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THE PRESIDENT'S VIEW

John Stirling

By the time you receive this edition of *Environmental Health Scotland* details of this year's Conference will have been finalised and the Council will have agreed its response to Dr David Old's Project Steering Group report.

This year's Conference will be held at the Menzies Glasgow Hotel between 22 and 24 November and I hope to meet you there. I would urge as many of you as possible to attend the Friday morning session, which is free to members, and thereafter take part in the Institute's Annual General Meeting.

Returning to Dr David Old's report, a number of Dr Old's recommendations relate to the need for improved communication between the Institute and its members, and between the Institute and the various public health and environmental health stakeholders across Scotland and the United Kingdom. I was reminded of these recommendations when participating in the recent REHIS roadshows while noting the comments made by delegates. The roadshows allowed the Institute's senior office-bearers and staff to meet, face to face, with members and with the wider environmental health community in Scotland. I believe that they were very useful in this regard!

The use of the Institute's recently revitalised website (www.rehis.org) to get the environmental health message out to all interested parties is currently being considered and I will ensure that you are kept fully informed of all such developments and initiatives.

The success of any and all publications relies on regular and informed articles by those 'in the know'. I would remind all Committee and Working Group Chairpersons, as well as members at large, that reports on their activities are of great interest to fellow environmental health professionals and take this opportunity to encourage submission of reports for publication. It is essential that all environmental health professionals are kept up to date with the work of the Institute and its partners.

The last 18 months in the Institute have been, at times, quite traumatic and I am pleased to report that the benefits arising from all the changes in staffing are now being realised. This is evidenced in the increase in the number of members taking part in Continuing Professional Development activities and in the increase in the number of Environmental Health Officers seeking Chartered status. The community training activities of the Institute continue to develop and we are seeing an increased uptake in food safety courses and in the recently launched food and health course.

Now, the really good news! Having discussed the matter with the Chief Executive, I am happy to report that the Journal will carry, in alternating issues, comments by the President and the Chief Executive. I have calculated that this is the last time that I will be writing as President, as the Chief Executive will undertake the next issue and, thereafter, it will be the turn of the incoming President. I therefore take this opportunity of thanking everyone for their support, not just over the past six months, but for all the time I have been active in the Institute.

MANAGING RISKS: WHO INFLUENCES BUSINESSES?

by Bridget Hutter and Clive Jones, ESRC Centre for Analysis of Risk and Regulation, London School of Economics and Political Science

How do businesses understand and manage their risks? What influences and drives their risk management practices? What is the role of regulation in this? Is government the only source of regulation? These are questions asked by researchers from the ESRC (UK Economic and Social Research Centre) Centre for Analysis of Risk and Regulation at the London School of Economics and Political Science in research on *Managing Risks and Responding to Regulation in Food Retail and Hospitality Businesses*. The research is ongoing and in this short article we aim to give you a flavour of our preliminary findings, especially as they relate to Scotland.

The Research Project

This project addresses a number of research questions relating to the range of risk management and regulatory sources influencing businesses. Of particular interest is the weighting of influence exercised by different regulatory and risk management organisations. We are all interested in mapping out how businesses manage the various types of risks with which they are confronted. This involves focusing on the drivers of risk management systems and practices, the resulting tools and techniques employed to manage risk, and the institutional and policy changes resulting from external/internal drivers and their impact (if any) on the everyday practice of businesses and individuals within them.

The research has been divided into three phases - each building on the preceding phase. Phase 1, the Consultation Phase, involved the collection of data through a literature survey and preliminary discussions with industry representatives, central and local government representatives, regulators and consumer organisations (see Table 1). While the researchers were familiar with the academic literature about risk and regulation they are not experts on food safety and food hygiene. The purpose of this phase was, therefore, to start to understand the main issues of relevance to this domain of risk management, for example, to gain an understanding of the main risks involved in the domain; to identify the range of potential sources of influence and regulation external to companies; to identify the main risk management tools in use in the sector; and also to collect information about the structure of the industry in England, Wales and Scotland, and the range of professionals likely to be involved in regulation.

The discussions were broad-ranging and offered a variety of perspectives on the state of food safety and food hygiene in the retail and hospitality sectors in the UK. It soon became apparent that there are distinctly different views with one person's matter of fact being another's point of contention. Two simple examples illustrate this. One concerns the value of asking managers of businesses about their knowledge of and compliance with state regulation. In the view of some of those we spoke to, this is a nonsensical question which will reap very obvious responses, namely that if something is a matter of law then it is known about and complied with:

> *'food safety hazards must be controlled by law by the business, therefore these are not options'.*

	England and Wales	Scotland	Total
Policy-makers from central government	6	2	8
Regulators: Central government related Local government related	9 2 (Greater London)	9 5	18 7
Trade associations	5	4	9
Food businesses	10	1	11
Consumer organisations	2	2	4
Total	34	15	49

Table 1: Participants in Phase 1 of the Research.

Others disputed this. They believed that not everyone does know or understand the law, and they saw one of the major challenges of regulation being to attain and maintain compliance.

Apparently self-evident 'truths' were also voiced about the importance of including large food retailers into the research. One view was that there would be little point in us including these businesses in our research as they are the gold standard at all times, so they would without doubt know the answers to all questions and have in place standards, procedures and practices far in excess of the law. One senior representative commented that things never go wrong in this sector. But other respondents spent some time listing examples of large companies where problems had become evident and occasionally necessitated widespread product recall. Some respondents from the retail and manufacturing sectors identified the catering sector as the riskiest part of the industry. From a research point of view such divergences are, of course, interesting in themselves. Moreover, they underscore the necessity of the research as there is evidently no broad consensus about what the state of food safety and food hygiene is in the UK today.

Phase 2 comprised a large mapping survey focusing on the differences and similarities which might exist between businesses. The sample was structured according to retailer type; notably the grocery; specialist retail; and hospitality sectors; and the size of business.[1] A total of 204 individuals across 31 businesses responded to the survey. Phase 3, which is ongoing, concentrates on variability within and between businesses and involves in-depth interviews with a cross-section of employees in food businesses.

Variability

An important objective of the research is to map out variability between businesses. To what extent does knowledge of food safety and food hygiene risks differ between different types of business? How familiar are food businesses with state and non-state forms of regulation? Do they use similar risk management tools, and do the same risk management drivers motivate them? If there are differences, are they patterned in some way?

The main variable which emerges as significant in the academic literature and, also, in discussion with experts in the food sector, is the size of business. One expert believed risk to be strongly related to size, with effort proportionate to the size of the business. Some reflected upon the ability of small businesses to manage risks:

> *'Smaller businesses expect inspectors to manage risks for them'.*

This may be related to the fact that many small businesses are not members of any trade or business association which might provide updates or even training on food safety and food hygiene matters.

A second factor which may be relevant in any variability between businesses is retailer type. Many of those we spoke to drew a clear distinction between the retailing and hospitality sectors. Retailing was seen to be concerned with distributing rather than manufacturing products. The catering sector was identified as 'the biggest challenge' partly because of the high turnover of staff, the handling of cooked and uncooked food together and changing menus being a source of new risks. A further risk factor associated with the hospitality sector is that:

> *'Catering is demand-led whereas food manufacturing is planned over a long period therefore HACCP sometimes goes out of the window as customers need to be served. Time pressures lead to corners being cut'.*

Another participant commented that:

> *'the hospitality sector is a very fragmented sector, they don't tend to gel as a sector'.*

The extent to which retailers were regarded as risky partly depended upon the type of food they sold, for example, whether it is fresh or pre-packaged. Also deemed relevant was whether or not they were small independent retailers or part of a broader company or franchise.

A third broad variable discussed in Phase 1 of the research was geography. Some of those interviewed in Phase 1 suggested that significant differences exist within the economic landscape of the UK retail sector. For example, some identified North/South and rural/urban variations. Different retail chains were seen to operate in different parts of the country and some believed that different regional diets may be significant. Urban areas were generally seen to have a higher turnover of staff and a high probability of language and literacy difficulties amongst staff. Rural areas on the other hand perhaps encounter greater training difficulties as:

> *'if a college is 30-40 miles away then a manager would have to close a shop for a day to attend training'.*

But there was not unanimity on this point. Some believe that the major regional differences relate to varying practices amongst Environmental Health

Officers (EHOs), especially the frequency of inspections and the relationships between EHOs and businesses:

> *'The DTI Small Business Service has highlighted the need for a level playing field for enforcement action taken between local authorities. The difference in the political make-up of a local authority is very important as the ethos changes'.*

Regional differences were also seen to be less relevant in the case of the larger food businesses which had their own standards, training and monitoring procedures. In these cases the quality of the local manager was seen to be key to how successfully food safety and hygiene risks are managed.

A number of experts in the first phase of the study suggested that Scotland is the one area which should receive particular consideration and it is to the discussion of this that we will devote the remainder of our discussion.

Scotland

There were a number of reasons identified by our respondents for taking particular note of Scotland in our research, notably that it has a devolved administration; that the structure of its food industry may be significantly different from the rest of the UK, thus presenting particular retailer logistics management; and also because in 1996 it experienced a major *E.coli* O157 poisoning in which just under 500 people were affected and 20 people died.

In order to try and gain some idea of the validity of these arguments the researchers visited Scotland on two occasions and spoke to representatives from central and local government, business, trade associations and a consumer group (see Table 1). These discussions revealed a mix of views.

On the subject of Scotland's retail landscape there was a broad view that it is probably little different from the rest of the UK in urban areas but differences might be identified in the rural areas. Three main differences arose in discussion - first it was suggested that the Scottish retail landscape possibly has a greater proportion of independent, family-run businesses than the rest of the UK, especially in rural areas; second, it was thought by some that there is a lot more local shopping in Scotland, especially 'C' (convenience) stores; third, logistical difficulties were identified especially in transportation to the Highlands and Islands. There was debate about whether these distances created higher risks to food safety or whether the main effect was increased costs and lower shelf life.

The regulatory landscape also attracted equivocal responses about how similar or different Scotland is compared to the rest of the UK. Devolution was not considered to be a major influence on food safety and food hygiene issues. A widely held sentiment is encapsulated in the claim:

> *'from a policymaking perspective Westminster and Europe are still driving regulation'.*

Some respondents felt that there may be some marginal differences resulting from devolution. The differences centred on a general view that there is a greater preparedness in the Scottish political system to listen and debate. One respondent suggested that the Scottish Parliament is 'more open, more accountable' and others felt that the Scottish political landscape is more 'joined up', more co-ordinated and that it has a social conscience about issues such as food hygiene and diet. But probably the key explanatory factor identified in distinguishing variation between the Scottish regulatory landscapes compared to the English centres on issues of relational distance. There was a general feeling that the size of the regulatory and retail populations in Scotland is relatively small and as a consequence people in the relevant food communities could get to know each other and meet up fairly regularly. Some also identified what they referred to as a cultural willingness to communicate. The size and the culture combined enabled:

> *'… people more readily to ask for help, phone around and discuss things'.*

This was something which existed pre-devolution and which endured organisational change. These were factors which were also identified by some as the reasons why, in their view, the Food Standards Agency (FSA) in Scotland was generally perceived to have better relations with their local food community than their counterparts in London. Indeed, the creation of the FSA was considered by some respondents to have had a greater impact on food safety and food hygiene in Scotland than devolution. This said, there was a general view that the FSA Scotland was:

> *'a branch of London' – 'FSA London says these are our strategies and Scotland goes along with them'.*

So their policies were seen to be led by London but their relations with business were considered to be particularly good in Scotland, possibly facilitated by the ability to have regular meetings with business and their ability to get to know the main players.

The one area where all respondents felt that there would be a major difference between Scotland and elsewhere in the UK was the events surrounding the *E.coli* O157 outbreak in Wishaw in Central Scotland in 1996. The resulting wide-ranging inquiry, led by Professor Hugh Pennington (Pennington 1997), into the outbreak recommended changes to food safety control in butchers' shops and a widespread education programme supported by additional funding. Those we interviewed varied in their views of the magnitude of the impact of the disaster and its aftermath but all agreed that these events had touched the industry and consumers, possibly with long term effects. At one level, the outbreak was seen to have influenced Scottish perceptions of food safety. Not only had it raised the profile of food safety and hygiene, it had also brought home the importance of EHOs and also the human costs which can be associated with poor standards and practices. The longer-term effects were largely related to the extra money which has been directed to improving food safety and hygiene in Scotland. The so-called 'Pennington money' was generally considered to have been wisely spent by local authorities to launch targeted education and improvement campaigns.

