Evidence for the health benefits of physical activity

Chief Medical Officer Sir Liam Donaldson shares his thoughts on physical activity and its role in public health and the wider society

At least five a week: evidence on the impact of physical activity and its relationship to health was published in 2004.

As well as re-iterating my recommendations for physical activity in adults and children, the report set out the available evidence from around the world for the public health benefits of physical activity, and placed physical inactivity alongside smoking cigarettes and an unhealthy diet as a major causal factor for chronic disease.

Whilst the key messages of the report remain unchanged, considerable progress has been made in linking these to key policy objectives, such as promoting healthy weight and achieving a lasting health legacy for the 2012 Olympic Games and Paralympic Games.

The health benefits of physical activity extend across the life course and relate to cardiovascular disease, diabetes, musculoskeletal health, cancer, mental health and wellbeing. Adults who are physically active have 20-30% reduced risk of premature death, and up to 50% reduced risk of developing the major chronic diseases. Indeed physical activity in the prevention of coronary heart disease has been described by Professor Jerry Morris as the ‘Best buy in public health’.

Physical activity can bring other benefits to the wider economy, including increased productivity and reduced sickness absence. Similarly, active ageing can extend our ability to live independently, reduce falls and improve social engagement, boosting the quality of life for individuals and saving on the costs of care.

New NHS guide to tackling climate change

www.fph.org.uk
Be active, be healthy is the Government’s plan for getting the nation moving. It builds upon this argument, but turns it on its head, by highlighting for the first time the local healthcare costs of inactivity. In much the same way, Change4Life is seeking to communicate the human cost of inactivity in the context of overweight and obesity.

Following publication of At least Five a Week, the Local Exercise Action Pilots (LEAP) were commissioned in 2004 to address the next link in the evidence chain – identifying the most effective interventions for getting people physically active. In recognition of the need to drive up mass-participation in physical activity and sport, a cross-government Activity Co-ordination Team (ACT) was created, feeding into Choosing Activity, a physical activity action plan for working in partnership across government.

More recently, Healthy weight, healthy lives transformed the debate by focusing upon an environment that inhibits healthy, active lifestyles and signalled a renewed focus upon physical activity as one-half of the obesity problem.

Linked closely to the Government’s legacy ambitions for the London 2012 Games, Be active, be healthy, emphasises the need for an approach to physical activity that is broad, inclusive and relevant to all, irrespective of their levels of physical activity.

In particular, by targeting those most at risk of inactivity and embedding the promotion of physical activity into general practice, we are responding to the important health benefits of physical activity set out in my report, At least five a week. Whilst scientific evidence continues to move on, this overriding case for activity remains just as relevant today as it was in 2004.

Prof Sir Liam Donaldson
Chief Medical Officer
Department of Health

As we prepared this edition of ph.com, focusing on physical activity, Andy Burnham gave his first interview as English Secretary of State for Health. He said that he would “make it a personal priority to embed in the NHS culture the promotion of physical activity”. This was music to the ears of the physical activity community: for too long physical activity has seemed to be a low priority on public health agendas. Increasing levels of activity across the population has huge potential for improving public health. The direct benefits to health are well known and obvious, but perhaps less immediately apparent is the fact that an environment that supports and promotes activity is healthier in many other ways, from more liveable neighbourhoods to safer roads and cleaner air.

Perhaps the time has finally come for physical activity. England has a new national plan, with an impressive range of commitments from social marketing and the Change4Life campaign through to joint action on town planning. There has been a large increase in investment in cycling, with the announcement of 11 new cycling towns and the first cycling city – Bristol. Many of the new Department of Health funded Healthy Towns are promoting activity, and we will see new walking routes in place by the time of the 2012 Olympics in London. And the Department of Health is putting the finishing touches to a new physical activity primary care pathway that will help to standardise the approach that primary care teams take to screening patients on the basis of their activity level and providing the most appropriate service. All of these initiatives will help to achieve the Secretary of State’s vision.

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This special edition of ph.com focuses on physical activity, and showcases some of the great work that is happening in the UK and beyond. Authors cover a wide range of approaches, from national to local, from syntheses of evidence through to local practical projects. We hope this provides the inspiration for our readers to make the promotion of physical activity their own personal priority.

Harry Rutter
Nick Cavill
National Obesity Observatory
Postcard from Scarborough
It was another great FPH Annual conference this year. There was a real positive buzz to it and the opening session, set against the beautiful Scarborough landscape (long sandy beach, ruined castle of the headland) set the scene: Yorkshire and the Humber’s RDPH Paul Johnstone introduced the session, focusing on tackling inequalities, while sporting a flat cap. Sheffield public health consultant Chris Nield in a miner’s helmet. Wendy Richardson, Hull’s DPH, outlining Hull’s huge health gap – and her local Rugby team’s prospects next season.

If I had to sum up the theme of the conference in a single word, I think I’d say – hope. Hope in a better, fairer world. Hope that we can help reduce the impact of global warming. Hope that we can work with developing countries to build public health capacity. Hope in tackling the health consequences of violence. Hope in promoting mental wellbeing. Hope that we can become more fit-for-purpose as a specialty. And hope we don’t get decimated by regime change or purpose as a specialty. And hope we...

The theme blossomed with Fiona Adshead’s RSPH Lecture: ‘Rhythms, reflections and hope’. Fiona gave us a wittily illustrated romp through the utility of futurology, or was it the futurology of utility, or perhaps the futility of futurology? It was thought-provoking stuff with references to Rousseau, Dickens, Machiavelli, Obama and virtually every deep thinker apart from John Prescott. Memorable quote: “Hope is pivotal for a deep thinker apart from John Prescott. It was thought-provoking stuff with...”

It was all very inspiring. So much so that I came away dreaming a dream – and feeling a bit like the Susan Boyle of Public Health.

This year’s DARE Lecture was delivered by another hard-hitting, high-impact speaker – Richard Smith, ex-editor of the BMJ and current Director of UnitedHealth Chronic Disease Initiative. His “daring” challenge to us was – just how ready are we to lead the change in health systems needed to stem the rising tide of non-communicable diseases in developing countries? Maybe the answer is simply to dish out the polypill. More lively debate. Two very different plenaries: one on the Olympics (featuring Richard Budgett, 2012’s medical director, and the HPA’s Brian McCloskey on the health protection horrors) and the other a very powerful session on violence featuring John Carnochan of Strathclyde Police (‘let’s face it, it’s all about alcohol!’) and Peter Donnelly on the Glasgow community initiative to reduce violence (tear-jerking stuff).

Some great parallel sessions (too many to mention) and an excellent showing of posters, particularly from Yorkshire and the Humber. Congratulations to the public health team from NHS Leeds for their prize-winning poster on ‘Smoke Free Homes in Leeds and Lahore’.

Finally, a couple of guest appearances by a brace of public health knights: an amusing after-dinner speech from Sir Sandy Macara, one of the founding fathers of FPH back in 1973 and recipient of a coveted honorary fellowship of FPH, and another talk on hope and the future from DH knowledge guru Sir Muir Gray – ‘If we don’t make the future, someone else will make it for us’. Sage words indeed. (Check out the centre pages for more conference highlights.)

It was all very inspiring. So much so that I came away dreaming a dream – and feeling a bit like the Susan Boyle of Public Health.

Alan Maryon-Davis
President

To comment on this editorial email Alan at
comments@fph.org.uk

INTERNATIONAL PUBLIC HEALTH ATTACHMENT IN SOUTHERN AFRICA
We are looking for a senior specialist registrar in public health who is interested in spending a six to 12 month attachment in Swaziland from September 2009 onwards. This is a great opportunity to develop personal public health skills and make a big impact on the health of the population in a rural African region.

Public health programme
Over the last five years a successful public health programme has been developed in the Lubombo region of Swaziland through a health partnership between NHS and academic public health specialists in Bradford and Leeds. The programme has been successful in evaluating local health needs and planning and implementing community-based TB, HIV/AIDS and chronic disease programmes.

Training attachment
We are looking for a motivated and dynamic individual who is interested in gaining experience and training in international public health and specifically the implementation and evaluation of HIV/AIDS prevention and treatment programmes.

Flights and accommodation will be paid for by the programme, with SpiRs seconded on salary from their existing training programme. The programme has been accredited for training secondments by the Postgraduate Medical Education and Training Board.

