), to gain membership. The OSPHE is based on the current areas of public health practice and will generally be taken six months after passing Part A. Those from a clinical background are likely to be familiar with Objective Structured Clinical Examinations (OSCEs). The public health equivalent will take candidates through a scripted Standardised Public Health Scenario, during which they will be expected to act as if they were in a real life situation with one or more individuals playing other roles, or with a public health problem set out in a computer simulation. Pilot scenarios have been developed and presented to the Education and Training Committee. It is planned that mock examinations will soon be available to give those taking the exam a chance to practice.

The OSPHE exam will, from end 2005, replace the current general oral examination as an adjunct to the Part II exam.

Interim arrangements for examinations
The Education and Faculty Advisers Committees discussed operating on a cohort basis (ie everyone in the current system would remain in the current system) but this was felt to be untenable, for several reasons. Foremost amongst them was the illogicality of forcing people to continue taking Part II once it had been decided to replace it. Only those who have a CCST date before the end of 2005, and those who have already taken it, will take the Part II in order to obtain specialist registration status. However, there may be those who are so far advanced towards taking Part II that they wish to take it anyway. For them, Part II will continue to be run until 2008. After this time, candidates who, for whatever reason, still wish to take it will only be allowed to do so at the discretion of the contemporary Chair of Part II Examiners and/or the Academic Registrar.

For those who have taken the current Part I but not Part II, given that the new Part A is so similar to the current Part I, they will be able to gain membership by taking the new Part B OSPHE exam from 2006 onwards.

Assessment of Training
Possession of Faculty membership alone will not be enough to gain entry to either of the two specialist registers, although for some it may be all that they require to practice. As now, candidates will have to complete a training period during which their competency to practice at a specialist level is assessed.

Requirements set out by the Postgraduate Medical Education and Training Board make it clear that assessment in the workplace is central to training, and also that methods of assessment need to be clear. It is no longer enough to assume that time spent in training equates to competency gained. Every competency we judge necessary to practice at specialist level must be assessable, and the method used to assess it must be transparent and transferable. It makes no sense to develop separate systems for those with a medical background and those with another background, and we are committed to developing common assessment frameworks for all.

Ten key areas of public health practice
The Standards Committee has also reviewed the current 10 key areas of public health practice. Although they reflect adequately the areas within which public health practitioners work, they are less suitable as a basis for a curriculum or for an assessment framework. However, with a little re-mapping the competencies contained within each area can form the basis for both a curriculum and

Continued Page 2

an assessment framework. As currently envisaged there will be four Core Competency Areas, in which everyone will have to demonstrate competency, and five Specific Competency Areas, related to areas of public health practice. Those wishing to undertake generalist training must demonstrate basic competency in all five Specific Competency Areas: those wishing to undertake training as a Defined Specialist will have to show advanced competency in at least one. What constitutes 'basic' and 'advanced' levels of competency is currently being reviewed, and the framework will soon be out for consultation. Also under discussion is the development of specific assessment tools for each competency, in order to help the trainer 'sign off' a particular competency area.

A final point to mention about assessment of competency relates to the current RITA system and how standards for RITA assessment vary around the country. For this reason, and certainly until we are sure that our system of workplace competency assessment is robust, we are considering an auditing system to monitor in-training assessment. A system of auditing the portfolios of work kept by trainees is envisaged. We are not trying to re-invent the Part II exam. Rather, the process will focus on the *whole* training process (not just on the trainee) leading to the piece of work audited. Neither is it intended that every piece of work signed-off by a trainer is audited. It is enough, we think, to suggest that it might be. It is also possible that individual auditors will take responsibility for different competencies, rather than for individual candidates or for different areas of the country. This should lead to a consistency of approach. We envisage this system starting in 2006.

What are current examiners going to be doing in the future?
For current Part I Examiners life will be straightforward: they will become Part A Examiners. For current Part II Examiners there is more choice: they may remain as Part II Examiners (the exam will run until 2008), they may wish to become Part B (OSPHE) Examiners — several have already indicated their willingness to do so. Or, they may wish to become Faculty Auditors and ensure the quality of in-training assessment. There is no shortage of jobs to do and all suitably qualified volunteers are welcome.

We are not the only College or Faculty currently undertaking modernisation of training and assessment. Most, like us, are in the process of deciding what must be done and how to do it. We are well advanced in our direction of travel, even if there is a long way to go. Please let us know what you think – we do value your views, because it's you that's going to have to make this work.

Steve George
Adademic Registrar

From the Editor

Heraclitus, a Greek philosopher, who lived in the 6th century CE wrote 'nothing endures but change'. This would seem a particularly apt motto for those of us working in public health, as change is an integral part of public health life. However, "change can be inspiring because the challenge exists to make things better". Presently, there are a host of imminent changes in education and training, from the launch of the Postgraduate Medical Education and Training Board to the proposed changes in the membership exams. This edition of *ph.com* is therefore devoted to giving you information on some of the developments in education and training.

Education and training
The lead article by the Academic Registrar and the article by the Part I Chair gives insight into the development of the 'new Part A' exam. This should help allay concerns. The process seems to be one of evolution rather than revolution, with education and training becoming more focussed, appropriate and flexible. Rob Cooper's article on 'Modernising Medical Careers' should inform of the opportunities this initiative presents for public health education and training.

Voluntary Register
Establishing this was a major milestone and the first successful admissions to this register, both through the formal training and portfolio routes, are indeed, to quote Lillian Sommervaille, "a huge occasion". The review of progress, developments with defined specialists, and tips from one of the first successful applicants to be admitted to the register on how to put together a successful portfolio, outline the Register's continuing progress.

The issue of specialists undertaking on-call has been handled differently across regions. The article on page 5 looks at the development of processes for assessing on-call competency in the Thames Valley, provides an example of how this sometimes controversial topic is being addressed by one group.

In this edition we also celebrate the life of Rosemary Rue, who sadly died on Christmas Eve, and her remarkable contribution to public health and to the Faculty.

In addition there are a wide variety of articles which give a flavour of the myriad of activities those working in public health undertake. I hope this edition of *ph.com* provides useful information about recent changes and developments, and demonstrates the opportunities that public health education and training has to offer.

Premila Webster
Guest Editor

From the President

These last few weeks have seen an interesting flurry of activity, here in England, as the Department of Health (DH) begins to pull together the delivery plan for its public health white paper: *Choosing Health*. Key to this is the setting up of a number of taskforces to deal with particular issues. The Faculty has been closely involved in these and I have been working with the DH, in particular, on workforce issues — as you know, the Faculty highlighted the shortage of public health specialists in its report: *The Specialist Public Health Workforce in the UK* which formed part of our submission to the initial white paper consultation.

However, I must admit to some mixed feelings about the work. On the one hand, I suppose I am somewhat disappointed that the delivery plan was not written in conjunction with the white paper — what is the point of a white paper if there is no plan for implementation? On the other, I am delighted that the Faculty is involved in informing the development of it, and I have assured the DH that we will work with them in whatever way we can to deliver the gains in public health that the white paper makes possible.

Health Protection Agency cuts
I have also been receiving, over the last few weeks, briefings from a number of different sources, about possible cuts at the Health Protection Agency (HPA). Whilst I can fully appreciate the desire to get money out of centralised, arms length bodies and into frontline services, my concern is that the HPA (although an arms-length body) provides services which are more akin to 'frontline' science, such as its work on possible flu vaccines. This is work which we will all benefit from and which has the potential to save thousands of lives. I have written to John Reid, Secretary of State for Health, to protest at these possible cuts and will keep you posted, either via *ph.com* or the electronic bulletins, on his response.

Electronic bulletins
Talking of electronic bulletins, you should have, by now, received the first editions of the Faculty's new electronic news bulletin. This is designed to provide a more 'immediate' briefing for members and to keep you up-to-date on Faculty news — particularly during the changes to its education and membership systems. If you have not received your copy (which is sent out via email) please contact the Faculty to check we have your up-to-date email address. I know there are some people who feel that email is more bother than its worth but with so much information now available electronically it is fast becoming the case that every up-to-date public health worker should have access to the internet and an email address. As a responsible, professional organisation, we have a duty to promote this — but, as with the electronic bulletin, our aim is to add value to this as well.

Rod Griffiths
Faculty President

From the Chief Executive

In the last three months the Faculty has started to develop plans to implement the proposed changes to its current education and training systems. This is a complex task and almost all of the changes have far-reaching implications for the way in which the Faculty works — both internally and with external partners. Close liaison with many of our partnership organisations and parent colleges will be essential. All staff have been briefed and asked to contribute to the implementation plan: only with their intimate knowledge of current procedures can a fully integrated and workable plan be developed. Of course, not only will we have the development of new systems, but for the period of transition, we will also continue to operate the existing systems. I am confident that with a planned and measured programme of implementation this can be achieved with the minimum of disruption to members. I hope that we can depend on your support and patience throughout this period as the Faculty staff do all they can to ensure that the changes are seamless.

Faculty business plan
The Faculty 2005 business plan has been agreed by the Board and can be found on the Faculty website. You will notice that much of the work centres on those tasks mentioned above. However, there are important developments within policy and communication that reflect the Faculty's commitment to the Government's public health white paper — *Choosing Health*. Full details will be available from the Policy section of the website.

Electronic CPD returns
For the first time members who are required to submit a CPD return can do so electronically. It is hoped that this development will make it easier for members to make their annual return. (Full details of how to do this are on the Faculty's website.) In order for members to be '*in good standing*', members are now required to be compliant with CPD requirements, in addition to paying their subscription fee.