The data from the Scottish interviews certainly suggest that the possible impact of the *E.coli* O157 outbreak and its aftermath is of particular research interest, for example, how would Scottish food businesses compare to their English counterparts? Do they know much more than their English counterparts? Unfortunately we were only able to research this to a very limited extent because of limited research funds, but let us conclude with a sketch of the limited data we do have.[2]

Phase 2 of the research project included two large businesses which had both Scottish and English branches. One was a convenience store operator, the other a branded restaurant chain. The data from these businesses is interesting.

The data from the convenience store contained a number of clear variations. These included differences in the profile of respondents. Staff in the Scottish stores were much more likely to have previously worked elsewhere in the food industry than their English based counterparts. Also over half of those responding in South East England use contract/casual labour, whereas in Scotland only one third of stores use contract/casual labour.

Variations emerged in the identification of risks. More than half of both samples consider that temperature control of food was a major risk, with a slightly greater concern in the Scottish stores. Specific areas of concern were said to be bakeries and delicatessens. One of the most striking differences centred on concerns about 'high risk products such as raw meat and eggs' with 26% of the Scottish sample referring to this as a risk compared with 3% of their southern counterparts. Also, more than half (65%) of the Scottish sample considered that cross contamination was a major risk compared to less than half (37%) of the South East England sample.

Questionnaires from the restaurant chain revealed few notable differences between Scotland and England. There were few differences in understandings of risk between the two regions. But, like the convenience store respondents, there were higher levels of knowledge of EHOs and their role in Scotland than in the English sample.[3] It is uncertain what accounts for these differences between the Scottish and South East England samples although the government and industry responses to the 1996 *E.coli* O157 outbreak in a Wishaw butcher's shop in Scotland may be a partial explanation. The difference between the convenience store chain and restaurant chain seems to be explained by their organisation. Whereas the restaurant chain has a highly centralised UK-wide organisation, the convenience store organisation is more federated so more sensitive to regional developments.

We find the apparent differences between the Scottish and English cases very interesting and think that they reveal some potentially interesting data about the effects of greater investment in education and training in food hygiene and food safety practices. Also, the suggestion that consumers as well as those in the food industry were so influenced by the events in 1996 is worthy of further exploration. One conclusion might be that the dreadful events of 1996 did, in concert with the subsequent inquiry and investment in food safety and food hygiene training, have a longer term impact in improving the management of these risks in the industry.

References

Pennington, T. H. (1997) 'The Pennington Group: report on the circumstances leading to the 1996 outbreak of infection with *E.coli* O157 in central Scotland, the implications for food safety and the lessons to be learned', Edinburgh: The Stationery Office.

The authors would be delighted to hear your comments on the issues raised in this paper and a related paper* Business Risk Management: The Influence of State Regulatory Agencies and Non-State Sources *available at www.lse.ac.uk/collections/carr/pdf/Disspaper41.pdf. They can be contacted at the following e-mail addresses:* b.m.hutter@lse.ac.uk *or* c.j.jones@lse.ac.uk.

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The Centre for Analysis of Risk and Regulation (CARR) is an interdisciplinary research centre at the London School of Economics and Political Science. Our core intellectual work focuses on the organisational and institutional settings for risk management and regulatory practices. CARR's wide-ranging remit also involves working closely with government policy-makers and business practitioners from a range of 'risk-processing-domains' such as food, finance, environment, operations; organisation-wide risk management; the interaction of different risk regimes; and 'complex risk'. CARR has rapidly established itself as an international reference point and centre of excellence for risk regulation studies.

http://www.lse.ac.uk/collections/CARR/

Footnotes

1 Company size definitions: Large firm: over 250 employees; Medium firm: 50 - 249 employees; Small firm: 10 - 49 employees; Micro firm (inc. sole trader): 0 - 9 employees. *Source: European Commission (1996).*

2 We did try to raise funds to expand the Scottish element of the research but unfortunately these attempts were unsuccessful, in one case because of the difficulties incurred by state agencies funding external research and in another because the findings were not found to 'add value'.

3 We should note that this was a relative difference, overall knowledge of EHOs was very high. This is the subject of a paper we hope to publish later this year.

THE REHIS ELEMENTARY FOOD AND HEALTH COURSE – UPDATE

by Graham Walker, Director of Training

The REHIS Elementary Food and Health Course is designed to provide candidates with a basic knowledge of the link between diet and health. The course is delivered by our extensive network of Approved Training Centres. The first course was run by Dundee College earlier this year and John Stirling, President, and Graham Walker, Director of Training attended the launch. The course has proved to be very popular and there are already 45 provisionally approved Centres and over 400 certificates have been issued.

From left to right: Graham Walker, Gordon Clarke (Curriculum Manager, Dundee College), John Stirling, and Leslie Dick (Assistant Principal, Dundee College).

The Food and Health Working Group

The Group, which is chaired by David Cameron, has now held a number of meetings and agenda items have included qualifications for Registered Presenters and the development of training resources.

Promotion of Elementary Food and Health Course within Low Income Communities

The Food Standards Agency Scotland (FSAS) and the Scottish Community Diet Project (SCDP), on behalf of the partners' group, are providing funding to boost the course's provision in low income communities.

SCDP has now employed a contractor to organise the delivery of this project. The contractor is familiar with training provision within Scotland, aware of food poverty issues and will be working closely with REHIS and our Approved Training Centres to provide the course in the relevant communities.

ASBESTOS IN THE CLASSROOM II, PRESENTATION OF DISEASE STATISTICS AND ASSESSMENT OF ANNUAL DEATH RISK

by Robin Howie, Robin Howie Associates, Edinburgh

Asbestos in the Classroom II

In Volume 18, Number 1, of *Environmental Health Scotland,* it was noted that teachers and pupils are at risk of being exposed to asbestos, and thus of developing mesothelioma, if their school or classroom contains asbestos, whether in good condition, or if damaged by sticking drawing pins or equivalent into walls or ceilings containing asbestos. It is, therefore, necessary to assess whether there is evidence of excess mesotheliomas in classroom personnel.

As the likely latent periods for mesotheliomas from low level exposures to asbestos are likely to exceed about 50 years, and as every adult will have attended school as a child, it is not possible to identify whether any given mesothelioma case was caused by exposure to asbestos in childhood or in adult life or from a combination of both. It is, therefore, not possible to identify mesothelioma cases resulting from childhood exposure to asbestos. However, it is possible to determine from national statistics how many teachers and other classroom personnel have died from mesothelioma.

When someone dies, the immediate and underlying causes of death are recorded against an occupational code and these records are regularly analysed to determine if any occupational code has a higher than expected incidence of any disease. For a person in employment the occupational code assigned is that for the current occupation, for example, 'Primary (and middle school deemed primary) and nursery teaching professionals' are assigned to Standard Occupational Classification (SOC) 234. For an unemployed or retired person aged under 75, the occupational code assigned is that of their last job. However, the most recent job may not be the job in which the exposure of concern occurred. For example, a female who qualified as a teacher in the 1960s or 1970s, and who left to have a family, but who either never returned to employment or who worked as, say, a librarian, will be recorded against a general catch-all code or as a librarian respectively. For each occupational code the number of observed deaths is compared with the number of deaths expected in a gender and age matched group in the general population. The ratio of the observed to the expected number of deaths is expressed in terms of the Proportional Mortality Ratio (PMR) where a PMR of 100 occurs when the observed and expected numbers of deaths are equal.

Although the accuracy of the occupational death statistics is limited by possible errors in the assigned occupational codes, the statistics are of great value, as long as their limitations are recognised.

The Health and Safety Executive (HSE) (2003) gave the following information on mesothelioma cases recorded for classroom personnel to age 74 during the period 1991-2000:

Standard Occupational Classifications for classroom personnel	Gender	Observed deaths	Expected deaths	Proportional Mortality Ratio (PMR)
233 – Secondary (& middle school deemed secondary) education teaching professionals	Male Female	43 3	72.2 2.5	59.6 122.5
234 – Primary (& middle school deemed primary) & nursery teaching professionals	Male Female	2 25	8.2 26.6	24.5 94.1
235 – Special education teaching professionals	Male Female	0 1	0.7 0.4	0 286.3
239 – Other teaching professionals not elsewhere specified	Male Female	3 1	3.8 1.6	79.8 63.7
652 – Educational assistants	Male Female	1 2	0.2 2.5	408 81.2
Total	Male Female	49 32	85.0 33.6	~58 ~95

As can be seen from the above, the total numbers of male and female mesothelioma deaths in classroom personnel to age 74 were 49 and 32 respectively, and that overall the PMR for both were less than 100, thus apparently suggesting that mesothelioma deaths in classroom personnel are about half that expected in the general population for males and not significantly different from the expected for females.

Based on such interpretation of the mesothelioma data, Mr David Miliband, the then Minister, wrote to the General Secretary of the National Union of Teachers stating that: "The statistical analysis we have received from HSE statisticians states that statistics gathered by HSE show that the mortality rate for female teachers is broadly in line with the average for the whole of the working female population, ie, there is no higher risk for female primary teachers", Miliband (2004).

As noted above, the expected number of deaths is calculated from the corresponding number of deaths in a gender and age matched general population. However, the number of deaths in the general population includes deaths from known occupational exposures. In the case of mesothelioma, where about 90% of cases have had identifiable or presumed occupational exposure to asbestos, the expected deaths include cases from former workers in shipyards, asbestos factories, railway workshops and the construction industry and former asbestos laggers. As such workers account for about half of all mesothelioma deaths in Great Britain, it is not surprising that mesothelioma rates in classroom personnel are lower than in such occupations.

HSE (2003) notes that hypothetical groups of males and females with zero exposure to asbestos would have PMR of 6 and 36 respectively. The 'expected' and PMR figures in the above table can therefore be corrected to identify the expected number of mesothelioma deaths in populations not exposed to asbestos by multiplying the 'expected' number of deaths by 0.06 for males and 0.36 for females. However, without knowledge as to how the figures of 0.06 and 0.36 vary with age, any such correction must be approximate. The corrected data are shown below.

From the corrected expected death figures it can be considered that the mesothelioma rates in male and female classroom personnel are respectively about factors of 10 and 3 higher than expected in matched populations not exposed to asbestos.

The figures below relate only to mesotheliomas up to age 74. As a significant proportion of mesothelioma deaths occur at ages 75+, it is necessary to correct the above mesothelioma figures to take account of all mesotheliomas.

From HSE (2005a, b) male mesothelioma deaths to age 74 over the period 1991 to 2000 accounted for 72% of all such male deaths; the corresponding

Standard Occupational Classifications for classroom personnel	Gender	Observed deaths	Expected deaths	Corrected expected	Corrected PMR
233 – Secondary (& middle school deemed secondary) education teaching professionals	Male Female	43 3	72.2 2.5	~4.3 ~0.9	1,000 333
234 – Primary (& middle school deemed primary) & nursery teaching professionals	Male Female	2 25	8.2 26.6	~0.5 ~9.6	400 260
235 – Special education teaching professionals	Male Female	0 1	0.7 0.4	- -	- -
239 – Other teaching professionals nes	Male Female	3 1	3.8 1.6	~0.3 ~0.6	10,000 170
652 – Educational assistants	Male Female	1 2	0.2 2.5	0.01 0.9	10,000 220
Total	Male Female	49 32	85.0 33.6	~5 ~12	~980 ~270

figure for females was 66%. That is, assuming that classroom personnel have the same life expectancy as the general male and female populations, the likely total numbers of mesotheliomas deaths to age 85+ would be 49/0.72 = ~68 for males and 32/0.66 = ~48 for females.

There is a marked inequality in life expectancy between socio-economic classes (SEC). From the Office for National Statistics (ONS) (1997) the life expectancies of males and females in SEC l-ll are 75 and 80 years respectively as compared with 70 and 77 years in SEC lV-V. It can, therefore, be assumed that teachers will have greater life expectancy than the general population and that the above calculated mesothelioma deaths to age 85+ are underestimates rather than overestimates.

That is, classroom personnel accounted for at least about 116 mesothelioma deaths over the period 1991 to 2000 and the mesothelioma rates were about ten times higher for males and about three times higher for females than expected in matched populations not exposed to asbestos.

Presentation of Disease Statistics

From the above mesothelioma figures for classroom personnel, it is very clear that basing PMR on data for the general population without taking account of known or presumed occupational disease is likely to cause the occurrence of occupational disease to be underestimated: very substantially so in the case of diseases where occupational exposures account for a significant proportion of the total incidence in the general population.

If the HSE statisticians fail to understand the limitations of the PMR, what chances have non-statisticians?