For further details please contact: Professor John Wright, Consultant in Public Health & Clinical Epidemiology, Bradford Institute for Health Research, Temple Bank House, Bradford Teaching Hospitals Foundation Trust, Bradford Royal Infirmary, Duckworth Lane, Bradford BD9 6RJ Email: john.wright@bradfordhospitals.nhs.uk
Where there’s a will there’s a way: guiding the NHS to a greener future

Q. How many NHS Managers does it take to change a traditional lightbulb to an energy-saving one?
A. All of them – if the will is there to change.

For the biggest single public sector contributor to the UK’s CO2 emissions, the will should be there. Think of the 10.5 billion kilometres the NHS travels each year, the £500 million it spends annually on energy use, the 13 million patient meals wasted every year. When you add it all up, the figures are staggering.

The opportunities for change are abundant. Putting an end to the hum of computers in empty offices across acute hospital trusts in England would save 90 kilotonnes of CO2. A 15% cut in primary energy consumption could fund 7,000 heart bypass operations. And so on...

Beyond these figures lie different, altogether starker facts about ill health and the human lives being lost every year due to flooding, heat waves, skin cancer, and respiratory infections. As the frontline organisation dealing with the health outcomes of climate change, the NHS have a responsibility to commit to change and lead the way to a greener, more sustainable future. The resources are there to do it. With the largest workforce in Europe – 1.3 million employees – and a procurement budget of around £17bn, the NHS’s potential to lead in the UK and the world is significant.

Change won’t be easy. A wholesale transformation in thinking, acting and decision-making is needed, on an individual and organisational level. To kick-start the action, FPH (in association with the NHS Sustainable Development Unit and the NHS Confederation) has published a new handbook, Sustaining a Healthy Future – Taking action on climate change. Its contents range from individual and organisational level. To kick-start the action, FPH (in association with the NHS Sustainable Development Unit and the NHS Confederation) has published a new handbook, Sustaining a Healthy Future – Taking action on climate change. Its contents range from individual action plans encouraging recycling and walking, to step-by-step checklists on how to integrate realistic carbon-reduction measures into organisation-wide strategies and policies.

The handbook aims to make sustainable strategies and policies.

For those of you unable to attend please visit our website (www.publichealthconferences.org.uk/annual) where you will find many of the presentations, lectures and plenary sessions available to view online and share with colleagues.

Those proving most popular at present seem to be the excellent update on swine flu provided by Lindsey Davies, National Director of Pandemic Influenza Preparedness at the DoH, and the presentation on how FPH is developing revalidation for public health. I hope you have the opportunity to view these important presentations. I would like to add my personal thanks to those who contributed to making this important week such a success and to those of you who found the time to attend.

At the AGM, FPH president and officers reported on the work and activity of FPH over the past 12 months. Our progress towards obtaining Royal College Status continues, having now received support from all four UK Chief Medical Officer’s and each of our parent colleges. We will work closely with the Privy Council to draft our petition for their consideration and progress will be reported in future issues of ph.com.

An area of continuing FPH work is international public health – both in its development and also in supporting our overseas members. I am delighted to report that following a period of covering maternity leave within FPH, Rosy Emodi has been appointed as International Development Manager. In addition to this change, Kristen Morgan has returned to FPH from maternity leave in the role of Business Manager/Executive Assistant.

Over the summer months, we will be developing our Business Plan for 2010. We face many challenges in this difficult climate, but we hope to take forward an ambitious programme of work focusing on improving the services we provide to you. Some of which you should begin to see over the coming months.

Paul Scourfield
CEO
Moving more in Wales

The Welsh Local Government Association is funded by the Welsh Assembly Government to co-ordinate the delivery of a National Exercise Referral Scheme across Wales. Under the scheme, health professionals refer patients for a supervised exercise programme with an appropriately qualified instructor. The instructors are trained in motivational interviewing techniques and qualified to meet National Occupational Standards.

All patients are given a consultation with the instructor at the start of the programme, which, through the use of motivational interviewing, enable them to set goals and identify their exercise needs. They are then offered 16 weeks of classes, where they are taught the skills to become independently active. A wide range of classes is on offer including: aquafit, gym-based circuits, walking and circuit-based activities, available at different times of the day and week. At the end of the 16-week period, patients have another consultation session with an instructor to discuss achievements and set new goals. Instructors then contact patients again at eight months to monitor activity levels and provide support, and have a final consultation one year after their initial referral.

In a bid to address the lack of evidence for the effectiveness of exercise referral identified by NICE, the Welsh Assembly Government have commissioned Cardiff Institute of Society, Health and Ethics, part of Cardiff University, in collaboration with the Centre for Economics and Policy in Health, Bangor University and the Department of Primary Care, University Hospital of Wales to undertake an evaluation of the scheme.

This will be a randomised controlled trial, with embedded economic and process evaluations. The trial randomises people to the intervention or a waitlist for 12 months, and seeks to investigate the following hypotheses:

- Self-reported physical activity, anxiety, depression, and quality-of-life and physiological measures will be significantly better in the intervention group (in comparison to the control group) at 12 months.
- The national exercise referral scheme will be more cost-effective than usual GP care in managing chronic conditions including CHD and depression.

The process evaluation will enable us to determine whether there are changes needed to improve the effectiveness of the scheme. The final results of the trial will be available in 2010.

Over the past year more than 4000 patients have accessed the scheme, which has focussed on providing exercise opportunities for clients at risk of chronic disease. The introduction of level 4 Occupational Standards and the development of new training has enabled work to start on introducing opportunities for ‘higher risk’ populations, including people with coronary heart disease, lung disease and at risk of falls. Work is also being conducted to develop pilot protocols for patients with diabetes and obesity and will be introduced once qualifications are made available.

Work is also being undertaken with the British Heart Foundation to look at the development of a risk assessment tool that will enable us to ensure that the correct level of exercise intervention is matched to the patient, be that brief advice from a health professional, or referral to an appropriately qualified instructor.

Elaine McNish
Physical Activity Specialist
Welsh Assembly Government

A plan for getting the nation moving

Be active, be healthy, published in February, sets out a new framework for England for the delivery of adult physical activity and sport. The plan establishes increased participation in physical activity as a key legacy for the London 2012 Olympic Games and Paralympic Games, but also sets out new ideas for Local Authorities and Primary Care Trusts to help determine and respond to the needs of their local populations.

The plan builds upon the physical activity commitments set out in Healthy weight, healthy lives, the Government’s strategy to tackle overweight and obesity in England. It reflects the wider health benefits of physical activity, including those related to mental health and mild to moderate depression.

While Be active, be healthy aims to deliver the 2012 legacy target, it also has a strong focus on deriving the greatest health benefits for the population, rather than simply ‘making the fit fitter’. The plan emphasises a broad definition of physical activity and re-affirms the Chief Medical Officer’s recommendation for a total of at least 30 minutes of at least moderate intensity physical activity on five or more days of the week. It emphasises the need to target interventions towards those population groups most at risk of inactivity – a key performance indicator for government.

A range of new national initiatives to promote physical activity is set out in the plan, however the real drive and momentum to drive up participation will come from local prioritisation and investment. Be active, be healthy therefore describes a new Physical Activity Alliance for England comprising organisations from the whole physical activity sector and an extended role for County Sports Partnerships (designated County Sports and Physical Activity Partnerships). Our ambition is for all PCTs to engage with these stronger local partnerships.

For the first time we have set out estimates of the primary and secondary care costs of physical activity for PCTs across England, based upon cost data taken from the National Programme Budget Project (NPBP) and related to five diseases defined by WHO as having some relation to physical inactivity. There are some limitations and assumptions in the approach taken, but this data represents an important first step in our understanding of the local costs. We hope this will inform the work of public health professionals in making the case for investment in physical activity for specific at risk populations, in the context of other local priorities.

Paul Stonebrook
Physical Activity Project Manager, Department of Health
**Healthy built environments and physical activity**

Activities at the WHO Collaborating Centre for Health Cities and Urban Policy, UWE Bristol

The links between the built environment and public health have been recognised for centuries. Historically, unhealthy built environments have been associated mainly with increased risk of communicable disease, as well as respiratory ill-health. However rising levels of obesity has focussed attention on the role the built environment can play in promoting physical activity. This offers challenges for both public health and planning professionals.

Learning lessons from elsewhere is crucial for promoting healthy built environments. In September 2008, the Collaborating Centre (funded by the South West Regional Public Health Group) led a delegation to the German city of Freiburg. Directors of Public Health from across the South West, and their Directors of Planning counterparts, toured the city, to see how settlements and the transport infrastructure has been planned to promote healthy behaviour, including cycling and walking.