A more accessible Faculty
Those members visiting the Faculty will have noticed that the Members' Room/President's Office has now been relocated to the ground floor. This is to enable members/visitors with special requirements to make use of these facilities. In addition to this, many other changes will be taking place to make the building more accessible. Whilst we realise that the building poses a number of restrictions on the changes that can be made, we feel it is important to make as many changes as reasonably possible to ensure that the Faculty building is as accessible as possible.

Annual Scientific Meeting
This year's annual conference in Scarborough (7-9 June) is already proving to be popular. The excellent programme provides a comprehensive and thought-provoking agenda, with excellent keynote speakers planned for the three days. I hope that as many of you as possible will try to join us for one of the largest public health events in the UK. I look forward to seeing you there.

Paul Scourfield
Chief Executive

The Diploma and Part I Examination

In light of the proposed changes to the Faculty's education and membership, Part I Examiners have been examining the current Part I syllabus, which has been in existence for about four years. During that time there have been changes to public health priorities, together with a re-organisation of public health professionals' work settings, both within and outwith the UK. The areas of most obvious change are:

- the widening of needs assessment into more general health impact assessment
- the increasing importance of genetics in influencing public health policies and strategies
- the steady incursion of health economics into many aspects of public health decision-making
- newer approaches to involving the wider public in health and healthcare
- lessons from the international community, and
- major changes in the background and training of those working in public health.

There are some rather dated parts of the Part I syllabus — management is an obvious example — and these need modernisation. There are also a number of redundancies in the content.

All examiners have seen, and many have contributed to, the proposed changes to the current draft of the syllabus. Regional training co-ordinators, Faculty Advisers and Heads of Academic Departments will also be given an opportunity for further comment, as will the Trainee Members Committee. Colleagues in Ireland have also been kept aware of the process.

The syllabus is *indicative* rather than proscriptive, as befits its postgraduate audience, and is likely to come into effect in early 2006. Expected standards will also be reflected in the examination questions, the key points, and sometimes examiners' comments.

This is an evolutionary process, not a revolutionary one, and the structure of the examination will not change in any obvious way. The imminence of the Objective Structured Public Health Exam and other changes in place of the existing Part II examination have, rightly, not influenced this tidying up of the Part I syllabus.

The internal structure of Paper 1 will probably shift to better reflect the key areas of public health. It is likely that there will be two questions on each area, with two additional questions reflecting the underlying knowledge base across all key areas. The existing ten-question structure will be maintained. This is broadly similar to the existing structure which can be 'mapped' onto it, but with a slightly altered emphasis, for example, on health protection. A more extensive re-mapping of the syllabus to any future revision of Faculty competencies might be necessary at a later stage. Paper 2 will not change.

The Part I examination will remain the basic assessment of knowledge across the whole of public health, together with some skills assessment in Paper 2, as at present. No doubt many of you will have views, both about the existing syllabus, and about the indicated direction of travel. I would welcome your comments.

Robin Knill-Jones, Chair, Diploma and Part I Examination.
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Changes to the Part II Exam

Most readers of *ph.com* will be aware of recent changes to the Part II exam. This article explains some of the context for these changes, and what has been achieved so far. There is no master blueprint for the future, so your comments and suggestions whether you are a trainee, trainer, or Part II Examiner would be welcomed.

Postgraduate Medical Education and Training Board (PMETB)
PMETB was established in 2003 to develop a single, unifying framework for postgraduate medical education and training across the UK. When fully operational it will take over from the Specialist Training Authority the power to confirm completion of specialist training.

PMETB has developed a series of principles for the assessment of postgraduate training which it expects all Royal Colleges and Faculties to adopt over time. This is published as a working paper (see: http://www.pmetb.org.uk/pmetb/publications/principles.pdf). This is a major driver for change. Our current assessment system has been reviewed in the light of these principles by Richard Wakeford, an independent consultant who has worked with several Royal Colleges on improving their assessment procedures.

Reducing the number of Part II Examiners
One of the main findings of the independent review was that the ratio of Part II examiners to candidates was much larger than in other Royal Colleges and Faculties and, if possible, should be reduced. A smaller group could be more intensively trained and should reduce the perceived variability in the standards for which the exam is sometimes criticised.

In response, Part II Examiners were asked to consider volunteering for a more intensive commitment including regular training days, participation at least twice a year, and marking a greater number of candidates written work on each occasion. A 'national panel' of 40 examiners, each serving for a minimum period of two years has now been established.

In order to be able to function with this smaller pool of active Examiners, the custom that Examiners should not come from the same region or country as their candidates has been relaxed. The requirement that Examiners do not have a relationship with candidates which could interfere with their judgments, of course, remains.

With the pressure of work now experienced by many Examiners in their day jobs, realising the extra commitment has not been straightforward. It was hoped that the new, smaller group would take over vivas in March 2005 but this has not been possible. The practicality of the change is therefore being reviewed.

Introduction of the Objective Structured Public Health Examination (OSPHE)
The evidence-base about assessment from which PMETB principles are derived shows that traditional vivas or short cases are an unreliable assessment method. The General Oral (GO) will therefore be replaced by an OSPHE. Subject to satisfactory progress of the development work which is now underway, the new exam will replace the GO from November 2005.

Further information
For more detailed information, consult the Exams pages of the Faculty website. The 'What's New' page will be updated after each meeting of the Education Committee, or when key decisions are taken. A letter alerting Part II Examiners and Training Programme Directors to changes will also be circulated.

Mike Robinson, Deputy Chair, Part II Examiners

Safe on-call

This article provides an overview of the accreditation process for undertaking health protection on-call in the Thames Valley

What is accreditation?
Accreditation is a process of granting recognition to those that fulfil certain criteria or attain a certain standard.

An accreditation process for health protection on-call was established by a working group, including a director of public health, the public health training programme director, a consultant in health protection, a formal training programme representative and a public health specialist.

Accreditation routes
In Thames Valley there are two accreditation routes:
- the formal training programme
- the TVHA accreditation process.

Formal training programme
Trainees are appointed to the formal training programme through an integrated, competitive selection process.

Trainees from a medical background appointed through this process will be allowed to take part in the first on-call rota if they have:
- worked in the NHS (in acute medicine)
- undertaken a two-week induction in the Health Protection Unit.

Those who do not fulfil these criteria must undertake a three month attachment with the health protection unit.

Trainees from a background other than medicine must undertake:
- a three month attachment with the HP Unit
- any additional training recommended by the supervising Consultant in Health Protection.

In addition, trainees will also be 'shadowed' by a senior trainee for a period of time (usually 3-6 months) until they are able to undertake on-call independently.

Thames Valley accreditation process
Thames Valley Health Authority (TVHA) has established an accreditation process for public health specialists who wish to be on the on-call rota.

First on-call rota
Those wishing to take part first have to gain those competencies outlined by the Faculty. This is usually achieved through:
1. successfully completing a health protection module (in the Thames Valley)
2. attachment with the local health protection team.

In addition, trainees must take a written exam (questions in scenario format covering all areas of health protection including emergency planning), followed by a viva. Successful completion of both results in the award of a certificate of accreditation. As with the formal training programme, trainees are 'shadowed' by a senior trainee.

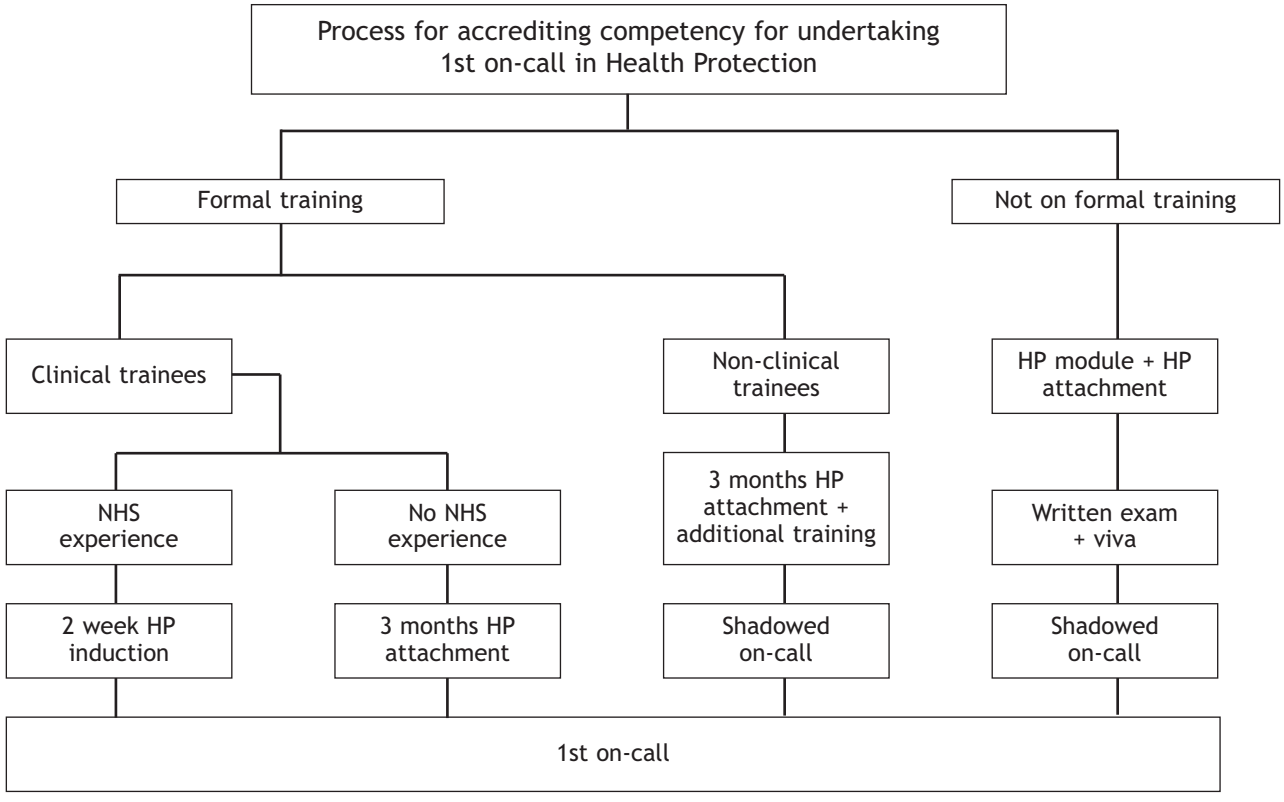
A log book to record on-call activity has also recently been introduced and this will be used in the future as further evidence of competencies covered.