As an example of the effects of not removing known occupational disease from the calculation of 'expected' figures, Howie (2000) reported that if the 'expected' figure for lung cancer deaths was corrected to take account of the excess of lung cancers associated with occupational codes that had a significant excess of mesotheliomas, the number of asbestos-induced lung cancers to age 74 over the period 1979-1980 and 1982-1990 was increased from about 1,700 cases to about 17,000 cases and that if further corrections were made for other likely occupationally-induced lung cancers, the total number of occupationally-induced lung cancers totalled about 26,000 cases, ie, about 15% of all lung cancers over the period of interest.

It is, therefore, considered that failure to exclude occupational lung cancers from the data used to calculate expected lung cancer deaths may reduce the assumed number of occupational lung cancers observed and, therefore, cause occupational lung cancers to remain undetected or under-recorded, and that such effect is likely to occur for all diseases where occupational exposures result in a significant proportion of the same disease in the general population.

All known or suspected cases of occupational disease should, therefore, be excluded from calculation of PMR and associated indices.

As an aside it is interesting to examine the number of mesothelioma deaths in health and safety professionals over the period 1991-2000, as shown below:

SOC	Gender	Observed deaths	Expected deaths	Corrected expected deaths	Corrected PMR
348 – Environmental health officers	Male Female	5 0	4.1 0.1	0.25 -	~2,000 -
394 – Inspectors of factories, utilities & trading standards	Male Female	4 0	3.0 0	0.18 -	~2,200 -
396 – Occupational hygienists & safety officers (health and safety)	Male Female	10 1	8.3 0.1	0.5 0.036	~2,000 ~2,800

The number of mesothelioma deaths in the above SOC is low, but where such deaths have occurred the corrected PMR is consistently about 2,000.

Males in such occupations consistently have a mesothelioma rate that is about a factor of 20 higher than in matched male populations not exposed to asbestos.

Assessment of Annual Excess Death Rates

In a series of documents, HSE addressed the tolerability of risk, HSE (1988, 1992, 2001). These documents defined an excess death risk of 1 per million per year (1/M/yr) as being 'acceptable' and risk of 10 per million per year (10/M/yr) as being 'tolerable', the difference in the two risk figures being that a tolerable risk results from a benefit. For example, as we all use electricity, it is reasonable that we should all accept some risk in return for the benefit which we receive from electricity.

Annual risk is assessed by determining the total risk, in terms of deaths per million, and then dividing the total risk by some factor of time.

For example, in assessing the risk to workmen removing textured decorative coatings containing asbestos, the Health and Safety Commission (HSC) assessed such risk against the acceptable level of 1/M/yr and assessed the annual risk by dividing the total risk by an assumed survival period of 50 years, ie, the total risk of 28/million was divided by 50 to give an annual risk of 0.6/M/yr, HSC (2005). However, HSE (1992) stated, regarding the cancer risk from exposure to radioactive materials, that: "In order to permit comparison with conventional risks it is necessary to average the total radiation risk over the number of years of exposure". If HSC (2005) had adopted the analysis technique of HSE (1992) the annual risk would have been 28/million divided by 5 years = ~6/M/yr.

Which divisor is correct?

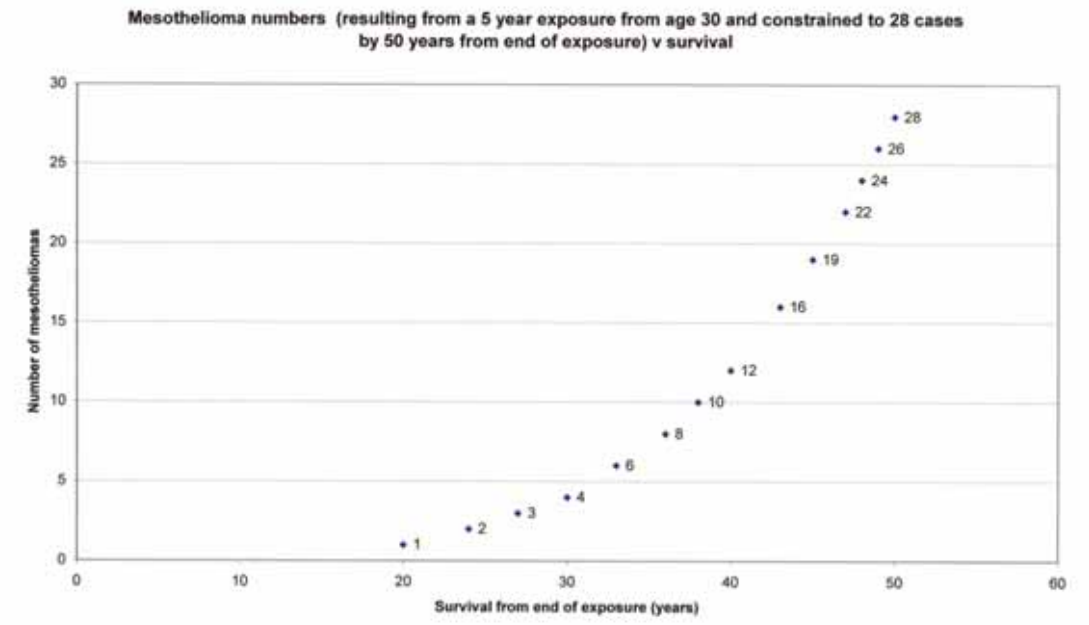
The effect of dividing total risk by survival period for mesothelioma can be seen from the figure below, which, for the HSC (2005) data, graphs the number of mesothelioma cases by time over a period of 50 years for a total of 28 cases/million by 50 years after the cessation of exposure, as calculated from the Doll and Peto (1985) model.

As can be seen from the figure, only four cases occur during the first 30 years of survival and about 16 cases occur during the last ten years of survival. Calculation of annual risk by dividing total risk by survival period is therefore invalid for exposures causing mesothelioma. Dividing total risk by survival period is effectively confusing outcome with risk.

It is, therefore, considered that annual risk should be calculated by dividing total risk by the duration of exposure which generates the risk, ie, as recommended in HSE (1992).

References

References are available from the Institute's office on request.



SCOTLAND CHIKWAWA HEALTH INITIATIVE

by Tracy Morse

Malawi and Scotland have long historical links. From the days of David Livingstone over 150 years ago, Scots have been travelling to the 'Warm Heart of Africa' to help develop this beautiful country, providing medical assistance, education, culture, faith, and most importantly all striving to improve the standard of living for Malawians. Hundreds of Scottish organisations travel to, and fund raise for, Malawi every year, and this link has become even stronger in the last two years with the involvement of the Scottish Parliament.

has been awarded a grant from the International Development Division of the Scottish Executive to work with the District Health Office in Chikwawa and the University of Malawi to target health improvements both at the District Hospital and at community level as the Scotland Chikwawa Health Initiative. The funding has been awarded for a three year period to allow a health initiative to be developed which will integrate capital investment, training and community development. Dr Tracy Morse

Food preparation at the district hospital for theatre patients and the new kitchen shelter currently being constructed to provide a better preparation area.

For over ten years, the University of Strathclyde has joined this group by developing links between the Environmental Health Departments of Strathclyde and the University of Malawi. This link has allowed a transfer of knowledge between the two institutions through visits to both Malawi and Scotland of academic staff, postgraduate and undergraduate students, and practising Environmental Health Officers (EHOs). REHIS has participated in this link helping to re-establish the Environmental Health Officers' Association of Malawi. This professional body was re-established last year after ten years' dormancy. As such, the link between the countries in the area of environmental health has grown and flourished over the years to assist the development of the environmental health profession in Malawi and allow Scottish professionals to experience public health in a developing country.

The institutions have carried out extensive health research in one of the poorest districts in the southern region of Malawi, Chikwawa. This research has concentrated on sanitation, water quality and the transmission of diarrhoeal diseases. In an extension of the existing work, the University of Strathclyde (previously an EHO at Aberdeenshire Council) has lived in Malawi for over five years now and is co-ordinating the project in Chikwawa.

Chikwawa, with a population of over 400,000 has some of the poorest health facilities and infrastructure in the country. Under five mortality in Malawi is one of the highest in the world with one in five children failing to reach the age of five due to preventable

Goat for sale at local market.

Traditional house in Chikwawa.

diseases such as malaria, upper respiratory infections and diarrhoea. Overall life expectancy is one of the lowest in the world at 40.2 years, and these poor life expectancies for both adults and children can be attributed to a number of factors not least HIV/AIDS, housing standards, quality and quantity of water, lack of sanitation and poor hygiene facilities and practices. These are compounded by a poor level of education and poor socio-economic status of the majority of families.

The majority of the population live in traditional housing (mud bricks and grass roof), with two rooms for an average of six family members. At least 50% of the population within the district have no sanitary facilities with the remaining using pit latrines of poor construction. 93% of the district population collects drinking water from communal sources, with approximately 50% of these collecting from unprotected sources such as shallow wells and rivers. Research in the district has also demonstrated that up to 30% of 'protected' water sources were contaminated with bacterial indicators of faecal pollution, and up to 90% of water stored within the household was also contaminated despite being collected from a microbiologically safe source.

The Scotland Chikwawa Health Initiative, which began work in February 2006, is now working to develop improved standards of health service, water, sanitation and hygiene within communities. This holistic approach to disease prevention, frequently avoided by non-governmental organisations (NGOs), should assist in reducing morbidity and mortality within the district and act as a model for other communities and districts throughout the country. The work will include all levels of individuals associated with health, water and sanitation within the district, including government employees such as Environmental Health Officers, water supervisors, Nurses, Midwives, clinical officers and health surveillance assistants, and voluntary members of the community such as traditional birthing attendants and village health and water committees. All of these personnel have an integral part in the improvement of health within Chikwawa and must be involved, trained and given the means to implement the knowledge which they have obtained. The work undertaken by the initiative will include a number of areas:

- The development of training materials for both government employees and volunteers within the community. These will particularly concentrate on health surveillance assistants (these individuals are the backbone of health provision at community level in Malawi), and village health committee members who are essential volunteers in ensuring that good standards of hygiene are maintained, water provided and that the community can access health care when necessary.
- Remediation of water supplies which are in disrepair and provision of further water supplies where necessary. It is known that water quantity is as important as water quality and, as such, in order to improve hygiene practices within the home, water must be accessible and available in adequate quantities.
- Development and piloting of eco-sanitation within communities. This will look at the problems, cultural beliefs and socio-economic factors which lead to poor sanitation coverage within the district. It is hoped to encourage communities to use ecological latrines which can be used for subsequent fertiliser, and to install sanitation platforms to ensure that latrines are safer for use and easily cleaned to reduce the transmission of helminth infections such as hookworm, *Ascaris* and *Strongyloides*.
- Provision of bicycle ambulances in communities. These allow incapacitated individuals to attend health clinics which may be up to 10km away. These are simply bicycles with trailers on the back and are a simple and effective answer to health access in rural areas.
- Provision of other items within communities which are identified as necessary for health improvements, eg, shelters for outreach clinics where children receive immunisations, drug revolving funds in communities to ensure they have access to simple treatments such as aspirin, malaria treatment, provision of mosquito nets for at risk groups to reduce malaria transmission, provision of water treatment for household level treatment to reduce transmission of diarrhoeal diseases.

- At the district hospital and health clinics, in addition to training, capital investments will include provision of medical equipment, construction of staff housing to allow increased staffing, provision of designated HIV clinics for both voluntary testing and counselling and distribution of anti retroviral drugs, extensions to offices, and other items as their needs arise.

All work carried out by the initiative will ensure co-operative work between individuals in Scotland, Chikwawa District Health Office, Chikwawa Water Office, Chikwawa Veterinary Office and the University of Malawi. It is hoped that this will give the project a well-rounded view of health and the work required.

Work on the initiative has already made good progress. Thanks to the Lord Provost of Glasgow's office and the fund raising of undergraduate students

Borehole remediation.

who have visited Malawi, six water supplies have been remediated, with three of these operating for the first time in at least two years. Bicycle ambulances are being fabricated for two of the four communities with others to follow, and measures to improve food hygiene within the district hospital are underway with the provision of a new kitchen shelter. Baseline data is also being collected from all communities involved in the initiative and it is hoped to start on sanitation improvements as soon as possible. Although funding from the Scottish Executive has allowed us to set up the initiative and make good progress, the funds are limited and therefore we are carrying out fund raising for a number of areas of our work. It is hoped that members of REHIS will take this opportunity to assist in public health improvements within Malawi and take part in this appeal.

Food Hygiene Training Appeal

Food hygiene within most food businesses and homes is now something we take for granted in Scotland. With Environmental Health Officers carrying out routine inspections, and children learning about hygiene as part of their education, food hygiene is of a good national standard.