This first visit helped to draw lessons for application in the UK, and developed relationships at a strategic level between public health and planning professionals.

A second visit is due later in the year, for planning and public health colleagues in the South West who have yet to visit.

Spurred on by the twin challenges of obesity and climate change, public health knowledge, skills and concepts need to be re-integrated into the curricula of built environment professionals, so that healthy built environments that promote everyday physical activity are the norm and not the exception. The Collaborating Centre, funded by the Department of Health, is co-ordinating the establishment of a network of Built Environment Faculties across England, to share good practice and develop tools to better integrate public health into the undergraduate curricula of planners, architects and other built environment professionals.

Empirical research is also needed to offer new insights into the links between the built environment and physical activity and so become part of policy advice to spatial planners. As part of SOLUTIONS, an ESPRC funded research programme involving a consortium of UK universities, the Collaborating Centre has examined the behaviour of outer city residents across four cities in the UK. This explores people’s use of local shops and services, their propensity to walk or cycle to them, and the role that spatial/design factors have on these decisions.

The WHO Healthy Cities program is also addressing the impact of the built environment on physical activity, supporting cities across Europe within the new ‘Healthy Urban Environments’ theme. The Collaborating Centre is now part of a new Institute for Sustainability, Health and Environment which brings together 18 research centres from across the university (www.uwe.ac.uk/ise). This underlines the WHO Collaborating Centre’s own commitment to linking across professional boundaries; a necessity if we are to make the changes necessary to attain built environments that promote walking, cycling and active play and use spatial planning to support healthier communities.

Paul Pilkington
Senior Lecturer in Public Health, UWE Bristol

Marcus Grant
Deputy Director
WHO Collaborating Centre for Healthy Cities and Urban Policy, UWE Bristol

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**Blackburn: a fresh approach to free leisure**

Doing nothing was not an option. The borough of Blackburn with Darwen has some of the worst health statistics in the country; people die on average eight years younger than in other parts. It is ranked 340th and 346th for life expectancy for males and females, respectively, out of 352 local authorities. Over 25,000 people drink harmful levels of alcohol, and the borough had the third lowest levels of physical activity with 58% doing no activity at all.

To address these appalling statistics a unique, groundbreaking initiative was launched by Blackburn with Darwen Borough Council and NHS Blackburn with Darwen. The scheme — re:fresh — saw £6 million set aside for three years as part of an innovative plan to get residents active.

re:fresh aimed to introduce a cohesive, co-ordinated and community initiative recognising people can be encouraged to exercise, if opportunities are provided and designed to meet local needs.

Free leisure is an important element of re:fresh and removes the cost barrier to exercise. It was introduced gradually over three stages, so that by April 2009 all adults who live, work, or are registered with a GP, had access to a free leisure activities. These include swimming, exercise classes, community gyms and an expanded junior swimming programme.

Clear targets were set. They include a 4% increase in adults taking exercise 3 times a week (Local Area Agreement NI8), the ‘beeZ’ free leisure card, which people need to access free leisure is one of the ways performance is monitored.

However, re:fresh is much more than just free leisure. Simply removing the price barrier will not encourage those who are inactive to participate. Support at community level is needed. Through consultation with communities, groups and individuals, barriers to participation are addressed and the successful, evidence-based Healthy Communities Partnership (HCP), already established in the borough was expanded. The HCP has over 100 volunteers working with council and NHS staff at neighbourhood level to promote the benefits of physical activity.

It was recognised that free leisure may result in those already active increasing their levels of participation, rather than encouraging new participants. However early performance monitoring suggests otherwise and performance objectives are being met. The number of new beeZ card members is significantly up on the same period last year 17,109 compared to 3943 (2 July 2008 to 31 March 2009), with new registrations in the ‘over 50’ category showing a ten-fold increase. The number of additional adults who previously were inactive now participating in exercise (July 2008 to March 2009) is 5878 against a performance target of 2116 and frequency of attendance has increased at all levels.

Further work over 2009 will see the use of social marketing and customer segmentation data to target specific groups and re-energise the campaign. The council and NHS are committed to re:fresh and are confident that it can help people improve their health.

Claire Ramwell
Head of Healthy Living & Sport
Blackburn with Darwen Borough Council
HEPA Europe and physical activity

HEPA Europe is an international platform for strategies and multi-sectoral approaches in physical activity promotion. Over the last decade, physical activity has been recognised as an important issue by international public health organisations, such as the World Health Organization and the Directorate-General for Health and Consumer Protection DG SANCO of the European Commission. The Sports for All movement has a long history, but with the exception of only very few examples such as Finland, Canada and the Netherlands, most of the existing long-term integrated physical activity promotion strategies at the country level have only been developed in the last few years.

For the development of such national strategies, exchange and access to experiences from other countries is essential. At the global level, Agita Mundo, and the Global Alliance on Physical Activity (GAPA) are two organisations specifically dedicated to this field. The new International Society on Physical Activity and Health (ISPAH) will probably become an important player in the near future. Within Europe, a comparable structure has existed since 1996 in the form of the first Network for the Promotion of Health-Enhancing Physical Activity, a programme funded by the European Union. This programme was instrumental in deploying evidence-based policies and strategies.

In 2004 the initiative was taken to re-create a European structure, and one year later HEPA Europe, the European Network for the Promotion of Health-Enhancing Physical Activity, was founded in Gerlev, Denmark. The network is open to organisations and institutions, willing to contribute to the promotion of health-enhancing physical activity, and it is working closely with the WHO Regional Office for Europe. Further annual meetings followed in Tampere, Finland and Graz, Austria. In September 2008, the first HEPA Europe conference, with more than 200 participants was organised by the Scottish Physical Activity Research Collaboration (SPARCOLL) and the University of Strathclyde in Glasgow.

At the annual meeting following the conference, an additional 33 member applications were accepted so the network now counts 81 member institutions and 2 individual honorary members from 26 European countries. The UK has a very strong representation with 22 member organisations.

HEPA Europe has already completed a number of projects such as the development of the ‘Health Economic Assessment Tool – HEAT for cycling’, others such as an analysis of national approaches to promoting physical activity and sports in children and adolescents led by the British Heart Foundation Health Promotion Research Group are still underway.

The HEPA Europe website includes the updated objectives of the network, a list of member organisations, activity reports and work programmes as well as details on future events.

Dr Brian Martin
Head of Physical Activity and Health Work Unit
Institute of Social and Preventive Medicine, University of Zurich

Moving more through active travel

Obesity arises from an imbalance between energy intake and energy output. Changes in diet undoubtedly contribute to the obesity epidemic but calorie intake alone is not capable of explaining it – changing patterns of physical activity are just as important.

Walking and cycling are major potential elements of physical activity. Walking and cycling have declined considerably over the period of the epidemic. Indeed there is a suggestion that they may be capable of explaining the entire epidemic, although it is difficult to draw conclusions due to the poor quality of transport statistics. For example the 2001 Census that I walk each day to and between stations is statistically part of two daily rail journeys and I do not make any daily walking journeys so far as official transport statistics are concerned.

There is a growing body of research much of which comes from the US – that finds lower levels of obesity in more ‘walkable’ environments compared to modern car-focused developments. One study found a 6lb difference in mean population weight.

Stockport MBC has taken the following steps to use its planning and highways powers to promote walking and cycling:

- emphasising sustainable transport in its planning requirements
- preparing special planning guidance on sustainable transport
- preparing a sustainable development guide for developers
- producing a Green A to Z for the Borough which emphasises walking and cycling routes by picking out lightly trafficked and aesthetically attractive routes
- contributing to producing a cycling map for Greater Manchester
- designating a cycling network and creating much of it
- designating two walking networks – an aesthetically attractive one which encourages walking a pleasant summer day and an ordinary one for the routes people would use to get home as quickly as possible on a wet November night.
- developing parks as foci for recreational physical activity but also as part of walking routes
- designating an attractive path (the Fred Perry Way) from one side of the borough to the other
- developing criteria for protecting local walking passages and ensuring that these are taken into account before implementing alley gating proposals
- identifying Safe Routes to School.

All of this work has been carried out by the Borough’s Sustainable Transport Team. NHS Stockport funds half a post in this team.