Second on-call rota
This process is very similar to that of the first on-call rota. Again, those wishing to take part on the second on-call rota will first have to gain the competencies outlined by the Faculty. They must also take a written exam aimed at a senior level, followed by a viva. Successful completion of the exam and viva results in the award of a certificate of accreditation. Following this, individuals will be allowed to join the second on-call rota.

Figure 1 illustrates the processes outlined above.

P Webster, J McWilliam, M Abid
Thames Valley

Figure 1:



A New National System to Study

Rare disorders, although individually uncommon, when considered together represent a considerable burden to families, carers and health systems. They are difficult to study and are therefore under-researched. Our knowledge is poor and any interventions are rarely based on robust evidence. The UK Obstetric Surveillance System (UKOSS), launched February 2005, is a new research initiative designed to study a changing programme of rare disorders of pregnancy, identified by health professionals as priority areas for research. This is a joint initiative by the National Perinatal Epidemiology Unit and the Royal College of Obstetricians and Gynaecologists, and is supported by the Faculty of Public Health.

British Paediatric Surveillance Unit
The British Paediatric Surveillance Unit (BPSU) developed methodology to study rare disorders of childhood and has been conducting research for nearly 20 years. Since its inception, more than 200 publications relating to its work have appeared in peer-reviewed journals. BPSU surveys have been used to inform policy decisions on antenatal screening. A BPSU survey also documented the association between Reye's syndrome and consumption of aspirin. The BPSU has also undertaken emergency surveillance in response to concerns about vitamin K therapy, water-births and whether variant CJD was appearing in British children.

UKOSS
UKOSS will use similar methods to the BPSU to conduct descriptive, case-control or anonymised cohort studies of rare disorders of pregnancy. Each month a report card is sent to an obstetrician, midwife, perinatal risk manager and anaesthetist in each UK hospital, with a list of conditions currently under surveillance. They are asked to complete the card, indicating the number of cases of each disorder seen in the hospital during the previous month. They are also asked to complete a 'nil return' where appropriate. Clinicians who report cases are sent a simple data collection form requesting information on case definition, management and outcomes which can be completed from the case notes. All information collected is anonymous.

In this way, the system allows parallel surveillance of a number of different conditions while removing the burden from clinicians of multiple requests for information from different sources. Each study will run for a different duration, depending on the incidence of a particular condition, and new studies can thus be introduced as previous research is completed. This allows for new studies to be introduced rapidly in response to emerging conditions of public health importance. The data collected will be analysed and reported on through quarterly newsletters, annual reports, and in peer-reviewed publications in order to provide rapid feedback.

UKOSS also provides a means by which rare 'near-miss' events can also be identified and studied. A 'near-miss' may be defined as "a severe life-threatening obstetric complication necessitating an urgent medical intervention in order to prevent likely death of the mother". Maternal deaths have been studied in depth in the UK for 50 years, and these have been key to identifying and introducing a number of changes in care which have subsequently led to a reduction in the numbers of deaths. Analysis of 'near-miss' events can complement death-only enquiries. The process involves more rapid reporting and allows the comparison of maternal deaths with near-misses and examination of the quality of care. Further advantages include the identification of additional risk factors amenable to change and the provision of information to improve service planning.

Initial surveillance
The initial conditions under surveillance will be diverse. Some disorders which will be studied, such as antenatal pulmonary embolism, eclampsia, acute fatty liver and amniotic fluid embolism, have been identified by the recent CEMACH report as leading causes of maternal mortality. This emphasises the importance of identifying and studying women who survive these events in order to provide further insight into why some women die. Others have been identified to be of importance for different reasons. Peripartum hysterectomy will be included because of the potential for an increase in incidence in the light of the recent rise in caesarean section rates. Tuberculosis is increasing in incidence generally and recent hospital-based studies suggest that there are important differences in the epidemiology of TB occurring in pregnancy compared with the non-pregnant population, which impact significantly on diagnosis and management. A UKOSS study will establish whether this is the pattern nationwide and identify current diagnostic and management practices.

UKOSS in the future
UKOSS can be used to conduct a wide range of studies with a number of purposes including improvements in prevention, diagnosis and treatment of rare disorders, and service planning. With the active participation of health professionals, we believe that the research UKOSS produces will lead to significant advancements in the care of pregnant women. However, in order for us to fulfil these aims, the surveys conducted through UKOSS need to answer

Rare Disorders of Pregnancy

questions of relevance to the care of women today. In this we would encourage all researchers, no matter how inexperienced, to contact the UKOSS team if they have identified a question which could usefully be answered through a UKOSS study. We will undertake to provide support in generating an appropriate research proposal. In this way, we hope that the information that UKOSS provides will be as useful to the care of pregnant women as the information from the BPSU has been to the care of children.

For further information see:
http://www.npeu.ox.ac.uk/UKOSS/index.php

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There is an end to training

When we completed our public health training recently, a new era in public health had dawned: we were the first specialist trainees (SpTs) to complete a regional public health training programme and the first to join the UK Voluntary Register for Public Health Specialists via this route. Today, public health training has become a truly multidisciplinary field reflecting amazing progress since those first tentative steps were taken six years ago. It's a good time to reflect on the progress that has been made.

The 1997 Public Health White Paper set the agenda for this new multidisciplinary public health workforce but was not very clear in how it was to be achieved. Therefore, the first three regions to establish specialist training programmes in 1999 had very different expectations of their new trainees. The length of the programmes varied from two to four years, Part II wasn't even on the agenda and no-one was quite sure what the situation would be five years down the line. Unsurprisingly, many of those who started at this time concluded that the uncertainty and insecurity associated with training was not for them and opted to go into substantive public health posts. However, today things have been transformed — all regions in England and Wales have now established integrated training programmes for SpRs and SpTs and most provide the same training opportunities. So how has so much been achieved in such a short time?

The development of fully integrated training programmes for SpTs and SpRs was made possible by a combination of factors:

- the central role of the Faculty in driving forward the necessary changes, including opening up membership by examination to non-medically-qualified public health professionals in 2001 and the development of the 10 key areas of public health practice to assess competence and standards of practice
- strong leadership within regional training programmes
- the commitment of trainers to providing appropriate opportunities to meet the needs of SpTs, and
- resolute support from SpR colleagues and recognition of the mutual benefits of working together in multidisciplinary training programmes.

Most of all, it has been the SpTs themselves who have shown resilience and adaptability during a prolonged period of uncertainty and change. In the very early days of specialist training programmes a national support network was established and SpT colleagues across the different regional programmes have shared their experience of issues affecting training to help identify solutions to common problems. Such problems have included uncertainty about continuing funding of training posts, less access to training opportunities than SpR colleagues and the perennial on-call issue. We have also celebrated the success of our colleagues, Margaret Jones and Sally Dowling when they were the first to Pass Part I in 2001 and Alison Pritchard from the East Midlands when she became the first to pass Part II in 2003.

Those who stayed the course have gone through ups and downs but almost all are glad they did, and are looking forward to the challenges that lie ahead on the other side of the scheme.

Maureen Whittaker, SpT, Yorkhire and the Humber PH Training Programme
Geoff Barnes, SpT, North West PH Training Programme

Faculty of Public Health
Annual Scientific Meeting

7-9 June 2005
The Spa Complex, Scarborough

A programme and registration form have been included in this mailing of *ph.com*.
Further information, programmes and registration forms available from:
www.fph.org.uk

Voluntary Register Progress Review

It seems a long time since establishment of the register was announced in June 2003. Today, there is the reality of a strong and highly skilled, multidisciplinary workforce, with training programmes and advertised posts seeking applicants who are on the Voluntary Register or working towards accreditation.

Promoting public confidence
In summary, the aim of the register is to promote public confidence in specialist public health practice in the UK through independent regulation. It will achieve this by:

- publishing a register of competent specialists in public health
- ensuring through periodic revalidation that specialists in public health keep up-to-date and maintain competence
- dealing with registered specialists who fail to meet the necessary standards, and
- promoting formal recognition of public heath specialists.