However, imagine a household of six people living in a two room mud hut, the mother cooks over a charcoal or wood fire on the ground. She cannot afford soap, she has no work surfaces, and has only one pot in which to cook. To keep food safe to eat in that environment requires skill and understanding of the risks, but how can she understand about bacteria and cross contamination when she has had minimal education and is illiterate?

What about the man who works in a local restaurant who is also illiterate? He wants to work hard at his job but has no understanding of the principles of food hygiene so carries on producing food while exposing it to the risks of contamination and the customers to the risk of food poisoning.

This may sound like an exaggeration but it is the reality for the majority of Malawian households living in both rural and urban environments, environments which are still regularly struck down by cholera outbreaks.

In order to overcome this, both food handlers and households require to be educated in appropriate hygiene behaviour. Nevertheless, the tools available for this to date are complex and require an ability to read. Therefore, an aspect of this appeal is to raise money to develop and produce educational materials for both communities and commercial food handlers on good and bad food hygiene practices. These materials will be illustrative in nature to overcome the necessity for reading and will be used by Environmental Health Officers and health surveillance assistants all over Malawi to improve hygiene standards in the home and food businesses.

Materials will be produced by local artists and tested with focus groups to ensure that they portray the desired messages. Once this is achieved, the two packages will be finalised and printed for distribution and use.

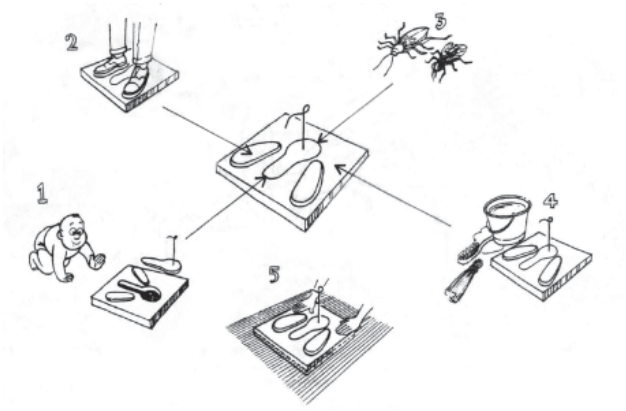
Estimated cost is still a bit vague on this one but I will stab at at least £5,000 taking into consideration the cost of artists and printing.

Sanitation Platform Appeal

Sanitation in Malawi is not a given right; it is a privilege. Less than 50% of the population is thought to have access to a pit latrine or toilet in the country and even less so in Chikwawa District. There are a number of reasons why sanitation coverage is so poor including, socio-economic restraints, sandy soil and high water table leading to collapse, and lack of understanding of the transmission of disease in absence of sanitation. To compound this, when pit latrines are in place they may not be used for a number of reasons including smell, darkness, children are scared to use them in case they fall in, children are not allowed to use them because they are used by adults, pregnant women are not allowed to use them in case men develop hydrocoele, men are not allowed to use them if their mother-in-law is also using it... Through better education and the provision of well constructed, cost effective pit latrines it is hoped that we can improve pit latrine coverage and use within communities and, therefore, reduce the risk of disease transmission through inappropriate disposal of faeces. One of the items shown to improve latrine use is the provision of sanitation platforms. These are concrete platforms with keyhole covers which are placed on the floor of the latrine. They ensure that the latrine is safe for children to use, and that they can be kept in a clean condition to reduce the risk of disease transmission and non-use due to smell and presence of faeces on the floor. The cost of a sanitation platform is related to the cement which makes it outwith the socio-economic capability of most families. As such, for £10 you can sponsor three sanitation platforms by purchasing the cement. All other work carried out

Typical pit latrine.

on construction, from the digging of the latrine, the provision of gravel and sand, and the latrine superstructure will be provided by the communities involved. In the four villages we are currently working in, there are 1,550 households, each of which would benefit from a well constructed latrine with a sanitation platform. As such, it is hoped to raise £2,700 initially in order to achieve this. A small amount considering the huge contribution to health improvement this could achieve! The communities have already shown their enthusiasm for improvements with the water point remediation and have provided the labour, gravel and sand for building work works.



Reasons for installing a sanitation platform.

Overall

Therefore, in order to develop food hygiene training materials for both domestic and commercial training, and provide improved sanitation in over 1,500 households, we need to raise £7,700. It is hoped that you, as a member of REHIS and an environmental health professional who cares about the public health of those living in the global community, will contribute to this appeal in any way you can, whether through individual support or through fund raising activities at offices or regional centres.

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Editor's note: Any donations to these appeals should be sent to: Mrs Margaret Hastie, Administrator, Malawi Millennium Project, The University of Strathclyde, McCance Building, 16 Richmond Street, Glasgow, G1 1XQ. Cheques should be made payable to 'The University of Strathclyde Malawi Millennium Project'. To ensure 'donor to recipient' traceability all donations and donor details will be recorded on receipt, and the specific purpose for which the monies are to be used will be recorded along with the date the monies were transferred.

MALAWI FACT FILE

Full Country Name:
The Republic of Malawi

Capital:
Lilongwe

Geography:
Malawi is a landlocked country in south central Africa bordered by Tanzania, Zambia and Mozambique.

Area:
118,484 sq km of which 1/5th comprises Lake Malawi.

Population:
12.6 million (2005)

Economy:
GDP US$ 1.6bn (2004)

GNI per capita US$ 160 (2006, World Bank)

UK GNI per capita US$ 33,630 (2006, World Bank)

Annual growth 4.2% (2004), inflation 11.4% (2004)

Major industries include tobacco, tea, sugar, cotton, sawmill products, cement and consumer goods.

Development:
10th poorest country in the world (UN Human Development Index).

People:
The most densely populated country in Africa with increasing poverty, low educational attainment (literacy rate 58%) and increasing prevalence of HIV/AIDS.

Life expectancy - 40 years for men and women.

UK life expectancy - 76 years for men and 81 for women.

65% of population live below the poverty line.

Under 5 mortality rate - 183 per 1,000 (2000)

Infant mortality rate - 104 per 1,000 (2000)

Maternal mortality - 1,200 per 100,000 (2000)

Water and sanitation:
40% of rural Malawians draw drinking water from unprotected wells and springs or from surface sources.

21% of rural Malawians have no sanitation facility and 78% use pit latrines.

Sources of information:
Malawi Demographic Health Survey, 2000

UK Foreign and Commonwealth Office, 2006

REHIS DONATION TO TIKONDANE ORPHAN FEEDING CENTRE, LIRANGWE, MALAWI

by Tracy Morse

Tikondane Orphan Feeding Centre was started by a group of local volunteers in 1997 in the area of Lirangwe on the outskirts of the city of Blantyre in the south of Malawi. The aim of the group was to try to assist families who were suffering from the ever increasing burden of orphans from siblings who had passed away due to HIV/AIDS in the six villages surrounding their centre. The Malawi Millennium Project (MMP) (University of Strathclyde and Bell College) first became involved with the centre in 2000, when they donated clothing to the children there. At that time there were approximately 80 orphans between nine months and 18 years old receiving food at the centre. Within the last five years further donations have been made, and the centre has been growing in all aspects. They now feed over 100 orphans daily under the age of five and have over 400 children aged between five and 18 years who are being trained in local skills, such as carpentry and tailoring using equipment donated by the MMP. In addition, they now offer home-based care for over 100 vulnerable members of the community which include the elderly, blind, disabled and HIV/AIDS sufferers.

One of the main problems for the centre was the l ack of a permanent building and, of course, sustainable income to assist with feeding. In 2004/05 the MMP funded the building of a permanent feeding centre/nursery school and the additional money to provide enough food for the under fives for the next five years. This year, with the food shortage, the MMP and other donors have also assisted the orphan families and home-based care participants with additional maize for the hunger season, as well as starter packs containing seed and fertiliser which have grown well this season and were due to be harvested in March.

From time to time, further donations allow us to assist the centre and its work in other ways. One of these was the recent donation from REHIS. The money was used to provide mosquito nets and water treatment for water stored in the home for over 200 families associated with the under fives and home-based care programme. This should assist in reducing the incidence of malaria and diarrhoea in the six villages in the area.

The sustainability of the centre is now being addressed and it is hoped to provide it with a maize mill after further fund raising, which will allow the centre to make money and purchase food independently in the future with less reliance on donors to ensure the future for the orphans of the area.

MANAGEMENT COMMITTEE

by Bernard Forteath, Chairman

The Management Committee's second meeting of the year took place on 5 April in Edinburgh. The Committee's responsibilities include personnel, general administration and financial matters, public and media relations, and it would be fair to say that a large part of every meeting is taken up with these items.

The other issues dealt with at the last meeting included:

Development Plan 2006/07

Final approval was given to the latest version of the REHIS Development Plan which is now available in the library in the members' area of the REHIS website.

Appointment of Honorary Vice Presidents

For many years, the Institute has been fortunate in having the assistance of a number of prominent people to serve as Honorary Vice Presidents (HVPs). The Committee was informed that, following a review, three of our existing HVPs had agreed to continue in this capacity (Professor David Bellamy, Sir Ken Collins and Mr Alan Johnson) and that replacements for those standing down should be considered. A number of names were proposed and these are being considered by the Council.

REHIS Elementary Food and Health Course

Now that the Food and Health Course is up and running, there is a requirement to appoint a Training Adviser in a similar role to the one occupied by Ian McGruther, specifically for this new course. This new post, initially on a one day per week basis, will be advertised in the near future.

REHIS Annual Conference

Arrangements for this year's Conference, which will be held in the Menzies Glasgow Hotel from Wednesday 22 November until Friday 24 November, are now at an advanced stage. Following the success last year of holding the Institute's Annual General Meeting on the afternoon of the last day of the Conference, it has been agreed to stay with this arrangement. The Annual General Meeting will, therefore, take place at the end of the Conference on Friday 24 November.

9th World Congress of the International Federation of Environmental Health, Dublin, 18-24 June 2006

Martin Keeley, a Chartered EHO with East Dunbartonshire Council, was the REHIS membership's representative at the World Congress in June. Martin joined the President and the Senior Vice President as REHIS representatives in Dublin. Members may remember that Drew Hall was the membership's representative at the last World Congress in Durban, South Africa in February 2004.

Twinning Agreement with APHI Cyprus

A report on the establishment of a Twinning agreement between REHIS and the Association of Public Health Inspectors, Cyprus appeared in the last issue of the Journal. The Committee discussed ways whereby younger Environmental Health Officers (EHOs) could be involved in work placements or exchanges with their Cypriot counterparts. It was agreed that any EHO member who is considering gaining some experience of environmental health work in Cyprus should consider the Travelling Scholarship route. Any member seeking information about the possibility of obtaining some work experience in Cyprus should contact me via the REHIS office.

Communication with the Membership – Scottish Roadshows

Last year the Institute decided to run a series of roadshows across Scotland to highlight its role in promoting environmental and public health and to promote the growing importance of Continuing Professional Development. The 'REHIS Roadshow' was presented in Ayr, Edinburgh, Dundee, Elgin, Aberdeen and Glasgow during April, May, and June. The roadshows provided an ideal opportunity for members to meet the Institute's office-bearers and senior staff who are based in Manor Place.

The Management Committee has responsibility for:

- *General financial matters*
- *Public and media relations*
- *Premises and equipment*
- *The Annual Conference*
- *Staffing.*

SOUTHERN CENTRE NEWS

by Evonne Tennant, Southern Centre Secretary

2006 - A successful start and more to come!

What a year it's been for the Southern Centre and its Management Committee!

Since electing an all new Committee at the AGM in September 2005, the new team has already lost one member, Carole Simpson, who has emigrated to a new life in New Zealand. Carol will be missed both by the Southern Centre and by her colleagues at West Lothian Council.

Nevertheless, the work of the Centre goes on, and those remaining on the Committee have busied themselves stretching the 2005/06 budget right up to the last day of March 2006, organising events for the membership!

What's new?

The Committee ran a seminar on the noise aspects of the Antisocial Behaviour (Scotland) Act 2004 on 9 February, bringing together an impressive array of speakers for the event held at the Novotel, Pitt Street, Glasgow. Speakers from the Scottish Executive (Duncan McNab, Head of Air, Noise and Nuisance Team; and Gillian McDonald, Antisocial Behaviour Unit), an acoustic consultant (Dr Bernadette McKell, Hamilton and McGregor Acoustic Division), Strathclyde Police (Chief Inspector Grant Manders, Head of Force Liaison for Strathclyde) and a local authority (John Arthur, Head of Environmental and Consumer Services, Inverclyde Council) put forward their experience and expertise to a capacity audience.