Stephen J Watkins
Director of Public Health for Stockport
Promoting active living: NGOs can help

Non-governmental organisations (NGOs) are playing a key role in health promotion, through developing policy and action on walking and cycling, in partnership with public health practitioners.

An excellent example of NGOs collaborating on practical delivery of healthy living is the £30million Travel Actively consortium, led by Sustrans. Travel Actively brings together the leading walking and cycling organisations, with expert health guidance from the National Heart Forum and the National Obesity Forum. Fifty projects across England will be delivered over four years, with a target to help two million people change their travel habits and improve their health, by focusing on regular journeys – to work, school or the shops. Each project has created a strong partnership with local authorities, PCTs, community groups and local volunteers.

CTC, the cyclists’ organisation runs thirteen Community Cycling Champions schemes across England, to bring cycling to communities that are known to have lower physical activity levels. Cycling development officers will work with volunteers to inspire, train and support 34,000 new cyclists.

Fitter for Walking is a Living Streets programme with local residents in five English regions, to improve their walking environment. This will benefit 25,500 people over the four years, as well as including training and tools for professionals beyond the project areas who want to implement similar projects.

Living Streets also runs Walking Works, a national campaign to encourage people to walk all or some of their journey to work, targeting 11,000 people, and Walk to School, already established in primary schools and now moving into secondary schools, through targeted information, social marketing, incentive schemes and a citizenship project. This programme will reach more than 87,000 pupils.

London Cycling Campaign has focused on hard to reach communities in central and outer London boroughs. LCC provides cycling specific support to community groups, including training in how to ride and maintain a bike, bike loan schemes and organised bike rides.

Sustrans is running ten Active Travel projects, in seven English regions, each promoting walking and cycling by improving local infrastructure, leading walks and rides, mounting events, loaning bikes to people at particular need, and addressing policy and culture. Sustrans also has nine Bike It projects, working with almost 100 schools, and three TravelSmart local programmes, which are proven to bring about significant and widespread shift to more active ways of travelling.

The Ramblers’ project Get Walking: Keep Walking helps people in deprived areas improve their health and well-being by walking regularly and independently from their doorsteps. A 12-week walking plan is supported by free locally based walking programmes combining information and motivation with led walks and other activities.

Walk 21 has established a social enterprise, Walk England, that works with professionals across the country to create local opportunities for people to choose to walk, to walk more often, to walk to more places, and to feel safe while doing so. The new website, www.walkengland.org.uk, is an online gateway for walking information.

All these initiatives demonstrate the practical contribution that the third sector can make to improving health through working in collaboration with local agencies.

More information at www.travelactively.org.uk.

Philip Insall
Director, Active Travel
Sustrans

Take action on active travel: Getting the policy right

People lead inactive lives because the environment encourages them to do so, and this is nowhere more true than in travel choice. Planners and transport professionals have for years concentrated on making motor access easier and – in theory at least – faster; a consequence of this has been a decline in physically active forms of travel, going right back to the middle of the last century.

Now transport NGOs, including Sustrans, Living Streets, CTC and the Ramblers, have got together with the Faculty of Public Health and other public health bodies to make policy recommendations for a more active travel friendly environment. Take action on active travel! recommends a major shift in transport investment towards health promoting forms of travel (which also means, of course, the most sustainable, least polluting and least dangerous).

It urges traffic restraint, lower urban speeds, and above all a shift in the way transport departments are directed and performance managed – they should have a clear public health remit, and should deliver on it.

‘Take action on active travel’ can be viewed on the website of the Association of Directors of Public Health (www.adph.org.uk), and organisations committed to improving health can sign up to show their support. You will be joining around 100 organisational signatories at time of writing – a powerful force advocating for better and healthier transport policy and practice.
FPH Annual Conference 2009
Leading for health, evidence, policy and practice.

I want to start by saying thank you to all of this year’s speakers for creating a great conference programme, packed with a fascinating breadth of public health topics. We’ve explored the health issues in the Yorkshire and Humber region (and travelled to Bridlington to see them at first hand) and around the globe; discussed the public health legacy of the Olympics; the key future leadership challenges; and learnt about some exciting initiatives tackling violent behaviour.

It was a busy week of plenaries, lectures and social events, but without all of our delegates it wouldn’t have had such an exciting buzz. All the sessions were well attended and the presentations fired up some interesting debates. Thank you for coming along and we look forward to seeing you next year too.

Thank you from FPH

Graham Bickler
Chair, Conference Committee

And my final thanks go to the organisers and our hosts in Scarborough. The Spa Complex was a great space for the conference, and the team even managed to turn the main hall into an atmospheric ballroom for the Annual Dinner in less than an hour – a real feat! Thank you for your hard work.

You will all be receiving an electronic survey soon and I urge you to fill it in with your feedback. It will help us make next year’s conference even more interesting.

See you next year!
Everybody hurts – making violence a top public health issue

Is violence a public health issue? There’s no doubt that it is when you hear the grim facts. Violence is one of the principal causes of death for people aged 15-44 years, costing between £20 and £33 billion to society in England every year.

It accounts for around 14% of male deaths in Europe. The effects of violence last a lifetime and lead to mental ill-health and a higher risk of heart disease, cancer and stroke. Teenagers who have been exposed to violence manifest an eight-fold risk of suicide and later in life a seven-fold risk of alcoholism. However, according to the violence plenary at the FPH conference, violence has been a somewhat neglected area of public health (despite it being recognised by the World Health Organization as a major public health problem).

The risk factor lies with the impact of violence on children and early-years development. Peter Donnelly, Professor of Public Health Medicine at St Andrews University, told the conference about gang violence in the east end of Glasgow where young men fight as a hobby. Their violent behaviour is based on territorialism, a need to have a sense of belonging, expected behaviour by their peers and often by their families.

But a multi-agency response to violence, Community Initiative to Reduce Violence, has been successful in bringing members of rival gangs together to voluntary sessions at the local courtroom; not to air their differences or grievances but to pledge an end to violence. Youth workers, victims of gang violence and former gang members are there to tell the young men about a future without violence.

Everyone who pledges not to fight is then is assigned a case worker who connects them to whatever services they need – such as social work, health or housing. The only condition is that they have to agree to stop fighting. The programme has proved to be a key success in the fight against gang crime in Glasgow.

These are the kinds of initiatives that are needed to stop violence in communities across the country. John Carnochan, Head of Violence Reduction Unit at Strathclyde Police, and his powerful photo presentation of the pain, sorrow and misery violence causes, made it quite clear: the only effective intervention is primary, secondary and tertiary services working together to change lives. Alastair Leyland, Head of MRC Social and Public Health Sciences Unit, pointed out the gross health inequalities prevalent in Scotland: that death by assault and deprivation go hand-in-hand.

The core message came from Jo Nurse, National Lead for Public Mental Health and Well-being at the Department of Health, who underlined that everyone is affected by violence and everyone is paying a price for it. To prevent violence from happening, we have to accept our shared responsibility to address the problem, to break the silence around violence, and to admit that yes, violence is a public health issue.

Watch this plenary and other video highlights from the FPH Conference at http://www.publichealthconferences.org.uk/annual/2009/
Conference highlights – a partner’s perspective

Dr Foster were delighted to be welcomed to Scarborough by leaders in public health donning flat-caps, miner’s hats and rugby kits.

Only the week before Andy Burnham had addressed the NHS Confederation saying, “We’ve been too timid at times on the public health agenda,” and stressing to delegates: “Don’t feel you have to wait for permission to invest in prevention.”

Given the positive political backdrop, how can this opportunity be used to achieve the best public health outcomes? Many of the presentations at the conference revolved around effective delivery though sharing of best practice. Priority setting was a strong theme discussed in workshops and plenary sessions.

The Isle of Wight delivered an informative workshop explaining their methodology for objectively evaluating investment decisions to maximize value for money. Peter Brambleby hosted a jam-packed session and fired up debate on Programme Budgeting and Marginal Analysis, and Sir Muir Gray further explored these themes in his plenary speech, urging the audience to focus on “value”.

It was also great to see such a terrific international focus with delegates from as far as New Zealand and Hong Kong.

The size of public health issues can be overwhelming, but the palpable desire to tackle these head-on was inspiring. The conference demonstrated that there are real challenges facing local and global populations, but also some excellent people leading the charge.

Dr Foster was particularly proud to support the annual dinner where interesting discussions continued and everyone enjoyed Sir Sandy Macara’s humorous speech. We definitely look forward to coming back again, and to continuing our conversations with many new friends.