The Voluntary Register
The register is open for the generalist category of specialist in public health and applications have been received from all four routes (**standard, transitional, dual and provisional**). It is particularly pleasing to have just received the first via the standard route (see the article by Lillian Somervaille in this edition of *ph.com,* p17) and further applications are expected. The Joint Register Board is anxious that the register is seen as inclusive; it seeks to be fair to those who have undertaken formal training in the past, and to those who are currently in training, as well as those in senior posts who have had wide experience and extensive expertise in the many areas of public health who are now seeking entry to the register through retrospective portfolio assessment. As far as retrospective portfolio assessment is concerned the Board recognises that it may be difficult for applicants to know exactly how to complete their applications. We have been most grateful for the excellent help and advice provided by the Development Needs Assessment Centre.

At its meeting in November 2004 the Board ratified some minor changes to the portfolio process. The modification allows for early contact with those applicants who have fully demonstrated competence in at least eight key areas and where all that may be required is some clarification of evidence already submitted. The Board has also agreed that the number of attempts will be increased to three, although there will be no overall extension of the time for submission — ie. within 18 months of the first. These changes do not alter the standards.

Defined registration
The next major development relates to defined registration. After the completion of a comprehensive feasibility study in March last year, the Board received funding from the UK Departments of Health to develop competency frameworks to enable senior public health professionals from defined groups to be accredited for registration by portfolio assessment. In July, the Board awarded the work on implementation to a group co-ordinated by the Public Health Resource Unit in Oxford (see the article by Jenny Wright in this edition of *ph.com,* p9). It should be noted that defined and specialist registration are deemed to be equivalent, and that the process of registration is essentially similar. It is anticipated that a few individuals may seek to be registered simultaneously as a generalist and as a defined specialist.

It is hoped that the Board will consider the final report in May 2005 and that implementation will follow rapidly. There is great interest in these developments and the enthusiasm of those working in the areas being considered bodes well for the future of a diverse and highly skilled public health workforce. The groups of defined specialists already accepted, and which form the basis of the current work, are based on current professional practice of senior people, reflecting the lack of formal training programmes, and professional and service settings over many years. There will be a period of several years when it will still be necessary to register those who have not had the opportunity of new formal training programmes.

With the opening of the register to defined specialists, for the next few years the only route that will be available will be retrospective portfolio assessment. From 2007, the Board has agreed that those seeking entry as generalists by portfolio assessment will be asked to justify their application. The Board will review the position in 2006.

Working together
There is close collaboration between the Register and the Faculty, and indeed with all the relevant qualifying and registration bodies. The Board also benefits from representatives from the four Departments of Health. There are likely to be many developments over the next few years, but I am confident that all of us in public health will be able to work together, and I hope that the Voluntary Register will make a valuable contribution.

Further information on the register, including application process, summaries of Joint Board minutes, and regular news bulletins are on the website at www.publichealthregister.org.uk

Professor Jim McEwen
Chair of the Joint Register Board

Voluntary Register - Further Information

UK Voluntary Register:
www.publichealthregister.org.uk

Public Health Resource Unit:
www.publichealthdevelopment.org.uk

Faculty of Public Health:
www.fph.org.uk

Registration of Defined Groups

The UK Voluntary Register Board received funding from the four UK Departments of Health to set up a project to develop frameworks to permit registration of specialists (ie. those already working at a very senior level) in a number of defined groups via retrospective portfolio assessment. These specialists will be expected to have the knowledge base across all ten key areas of public health and to demonstrate the application of knowledge ('shows how') in specific competencies. However, they would be expected to show this at a much higher specification than the current generalist/ specialist level (but which, overall, demonstrates an equivalent weight of evidence to that required of generalist specialists). The principle behind registration for those in defined groups is, as for the generalist specialists, public protection. In addition, the recognition and registration of people working in these defined areas will strengthen the capability of public health, and further endorse it as a multidisciplinary function.

Defined project groups
Nine separate groups are covered:

- health protection
- environmental health
- health promotion
- public health intelligence
- public health pharmacy
- public health nutrition
- health economics
- academic public health
- health psychology

Small working groups, with representatives from the main UK stakeholders, put together draft portfolio frameworks (PAFs). These will then be sent out to all stakeholders for wider consultation.

The group leading this work is also working closely with the Faculty of Public Health team developing the competencies for defined specialism training within the formal Faculty training programmes. The possibility is that, in due course, the option for training in a defined specialism, ie. domains of practice, (as outlined in *Education, Training and Membership — a consultation document*, Sept 2004, see: www.fph.org.uk) will be open to everyone entering higher specialist training through a prospective training assessment route.

Agenda for Change
A key strand of work is the need to link with the *Agenda for Change* process and the underpinning development strand outlined in the *Knowledge and Skills* framework. The purpose of the Knowledge and Skills framework is to enable the development of individuals in their posts and across their careers through competence based progression. Nine levels in competence progression are defined in the Modernisation Agency's NHS career framework and these levels, and associated competencies, need to be defined for public health. The levels correlate to *Agenda for Change* pay scales.

It is going to be a very busy summer, but these initiatives will hopefully lead to an approach to development which is competence-based, flexible, and which fits with identified service roles.

To see the draft PAFs as developed for the defined groups project or if you have any queries please contact: definedgroups@phru.nhs.uk

Jenny Wright and Ros Dunkley
Project Leads,
Public Health Resource Unit, Oxford

'DOs' and 'DON'Ts' for developing a successful portfolio

There is, of course, no right or wrong way to develop a successful portfolio but I hope the following thoughts, which are drawn from my own experience, provide some useful guidance.

Getting started
From the outset **DO** acknowledge that the portfolio route is not a quick or easy option. **DON'T** underestimate the personal commitment needed. **DO** join or establish a learning set, and identify and discuss the role of others in your network including employers, peers, referees etc. **DON'T** be afraid to ask questions or to be challenged.

Like any other public health project it is important that you **DO** adopt a structured approach. **DO** identify someone who is willing to monitor and evaluate your personal progress and **DON'T** set over-ambitious timetables.

DO thoroughly scope and research the topic. Excellent advice and resources are available from the UK Voluntary Register (www.publichealthregister.org.uk) and the Public Health Resource Unit (www.publichealthdevelopment.org.uk). Links are also available from the Faculty website. In Wales, information is available from the Wales Centre for Health.

Develop a matrix which addresses each section of the ten core competencies. **DO** identify your strengths first and **DON'T** be put off by the competency gaps that you identify. **DO** seek to illustrate your personal 'knows how' and 'shows how' from as wide an experience as possible. Remember: generalist specialist accreditation requires a breadth as well as a depth of knowledge and experience.

DO seek to use 'top-up training', other training opportunities, work objectives and personal development plans to address any competency gaps. Adopt a timetable for learning but **DON'T** treat the accreditation process as a stand-alone task.

Compiling and writing your portfolio
When compiling your portfolio **DO** think about its assessment. Adopt a clear and consistent style which will be straightforward to assess. **DO** remember that you are setting out to convince someone who may never meet you, that you are a competent public health specialist. **DON'T** forget to demonstrate insight into your own strengths and weaknesses through reflection.

When writing up, **DO** start initially with an area of strength. Write a first draft, get it critically assessed and repeat. **DON'T** write up any others until you are satisfied that your chosen format is acceptable. **DO** summarise each piece of work in your portfolio and include supporting evidence of 'knows how' and 'shows how'. Reference your work appropriately and **DO** make any supporting evidence that you have collected and your personal contributions easy to find.

In compiling submissions **DON'T** try and claim too many competencies from any one project. Avoid duplication and remember that the portfolio is about you and what you know or can do, so make sure that you **DO** use lots of personal pronouns.

And DON'T forget to…
Celebrate your own success, from writing your first submission or filling a competency gap, right through to finally submitting the completed portfolio. At whatever stage you find yourself, if at first you're not successful, definitely **DON'T** give up.

DO set out to enjoy the whole learning experience, it does become a big part of your life!

I wish you all the very best.

Andrew Jones
Local Director of Public Health and Team Leader Environmental Public Health
National Public Health Service for Wales

Modernising Public Health Careers

Background

Modernising Medical Careers (MMC) starts with a two year, post-graduate Foundation Programme, consisting of two stages — F1 and F2. The F1 stage is similar to the pre-registration House Officer year - following completion of this stage doctors will be fully registered with the GMC. In the F2 stage they will generally sample three other specialties, each for four months. The Foundation Programme will provide generic training in a number of competency areas (see Table 1). All trainees will have approximately half a day per week of generic study. F2 will be followed by Run Through Specialist Training Programmes (RTSTPs) in a chosen speciality. It is expected that the finalised Foundation Programme Curriculum will be published at the end of March and that all newly qualifying medical students will enter their Foundation programmes in August 2005.

Table 1: Foundation Programme generic competency areas

Competency Area	Public health suited?
1. Consultation, history, examination	N
2. Acute care, investigations, decision making	N
3. High quality care & patient safety	C
4. Infection control	S
5. Communication skills	S
6. Team working & seeks appropriate help	S
7. Personal education	S
8. Audit & evidence-based medicine	S
9. Professional behaviour & probity	C
10. Teaching & training	S
11. Team working & time management	S

Note — these are based on the foundation curriculum consultation — www.mmc.nhs.uk

S: PH suited to cover
C: PH could cover
N: PH not suited to cover

It is envisaged that the F1 stage will be dominated by acute specialties and that public health training opportunities are best placed in the F2 stage – starting in August 2006, so it is important to plan now. Public health training in the Foundation Programme should:

1. be part of generic (half) study days for all trainees to gain knowledge and awareness of key public health and health promotion issues.

2. have four month F2 placement opportunities to encourage recruitment to public health RTSTPs and to provide further basic public health training for doctors, who may then train in other specialties eg GP.