Such was the demand for the seminar that the venue was booked to capacity well in advance of the day and a number of people couldn't have their late bookings accepted.

The seminar also overran its time slot on the day due to the enthusiasm of the audience participants who had travelled from all around Scotland to listen to the speakers and discuss their experiences of enforcing the noise provisions of the Antisocial Behaviour (Scotland) Act 2004. The Centre may run an update for this in the future to meet member demand.

What's to come?

Looking forward to the 2006/07 financial year, the Southern Centre Management Committee has been busy making arrangements for future events. It recently joined with Falkirk Council in promoting a Continuing Professional Development food-based update on 3 May in Callender House, Callender Park, Falkirk. The event focused on food sampling with John Waddell (Senior Microbiologist at Glasgow Scientific Services Laboratory) reviewing the latest microbiological criteria for food, Stuart Joyce (Public Analyst, Deputy Agricultural Analyst and Food Examiner at Glasgow Scientific Services Laboratory) discussing colourings in food, and John Sleith (Food and Safety Regulation Manager at Falkirk Council) briefing on formal sampling.

The Southern Centre Management Committee: back row, left to right: Lorrainne Macgillivray, Drew Hall, Martin Keeley. Front row, left to right: Ruth Robertson, Evonne Tennant.

Following on from this, the Southern Centre decided at its most recent Committee meeting in Glasgow on 9 May (that's when the group photograph was taken!) on a provisional line up of events to run before and after the next AGM in September this year.

The proposed events for the year ahead include a joint event with Health Protection Scotland, providing an overview of health protection activities, surveillance systems, environmental health research and the evidence base for action, etc.

Updates are also planned in the following subject areas; the new smoking legislation - a review of enforcement issues so far; issues surrounding water

and waste services - public and private; and environmental incivilities and health. An event looking at the Freedom of Information Act and Regulation of Investigatory Powers (Scotland) Act is also planned.

The Southern Centre is also committed to the promotion of REHIS and environmental health at a national level within the public health and health improvement agendas. The Committee proposes to assist the REHIS Council in progressing the recommendations of the Project Steering Group (PSG), chaired by Dr David Old.

Finally!

The Southern Centre is run by the members, for the members, so if any members have inspirational ideas for training, workshops or seminars that they would be keen to see organised, please contact the Southern Centre Secretary, Evonne Tennant, to discuss. (Tel: 0141 761 4876 or e-mail evonne.tennant@eastdunbarton.gov.uk). I look forward to hearing from you!

Remember, all Southern Centre events count towards the REHIS Scheme of Continuing Professional Development, important for individual professional development and for progression towards, and maintenance of, Chartered status!

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LAUNCH OF NEW REHIS JOINT AWARD: ELEMENTARY CERTIFICATE IN CONFLICT MANAGEMENT

by Graham Walker, Director of Training

Where a standard REHIS qualification is not appropriate, we work with a partner to develop a sector or organisation specific qualification which can be certified by the Institute.

This new short course covers conflict management and personal safety awareness. It is designed to provide safety information and strategies to people working in a wide range of jobs. Developed as a joint award in conjunction with an organisation called Tactics Management, the course covers the following areas:

- How to recognise the physical signs of aggression
- How to deal with situations in the workplace, in the street and in clients' homes
- Understand how conflict and stress can affect your performance at work
- Explore strategies and techniques available to help manage situations of conflict
- Learn and practise basic but effective breakaway techniques.

Participants will have an increased awareness of their strengths and weaknesses in relation to dealing with conflict and aggression. They will also gain adequate knowledge of how conflict can begin and escalate and what options they have to effectively manage conflict in the workplace.

The course is expected to appeal to people working with people and can be individually designed to suit your organisation's needs. This course can help you keep your organisation and your employees safe. Occupations where employees come into contact with clients or members of the public, either in person or over the phone, would benefit the most. Reception staff, emergency services' support staff, carers and those involved in the service industry can all benefit from attending this course and obtaining the REHIS approved Elementary Certificate in Conflict Management.

Joint awards are qualifications which have been designed to meet the specific skills needed by the partner organisation/sector. The partner organisation determines the skills required and the level; REHIS provides the certification for the course and the appropriate award. The Institute applies the same level of quality assurance to joint awards as it does to its own courses.

For further details contact me at the REHIS office on 0131 225 5444 or gw@rehis.com.

REHIS ROADSHOWS 2006

by Tom Bell, Chief Executive

The Institute presented a series of six roadshows across Scotland to highlight its role in promoting environmental and public health and to promote the growing importance of Continuing Professional Development (CPD) for all environmental health professionals. The roadshows were presented in Ayr, Edinburgh, Dundee, Elgin, Aberdeen and Glasgow on separate dates between the end of April and the beginning of June. While aimed primarily at existing members, many non-members, working in Scotland's wider environmental health community, attended the roadshows.

The Institute was reprsented by John Stirling (President), Bernard Forteath (Senior Vice President), Tom Bell (Chief Executive), Val Cameron (Director of Professional Development) and Graham Walker (Director of Training) with the latter three presenting brief papers.

I outlined recent developments in environmental health in Scotland including the launch of Chartered status for Environmental Health Officer (EHO) members, the introduction of the ban on smoking in public places across Scotland, the developing relationship between REHIS and the Scottish Executive and Scottish Parliament, the re-launch of the REHIS website and the Institute's response to the recommendations made in the Old Report which was published earlier in the year. In my presentation I praised the EHO members who had attained and maintained Chartered status and reminded them that Chartered status was not elitist, as some on the periphery of the Profession have implied, but was a demonstration of each individual's commitment to maintaining and developing their knowledge, skills and competence through compliance with an externally audited Scheme of CPD. Surely any employer should recognise the benefits associated with a member of their staff gaining Chartered status and should be aware of the benefits to them.

Val Cameron's paper covered the benefits of the REHIS Schemes of CPD for EHO and for non-EHO members, Chartered status for EHO members, training and education initiatives for all environmental health professionals and the Institute's role in the United Kingdom Voluntary Register for Public Health Specialists (UKVRPHS). Any member wishing further information on how to comply with the REHIS Schemes of CPD, on becoming a Professional Examination examiner or on registering with the UKVRPHS should contact Val at the REHIS office.

Graham Walker's presentation covered an update on the community training activities of the Institute and of its courses and network of training centres 'from Lerwick to Chichiri'. Graham also advised those present that the recently launched Elementary Food and Health Course was proving to be very popular with the Institute's community of trainers. Anyone interested in presenting one of the REHIS training courses or in becoming an examiner for any of these courses should contact Graham at the REHIS office.

The Council of the Institute takes this opportunity to thank all who contributed to the success of the roadshows especially those involved in the hosting of each event. The success of the roadshows was enhanced by the enthusiasm of those who attended and who actively participated in the question and answer sessions that brought the events to a close.

If you were unable to attend one of the roadshows and would like a copy of the presentations made please contact the REHIS office. If you are interested in hosting a roadshow in your area at some time in the future please also contact the REHIS office.

REHIS WEBSITE

www.rehis.org

Have you visited the re-vamped REHIS website? Member and trainer log-in information is available from the REHIS office.

REHIS/SFSORB PROFESSIONAL EXAMINATIONS

7/8/9 November 2006
Ramada Jarvis
Mount Royal Hotel, Edinburgh

MEMBERSHIP, EDUCATION AND TRAINING COMMITTEE

by Robert Howe, Chairman

The Committee's meeting on 15 February dealt with a variety of issues including:

Centres

The Southern Centre event on anti-social behaviour noise held on 9 February had received positive feedback demonstrated by the over-subscription for the event. In light of this success the Centre Management Committee has undertaken to consider a larger venue for future events.

Professional Courses

The new professional development team of Val Cameron and Jennifer Watkins is in place and is now responsible for the organisation and delivery of professional courses. The new team possesses the skills required to enhance the Institute's work in this important area.

The Health and Safety Update Course held in Cumbernauld in September 2005 received positive feedback from the 43 delegates. The HACCP for Auditors' Course and the Food Update Course took place between February and May 2006.

CPD Training Provision

As a new and welcome initiative the Institute has arranged a number of roadshows aimed at promoting the work of the Institute and encouraging participation in the CPD scheme. The roadshows took place between March and June and, dependent on demand, may be rolled out further later in the year. Members are urged to attend these events and encourage non-members to come along with a longer term view of joining the Institute.

Promotional Campaigns for Membership

The Institute has produced a membership information/ promotional leaflet. The leaflet will be used to attract new members and to promote the key role it plays in protecting and improving public health.

Community Training

The Institute continues to be extremely active in the provision of community training and the Director of Training advised the Committee that 38,871 and 37,341 course certificates had been issued for a range of courses during 2004 and 2005 respectively. Details of the courses are as follows:

Course Certificates Issued	**2004**	**2005**
Introductory Food Hygiene	3,540	2,744
Elementary Food Hygiene	30,667	30,583
Intermediate Food Hygiene	931	707
Advanced Food Hygiene	80	74
Elementary Health & Safety	3,615	3,149
Intermediate Health & Safety	35	37
Advanced Health & Safety	0	0
Introduction to HACCP & Hazard Analysis	0	22
Intermediate HACCP Practices	3	25
Total Certificates	**38,871**	**37,341**

The Director of Training presented a comprehensive report on a range of courses and initiatives being run in 2006 including a joint programme with Tactics Management to set up a joint award in conflict management which was agreed subject to fine detail being agreed between the Director of Training and Tactics Management. The demand for training certificated by REHIS remains at a high level and it is encouraging that we are attracting new courses.

The Membership, Education and Training Committee has responsibility for:

- *Centres*
- *Matters regarding Community Training*
- *Professional Courses*
- *CPD Training Provision, except for scheme monitoring*
- *Promotional campaigns for membership of the Institute.*

ENVIRONMENTAL HEALTH PROMOTION COMMITTEE

by Paul Bradley, Chairman

The Committee has not met since my last report but I can report progress on a few projects.

The Annual Report *Environmental Health in Scotland 2004/5* has been published. Copies were distributed to local authorities and the report is available on the REHIS website. Anyone who would prefer a paper copy should contact the REHIS office.

The response to the consultation on the future content of *Environmental Health in Scotland* was disappointing. However, based on the responses received, a few content changes will be made for this year's questionnaires and these will be sent out soon. I would thank all of those who responded to the consultation.

The Institute's Journal continues to be an important service to members and the Manor Place team is working on the next edition. As usual I would encourage regular and, particularly, new contributors to send in any articles that they think may be of interest to the wider membership.

The Institute's website offers, through the bulletin board, a useful tool to allow members to share information and advice on professional matters. It has been encouraging to see that some members are making good use of the facility, particularly to discuss smoking control enforcement, but the facility could be better used if more members became involved.

The Environmental Health Promotion Committee has responsibility for:

- *Matters regarding environmental health of a technical nature, with the exception of education, training and professional practice*
- *Responses to consultation and other similar exercises from Government Departments, etc, with the exception of those regarding education, training and professional practice*
- *Matters regarding the establishment and organisation of Technical Working Groups with the exception of the appointment of Council representatives to these Groups*
- *All Institute publications with the exception of documents concerning the AGM and the Community Training/Scheme of Practical Training Documents*
- *Promotional campaigns, except for the promotion of membership of the Institute.*

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REHIS
ANNUAL CONFERENCE
AND AGM

22-24 NOVEMBER 2006

MENZIES GLASGOW HOTEL

A RESPONSE TO THE MORRIS - ROBERTSON REPORT 'ENVIRONMENTAL HEALTH IN SCOTLAND AND THE HEALTH IMPROVEMENT CHALLENGE'

Presented by the Project Steering Group, chaired by Dr David Old
A report commissioned by the Royal Environmental Health Institute of Scotland, February 2006

Executive Summary

In the 21st century there are many health challenges facing Scotland. The nation's health is poor, with an apparent chronic burden of disease and enormous health inequalities among the different sectors of society. In response to these challenges the Scottish Executive produced a key policy document 'Improving Health in Scotland - the Challenge' (1). That document highlighted the view that Scotland's poor health record cannot be altered by curative medicine alone, but rather by the collaboration of the many agencies involved in influencing the lifestyles and life circumstances of the population. The role of local authorities in the challenge was clear, but less evident was the role that environmental health could play in meeting this challenge. The Environmental Health Profession was acutely aware that, having suffered a period of decline, the health improvement policy was another opportunity for them to be fully engaged in the public health debate.

In response to this perceived opportunity the Royal Environmental Health Institute of Scotland (REHIS) commissioned consultants (Professor George Morris and Mrs Ruth Robertson) to produce a report that it hoped would provide recommendations as to how the environmental health community could engage fully with the health improvement challenge. That report, entitled 'Environmental Health in Scotland and the Health Improvement Challenge'(2) was duly delivered in November 2003.