Pete Sinden, Head of Government Services, Dr Foster

FPH conference – the Yorkshire perspective

We were really pleased to be able to welcome the Faculty of Public Health Conference to Yorkshire & the Humber in general and Scarborough in particular.

The region was featured in the opening plenary, parallel sessions on health inequalities and poster presentations, and it was a great opportunity for those of us in the patch to showcase our area, celebrate our progress and share our concerns. I know that many colleagues were pleased to be able to take the time to reflect and network, while also having the opportunity to hear from authoritative speakers on a wide range of subjects.

Personal programme highlights included the plenary sessions on Climate Change, the Olympics and Violence – a selection that demonstrates the significance and variety of public health practice in modern times. The quality and scope of the parallel sessions was excellent – making it hard to choose which to attend. This means that follow-up access to presentations through the Faculty Website is an important facility to allow us to see what we missed. I also ‘enjoyed’ the session on revalidation, learning a lot about what we need to prepare for.

As you will know from our presentations, Scarborough is an area with a mixed health and wealth experience: coastal communities are often set against the backdrop of coastal erosion, deprivation and older than average population. It’s important for the area that it is seen as a good place to come to, so I hope that you all enjoyed the conference and the town itself. We were glad to welcome you all to our area and to be able to reflect back to our organisations the importance of public health nationally.

Rachel Johns
Associate Director of Public Health
NHS North Yorkshire and York

other global issues were emphasised. Richard Smith highlighted the pandemics of, among others, cardiovascular disease, obesity and physical inactivity. Professor Alan Maryon-Davis chaired a lively debate on health threats including global health inequalities and the impact of climate change.
Morbid thoughts and thoughts on morbidity at the DARE Lecture 09

It’s no surprise to hear that Richard Smith, Executive Director of the UnitedHealth Chronic Disease Initiative, comes from a family of comedians.

His lecture ‘Rediscovering public health through global health: simple lessons we need to keep relearning’ on the second night of the FPH Annual Conference was packed with provocative one-liners. For example, Richard’s insight into one of his obsessions: “I talk and think about death all the time. I advise you to sit at the dinner table tonight and think of death constantly too. Maybe someone will die while you’re eating and it will add to the whole atmosphere.” Ripples of laughter ensued. It seemed that everyone was enjoying this daring DARE lecture.

**Chronic diseases are now displacing deaths from infectious diseases in low-income countries, but every year roughly $1,200 is spent in aid for each death from AIDS and $3 for chronic disease**

Like every good comedian, he unearthed some serious truths about modern medicine. It is our relationship with death that dictates the decisions we make about healthcare – which research needs are prioritised, which intervention funded.

He raised the challenging dilemma of spending tens of thousands of pounds on operating Faith and Hope Williams, the conjoined twins who sadly died as a result of surgery, as opposed to putting that money towards saving a hundred, perhaps a thousand malnourished children in sub-Saharan Africa? A difficult question that leads one to wonder whether there can be a price tag attached to life. Richard Smith didn’t shirk from such harsh realities, but branded modern medicine as out of control and as unaffordable as the global banking system. If so, healthcare professionals are staring into the abyss.

Richard Smith wasn’t there to push us over the edge, but to offer a vision of an alternative reality. The key to which is to shift medical professionals’ thinking from disease to health, from cure to prevention, and accept death as normal. Healthy people are part of a healthy society; unhealthy places and an unhealthy planet make us sick. Well-known paradigms for a public health audience, of course. This shift, Richard explained, would allow us to lead a full life until 84 years of age, singing, dancing and playing football, then disintegrating in a matter of months. “Good for us, our families, the planet and the healthcare system,” he declared.

But Richard went further: having every joint in our bodies replaced and employing every high-cost intervention under the sun to add a few months to our lives is simply unsustainable and futile; we must think of the money and whether the cost correlates with the quality and effectiveness of the treatment. Deaths from non-communicable chronic diseases are now displacing deaths from infectious diseases in low-income countries, but every year roughly $1,200 is spent in aid for each death from AIDS compared to only $3 for chronic disease.

Richard believes that public-private partnerships are the way forward and that it is vital to work with the private sector to improve health in developing countries - particularly where there is no or inadequate, publicly funded, health infrastructure. We can learn from the developing countries; it is wrong to think that we in the developed world are the only ones who can lead. Be truly global and shift resources between societies, not just within societies. Radical ‘relearning’ is needed, and quickly. These less comfortable thoughts were designed to prod the delegates out of any complacency.

Whilst the conference guests were tucking into their main course that evening, the BBC was showing a documentary called ‘The Price for Life’ which examined the approval process for a new cancer drug, Revlimid. It explored the complex web of public interests and commercial incentives, and highlighted all too clearly the dilemma the NHS and NICE face when deciding which types of healthcare to fund. Entangled somewhere in the middle was the patient. A picture of reality, which is still very far from Richard Smith’s alternative vision.

Next year’s FPH Annual Conference: Dates and venue to be announced soon!
A health revolution: the role of cycling in the UK’s public health challenges

Most people know instinctively that cycling is ‘good for you’, but Cycling England’s research – and early indications from our projects on the ground – show that cycling has real potential to have a major impact on public health.

In 2007, we published economic research which estimated that a 20% increase in cycling by 2015 would result in decreased mortality valued at £107m, with potential savings to the NHS of £252m from reduced illness, and a further £87m saved by employers through reducing absence. We also published our Cycling and Health report, which compiled for the first time all the available evidence of the health benefits of cycling into one report for health practitioners.

That evidence is compelling: cycling is an easy and low-impact activity which slots into everyday life, yet can help to reduce the risk of a range of health problems, particularly heart disease and cancer. One study found that people who cycle to work experienced a 33% lower rate of all-cause mortality compared to those who did not.

Though one of the barriers to taking up cycling is the perceived danger posed by road traffic, the real risks are minimal and, research suggests, are outweighed by the health benefits by a factor of around twenty to one, suggesting that being sedentary is more risky to health.

All this research indicates that it is crucial for health professionals to encourage adults and children to cycle regularly. There is already much good work in this area. In Nottingham, the PCT is developing an innovative approach to promoting cycling through working with NHS Health Trainers, who will be encouraged to offer cycling as a core part of their public health work alongside issues such as smoking prevention and promotion of healthy eating.

In Northamptonshire, cycling is being included in the award-winning work of the Healthy Communities Collaborative, which recruits local people as volunteers to take part in health promotion programmes. The Easy Rider programme offers guided leisure cycling rides, access to bikes at low or no cost, and transport for cyclists to safe places to ride.

Alongside the pioneering work being undertaken in ‘Cycling Towns and Cities’ across England, Cycling England is investigating opportunities for a major regional pilot in the North East and South West of England to increase cycling within the NHS. As the UK’s largest employer, the NHS could set an excellent example and effect real change. Through the pilot, hospitals and PCTs in each region will encourage their staff to cycle through a range of measures including cycle parking, showers, changing facilities, cycle groups and route planning.

With obesity at epidemic levels in the UK, the humble bicycle has enormous potential to help defuse the country’s public health time bomb – if health professionals join us in encouraging more people to cycle, more often.

Phillip Darnton
Chairman, Cycling England
What works?

The Department of Health has referred four topics on promoting physical activity to NICE

Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling was published in March 2006 (www.nice.org.uk/Guidance/PH2). This guidance provides six ‘practice’ recommendations. For three areas, the advisory committee felt that the evidence was not sufficient to make positive recommendations and indicated that exercise referral schemes, walking and cycling exercise programmes and pedometer schemes should only be endorsed as part of a research study to produce evidence of effectiveness. For brief interventions in primary care, the committee recommended that primary care practitioners should, when possible, identify inactive adults and advise them about increasing their activity levels. The guidance also encouraged a focus on the activity levels of ‘hard to reach’ and disadvantaged communities.

Guidance on environmental factors in the promotion of physical activity was published in January 2008 (www.nice.org.uk/Guidance/PH12). It noted that:

“…While individual interventions to promote activity may be important, they are not the only (nor possibly the main) solution. Other issues, including environmental factors, need to be tackled. As Schmid and colleagues say (1995), ‘it is unreasonable to expect people to change their behaviours when the environment discourages such changes’.”