Based on recent discussions, the Faculty Executive considers that, by August 2006, there need to be 150 public health F2 posts in the UK. Assuming each post accommodates three trainees per year, each on four month placements, this would mean 450 doctors each year would have the opportunity to undertake public health training – comprising about 7% of all qualifying medical students. Half of all training schemes already have F2 posts or plans to establish them. The West Midlands and Eastern schemes are not far off their pro rata share of the above.

West Midlands 'Taster' Pilots
In 2001/02, the West Midlands piloted junior 'taster' SHO posts, resulting in the piloting of public health F2 posts. There are currently 15 posts in the region, based on the four month placement model — which generally appears to be the norm — although different models may suit different circumstances. It is worth noting that most of the likely generic competencies for the Foundation Programme can be covered by a public health F2 training post (see Table 1). It will be necessary for an acute specialty to be part of an individual's programme to cover competencies, such as acute patient care.

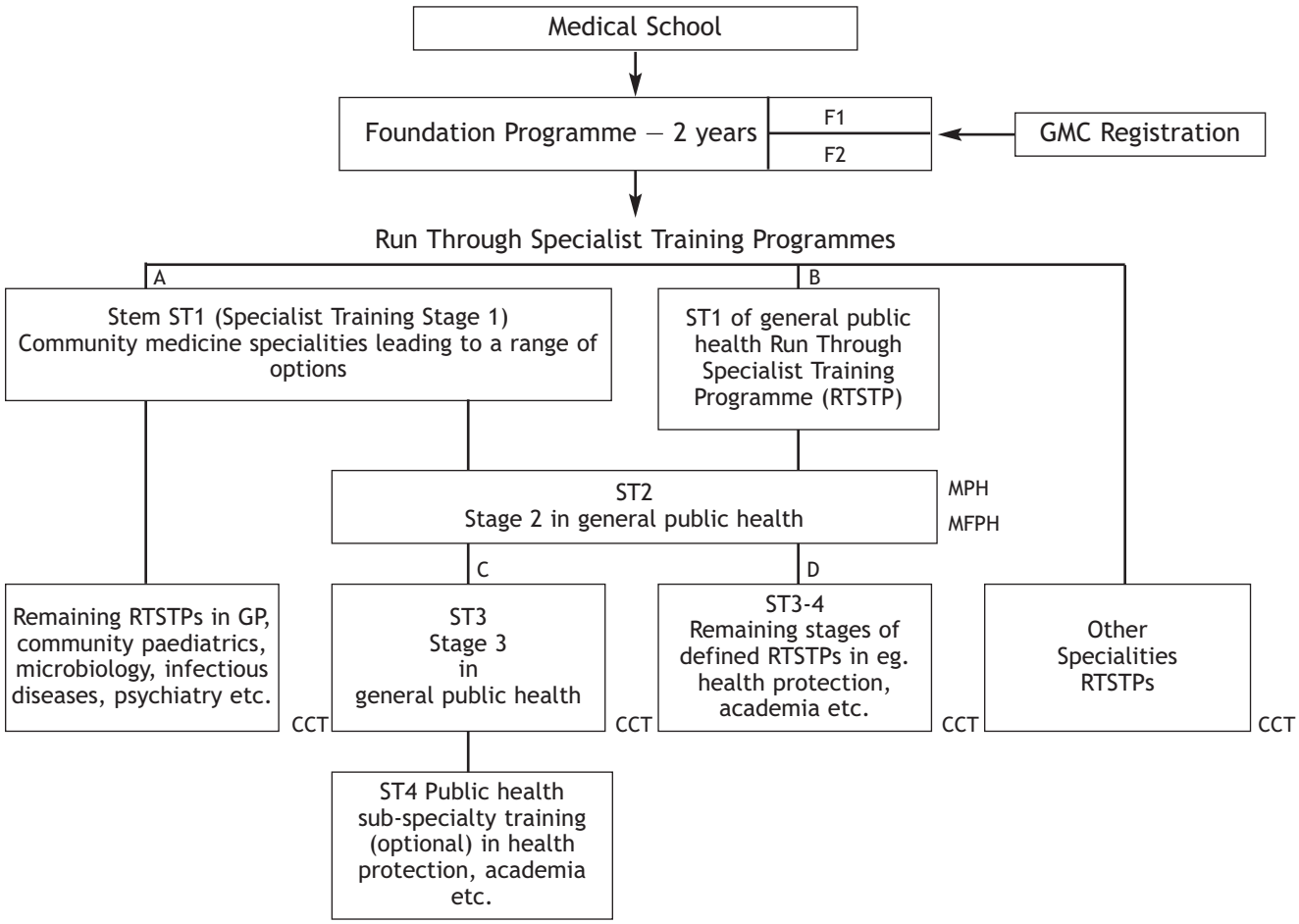
Summary of West Midlands guidance for public health F2 trainers

Generic Competencies
The public health trainer is responsible for assessing and signing-off those generic competencies covered in the placement. Trainers need to be aware that F2 doctors are relatively junior and need careful supervision. They should agree with the trainee how other competencies will be covered in the F2 period and draw up a training agreement on competencies to be covered in each four month block. This should be shared with trainers in the other specialties. If necessary, the trainer should have discussions with the other trainers to clarify which competencies are covered, when and who will assess them.

Public health competencies
In addition to the generic activities in the public health period, the following should be covered (preferably through work-based activities):

- Population health need assessment
- Population healthcare evaluation
- Understanding the NHS, local authorities etc
- Screening services

Figure 1: Training Routes



- Health promotion
- Health protection (to include infection control)

It is particularly important that F2 public health trainees have a clearly identified health needs assessment or healthcare evaluation project which is well planned prior to arrival. It must be achievable within four months and be something which they are proud to include in their future CV.

Run Through Specialist Training Programmes (RTSTPs)
The first MMC cohort will complete F2 training in July 2007. RTSTPs need, therefore, to be planned by early 2006 to allow adequate time for implementation by Programme Directors. In the MMC model, doctors will probably start applying for RTSTPs part way through their F2 period. One option would be to have a period of general professional training in the first year of Run Through training allowing trainees some flexibility on when to undertake public health training. The eventual shape of the programmes (see Figure 1) will depend on the outcome of the proposed changes to the Faculty's Education, Training and Membership consultation and further guidance from the Postgraduate Medical Education Training Board.

Training Routes (see Figure 1 above)
Route A: Stem RTSTP for those wishing to practice in a community medicine type specialty but not sure which one. At the end of ST1 they would compete for a RTSTP in their chosen specialty.

Route B: Available to those in the F2 period who wish to compete for Public Health RTSTPS.

During ST2 there could be an option to remain in general public health training (**Route C**) leading to a CCT, or to undertake a defined RTSTP (**Route D**) in, for example, health protection. The Higher Specialist Public Health competencies required for CCT would, wherever possible in Route D, be obtained whilst undertaking defined specialist training. For those who follow Route C it would be possible to then opt to undertake defined sub-specialty training post CCT.

It is important that opportunities to train in public health are available for people with experience in other specialties or career paths, following a competency assessment of previous skills and to join at an appropriate stage in Fig 1.

These options will be discussed at the forthcoming Faculty Training Conference (15 April) so that the Faculty and PMETB can agree a way forward. The length of time in each Stage of Specialist Training will also need to be considered and preferably influenced by competency based assessment.

Clearly, we also need to consider the needs of people from backgrounds other than medicine and ensure that future public health training programmes are appropriate for people from a wide range of backgrounds to include F2 and RTSTP opportunities. MMC provides a window of opportunity for public health. It is important that, given the changes to the Faculty's education and training systems, we make the most of these.

Rob Cooper
West Midlands Programme Director
& Executive Committee Member

Department of Health International

Healthcare is now firmly on the international agenda; indeed as countries pursue innovative and technological advancement, it is more important than ever to secure international cooperation. Clinical partnerships, medical device development, training and development programmes, innovative and creative solutions such as Private Finance Initiatives, all offer themselves as candidates for international examination as countries pursue healthcare improvement against a background of cost containment and pressures from aging populations.

DH International is the Department of Health's trade promotion arm, working closely with UK Trade and Investment over a wide range of issues to promote the NHS and support the British healthcare industry overseas.

Firm links have also been established with the Health Protection Agency, the Modernisation Agency, the National Institute of Clinical Excellence and many other key health agencies. Further links have been established with the Foreign and Commonwealth Office, the Royal Colleges, the Association of British Healthcare Industries, the British Consultants and Construction Bureau and others to galvanise activity to support the NHS and the British healthcare industry overseas.

DH International has also been proud to organise in excess of 50 visits to the NHS during the last year when overseas governments and officials have expressed interest in learning more of the successes that have now been installed within the UK. This in turn provides an important platform of goodwill, on a government to government basis, on which hopefully commercial trade activities can subsequently flourish.

DH International also supports and briefs ministers on international healthcare trade issues. UK Trade and Investment also requests DH International to contribute towards overseas country scoping missions with a view to advising the British healthcare industry on the marketing potential for healthcare products/services. These programmes are coordinated with the British Embassy in the country under review. They include visits to the ministry of health, hospitals, healthcare facilities and healthcare businesses. A report is then produced and presented at a range of seminars to the British healthcare industry.