Based on a recommendation contained in that report, REHIS convened a small Project Steering Group (PSG). The remit of the Group was to provide REHIS with an independent assessment of the Morris - Robertson report and to suggest priorities for future action. The PSG consisted of a cross-section of the environmental health community in Scotland. The independence of the group was further enhanced by the appointment to the PSG of a Chairman who had no previous links with environmental health but who was eminent in the public health field.

The PSG met during 2005 and early 2006 and decided, at one of its initial meetings, to consider the recommendations of the Morris - Robertson report in terms of 'Identity', 'Territory', 'Communications and Promotions' and 'Competencies and Training'. The main group and small 'focus' groups deliberated on these areas of work. As a result of these deliberations, the PSG was in a position to produce a number of recommendations that are contained in the main report.

It was felt, however, that to assist further the commissioning Council, it would be prudent to hone these recommendations into five priority actions, which are detailed below and these should be viewed as areas of work requiring immediate attention.

The priority actions are:

- **The adoption of the PSG Public Health Communications Strategy;**
- **The commissioning of an Education and Training Needs Analysis (ETNA) of the environmental health workforce to ensure that it is competent and confident to meet the health challenges of the 21st century;**
- **The consideration and implementation of methods to catalyse the necessary culture change in the environmental health community to ensure the acceptance of the health improvement agenda as pivotal for the survival and future growth of the environmental health profession;**
- **The fundamental review of current and future resources within REHIS. The PSG is aware that its recommended actions will require investment in monetary and staff terms;**
- **The formation of a Scottish Environmental Health Advisory Group. Such an advisory group would provide a focussed and strategic approach to environmental health in Scotland by ensuring effective collaboration and communication among all stakeholders.**

The PSG is acutely aware that a two-year period had already elapsed since the presentation to REHIS of the original Morris - Robertson report. The public health arena is evolving and changing at a relentless pace, with the health workforce being currently reviewed by a number of organisations. If the environmental health community aspires to being full players in health improvement work, then the time to act is now.

1. Background

Environmental health has always been a practical discipline. It has made a positive and identifiable contribution to the nation's health. The defining feature of the environmental health professional has been a focus on changing or preserving the physical environment as a means of achieving public health goals.

However, the profession in recent times has suffered diminishing fortunes, losing seniority and influence within its traditional institutional setting of local government. Environmental health is increasingly relegated to a rather narrow statutory role, driven by pressures to meet performance management targets which generally relate loosely, if at all, to Scotland's priorities for health. This situation coincides with the clearest articulation from government for many years, of the health challenge facing Scotland. The nation's health is poor, with an apparently intractable burden of chronic and infectious disease and enormous health inequalities among different sectors of society. The Scottish Executive response has been to present the circumstances as a Health Improvement Challenge within 'Improving Health in Scotland - The Challenge'(1). Full participation in this new agenda would allow environmental health as a discipline and as a profession to raise its profile in the public health arena.

This potential opportunity for environmental health has been recognised for some time by the Royal Environmental Health Institute of Scotland (REHIS) (Appendix 1).

REHIS recognised that the multidisciplinary environmental health workforce had an important role to play in helping to meet this health improvement challenge.

To consider how best the environmental health profession in Scotland could fulfil this role, the Institute decided that it would commission external consultants to undertake a report on how REHIS and the professionals, who are its members, could assist in meeting this challenge.

The result was the production of a report by the consultants (Morris and Robertson) in November 2003 entitled 'Environmental Health in Scotland and the Health Improvement Challenge'(2).

The report was received positively by the Institute and the wider environmental health community. After considering the recommendations of the report (Appendix 2), the Institute's governing Council decided that REHIS should accept the challenges contained in the report, and, accordingly, sought a mechanism to guide its response.

A major recommendation of the report was the setting up of a Project Steering Committee to provide independent advice to REHIS on a way forward in implementing the report. The Council agreed to the formation of such a group.

2. The Project Steering Group (PSG)

a) Remit

The PSG that was subsequently formed should be recognised as the first group commissioned by REHIS to review and assess independently the recommendations of the Morris - Robertson report for the purposes of future implementation.

In its commissioning documentation (Appendix 3), the Institute specified in the Terms of Reference that the PSG should, in the context of the Health Improvement Challenge, undertake twenty specific tasks (Appendix 4), as referred to in paragraph 1 of the Terms of Reference.

The PSG comprised a cross-section of the environmental health community in Scotland in terms of experience and where that experience had been obtained. The composition of the group is different from that which was suggested in the Morris - Robertson report, which had envisaged a more strategic group consisting of representatives from stakeholder organisations. The future formation of such a group will be discussed later in the report. However, what is apparent is that the initial decision by REHIS to convene this small, short-life, independent Project Steering Group was prudent as it would have been premature to have convened a strategic group before any detailed discussion of the consultants' report had taken place.

At an early stage the PSG realised that it could not undertake many of the tasks allocated to it. Contact was made with REHIS to advise the Institute of the tasks that would have to be referred to the Institute on the basis that the Group had neither the capacity nor the authority to undertake them. The tasks referred back to REHIS are listed at Appendix 5.

b) Membership

Chairperson

The key appointment within the Group was the position of Chairperson, someone who had to be seen as an 'independent, non-environmental chair with a strong background across the range of public health competencies'. Dr David Old was appointed by REHIS to the Chair of the PSG. Dr Old is a well-known and respected professional in the public health community with particular expertise in medical microbiology, including infection control and health care acquired infection.

Executive Secretary and Minute Secretary

Ruth Robertson, a co-author of the original (Morris - Robertson) report, agreed to act as the group's Executive Secretary. Mrs Robertson is Environmental Health Adviser with Health Protection Scotland.

Michael Halls agreed to provide administrative support as Minute Secretary. Mr Halls is a retired Director of Environmental Health and currently acts as Honorary Secretary of the International Federation of Environmental Health.

PSG Members

Tom Bell, now Chief Executive of REHIS, in consultation with the Chairman, selected the other PSG members. The full membership of the group is as follows:

- John Beveridge, Chartered EHO, Environment and Business Adviser in private practice;
- Karen Budewig, formerly Specialist Registrar in Public Health, Scottish Executive Health Department, now working in Germany;
- Dr David Cameron, Managing Director and Consultant in Food Safety in private practice;
- Karen Foote, EHO, Aberdeenshire Council;
- Tony Grimason, Head of Environmental Health, University of Strathclyde;
- Drew Hall, Principal EHO (Environment), Inverclyde Council and Chairman of REHIS Public Health and Housing Working Group;
- Morgan Sales, Undergraduate Student EHO at University of Strathclyde, employed by Shetland Islands Council;
- Sandy Taylor, Chief EHO, Argyll and Bute Council;
- Evonne Tennant, Chartered EHO, East Dunbartonshire Council;
- Lorraine Tulloch, formerly Team Leader, Public Health, Glasgow City Council, now Senior Policy Officer, Air Quality, Greater London Authority;
- Jennifer Watkins, formerly EHO with City of Edinburgh Council, now with REHIS as Professional Development Officer.

A record of the attendance of members at meetings of the PSG is contained in Appendix 6.

c) Workings

The PSG met on eight occasions during 2005 and once in 2006 and the minutes of all of the PSG's meetings are contained in Appendix 7. In order to complete its assigned tasks, three subgroups were established to look in detail at three areas:

- Identity and territory;
- Communications and promotion; and
- Competencies and training.

The minutes of the meetings of two of the subgroups are to be found in Appendices 8 and 9.

Throughout the discussions that took place, an awareness emerged that some of the ideas that the Group were formulating might not be unique and might well be in the corporate mind of REHIS as matters that it had already determined to do; nonetheless, the PSG felt that it would be useful to reiterate these ideas.

Each subgroup consisted of a small number of PSG members and subsequent recommendations made by these subgroups were discussed and approved by the full PSG. These recommendations are detailed in section 3 below.

To assist further the commissioning body, the PSG carried out additional work to present these recommendations in terms of five priority actions, which appear in section 4 below. These priority actions should be seen as requiring immediate attention and they are the key outputs of the PSG considerations.

3. Recommendations

The recommendations are as follows:

IDENTITY

Recommendation 1

The identity of environmental health, as originally suggested in the Morris - Robertson report and further endorsed by the PSG, should be accepted

by REHIS and used, as and when appropriate, in its pursuit of a clear recognition of the role of environmental health. The definition of environmental health is as follows:

"Environmental health is that area of public health activity which strives to improve, protect and maintain health and well being through action on the physical environment."

TERRITORY

Recommendation 2

The definition of territory as originally described in the Morris - Robertson report should be accepted by REHIS. Thus the following definition was approved by the PSG:

"The activities comprising what the report terms 'the protective envelope', that is, activities which explore the relationship between the physical environment and health and which describe, in respect of different aspects of the environment, what is acceptable and unacceptable in terms of health, together with activities which are concerned with controlling those environments in order to preserve, protect and improve human health.

The integrity of the protective envelope is maintained and developed through input from a number of players of which the environmental health professional is but one."

Recommendation 3

The PSG also felt that a more discursive definition of territory would be helpful for the purposes of REHIS. Thus the following definition was approved by the PSG:

"Environmental health is involved in exploring the relationships (both positive and negative) between the physical environment and health, and in controlling aspects of the environment to preserve, protect and improve health and well-being. One way of visualising this is to think of the activities of environmental health as providing a protective envelope for the physical environment. The envelope comprises four key areas (see figure below). To identify those aspects of the environment which we should control, we need adequate information in the form of biological and epidemiological evidence. Biological evidence is assembled from insights across the field of science and medicine. Epidemiological evidence allows the study of possible health effects of exposures at a population level as well as the effects of any intervention targeting their reduction or removal. The remaining key areas relate to how to use this evidence to achieve change, identifying the interventions, which are available to limit or mitigate against the effects of exposure (for example, legislation or fiscal control) and the way in which such interventions can be monitored and policed."

It can be seen, therefore, that the primary focus of environmental health activity is to ensure the integrity of this protective envelope and a healthy physical environment.

COMMUNICATION

Recommendation 4

REHIS should adopt the Public Health Communications Strategy devised by the PSG (see Appendix 10) and should engage with identified stakeholder groups, as recommended in that strategy. It is essential that the strategy is kept up to date and that it be reviewed annually.

The public health agenda holds the future of environmental health, within a territory of the physical environment and health. For this to be recognised, a culture change within REHIS is necessary. The environmental health profession and the REHIS membership must comprehend that public health is the umbrella agenda under which REHIS and the profession should operate. The adoption by REHIS of a communications strategy is a crucial step in achieving this. The PSG felt that the Institute's existing vision and objectives are now outdated and need to be revisited. In reaching its conclusions in terms of communication, the subgroup had regard to the advice given by a public relations expert whose views are summarised in Appendix 11.

Evidence		**Levers for Change**	
Biological	Epidemiological	Mode of intervention	Means of intervention

The Protective Envelope - Adapted from Morris and Robertson (2)

The acceptance of this recommendation will help to ensure that:

- REHIS, the Profession and other stakeholders recognise the primary role of environmental health within public health in Scotland;
- REHIS provides an inclusive and focussed approach to environmental health promotion;
- REHIS becomes a revitalised Institute and impacts similarly on the Environmental Health Profession; and
- REHIS becomes more proactive.

REHIS has a number of strengths that can be relied upon to help it achieve these goals. The strengths include the fact that it is the only national body for environmental health in Scotland. It is the Professional accrediting body, has recently acquired its Royal Charter and has the facility for its members to become Chartered EHOs.

It is for REHIS to decide how to take forward the proposed Public Health Communications Strategy but the PSG feels that perhaps an existing Committee or Committees could be given the task or that an internal working group could be convened.

REHIS might wish to explore the possibility of the PSG (or some of its members) assisting in the longer term with the Public Health Communications Strategy.

Recommendation 5

REHIS should establish an internal working group or Committee (it may be appropriate to use an existing Committee for this purpose) to be tasked with long-term policy development and communication within national frameworks for different environmental health subject areas. The work of such a group should, of course, be undertaken in sympathy with the visions of the Communications Strategy.

The acceptance of this recommendation will help ensure:

- Clarity in REHIS's policy stance in specific interest areas;
- Direction in REHIS's future development including training;
- An agreed platform for REHIS spokespersons; and
- A source for proactive promotional action.

Recommendation 6

REHIS needs to establish closer links with the Society of Chief Officers of Environmental Health in Scotland (SoCOEHS) to develop a shared vision for the profession in Scotland. This might involve sharing costs for the additional resources needed to promote and communicate environmental health as a public health profession.