This guidance looked at evidence on transport, urban planning, the built environment, the natural environment and policy, and provides recommendations about strategies, policies and plans. These include the need to: assess the likely impact of policies on physical activity and prioritise the need for physical activity; give the highest priority to active modes of transport; develop networks of cycling and walking routes; ensure that open space and parks can be reached by active modes of transport and that they are maintained to a high standard; link workplaces to cycling and walking networks, develop networks between buildings and ensure that stairs are signposted and attractive to use; ensure that playgrounds encourage active play.

The third physical activity guidance, published in May 2008, addressed workplace physical activity (www.nice.org.uk/Guidance/PH13). This guidance will be discussed in more detail in a subsequent issue of ph.com addressing workplace health.


Recommendations were grouped around:
- national policy; high-level policy and strategy; local strategic planning; local organisations; planning, delivery and training; local practitioners; and delivery.
- The key themes are:
  - Promoting the benefits of physical activity and encouraging participation
  - Ensuring high-level strategic policy planning for children and young people supports the physical activity agenda
  - Consultation with, and the active involvement of, children and young people
  - The planning and provision of spaces, facilities and opportunities
  - The need for a skilled workforce
  - Promoting physically active and sustainable travel.

Several other pieces of guidance are in development. These include population-level cardiovascular disease prevention, and transport policies to promote cycling and walking. For details of all NICE guidance and to register as a stakeholder see www.nice.org.uk/.

Hugo Crombie
Public Health Analyst
National Institute for Health and Clinical Excellence

The Health Walk scheme

Anna Kelly joined a local Health Walk scheme in Tavistock while recovering from breast cancer. “Months of radiotherapy had left me feeling tired and low and the walking gave me a real boost. The added bonus was the wonderful camaraderie I found during our weekly walk”. After recovering from her illness Anna trained to become a walk leader and is now inspiring others to get walking back to health.

Health walks were started in my surgery in South Oxfordshire in 1996 and then developed into Walking the Way to Health by the Countryside Agency, British Heart Foundation and Big Lottery. Natural England has continued to expand the scheme so that 35,000 people walk each week on 16,000 walks in 560 local schemes. However, there is significant potential for growth by linking the scheme to the NHS. Some areas like Sheffield have health walks successfully embedded into their exercise referral scheme, but other areas focus only on the indoors.

The launch of Be Active Be Healthy by the Department of Health, changed the emphasis from indoor formal exercise to outdoor informal activity. One commitment in the plan was to work with Natural England to quadruple the number of participants on Health Walks to 130,000 per week by 2012, as part of the “two million more active people” Public Service Agreement.

A Health Walk is a very local walk with 2 or more leaders who allow people to walk at their own brisk pace along a 1-3 mile route that includes some green space even in the most urban of environments. Most walks take place in inner city areas or on the urban fringe. Natural England provides the insurance, training of leaders (39,000 leaders have been trained) accreditation (to ensure each walk is inclusive of the least active) and evaluation. The delivery is through local co-ordinators funded by PCTs and Local Authorities.

The evaluation is particularly important since although NICE have approved ‘led walks’ for mental health and wellbeing in the elderly, more evidence is required to demonstrate its effect on the least active. We know that Health Walks help older people maintain their activity levels which would usually fall away with age. Natural England is working to collect data from every person on every walk using the Outdoor Health Questionnaire. This questionnaire collects the demographic details from every participant and then tracks their participation on walks. Crucially there is a single question to measure physical activity that has been developed in conjunction with the British Heart Foundation. Data have been collected since August 2008, and have been transferred to an online database which holds data from 27,000 walkers who have walked 161,452 hours.

The expansion of Health Walks is a significant step forward to embed a culture of walking in local communities and within the NHS so that more people like Anna can benefit.

For further information please contact Huw Davies at Natural England:
Huw.davies@naturalengland.org.uk
Dr William Bird
Strategic Health Advisor
Natural England

www.nice.org.uk/Guidance/PH1
Surveillance systems for physical activity in England

The National Obesity Observatory has recently produced a briefing note that summarises the data that are routinely collected to describe the level and type of participation in physical activity across England. The briefing described the main sources of national-level surveillance data on physical activity in adults and children in England, in order to identify any important gaps. The paper focuses on data on the population prevalence of physical activity, but also includes key sources of available data on determinants of physical activity (such as characteristics of the built environment).

Adult participation in physical activity

Participation among adults is measured in the following surveys:

- **Health Survey for England** – reports on adults' participation in a wide range of types of physical activity
- **Active People survey** – focuses on activities that are done primarily for sport and active recreation
- **National Travel Survey** – investigates all aspects of personal travel, including walking and cycling as transport
- **General Household Survey** – includes measures on sport and recreation including walking

Participation among children

Participation among children is measured in the following surveys:

- **Health Survey for England** – focuses on sports and exercise, active play and walking
- **National Travel Survey** – collects data on all travel, including to school
- **General Household Survey** – covers sport and recreation
- **Physical Education School Sports and Club Link Survey** surveys curricular and extra curricular sport and physical activity in schools.

The data collection systems for physical activity in England are relatively strong, with a number of large-sample representative surveys that collect information on different aspects of physical activity. However, these would benefit from greater co-ordination, as each survey tends to focus on one type of physical activity and therefore it is difficult to gain an overall picture of activity levels. A good example is walking; the Active People survey focuses on walking for leisure and recreation (and excludes walking for transport); the National Travel Survey collects data on walking for transport (and excludes leisure); and while the Health Survey for England does collect information on total walking, it does not ask about the purpose of walks. Hence we do not know about the contribution of active transport to total walks.

The most comprehensive data on physical activity come from the Health Survey for England (HSE). In 2008 the HSE focused on physical activity and health, and included accelerometer data on a sample of approx 3,600 adults together with a step test to measure cardiovascular fitness. This is an extremely encouraging development as it will provide much more robust assessments of physical activity and fitness than were previously available. As the HSE is to be replaced in 2011, it will be very important to build on this investment in physical activity and fitness data, by continuing some or all of these measures in the new survey.

For more detail on these surveys, access the full briefing paper at [www.noo.org.uk](http://www.noo.org.uk)

Nick Cavill
Independent health promotion consultant
Cavill Associates

WHO guidance and a practical tool for economic valuation of health effects from cycling and walking

Economic appraisal is an established practice in transport planning. However, the health effects of transport interventions are rarely taken into account in such analyses. A recent WHO project has developed guidance and a practical tool for practitioners on the economic valuation of health effects related to cycling and walking. The project was led by a five-member core project group (including both guest editors of this newsletter) which worked in close collaboration with an advisory group of international experts.

The result is primarily intended to be integrated into economic analyses of transport interventions or infrastructure projects, but can also be used to value existing infrastructure or investments made in the past. By focusing on economic rather than health impacts it can be a powerful tool for discussions with non-health sectors.

The products of the project include a systematic review of existing relevant studies and approaches to quantify the health gains associated with active transport, and a guidance document discussing the main methodological issues in economic valuation of health effects of active transport. A Health Economic Assessment Tool (HEAT) to calculate cycling-related health savings (HEAT for cycling) and its user guide were also developed.

The tool estimates the economic savings resulting from reduced mortality due to cycling, i.e. if x people cycle y distance on most days, what is the economic value of the reduction in their mortality rate? HEAT for cycling is based on best available evidence and designed for use by transport planners, with variables and parameters that can be adapted to fit a variety of situations. For example, when planning new cycling infrastructure, the tool allows the user to model the impact of different levels of cycling, and attach values to them. This can be compared to the costs to produce a benefit:cost ratio, or as an input into a more comprehensive cost benefit analysis.

It can also be used:

- to value the mortality and economic benefits from existing levels of cycling, such as cycling to and from a workplace or within a city
- to provide input into prospective health impact assessments, for instance, to estimate the mortality benefits from achieving national targets to increase cycling, or to illustrate potential cost consequences to be expected in case of a decline of the current levels of cycling.

HEAT for cycling is being used in several countries within and outside the WHO European Region. For example, England's Department for Transport has adopted the HEAT for cycling approach as part of its official guidance on the appraisal of transport projects. The University of Auckland, New Zealand, used the HEAT for cycling to estimate changes in mortality associated with additional regular urban commuter cyclists, and showed that substantial savings could be expected.