DH International has in the last 12 months focused much of its work on developing relations with China. This culminated in two Memoranda of Understanding with both the Shanghai and Beijing health authorities (see above picture). China is undergoing a period of radical reform and recognises the world-class achievements in UK clinical practice and medical education and seeks to develop a number of partnerships to improve the services within China. DH International has facilitated entry into these areas. Developing new hospitals by the PFI financial structure is of real interest and currently DH International is facilitating the first pilot project in Shanghai.

Other areas of success in the last 12 months have included Chile, Columbia and Mexico where there has been real and sustained interest in the models of service within the UK. Of particular interest is the fact that the Columbians, following a five country review of undergraduate medical education systems, has selected the UK model for their future curriculum.

An international database has also been established to support international activities. Anyone wishing to register on the database should contact dhinterntational@dh.gsi.gov.uk.

Stuart Smalley
Head of International Developments
DH International

Gaining International Experience

I was part of a project team who worked on HIV and AIDS in Honduras. The project's aim was to improve the monitoring and evaluation system for HIV/AIDS — particularly important in large-scale HIV/AIDS programmes. A key prerequisite was ensuring sufficient technical capacity to measure the success of these different programmes.

The actual work
Initially, a baseline analysis was undertaken to look at the different efforts to monitor and evaluate HIV/AIDS programmes. Conducting stakeholder interviews also enabled me to integrate quickly with people working in the field. The baseline analysis, in conjunction with UNAIDS guidance on monitoring and evaluation, led to recommendations for new indicators and improved co-operation between the different agencies involved, as well as better co-operation between the different Central American countries.

Experience
This overseas experience was not part of my UK training. However, the work has been successfully used for the Faculty's Part II exams. I have some background in public health in developing countries and I thought it would be useful to mix my portfolio with experience in the developed and developing world. The most important part for me was to see how well I was able to use the newly gained knowledge from the rotation in public health in the UK, in a different setting. My impression is that overseas experiences are extremely valuable for training in public health, since much of the work in developing countries needs to be done with little extra resource, and organisational and managerial capacities are improving rapidly. This can mean a higher risk of failure and disappointment for projects but as long as they are well planned this risk should be minimised.

Olaf Horstick
SpR in Public Health

International Health Conference for UK Public Health Trainees

A conference, sponsored by the Yorkshire & Humber Public Health Trainees' Committee, was held in Leeds to raise the profile of international health among UK public health trainees. It explored ways in which trainees could contribute to the international public health agenda, gain valuable public health experience at international level, as well as explore different career opportunities in international public health.

Benefits of international experience
International experience can expand the thinking of public health specialists and provide a more holistic approach to addressing health problems. In addition, lessons can be learnt from the experience of low-income countries in areas such as community development, prioritisation and multi-sectoral working. Overseas experience can be enriching: the skills gained are unique, transferable and complementary to those obtained in the NHS. People working in international health need to have the appropriate qualifications and sensitivity to local social and cultural issues. Alexis Macherianakis rated his placement at the EU Commission as the best experience of his training!

Career opportunities
International health career opportunities exist in voluntary organisations (eg VSO), NGOs (eg Oxfam and MSF), aid funded projects (eg World Bank), bilateral organisations (eg DFID), multi-lateral organisations (eg. WHO, UN, EU), UK universities (LSHTM, Nuffield Institute for Health) and consultancy organisations (eg Institute for Health Sector Development).

Academic R&D
A number of different options were available in international health within UK universities, short-term secondments with universities that have international links and fellowships with overseas institutions. For example, a training opportunity had recently arisen for a public health trainee to be involved in evaluation of the University of Leeds, TB/HIV care research and development project in Swaziland.

PCTs and international health
Primary care trusts (PCTs) should also be involved in international health work because the problems they face are similar to those faced by other organisations in different countries (eg health inequalities). Involvement in international health work could also assist in understanding the cultural and socioeconomic factors that affect the health of ethnic minority groups and asylum seekers. Suggested ways of raising the profile of international health within PCTs include discussing topical issues, supporting staff to gain international health experience, twinning between PCTs and other health authorities abroad, and disseminating good practice from those who have been involved in international health work.

In terms of involvement in European Public Health, the European Public Health Alliance (www.epha.org) provides opportunities for funding and action within Europe. Trainees can be involved whilst still based in the UK through the FPH European Working Group, the Government Office links with the EU, visits to European Institutions as part of delegates from the FPH and using study leave (time and budget) to visit European Institutions. Examples of external sources of funding available to facilitate working with European partners included the Churchill Fund, European Union and the Harkness Fellowships.

Educational approval for international health posts was also discussed in detailed and guidance is available from FPH website. Overseas placements that are already approved by the Faculty include the WHO, the Directorate General SANCO in Luxembourg, CDC Atlanta, the Helsinki Department of Public Health, EPIET European Centres and other locations that are covered by the mutual recognition with other Royal Colleges/ Faculties such as New Zealand, Hong Kong and Australia. Trainees who intend to obtain international experience were advised to indicate their interest early and obtain membership as early as possible (most programmes require trainees to have at least Part I MFPH). Trainees also need to be opportunistic and prepared to grab a training opportunity when it arises.

Delegates of the conference also learned about the role of the Faculty's International Committee and the cross-government initiative with the Department of Health (DH), Department for International Development, and others on international health issues. The DH Toolkit to support good practice in international health work (*International Humanitarian and Health Work*) was highlighted as a source of invaluable guidance (available from www.dh.gov.uk).

Emmanuel Nsutebu
SpR, Bradford & South West PCT

EUPHA Annual Conference

11-12 November, 2005
Graz, Austria

The main theme of the Conference is *'Promoting the public's health: reorienting health policies, linking health promotion and healthcare'*.

Further details available from: www.eupha.org

The Faculty is a member of EUPHA and Faculty members should therefore be eliglble to pay the reduced registration fee for EUPHA members.

Policy and Advocacy

Public Health White Paper
The Faculty submitted an immediate media response to *Choosing Health* which was picked up by the *Times*. Rod Griffiths was also invited to speak on the *Today* programme and *BBC News 24*. The Secretary of State for Health gave the Faculty's Annual Public Health Lecture following publication of the White Paper. The Faculty produced evidence for the Health Select Committee's Inquiry into *Choosing Health*. We are also in the process of deciding how best to support the implementation of the White Paper whilst continuing existing workstreams.

Joint Working

Sexual Health
The RCP led sexual health working group has been disbanded in the light of the Public Health White Paper. It was felt that the sexual health content of *Choosing Health* superseded the remit of the group.

However, Rod Griffiths met with the chief executive of the Family Planning Association. It was agreed to hold a joint event on sexual health. A proposal to hold a seminar in September entitled 'Sexual Health — Delivering the Public Health White Paper' has been submitted to the Department of Health. We await confirmation of funding before proceeding with the event.

Developing a healthy and active workforce
A joint working group of the Faculty and the Faculty of Occupational Medicine has been set up to produce a practical guide for the employer on developing a healthy workforce. This is being co-chaired by Faculty Registrar, Selena Gray. The aim is to publish a guide (in hard copy and/or on the website in September 2005) for employers and employees that sets out the case for promoting a healthy workplace and the simple steps that all employers can take to improve the health and well-being of their workforce.

The Coalition for Public Health Action
FPH has joined forces with RIPH, RSPH, UKPHA and CIEH to produce a joint public health manifesto. The draft focuses on key public health priorities and gives background, key facts and recommendations for action. We hope to launch this in March.

Public health genetics
FPH plans to hold a joint conference in January 2006 on public health genetics with the Public Health Genetics Unit and the British Society for Human Genetics. A timetable of action has been drawn up and we are in the process of forming a specific plan for the event.

Communications

Website
The improvement of the usability and navigability of the Faculty website is progressing well.

Monthly bulletins
Early feedback suggests that the electronic bulletins have been extremely well received.

Publications

Hypertension Toolkit
The FPH Cardiovascular Health Working Group, in conjunction with the National Heart Forum, is producing a hypertension toolkit. The Faculty has received a grant from the Department of Health to cover distribution costs. It is hoped the toolkit will be launched as part of a wider programme of work with NHF.

Tackling Obesity Toolkit
The National Institute for Health and Clinical Excellence will produce comprehensive best practice guidelines for the prevention and management of obesity in 2007. However, it is imperative that local strategies for tackling obesity are developed immediately and PCTs need appropriate tools to do this. Through evaluation, the Faculty has found that its *Tackling Obesity* (2000) toolkit is being used by PCTs to develop local obesity strategies, but it is in need of revision in order to maximise its effectiveness. The Health Development Agency approached the Faculty with a view to revising the toolkit as interim guidance on the prevention of obesity. FPH and NHF have agreed to carry out this work with appropriate support from other stakeholders. We are seeking funding from the Department of Health and hope to publish in autumn 2005.

Departmental Update

Caroline Moss, currently Education Administrator (Training), will be taking up the post of Communications Administrator in March. Caroline will act as website administrator, in-house editor for *ph.com* and monthly bulletins, and will also be actively involved in our reactive media work. We look forward to Caroline joining the department.

Future Public Health Events

5-7 April 2005
UKPHA Public Health Forum
Gateshead
The Faculty will run a workshop session

15 April 2005
Faculty's annual training conference
Warwick University

6 May 2005
DPH Masterclass
London.
Organised by the Faculty and ADsPH

7-9 June 2005
Faculty's Annual Scientific Meeting
Scarborough

10-12 November 2005
EUPHA Conference,
Graz, Austria
(Faculty members should be eligible to pay a reduced registration fee)

Letters

The editor,

There appears to be a misconception that water fluoridation has been banned in Scotland. This is not true.