The acceptance of this recommendation will ensure:

- The provision of an inclusive vision;
- A shared vision which will impact at both national and local government level;
- Production of national policy, guidance, best practice, etc;
- Effective use of the limited resources of both organisations;
- The development of shared actions; and
- Less division on topics of importance at the national and Scottish levels.

Recommendation 7

REHIS should encourage the production of publications to promote its public health role, ie, the quarterly magazine, the website and the proposed electronic newsletter. Considerations might be given to extending the circulation of the magazine and electronic newsletter to wider stakeholder groups, or the possibility of producing a completely separate stakeholder newsletter. A person employed in the role of editor for the magazine and any newsletters is further recommended. It may be necessary for a new employee(s) to be appointed within REHIS to take forward this recommendation.

The acceptance of this recommendation will ensure that:

- Resources are available to deliver effective communication and promotion to relevant stakeholders;
- REHIS's role in the public health territory is supported; and
- There is potential to increase income via adverts, etc, and added interest in the Institute's services.

The new employee(s) might be, for example, a Project Manager and/or a Public Relations Person (possibly with administration or editorial skills). There is the potential for this latter post being shared with SoCOEHS, for media handling, press releases and promotional publications about the Profession.

REHIS should also consider redirecting their existing media-handling budget into these staffing costs.

Recommendation 8

Sentinel projects should be developed as suggested in the Morris - Robertson report. These projects should:

- Involve partnership working;
- Be topical and appropriate to current policy/ thinking;
- Seek to improve the health of the public;
- Be measurable; and
- Raise the profile of environmental health.

Ongoing supervision of the sentinel projects by a longer-term PSG (or its constituent members) should be considered. Promotion of the sentinel projects should be fed back through the Public Health Communications Strategy. Short-term secondment of environmental health professionals to lead the sentinel projects should be considered. Agreement should be sought through SoCOEHS for staff secondments. Consideration should be given to developing a sentinel project centred on the EU and WHO Environmental Health Action Plans policies.

The acceptance of this recommendation will ensure that:

- REHIS, and the role of the profession within the public health territory, are under-scored;
- Future policy development is enhanced; and
- Opportunities arise for interaction with other agencies.

COMPETENCIES AND TRAINING

Recommendation 9

In order to promote a confident and competent workforce in environmental health, REHIS should consider formulating a framework for workforce education development.

Such a framework would allow the environmental health community to build action plans for facilitating, delivering and evaluating workforce education development activity for staff.

The acceptance of this recommendation will help to ensure that:

- Staff can access appropriate education opportunities to enable them to develop their competencies on an ongoing basis;
- Organisations avoid the risk of duplicating the efforts of others; and
- Opportunities for organisations to work in partnership to deliver workforce education development are increased.

It is suggested that the Framework for Workforce Education Development for Health Protection in Scotland, which is currently being developed by Health Protection Scotland in partnership with NHS Education (Scotland), might be a useful tool for the development of that framework (the source for accessing the draft is given in Appendix 12).

The adoption of this recommendation would entail the allocation of significant financial and human resource to develop the strategy and to undertake the Educational and Training Needs Analysis (ETNA).

It is also suggested that during the development of such a framework the following issues should be considered:

- The need for the evidential base in environmental health to be strengthened;
- The work being done by other groups within public health, which may be looking at competencies - for example, the Public Health Workforce Partnership Group that is currently meeting and is chaired by the Scottish Executive; and
- Specific areas of training such as epidemiology, IT, research skills and community development.

Recommendation 10

An appropriate REHIS Committee, in collaboration with the SoCOEHS, should review the REHIS Practical Training Manual for Student and Graduate Trainee Environmental Health Officers.

Any such REHIS Committee and SoCOEHS may wish to:

- Consider the findings from any ETNA study of the environmental health workforce;
- Review the findings of the US Public Health Association study on ‘Core Competencies for Local Environmental Health Practitioners’ (the source for accessing this document is given in Appendix 13); and
- Consider any recommendations on core competencies, which may be made by the Public Health Workforce Partnership Group, or another group.

There is little doubt that the findings from such a review would benefit all environmental health degree courses accredited by the Institute.

The PSG recommends that REHIS should continue to liaise with the Chartered Institute of Environmental Health in all aspects of competencies and training.

Recommendation 11

REHIS should consider at an early stage the development of an MSc in Environmental Health by instruction and/or distance learning to:

- Address, in part, the shortage of practising Environmental Health Officers in Scotland;
- Meet the needs of many life-science graduates (some of whom are already members of REHIS) currently working within the environmental health workforce, but not as Environmental Health Officers; and
- Enhance the environmental health professions by providing additional professional skills and knowledge.

FORMATION OF A SCOTTISH ENVIRONMENTAL HEALTH ADVISORY GROUP

Recommendation 12

The PSG would strongly recommend that REHIS seeks the establishment of an advisory group to provide a forum for independent experts to discuss and identify measures to ensure that the environmental health profession participates fully in the public health arena and suggests that it be entitled the Scottish Environmental Health Advisory Group. It is envisaged that this group should be formatted as the original Project Steering Committee was described in the Morris - Robertson report. Although the PSG would not necessarily advocate that REHIS provide the secretariat for this group it feels that REHIS should be prepared to take a lead in its formation.

The acceptance of this recommendation will help ensure that:

- A number of influential bodies with a health remit, including the Scottish Executive, have regular dialogue with REHIS and the Environmental Health Profession;
- REHIS is able to influence national policy development in public health; and
- REHIS is seen as a body that recognises the importance of public health and is able to deliver commitment and support to health improvement policies.

4. Priority Actions

The PSG is aware that the simultaneous implementation by REHIS of all of the above recommendations might be unrealistic. As a means of further assisting the commissioning organisation, the PSG decided to condense its recommendations into priority actions - that is, actions that, in its opinion, REHIS should address immediately. This, of course, does not mean that the other recommendations should be ignored but merely that taking action in these priority areas should be the first stage in the implementation of the work of the PSG.

There are five priority actions, which are:

- **REHIS should adopt the Public Health Communication Strategy as detailed in Appendix 10 of this Report. The aim of this Strategy is to communicate and promote the environmental health profession with all stakeholder groups as defined in the strategy document. This will assist in policy formation and enable the Institute to engage fully with appropriate stakeholder groups to promote the environmental health profession as a major player within public health in Scotland;**
- **REHIS should seek to commission an Education and Training Needs Analysis to ensure that the environmental health community is competent and confident in meeting the new challenges ahead;**
- **The public health agenda holds the future of environmental health, within a territory of 'the physical environment and health.' The consideration and instigation of work that will allow this culture change within REHIS to begin is crucial because, without the commitment of the environmental health community as a whole to this new agenda in public health, it is difficult to envisage real progress being made;**
- **REHIS must fundamentally review its current resources and give serious consideration to the funding of the**

recommendations of the PSG, as without sufficient dedicated staff and monies being made available the achievement of full participation in the public health debate will fail;

- **Advocate for the formation of a Scottish Environmental Health Advisory Group in line with the original suggestion for a Project Steering Committee in the Morris - Robertson report.**

5. Conclusion

In setting down the recommendations and priority actions in this report, the PSG considers that it has completed the tasks that it felt it was in a position to undertake. The PSG would stress to REHIS the need for urgent action, because the Environmental Health Profession and discipline cannot afford another two years to elapse before further action is taken.

The strong view of the PSG is that now is the time to act if the environmental health community wishes to meet the health improvement challenge.

6. References

1. Scottish Executive. Improving Health in Scotland - The Challenge. 2003. Scottish Executive. http://www.scotland.gov.uk/Publications/2003/03/16747/19929.
2. Morris G, Robertson R. Environmental Health in Scotland and the Health Improvement Challenge: a report commissioned by the Royal Environmental Health Institute of Scotland. November 2003. The Royal Environmental Health Institute of Scotland.

7. Appendices

A list of appendices and copies of the appendices are available from the Institute's office on request.

THE DIRECTIVE ON ENVIRONMENTAL NOISE (END)

Directive 2002/49/EC - more commonly known as the Environmental Noise Directive (END) concerns noise from road, rail and air traffic and from industry. It focuses on the impact of such noise on individuals, complementing existing EU legislation which sets standards for noise emissions from specific sources. The aim of the END is to define a common approach across the European Union with the intention of avoiding, preventing or reducing on a prioritised basis the harmful effects, including annoyance, due to exposure to environmental noise.

This will involve:

- informing the public about environmental noise and its effects;
- the preparation of strategic noise maps for: large urban areas (referred to as 'agglomerations' in the END), major roads, major railways and major airports as defined in the END; and
- preparing action plans based on the results of the noise mapping exercise. Such plans will aim to manage and reduce environmental noise where necessary, and preserve environmental noise quality where it is good.

Agglomerations

In Scotland there are two designated major agglomerations namely Glasgow and Edinburgh. These agglomerations are the first to be mapped and the non-major agglomerations to be mapped in 2012 include; Dundee, Falkirk and Aberdeen. Once prepared the noise maps will show the levels of the predicted noise levels within the agglomerations.

A key purpose of the END is the collection of data on the noise climate across Europe by harmonised means with a view to inform future policy.

This article appeared originally on the SEPA website.

Stop Press:

The Institute's response to Dr Old's PSG recommendations will shortly be published on the website (www.rehis.org). Hard copies will be available from the Institute's office on request.

REHIS HEALTH & SAFETY UPDATE COURSE 2006

26-28 September
Westerwood Hotel, Cumbernauld

SCOTTISH FOOD SAFETY OFFICERS' REGISTRATION BOARD

by Colin Wallace, Chairman

The list of previous Chairmen contains the names of many illustrious individuals. Our current President, John Stirling, has held the post of Chairman twice and has been a staunch supporter of the Board since its inception. John has always been very active and his encouragement influenced me to accept the post. Thanks John, I think!

As there have been several personnel changes in recent times, it would be useful for me to list the full membership of the current Board:

- Colin Wallace (REHIS)
- Ron Dunn (REHIS)
- Sandy Fraser (REHIS)
- Peter Midgley (Food Standards Agency Scotland)
- Rod House (REHIS)
- Nicola Gauld (Scottish Food Safety Officers' Association)
- Angus Lowden (Association of Meat Inspectors)
- Professor Kofi Aidoo (Institute of Food Science and Technology)
- John Stirling (REHIS).

One of the most important individuals involved in the Board is the Secretary, and the amount of support the Board receives through the Secretary's involvement with external bodies and the provision of the necessary backup in relation to administrational aspects is invaluable.

Latterly the Board has seen an increase in the number of applicants for the Ordinary Certificate in Food Premises Inspection, and the recently developed matrix allows accurate assessment of the minimum academic requirements. There is, however, no automatic progression from the Ordinary to the Higher Certificate. The pre-entry academic qualifications for the Higher Certificate must equate to HNDs in Food Technology or Food Science, or better. To assist candidates in bridging what is a potential gap, investigations are currently underway to explore alternative avenues of approved study at educational establishments. If this initiative proves fruitful, candidates will be able to have their existing qualifications assessed and be advised on what and how supplementary modules can be obtained to provide equivalence, thereby satisfying the Board's minimum entry requirement. The Board is keen to provide as many avenues as possible to improve career development and has also considered, assessed and approved a number of other equivalent qualifications.

Work is in progress on the consideration of the new qualification concerning the Inspection, Detention and Seizure of Food, otherwise known as the Higher Certificate in Food Control, for which the Board will be the awarding body for Scotland.

The Scottish Food Safety Officers' Registration Board has responsibility for:

i. All matters relating to the examinations for the Higher Certificate in Food Premises Inspection, Ordinary Certificate in Food Premises Inspection and Higher Certificate in Food Standards Inspection

ii. Matters regarding the pre-entry/pre-registration academic standard leading to entry to the practical training programmes for the examinations at i. above

iii. All matters relating to the practical training programmes for the examinations at i. above

iv. Liaison with the Food Standards Agency and with other awarding bodies offering equivalent qualifications as i. above.

HEALTH PROTECTION SCOTLAND - NEWS UPDATE

by Rod House, Consultant in Environmental Health, Health Protection Scotland

Introduction

April saw Health Protection Scotland (HPS) in partnership with REHIS hosting a Communicable Disease update attended by 66 delegates in Glasgow. Topics covered included Avian Influenza, Pandemic Flu Planning, Infections Update including E.coli and Foodborne Infections, Travel Medicine and the International Health Regulations.

Feedback suggests that the update was well received by environmental health colleagues and it is hoped to provide a similar update sometime in 2007. Thanks go to the REHIS President and Senior Vice President for chairing the morning and afternoon sessions.