Sonja Kahlmeier, Technical Officer
WHO Regional Office for Europe

The views expressed in this paper are the author's and do not necessarily reflect those of the World Health Organization.
Public health in a change of age

The theme ‘Public Health in a Change of Age,’ recognises the importance of us living in a world of unprecedented change like nothing we have known before. Changes are unpredictable and interconnected requiring a different mind set to operate effectively. A fresh approach is needed, to frame and respond to the major health challenges, obesity, alcohol-related harm and mental illness, ageing population, fuel and food poverty and living in an ‘interrupted society.’

The Conference provides the opportunity for those involved in protecting and improving health in Scotland to meet, learn, debate, and address some of the key health challenges faced in Scotland. The Conference will comprise of keynote speeches from leading opinion-formers and decision-makers plus parallel sessions and poster displays. This format will provide an opportunity for fringe sessions and meetings of related groups.

To book on line: www.shsceventsbookings.co.uk then select Public Health 2009

Revalidation

To provide clear and concise information on revalidation (including relicensing and recertification), a new FPH leaflet was launched at the annual conference in Scarborough last month. The leaflet is included with this edition of ph.com and should act as a guide for all members answering many common questions about revalidation. We hope you will find it useful and will continue to keep you updated as revalidation unfolds.

The FPH Revalidation Working Group (RWG) has recently expanded its membership to include experts in health protection, health improvement, health and social services quality and others. This expanded group is active in taking forward all aspects of public health revalidation.

Recently, the RWG has focused on several specific areas including specialty specific standards, working with other medical royal colleges/faculties on an e-portfolio system and the importance of public health audit. Current areas of work also include enhanced appraisal, MSF, CPD development and remediation.

Educational prizes of the Faculty of Public Health

Littlejohn Gairdner prize:
- Application to consist of a written submission (max 5,000 words) that could consist of e.g. a Board-level or published paper, a needs assessment, or a report on a specific topic. The submission requires a high level of personal involvement by the candidate and a signed declaration from the applicant’s trainer.
- Awarded to Trainee Members in Scotland, who are enrolled with FPH and have passed the Part A examination.
- The winner will receive a medal and a cheque of £100 at the Annual Public Health Medicine Conference in Scotland.

Deadline for entries: 1 September 2009

Sir John Brotherston prize:
- Awarded for the best essay or research on a public health topic (max 3,500 words) written by a student or a young graduate (for medical students this is prior to full registration).
- The entry shall be certified as the entrant’s own work, signed by the entrant and countersigned by the Head of the Department of Public Health at the University concerned.
- The winner will receive a certificate, medal and a cheque of £100 at the Annual FPH Award Ceremony.

Deadline for entries: 1 December 2009

To view the regulations for these and all other educational prizes, please refer to the FPH website at http://www.fph.org.uk/prof_affairs/prizes/ or contact Marijana Curic, Education and Training Department, on 020 7224 0642 or by email educ@fph.org.uk

You must read and follow the regulations closely and adhere to the closing date carefully before applying for any prize.
Social marketing and health services

A recent conference in Cambridge heard contributions from leading experts on how social marketing can be used to improve health services. The conference, organised by public health trainees in the East of England together with the National Social Marketing Centre and the NHS East of England Deanery, also looked at how to address their educational training needs.

The day began with a colourful introduction from John Drummond on the theories of social marketing, focusing on what motivates people to act and strategies to achieve social change. Following this, teams of trainees pitched to a Dragon’s Den panel with ideas to address health-related behaviours such as healthy eating, excessive drinking in middle-aged men and encouraging teenage mothers to breastfeed. Later, Jeff French outlined the role that strategic social marketing can play in shaping policy.

The afternoon also featured a showcase of successful social marketing projects including: community-based diabetes services in London, infection control in a hospital trust, services to address smoking and oral health and how social marketing is being used to help improve a Chlamydia screening programme.

The Eastern Region Trainees Action Group would like to thank all of the speakers, the National Social Marketing Centre and the East of England Multi-Professional Deanery for their funding and support in providing an excellent training day.

FPH Information and Intelligence Committee needs you

The Information and Intelligence committee of FPH feeds into Standards and is a vital committee in the life of FPH. The committee looks at informatics and data quality and their importance in public health. Current areas of work include writing questions for the curriculum, ensuring public health is represented through Connecting for Health and the Information Centre, and working with the Healthcare Public Health Committee and APHO to develop Clinical Quality Indicators for Public Health. We are a really active committee meeting four times a year with ambitious plans for development. We are now seeking more members from frontline PCTs to help us develop our work.

If you are interested in joining the committee please email laurawebb@fph.org.uk (Head of Professional Affairs) or Mike Catchpole, (Chair) on mike.catchpole@hpa.org.uk

Training placement in the Caribbean

Think of the Caribbean and images of beautiful beaches lined with palm trees, beach cricket and incredible coral reefs cross your mind. Add in the word hurricane and the picture quickly crumbles.

Natural disasters can occur at any time, in any location in the world with no respect for vulnerability or borders. The Caribbean region is one of the most disaster-prone areas with regular storms, earthquakes and flooding, and an annual hurricane season lasting for six months a year, every year.

As part of my training to gain experience in disaster management, I joined the Caribbean sub-region’s disaster preparedness and response unit of the Pan American Health Organization in March 2008. The sub-regional unit provides the region with disaster preparedness, risk reduction and response support. My work fell into two main areas, pandemic influenza and older persons in disasters.

Overall this was a fantastic experience. I had amazing exposure to the different agencies involved in disaster management in the Caribbean and saw and understood the move away from primarily providing response assistance, to advocating and assisting in preparedness and risk reduction activities.

I would definitely recommend a stint in the Caribbean for those considering disaster management, and just to convince you, the beaches, diving and turtles aren’t so bad either when the storms aren’t a’ brewing!

For further information contact jaybagaria@msn.com
Our March issue looked at patient safety and clinical quality, and raised some interesting comments from readers.

**Ref: Sir Muir Gray’s article**

It is not, as Sir Muir says, a sad fact that half of all services are below the average. It is a matter of definition of the word ‘average’ (the median splits the distribution in half, the mean does the same in a normal distribution, and the mode will usually do the same). Equally, if all services performed at the average level there would not be, as Sir Muir says, a significant improvement. There would be no improvement (on average)! We need clearer thinking on the subject of variations and how to improve health using them. The word average should not be equated with mediocre or poor.

Raj Bhopal
Bruce and John Usher Professor of Public Health
University of Edinburgh

**Author’s response**

What I intended to convey with this piece was that:

1. Improvement in service quality increases the value derived from resources invested (commissioning’s main aim)
2. Although some would view the primary role of the commissioners as increasing value by improving the allocation of resources, they can also accelerate quality improvement
3. Where there are explicit quality standards, these can be included in the specification. Where none exists, another benchmark is needed
4. Approaches include: taking the cut-off point between the top quartile and remaining services as the benchmark; for below average services to, at least, reach the average benchmark; for average services to strive for the top quartile; and for the top quartile to match the best
5. When approached by services performing below the benchmark, but seeking more money, commissioners should tell the provider to improve performance and find the extra value not from extra resources, but through quality improvement.

My apologies for the loose drafting of the article.

**Sir Muir Gray**

**The future of public health information and intelligence: needs and applications**

When public health practitioners descended on Central Hall, Westminster, in February, to consider the public health requirements for, and from, health and social care data, and the national agenda for health informatics, no-one was particularly expecting a queue at the door! This national conference was co-hosted by NHS Connecting for Health (NHS CFH), the NHS Information Centre (NHS IC), and FPH.

**The ‘take home’ message** was that there was a unique opportunity for public health to influence and inform ongoing developments at NHS CFH and NHS IC, and a need for strategic and operational public health input which could be facilitated through FPH.

**Emerging themes for public health requirements included** –

1. **Identification of the basic requirements for public health information and intelligence**
2. **Governance and technical processes** to safeguard data availability, data retrievability and its application to population health and well being
3. **Tools** to support routine practice and workforce training and development
4. **Engagement in clinical dataset / clinical content development** – to inform data collection at source
5. **Calls for themed workshops** for detailed discussions and an annual meeting on public health intelligence.

The full report of the meeting is available on http://www.connectingforhealth.nhs.uk/engagement/clinical/occo/publichealth

Parul Desai, National Clinical Lead for Public Health
NHS Connecting for Health
Mike Catchpole, Chair
Information and Intelligence Committee, FPH

**Editor’s response**

We do always make space available for readers’ letters and also try to include a response wherever possible. However, as a rule, we don’t get many readers’ letters to justify dedicating a complete reader’s page in every issue of ph.com – though we would very much welcome letters from readers.