The First Minister (Jack McConnell) stated: "I confirm that we are currently considering our full response to our consultation on improving the oral health of Scotland's children… I can confirm that, having listened to the views that have been expressed, we will not be changing the current legislation on fluoridation of water supplies in this (Scottish) Parliament…".

Therefore, no changes to the current legislation on water fluoridation are planned within the Scottish public health legislation, which means that the current legislation will remain in force. Further, it appears that it applies only for this current Parliament which has less than three years to run. There are rumours that the announcement was made purely for political expediency to ensure the ban on smoking in public places is passed. The rumour suggests that the smaller of the two coalition parties in Scotland, who do not support water fluoridation, refused to support the legislation introducing a ban on smoking in public places if water fluoridation was included in the same bill.

No criticism of the safety of this effective public health measure has been made and fluoridated water continues to flow to homes in Scotland.

Yours etc.

Colwyn Jones
Consultant in Dental Public Health
Lothian NHS Board

Salman Rawaf and Siân Griffiths of the Faculty's International Committee wrote to all Faculty members in the affected region offering the Faculty's sympathy and support. Below is a response received from Vinohar Balraj based at the Christian Medical College, Tamil Nadu.

Dear Professor Rawaf & Professor Griffiths

Thank you for your letter dated 30 December 2004 expressing your sympathy and support for the effects following the Tsunami. Currently, we have seen a massive relief support in India, organised by the government public health system as well as the government run curative health services. Besides this, there has been an outpouring of support and help from non-governmental agencies mostly from within the country and some from overseas. The institution I work for has had many teams going out, starting with the trauma teams in the early stages, followed by the public health teams and more recently we have had counsellors and psychiatrists spending time in the affected regions of Tamil Nadu. What is currently apparent is that besides the long-term development work that is needed, it is bereavement counselling which seems to be most essential. This I believe is going on quite satisfactorily. Many agencies (both government and private) have put up surveillance systems for early recognition of communicable diseases. So far, there has been a small outbreak of measles in one of the areas and one of diarrhoea and vomiting in another area, and these seem to have been identified early and controlled reasonably well. Interestingly enough, those most affected were persons living within 500 meters of the sea, despite the government ban on people taking up residence so close to the shore. Needless to say, these were the fishermen and their families and it appears that when a person lives in an 'unauthorised area', one does not make it on the local census. So it has been difficult to state accurately, how many were affected.

As things stand, there is perhaps very little the Faculty of Public Health could offer in the short term. After consultation with my colleagues in this department, I believe that in the long term, training in disaster management for health personnel or perhaps training the trainers may be something that the Faculty could offer.

I am marking a copy of this response to our Academic Dean, Professor Jayaprakash Muliyil. A younger colleague of mine Dr Venkatraghavan (public health) and Dr Suresh David (head of the casualty services) are two of the persons who led the first two teams to the affected areas and have followed up on what has happened subsequently. It is possible that they could coordinate the training from the Indian end of things, should such a programme get underway.

Thank you once again for your concern and the offer to help.

With best wishes,

Yours sincerely,

***V*inohar Balraj**

Scottish Forum for Public Health

The Elizabeth Russell Scholarship

The Scottish Forum for Public Health (SFPH) is announcing new scholarship grants to help promote multidisciplinary approaches to public health in Scotland. The Elizabeth Russell Scholarship programme offers up to ten scholarships of up to £1000 each. These will be awarded to individuals or groups to undertake projects — in any field of public health work, action or education — which help further the aim of promoting multidisciplinary public health in Scotland.

SFPH is an independent body bringing together those professions involved in public health in Scotland. It evolved from the Office of Public Health in Scotland (OPHIS), created in 1997 by the Faculty's Scottish Affairs Committee, to act as a single focus for all public health interests in Scotland. The programme is named after Professor Elizabeth Russell, the former chair of OPHIS.
SFPH provides an interdisciplinary professional voice for public health in Scotland. It does this by:

- being inclusive of all professional groups currently working in public health in Scotland.
- acting as a forum for discussion, providing an interdisciplinary perspective on Scottish public health issues.
- providing a non-aligned view on professional issues such as training, governance and capacity.

The Forum's work is supported from a wide range of individuals and organisations. For further information on the Elizabeth Russell Scholarship see: www.show.scot.nhs.uk/scieh/sfph or contact the SFPH secretary: catherine.keachie@lanarkshire.scot.nhs.uk **The closing date for applications is 27 May 2005.**

Welcome to new Faculty members

SPECIALIST REGISTRAR/SPECIALIST TRAINEE MEMBERS

The following Specialist Registrar/Trainee members have recently been admitted:

CORDERY	Rebecca Jane
DAY	Fiona
DONNELLY	Angela Bridget
GRIBBIN	Jonathan Farquhar
GRYNSZPAN	Delphine
KAVANAGH	Paul Michael
MAKKI	Sophia
MALLINSON	Julian Robert
NSUTEBU	Emmanuel Fru
PADFIELD	Simon James
QARIZADAH	Muhannad Musa
SHERINGHAM	Jessica
STRONG	Mark Richard
TAYLOR-ROBINSON	David Carlton

DIPLOMATE MEMBERS

The following Diplomate members have recently been admitted:

EJIDE	Samuel Afamefuna
HO	Siu Fong Alexandra
MOK	Tina

MEMBERS

The following Members have recently been admitted:

BROWN	Richard Clive
CRAMP	Geoffrey Joseph
CROWTHER	Rachel Louise
HAMLET	Neil William
JENSEN	Juliet Helen
LAMBERT-HUMBLE	Stephen
MAPSTONE	James
PLESS-MULLOLI	Tanja

Deceased

The following members have, sadly, passed away:

EDGE	May Bulloch
HAY	Arthur William
MCHUGH	George
MILLIGAN	Hamilton Cassells
NICHOLSON	John Alan Bennett
PARKER	William Shepherd
PEARCE	Richard David
RUE	Elsie Rosemary
SEFTON	Elizabeth Margaret
TAYLOR	George Rowland
THOMAS	Ann

Rosemary Rue

Rosemary Rue was an inspiration to many of us in public health who were lucky enough to have known and worked with her. She was the first woman to hold the position of Faculty President — an apt accolade for one of the greatest champions for women doctors. Early in her career Rosemary fought hard to overcome the prejudice of the medical profession and later went on to start the first part-time training scheme for women doctors wishing to become specialists.

Rosemary began her medical career at the Royal Free Hospital in 1945. When she married in 1950 she was told she had to leave the medical school: it did not accept married women. Finishing her training in Oxford she worked in a long-stay hospital until the authorities found out she was married with a baby and dismissed her. She then went into general practice. In 1954 she contracted polio, the last case of paralytic polio in the county of Oxfordshire. With typical determination she overcame the disability left by the disease to take up her first post in medical administration in 1960. This career move was to culminate in her appointment as Regional Medical Officer for Oxford RHA from 1973 to 1984, and then as Regional General Manager. She combined her daily work, which included driving an extensive hospital building programme, with national activities including Professor at the London School of Hygiene and Tropical Medicine, Presidency of the BMA, and Presidency of the Medical Women's Federation.

However, of her many contributions and her many prestigious roles, the one achievement that stands out is her contribution to medical training and careers for women. She personally opened career opportunities for women doctors, enabling them to work part-time while training to be specialists. It was as Assistant County Medical Officer in Oxford in the mid-1960s she argued for funds to support four married women doctors in specialist training. By the end of the year she had placed 40, with many others queuing to be placed. To achieve this she had to convince the Royal Colleges and consultants that they could accommodate women training part-time. Her success is institutionalised in the flexible training schemes that exist today.

Throughout her career Rosemary was a strong supporter of the Faculty. In 1972 she was one of its Founding Fellows, becoming President in 1986. In 2003 we were delighted to welcome her as Honorary Fellow, and in her retirement she continued to actively support the Faculty, travelling to Edinburgh last summer, despite increasing poor health, to join us at the annual dinner. Her energy, interest, warmth and humour sustained many of us who knew we could pick up the phone or drop in to her house for a glass of sherry, a bite to eat and some sound advice. We will miss her.

Siân Griffiths & Selena Gray

Welcome to the first formally trained Public Health Specialist

A moment of confusion in the offices of the UK Voluntary Register of Public Health Specialists: this application for registration contains no box files of past reports and papers — just a single piece of A4 paper. But this piece of paper says it all.

The applicant has passed both parts of the Faculty of Public Health examinations and has successfully negotiated her way through a formal public health training programme, getting all the parts of her RITA signed-off and approved. There is no need for any further process of assessment. The Faculty has recommended that she be placed on the UK Voluntary Register as a Public Health Specialist, she has paid the fee and on she goes!

Such a small piece of paper but such a huge occasion: the first fully trained Public Health Specialist to be launched into the workforce. Properly trained, accredited and regulated — the first of many, much needed in today's public health.

So, congratulations to the UK Voluntary Register for now having registrants in each of its four routes to general registration. Congratulations to the Public Health Training programmes for attracting such talented people into public health and ensuring they are fully trained. Congratulations to the Faculty of Public Health in providing the standards for this multidisciplinary public health world. And many congratulations to our first fully and formally trained Public Health Specialist.

Lillian Somervaille, Director of Training (Voluntary Register)

One of our newest Faculty Members has just taken another step in specialist public health practice. Alison Pritchard is the first specialist trainee to have successfully negotiated the training programme, and to be recommended for admission to the Voluntary Register by the Faculty.