Legionella

Following the publication of the report on the investigation of the legionella outbreak at Rosyth, the Scottish Executive asked HPS to consider available expertise in Scotland, availability of current guidance, training field officers in investigation and the control of legionella in water systems, etc. HPS is currently establishing an Expert Group drawing from public health, environmental health, laboratories, industry and the Health and Safety Executive to consider the key issues. REHIS members will be kept updated on the progress and outcomes from the Group but it is anticipated that update training for officers will form part of the outcomes and key tasks which will be identified.

Campylobacter Case Control Study

HPS, in collaboration with NHS Grampian Department of Public Health and the Department of Medical Microbiology, University of Aberdeen, is conducting a case control study to investigate the role of private water supplies as a risk factor for *campylobacter* infection. The study is funded by the Food Standards Agency Scotland and the Drinking Water Quality Division of the Scottish Executive. The pilot study commenced in August 2005 and the full study started in November 2005 and will run for two years.

The study consists of two parts; the first is a questionnaire sent to laboratory confirmed cases of *campylobacter* infection in Aberdeen City and Aberdeenshire and to frequency matched controls. The questionnaire asks about exposure to a range of factors including travel history, animal contact, food and water consumption and type of domestic water supply (mains or private supply). The second component of the study, which participants can also take part in, is to have a sample of their domestic water supply collected and microbiologically tested by the Department of Microbiology, University of Aberdeen.

Cryptosporidium Sero-epidemiology Study

HPS, in collaboration with the Scottish National Blood Transfusion Service (SNBTS) and the Scottish Parasite Diagnostic Laboratory (SPDL), is conducting a study investigating the relationship between *Cryptosporidium* seropositivity and drinking water, taking advantage of the planned introduction of more effective water treatment technology at locations within Scotland in the next few years. The main aim is to determine whether different drinking water treatment processes, which have different efficiency in removing *Cryptosporidium* oocysts from drinking water, are associated with variations in levels of seropositivity (and hence potentially to the level of immunity) to *Cryptosporidium* in the normal population.

The study design is a longitudinal study of two defined populations. The first population will reside in an area where drinking water is currently supplied from an unfiltered source, but which will be supplied at a future time, within the study period, from the same source, using a multi-barrier approach designed to reduce *Cryptosporidium* oocyst contamination of drinking water. This population will serve as its own control group. The second population will act as an external control.

The study will run for three years.

Student Training

HPS will be running its annual student training day, probably in August, and details will be issued by the REHIS office to all eligible students in the near future.

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REHIS welcomes reports of interesting court cases for publication in *Environmental Health Scotland.*

HSE LAU NEWS

by Allan Davies, Head of Local Authority Unit, Health and Safety Executive

The Local Authority Strategic Programme is almost at an end, indeed the structures that it sought to help create are substantially in place across Great Britain and nowhere more so than in Scotland. Partnership working should be the way we do our business, both at a central and local level, a message that the Health and Safety Executive (HSE) definitely wants to take on board. A message, too, that the Minister responsible for health and safety, Lord Hunt, is also keen to see delivered. At a recent Chartered Institute of Environmental Health (CIEH) conference in Newcastle, in response to a question about Ministers being more directing, like the Food Standards Agency, he responded by saying how impressed he was with the partnership approach.

The Health and Safety Commission received a report in February this year, which set out the structures established and signalled, from the responses at the consultation workshops held last November, the work that needs to be completed on Section 18 guidance. There was an overwhelming positive reaction from the Commissioners, recognising that this was the most progress in bringing HSE and local authorities closer together ever recorded.

Work continues on establishing a new S18 guidance document, which will be much clearer about the expectations of local authorities and will enable officers to establish the case for adequate resourcing. The Enforcing Authority Regulations, which it was originally thought should be repealed will be amended to deal with anomalies but will remain, a clear wish of local authority officers during the consultation exercise. However, as greater flexibility in applying the regulations is important, further work on the use of flexible warrants continues, including an evaluation of the benefits and problems. Lastly and critically, the third aspect of the consultation process, performance management, continues to develop but will be influenced heavily by other cross government work following the Hampton review. The Local Better Regulation Office (LBRO), being developed in the Department of Trade and Industry (DTI), will be focusing on performance management, and it is expected that the work already undertaken in the health and safety local authority programme will help to determine the final approach taken across Regulators. The LBRO has a national remit and the Scottish Executive will be working with the DTI to establish relevant and appropriate performance measures in Scotland.

I have said it before but it's worth re-stating, this is a 'test year' for partnership working, a huge commitment from local authorities to the FIT3 programme of work. This is the programme of work that will have a substantive impact on the Commission's priorities and demonstrate that HSE and local authorities working together is the way of the future.

In the past I believe that local authorities have not been given the credit deserved for their contribution to the health and safety agenda, in part because the reporting mechanism was entirely based upon the planned programme of inspections and didn't allow other work to be counted. It is clear that work, other than inspections, has made an impact and for the year 2005/06 the reporting format has been changed to allow full reporting. Reporting on 2006/07 will be even more critical as we will all be looking at the impact of applying the FIT3 model and priorities within the programme. The Extranet and its capabilities (a web-based data sharing tool) will be fully tested reporting on FIT3 and will provide essential information to allow for proper evaluation of the work. It is vital, therefore, that colleagues utilise all the reporting mechanisms established, the Extranet, including the HELA Training and Coord Web site and the revamped LAE1 return. These will be the means by which local authorities will be able to demonstrate their contribution, whilst we continue to work on more effective, less time-consuming means of sharing data.

Another good year ahead and the last of my contract with HSE but how things have changed in the last almost four years; the willingness of colleagues in Scotland to make changes and the determination to 'make a difference' has given me the motivation to drive the local authority programme forward. Thank you.

As always, please let me have your views.

Allan.lau.davies@hse.gsi.gov.uk.

REHIS welcomes the submission of articles for *Environmental Health Scotland*. Submissions of research-based articles are especially welcome.

PROFESSIONAL DEVELOPMENT: COURSES UPDATE

by Jennifer Watkins, Professional Development Officer

Every year REHIS organises a number of professional development training courses. It is one of the key aims of REHIS to disseminate environmental health knowledge and ensure high standards of professional practice.

Since starting working for the Institute last October, I have been busy working on a number of training courses including the Law Enforcement Course, HACCP Auditing for Enforcement Officers' Course and the Food Update Course. It has been great travelling across the country to host these events and meeting speakers and members. At this year's Food Update Course in Dunkeld we worked closely with the Food Standards Agency (FSA) to ensure that an interesting and informative programme was put together and delivered. Overall, we received very positive feedback. In particular the delegates found the workshops prepared by the FSA on the new legislation very valuable and the talk by Dr Ian Leitch on Allergens especially enjoyable.

In addition to these regular courses over the past year, we have also facilitated several training events in association with the Scottish Executive for emerging issues such as the new smoke-free legislation and the new Code of Practice on Sewage Nuisance. We were also involved in assisting the Scottish Executive to present training for the new Private Water Supply Regulations.

Court Case at the Law Enforcement Course, Tulliallan Police College, February 2006.

Training courses are an excellent way for members to keep their professional knowledge up-to-date and gain Continuing Professional Development (CPD) hours. We are finding that, following each course, many delegates go back to their workplace and conduct cascade training for their colleagues. This is an excellent way of disseminating information and ensuring all staff are suitably trained and aware of any emerging issues. Each REHIS training course is given a maximum value of CPD. This gives the delegate an indication of how many hours they can claim towards the REHIS CPD scheme. If an individual is conducting cascade training, it is beneficial to highlight to colleagues that in-house training can contribute towards the REHIS Scheme of CPD.

Sewage Nuisance Training, Glasgow, April 2006.

In addition to these training events we also run four seminars with our partner agencies specifically for the Student/Graduate Trainee EHOs. These will be held throughout August and September this year in conjunction with the Scottish Environment Protection Agency, Health Protection Scotland, Food Standards Agency and Scottish Water.

At each training event we actively ask delegates for feedback on the training course. There has been a high return of evaluation forms from recent events and the comments on these forms really help us to continually review and improve the quality of training provided. In addition to the presentations, we have found that delegates particularly enjoy being able to meet and exchange ideas with others.

We are always keen to hear members' views on what training they require to enhance their professional development, so please contact us if you have any suggestions or comments.

ENHANCING SKILLS, KNOWLEDGE AND COMPETENCE

The REHIS Scheme of Continuing Professional Development for ALL members.

by Val Cameron, Director of Professional Development

During the first few months of the year, I was monitoring and assessing Continuing Professional Development (CPD) claims received from members, and I am impressed by the diversity of training and development going on across Scotland. It is gratifying that so many members are involved in training courses, seminars, degree programmes and research projects covering such a wide range of subjects.

Some of you will have had the opportunity to attend one of the REHIS roadshows, so will be up-to-date on the requirements of the CPD Scheme. However, since then, I have had a lot of enquiries about how to take part in the Scheme and what needs to be done to comply.

The CPD Scheme is quite straightforward. Throughout the year a CPD record needs to be kept of all of the CPD activities you have been involved with. The CPD record should contain research papers, diplomas, certificates, minutes of meetings, training course programmes, etc and could be kept in, for example, a file, folder or envelope. Your CPD submission should include the record card **and** copies of the evidence you have collected during the year. CPD submissions should be forwarded to the REHIS office by 31 January.

CPD activities take two forms, 'core' and 'supplementary'. Core CPD is directly related to environmental health subjects, eg, pollution, food, and occupational health and safety. Supplementary CPD includes the skills required to undertake environmental health duties, eg, IT training, budgeting and management training.

You are required to undertake a minimum of 60 hours CPD over three years, with a minimum of 15 hours per year, of which a minimum of ten hours per year must be core activity.

In some local authorities the submission of CPD records is co-ordinated by one colleague. For example, the Moray Council submitted all the CPD claims for 2005 together and all of the EHO members are now Chartered EHOs.

Remember, CPD should **enhance** your existing knowledge, skills and competence, and participation is open to all REHIS members.

For more advice and assistance, please contact the REHIS office, tel: 0131 225 5444, or Val Cameron (vc@rehis.com) or Jennifer Watkins (jw@rehis.com).

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ENVIRONMENTAL HEALTH IN DISASTERS AND EMERGENCIES (EHIDE)

by John Sleith

After the tragedy of the Tsunami last year, many Environmental Health Officers felt that perhaps more could have been done by the environmental health community to respond and offer practical assistance. As a result, a group of EHOs from the Irish Republic and England have teamed up to form a group called Environmental Health in Disasters and Emergencies (EHiDE).

The plan is to build a register of names of environmental health professionals who may be available, at fairly short notice, to deploy to emergencies to offer their services. Volunteers are, therefore, being sought for such emergency responses. Basic training would be given and the body is already working with major aid agencies such as Oxfam, Concern, RedR and the International Red Cross. These organisations view EHiDE's role as one which would augment what they do and are delighted to work in partnership. In particular they have provided speakers at two training events held in England recently.

The current list of interested volunteers is around the 80 mark. The volunteers are mostly EHOs and technical staff from Ireland, Wales and England, and expressions of interest are invited from Scotland. If demand is sufficient, a briefing session will be held in Scotland in the near future. Any REHIS member who may be interested should contact me at john.sleith@falkirk.gov.uk, or tel: 01324 504780.

THE ROYAL ENVIRONMENTAL HEALTH INSTITUTE OF SCOTLAND

The Institute was incorporated as a Company Limited by Guarantee on 16th February 1983, to give effect to the amalgamation of The Royal Sanitary Association of Scotland and The Scottish Institute of Environmental Health. The Institute was Incorporated by Royal Charter on 8th March 2001, following which the Company was wound up.

The Royal Environmental Health Institute of Scotland is a Recognised Scottish Charity, Number SC009406.

The objects for which the Institute is established, contained in Article 3 of the Charter, are for the benefit of the community to promote the advancement of Environmental Health by:

a. stimulating general interest in and disseminating knowledge concerning Environmental Health;

b. promoting education and training in matters relating to Environmental Health; and

c. maintaining, by examination or otherwise, high standards of professional practice and conduct on the part of Environmental Health Officers in Scotland.

The Royal Environmental Health Institute of Scotland is an independent and self-financing organisation. It neither seeks or receives grant aid. The Institute's charitable activities are funded significantly by the subscriptions received from its members.

The Institute's affairs are managed by a Council which is elected by members. The Royal Environmental Health Institute of Scotland is a founding member of the International Federation of Environmental Health.

The Institute frequently uses the acronym: REHIS®.

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