With regards to your comments on the use of incomprehensible acronyms in ph.com, we always endeavour to ensure that all acronyms are explained in full the first time it appears within the article in which they have been mentioned.

Dr Ash Paul, Editor

**Quitting in Mind**

FPH recently endorsed Quitting in Mind, an online resource aimed at clinicians, researchers, service users, and anyone with an interest in the area of smoking and mental health. Quitting in Mind collates current knowledge in this rapidly expanding area of work. As part of this, it describes a new ‘Four Dimensional’ Treatment Framework that brings together a range of evidence-based intervention elements into one, coherent approach. In addition, the guidance is supplemented by a range of resources, including posters, leaflets and training presentations.

Quitting in Mind is authored by Dr. Lisa McNally of the Smoke Free Minds project group. It was commissioned by the London Development Centre and endorsed by the Royal College of Psychiatrists and the Faculty of Public Health. It also receives the ongoing support of Professor Louis Appleby, the National Director for Mental Health.

For more information, please visit www.quittinginmind.net

**Author’s response**

What I intended to convey with this piece was that:

1. Improvement in service quality increases the value derived from resources invested (commissioning’s main aim)
2. Although some would view the primary role of the commissioners as increasing value by improving the allocation of resources, they can also accelerate quality improvement
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5. When approached by services performing below the benchmark, but seeking more money, commissioners should tell the provider to improve performance and find the extra value not from extra resources, but through quality improvement.

My apologies for the loose drafting of the article.

**Sir Muir Gray**
Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to the Faculty between 18 February and 25 June 2009.

New diplomat members
Nicholas Walmarin AIGBOGUN
Fiona BRAGG
Helen Anne BROMLEY
Anna Elizabeth BRYDEN
Rachel Mary CLOKE
John Kevin DUNBAR
Obadiah Tamurunci-Opulu ELEKIMA
Gracia Lisabeth FELLIMETH
Ifan GHANI
Saurabh GUPTA
Louise Ruth HURST
David Adedapo ISHOLA
Benjamin William Hubert LACEY
Samia LATIF
Kate Elizabeth LEES
Soo Fon LIM
Katy LYNCH
Kirsteen Louise MACLEOD
Julie O’BOYLE
Suzanne Elizabeth Tanis O’DAMS
Brian Joseph Edward O’NEILL
Virginia Amen PAUL-EBHOMICHEN
Sarah Louise SCOTT
Colin THOMPSON

New trainee members
Lauren Claire AHYOW
Victor Kayode AIYEDUN
Charles Richard BECK
Deborah Louise BLACKBURN
Marie CASEY
Steven CASSON
Charlotte CHAMBERLAIN
Rebecca Claire COOPER
Dhanika Gavin DABRERA
Alisha Ruth DAVIES
Tim FIELDING
Catherine Mary GOODALL
Sally Rebecca GREATEX
Thomas David HALL
Katharine Harvey KIRKWOOD
Chaamila Lilani KLINGER
Dominque Sarah LE TOUZE
Sarah Jane LOCK
Subhadra RAJANANDU
Emma Jane RICHARDS
Jonathan ROBERTS
Jessica Elizabeth SMITH
Sarah Lucy SOWDEN
Shahen SUTARIA
Kyla Hayley THOMAS
Kirsten WATTERS
Rachel Louise WESTON

New members
Neil Geoffrey ADAMS
Edwina Marion AFFIE
Yousef Ahmed Jasim AL-NESEF
Sandra Mary BARRETT
Angela BONE
Anna CICHOWSKA
Maria Sarojini D’CRUZ
Valerie DELPECHI
Susan ELDEN
Julie Lyn HALL
Richard HEALICON
Christine HILL

Anita Margaret HOUGHTON
Ruth Mary HOWLETT-SHIPLEY
Angela Tracy JONES
Richard Mayne KEATINGE
George LEAHY
Bernadette LEE
Susan Nerina MANN
V Bhargavi RAO
Bharat SIBAL

New fellows
Ikechuku Oji Chukwunemeka ANYA
Abhijit Chandrakant BAGADE
Naomi Mary-Rose BANKOLE
Simon Gareth BOWEN
Adrian Christopher BROWN
James Irvine CROMARTY
Anna Teresa GAVIN
Marysia Teresa Joanna HAMILTON-KIRKWOOD
Christopher John HARRISON
Martin Daunton HAWKINGS
Eva HROBONOVA
Ruth HUXT
Tracey IRONMONGER
Andrew John KINGDOM
Daniel Noni LANTUM
Michelle Lisa LOUGHLIN
Chris LOVITT
Ravindra MAHESWARAN
Mary-Ann MCKIBBEN
Gordon Leonard MCLAREN
Richard Alan MENDLESON
Babatunde OWOLOKURE
Hamsa Abdulla OTUBA
Paul Julian Taylor SCOTT
Alan SMITH
Edward Timothy SMYTH
Alan Kerr SPENCE
Sarah Joanna VENN
Richard Geddie WATT
Faisal YUNUS
Douglas Munro FLEMMING
Olutonyin Aderonke AMUSAN
Margaret Valerie BARKER
Clare Anne BEARD
Mnrind BOWLEY
Luca CEGOLON
Rory Edwards COLLINS
John DANISH
Caroline Susan DRUGAN
Roger Philip ELLWOOD
Pip FARMAN
Steven GEE
Barry GILLESPIE
Susie Elizabeth HARNETT
Sue HARVEY
Fiona KINGHORN
Elizabeth LEE
Lucy M MACLEOD
Sarah Michelle MUCKLE
Katie NEEDHAM
Steve PINTUS
Wasem QUIRESI
Abdul RAZZAQ
Gregory ROSE
Martine STANDISH
Valerie THOMAS
Deborah Clare WATSON
Deborah Anne WHITE

FPH would like to congratulate those members who received recognition for their contributions to public health in the recent Honours list:
Mark Bellis
Penny Bevan
Mary Piper
The reluctant cyclist

I was asked to write about why I am a keen cyclist – the problem is I am not - I am reluctant and have been for 20 years. I cycle purely for transport. In 1989, I had a BMJ personal view published about the Healthy Sandwell bike ride – a large event of ours which forced me to get back on a bike for the first time in many years. That experience gave me a lesson in unhealthy public policy; cycling has been important to me, and to Sandwell public health, ever since. We are the first PCT to achieve the Bikeability standard and we employ about 30 sessional cycle instructors. As well as the environmental changes we advocate we have to support the individual cyclist.

I am a reluctant cyclist. There are all sorts of bad reasons I have for cycling, I cycle because I hate walking in the city; you just can’t get anywhere fast enough and concrete is unforgiving. I cycle so I can justify, and maybe offset, the calories of my chocolate consumption. However, cycling is one of the few things I do to improve my health – in my busy schedule it is the only thing I do for exercise and it offers the chance for ‘active living’ as an integral part of my day, rather than seeing exercise as an add-on and a leisure activity. Cycling does have its moments – the days I cycle, four or five per week – I feel clearer in mind and much better equipped to face the day. A nice incident of bike rage really sets me up for the day with some primaeval heart-racing – conflict in the polite world of health services is easy after that.

Cycling has to be on-road in order to get me where I want to be in a hurry – but cycling the canal towpaths of the Birmingham conurbation is beautiful. It is like another world: wild, barely inhabited in the heart of the city and full of surprises when I have a little longer to enjoy it. If you cycle you can feel the weather, feel the seasons, feel life more keenly than you do behind a windscreen.

From a public health viewpoint of course cycling and walking are often the only ways people can get the exercise they need on a lifelong basis to protect their hearts, lungs, bones and minds. Driving to the gym five times a week is hardly sustainable health promotion. For Sandwell my fag packet calculation suggests that 300,000 people electing to get their exercise by swimming five times a week for half an hour would require about 140 swimming pools operating 47 weeks of the year for 16 hours a day.

I made a conscious decision to live in the area I am responsible for – it’s a small Metropolitan council, maximum distance about 12 miles across. I can cycle from home to government office, strategic health authority, my office and the university all within half an hour. Some people in shire counties don’t have that luxury for their transport from home. But many people choose to live as far away as possible from where they work – a poor principle for public service as far as I am concerned and a poor principle for sustainable transport systems. People need to consider distance to work and accessibility much more highly on their priorities in the climate change era. I may be a reluctant cyclist, but I know it makes sense.

John Middleton
Director of Public Health
Sandwell