She has been with the East Midlands programme in a number of guises, over the last five years, as we first started specialist training and then developed a fully integrated scheme. The process has not been plain sailing as we have had to overcome a number of hurdles together, such as involvement in health protection work. The rules of engagement have also kept changing around us; first access to the diploma, then full membership, finally the voluntary register and clarity around the requirements of training and competence.

Alison has certainly helped improve the East Midlands programme, and hopefully she has benefited from the process. We look forward to working with her as a trainer in future. Welcome.

David Williams
East Midlands Training Programme Director
Director of Training (Faculty Visits)

2005 Training Conference

15 April 2005
University of Warwick

This is your opportunity to consider and discuss the fundamental restructuring of the Faculty's membership and examinations, and to put your views to key Board members including Faculty President, Professor Rod Griffiths, CBE.

Registration fee: £100

Trainees who attend will be entitled to a subsequent reduction of £100 in the registration fee for the 2005 Annual Scientific Meeting, if attending the whole event.

For further information contact:

Professional Briefings
T: 020 7233 8322
E: london@profbriefings.co.uk

Registration forms also available from:
www.fph.org.uk

Closing date for registration: 1 April 2005

Electronic Submissions for Part II Examination

Effective July 2005, candidates will be required to submit reports electronically, in addition to hard copies. **Please note that the statutory requirement to submit hard copies remains mandatory** so that on successful completion of the Part II examination theses can be bound and presented to the library.
Those candidates who choose to take the Part II examination in July 2005 will be required to submit their application and reports on or before **22 April 2005**.

VACANCIES FOR PART I INVIGILATORS

We wish to expand our pool of retired Fellows willing to act as invigilators for the Part I Examination. We are particularly keen to hear from members living locally. As experienced professionals in public health, our invigilators help to maintain Faculty standards and retain an active interest in the process of membership recruitment. Two sittings of the examination are held each year, in January and June, over two consecutive days. If you are interested in helping the Faculty with this important task, please write to Part I Administrator at the Faculty.

COMMITTEE VACANCIES

Risk Management, Audit and Finance Committee

Do you have an interest in risk management and/or finance? If so, we'd like to hear from you.

We currently have a vacancy on the Faculty's Risk Management, Audit and Finance Committee and are looking for an individual with energy and commitment to join its membership. The committee meets four times a year in London.

For further details, contact: Pauline Blackmore, Head of Finance and Membership (paulineblackmore@fph.org.uk).

Journal Board

We will also have a vacancy on the Journal Board from June 2005. The board is responsible for overseeing the management and editorial policy of the *Journal of Public Health*. It meets once a year, in May, in London.

For further details, contact: Caroline Wren, Committee Secretary, (caroline.wren@talk21.com).

Both appointments will be for a term of three years.

Applications should be submitted to:
Caroline Wren,
Faculty of Public Health,
or caroline.wren@talk21.com

Deadline for applications: 22 April 2005.

FACULTY OF PUBLIC HEALTH

European Journal of Public Health

The new European Journal of Public Health is setting up an advisory council to serve as a sounding board for the editors of the journal, and to give feedback and advice on editorial policy.

EUPHA's national member associations have been invited to nominate one representative per country. Representatives will be informed about matters relating to the journal and invited to attend a common meeting of the advisory council with the editorial board during the annual meetings of the European Public Health Association.

If you are interested in this role, please contact Caroline Wren at the Faculty (caroline.wren@talk21.com), ***by Friday 22 April 2005***.

Members of the Society for Social Medicine are also being asked for nominations. If there is more than one nominee, an election will be held.

CPD is for Everyone!

All members of the Faculty should be meeting the Faculty's minimum CPD requirements to remain 'in good standing'. Members, Honorary Members and Fellows should all be recording their CPD activity and submitting annual returns, or should inform the CPD unit if they qualify for exemption from the scheme.

Members can now submit CPD returns electronically bia the Faculty's website. CPD participants are encouraged to use this to record their CPD activity, as well as record a reflective note for each CPD session.

SECONDMENT OPPORTUNITY – EU COMMISSION

A secondment opportunity exists for a senior specialist registrar in public health/public health associate, to work in the Public Health Directorate of DG Health and Consumer Protection (DG SANCO) in Luxembourg.

The secondment is for six months and can be renewed for a further six months, if requested.

Interested?

For more information please contact either

Dr Alexis Macherianakis (alexis.macherianakis@dh.gsi.gov.uk, T: 0161 9524173)

or Dr Chris Birt (christopher.birt@southsefton-pct.nhs.uk, T: 0151 4781234).

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In the next edition
If you would like to submit an article, please see guidance below.

Guidance for contributors to *ph.com*

◆◆ The editors reserve the right to edit and amend copy. ◆◆ When submitting an article, remember to include your name, job title, employer and contact details. ◆◆ Send articles in Word via email/diskette to the Policy & Communications Department at the Faculty. Handwritten copy cannot be considered. ◆◆ Avoid abbreviations, acronyms and jargon. ◆◆ Keep sentences and paragraphs short. ◆◆ Always attribute other people's work. ◆◆ Declare any conflict of interest. ◆◆ Avoid automatic formatting of articles and using the footnote function. ◆◆ Illustrations and photos can be accepted in Tiff/Giff form only. ◆◆

SUBMISSIONS FOR THE JUNE EDITION TO REACH US BY FRIDAY 13 MAY 2005

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The views expressed in this publication do not necessarily reflect those of either the editors or the Faculty of Public Health.

Moving?

If you have recently moved, please notify the Faculty of your new contact details to ensure you will still receive Faculty communications.

The James Lind Alliance

Introduction
Two hundred and fifty years ago there were many conflicting opinions about how to treat the deadly disease scurvy — as reflected in the wide variations in practice, from using diluted sulphuric acid or vinegar, to burying patients up to their necks in the ground.

Faced with this confusing situation, James Lind, a Scottish naval surgeon, wondered how to treat patients dying from scurvy. He decided to confront his uncertainty by treating patients within a controlled clinical trial, comparing six of the proposed remedies. Lind's controlled trial showed that oranges and lemons were dramatically better than other supposed treatments.

Important uncertainties about the effects of treatments exist today and, as in Lind's day, these are reflected in variations in clinical practice. These uncertainties must be confronted to help improve the quality of care provided for current and future patients. The James Lind Alliance has been established to foster discussion among patients and clinicians about these variations, and to identify which uncertainties about the effects of treatments should be addressed in clinical trials.

The Alliance was co-convened in April 2004 by INVOLVE (formerly Consumers in NHS Research), the Royal Society of Medicine, and The James Lind Library. It was formally launched in December 2004 and will be developed under the guidance of a steering committee.

Exploratory meetings
To identify which uncertainties should be addressed in clinical trials, the James Lind Alliance will provide the aegis for meetings co-convened by a partnership consisting of at least one patient representative and at least one clinician representative. Every meeting will be facilitated by a chair from outside the field concerned and will have the following elements:

- Declarations of competing (financial) interests by all contributors
- Presentation of data on variations in practice, suggesting collective uncertainty
- Presentation of the results of systematic reviews relevant to practice variations
- Discussion about how to confront important residual uncertainties
- Agreement on an action plan by the organisations convening the meeting

Database of Uncertainties about the Effects of Treatments (DUETs)
A database is also being established to identify uncertainties about the effects of treatments. These uncertainties are reflected in the questions that patients and clinicians bring to services such as NHS Direct and ATTRACT. Some of their questions can be addressed by reference to up-to-date, systematic reviews of reliable research studies. For many others, however, information is not readily available. Sometimes this is because no systematic reviews of the relevant evidence have been prepared; sometimes it is because existing systematic reviews have not been kept up to date; and sometimes it is because systematic reviews have shown that uncertainties about treatment effects will not be reduced without further research.

DUETs is being created to capture and classify questions about the effects of treatments which cannot be addressed satisfactorily using existing systematic reviews. Although DUETs is being created particularly as a resource to help patient and clinician organisation partnerships identify and prioritise shared uncertainties within the context of the James Lind Alliance, there will be open access to DUETs through the NHS National Knowledge Service.

Actual and potential sources of unanswered questions about the effects of treatments include NHS Direct/NHS Direct Online, ATTRACT, question-answering services for patients in national voluntary organisations, Patient Advice and Liaison Services (PALS), Cochrane Review Groups, the Centre for Reviews and Dissemination, National Institute for Clinical Excellence, and the NHS Health Technology Assessment Programme.

Two working groups are taking forward the creation of the database. The first of these is formulating and classifying questions about the effects of treatments and considering other data items for inclusion in DUETs. The other working group is developing guidance for improving the formulation of proposals for further research by those reporting systematic reviews and publishing clinical guidelines.

Annual meeting of the James Lind Alliance
The first annual meeting of the Alliance was held in December 2004. Future meetings will provide opportunities for members to share experiences of progress and obstacles, and to identify common themes. It will also be used to inform representatives of the facilitating and regulatory organisations on progress and help overcome obstacles experienced by the patient-clinician partnerships. Facilitators and regulators include:

- Department of Health
- NHS Trusts and Strategic Health Authorities
- Research funding organisations (particularly the MRC and the NHS Technology Assessment Programme)
- clinical researchers
- academia, including the Higher Education Funding Council
- information providers and educators (including the print, broadcast and electronic media)
- the Medicines and Healthcare Products Regulatory Agency
- the research ethics committee system.

More detailed information about the James Lind Alliance can be found at: **www.lindalliance.org**.