**Welcome**

IT IS a particular pleasure for me to welcome so many of our members, fellows and friends to Sage in Gateshead for this year’s Faculty of Public Health conference. The response has been made possible thanks to a record number of delegates registered and a meaty and stimulating programme. We must be especially grateful to our conference planning team of Mag Connolly, Dumi Vincent, Keith Carter and Church Githahama-Leh as well as our extended planning committee.

For myself it is an especially nostalgic trip back to my medical alma mater. It is exactly 50 years ago that a skinny, small, well-behind-the-ears youth from Liverpool arrived on the town at Newcastle Central Station and struggled to understand an accent, which I later came to know and love, and brave the harsh autumn fog on the Tyne to find my way up to the old medical school and a journey into adulthood and a life in medicine and public health. It was and is a remarkable place, and in the period of 1865-70, embracing as it did the summer love of 1967 and the year of global youth cultural revolution in 1968, it is amazing to be a student in this special place. How it has changed from a grimy city colonising in a forgotten post-industrial corner. It could scarcely have anticipated the vibrant European metropolis that Newcastle/Gateshead and the rest of the Tyne and Wear region has become today. But beneath the sophisticated surface, the challenge of economic disadvantage and health inequality remains as stark as ever. There is much public health work to be done. Fortunately the Government inclined to public health action has never been far away. John Snow came to Newcastle from York, where he was born, in 1827 at the age of 14 to be apprenticed to Dr George Hetherington, a surgeon-apothecary. This apprenticeship lasted six years during which he had his first encounter with cholera during the 1832-33 outbreak, and he also became an active member of the temperance movement. Then, as now, alcohol was clearly a major public health issue in the area. We will no doubt hear more of it now in the 21st century, we are in Gateshead. He left the North East in 1836 and travelled home to York, then returned to Cambridge to start his formal medical education in London at the Hunterian School of Medicine. The rest, as they say, is public health history.

The tradition of public health, social medicine and primary care runs deep in this area. Social obelists, paediatrics and psychiatry are in the genes of medicine here. Sir James Spence set the standard when it came to a medical school taking responsibility for the children of poverty at the gates of the teaching hospital. Domiciliary family planning and day care abortion services were pioneered here and the department of family medicine was fully integrated with public health in the new curriculum which was fortunate to be exposed to in the 1960s. Newcastle boasted the first general practice training scheme in the country, the first director of children’s services and much more. In our first week of study we walked the streets and the streets under the expert guidance of Professor Johnny Walker and saw the backside of the city from the river, across the river, from the Tyne bridge to the North Sea. It made an enduring impact on many of us who pursued careers in the unfashionable areas of public health and general practice. I hope this gives a flavour of the spirit of the place for us to savour while we are here.

This edition of Public Health Today appropriately focuses on some of the areas of sexual health and wellbeing which are so close to the interests alluded to above.

As we move on in ever wider circles of public health engagement and influence and embrace more disciplines to create a truly integrated approach, what better place could there be? Let’s enjoy a wonderful and successful conference.

**John Ashton**

FROM THE PRESIDENT

**How prevention could save the health service**

AS THE Government embarks on its next five-year term, FPH welcomes the Prime Minister’s recognition of the underfunding of public health and the unsustainable costs of obesity, smoking, alcohol and diabetes — and its commitment to ensuring public health and preventable disease are at the “heart of the plan”. That plan, given form through NHS England’s Five Year Forward View in 2015, shows the Government unambiguously sets a “no brainer” - pull out all the stops on prevention, or face the music.

In truly integrated care, people keep healthy and independent as long as possible, and cross-sectoral policies reduce health- and socio-care demand. Doctors need to develop their role in preventing illness and enabling rehabilitation.

We must improve mental resilience and family and social support to help people live rewarding lives and prevent crises.

Primary care is central to preventing illness but needs more support to deliver its true potential. Creating crisis-free emergency care requires prevention of alcohol-related harms, accidents and major causes of hospital admissions such as cardiovascular disease and self poisoning. It requires attention to capacity problems caused by healthcare-acquired infections and housing and social-care problems. Indeed, all aspects of the NHS need a population medicine overview. In the digital revolution, population-based risk stratification and primary-care data extraction tools offer chances for systematic disease prevention and control of long-term conditions.

Finally, we continue to make the case for the 12 priorities outlined in our manifesto, Start Well, Live Better, which we believe will improve health and wellbeing and save lives.

**Mark Weiss**

Senior Policy Officer Faculty of Public Health

**Up Front**

**FPH launches major offensive against violence**

"VIOLENCE is predictable and therefore preventable." This simple, powerful message underlines the World Health Organization’s case for investment in violence prevention and is the bedrock of the Faculty of Public Health’s (FPH’s) developing work in this field.

"Violence is an act of war against society." This is the message carried by FPH in its manifesto, Start Well, Live Better: Stop Violence, which was launched at this year’s conference.

The paper will provide up-to-date statistics, explore violence’s different forms, outline the key risk factors and most vulnerable groups, and identify evidence-based, multi-systems approaches, community development, fostering economic and social equality, and education and training for health professionals. Interventions across primary, secondary and tertiary settings will be explored.

**Mark Weiss**

Senior Policy Officer Faculty of Public Health

**News in brief**

Fifth of teenagers trying e-cigs

Many teenagers, even those who have never smoked, are experimenting with e-cigarettes. A national study in north-west England says. A survey of more than 16,000 14-17 year-olds, published in BMC Public Health, showed one in five had tried or bought e-cigarettes. The researchers described e-cigarettes as the “a$copps of the nicotine world”.

Beaches risk water-quality failure

A record number of 183 of the UK’s beaches are at risk of failing to meet EU water quality standards this year, the Environment Agency has warned. It suggests new EU regulations will make it much harder for beaches to attain the top rating. The water of 25 beaches is forecast to be classed as “poor”.

Dutch are getting thinner

Holland is the only country for which the World Health Organization (WHO) is predicting a decline in obesity rates. WHO’s obesity report predicts 49% of Dutch men will be overweight, and 8% obese, in 2030 — compared to 54% and 10% in 2010. The overweight rates for women are expected to remain stable at about 43%, though obesity is set to dip from 13% to 9%.

School rugby plan ‘too dangerous’

A government drive to boost participation in rugby in English schools risks children getting seriously hurt, public health doctors have warned. Prof Alwyn Pollock and colleagues at Queen Mary University of London say the contact sport is too dangerous and needs to change.

Scientists artificially make heroin

Home-brewed heroin could become a reality, scientists have warned, following the creation of yeast strains designed to convert sugar into opiates. Tania Bubela, a public health professor at the University of Alberta, wrote in the journal BMC Public Health: “Scientists artificially make heroin...”

UK’s unhealthiest high streets

A league table of the unhealthiest highstreets has named Preston as the UK’s worst. The Royal Society for Public Health assembled 70 indices of the types of businesses found there. Bookmakers, loan shops, tanning salons and fast-food outlets were involved in a “negative impact” on public health, while leisure centres were deemed positive.

UP FRONT
You’ve talked about medicine being an art as well as a science. How do you see public health supporting general practice, and vice versa?

Public health and general practice are probably two of the most similar specialties. I always consider as a GP that I am predominantly a public health doctor who looks at the social determinants of ill-health and how we address them. I have always felt that public health people should lead clinical commissioning groups and be at the centre of the NHS. If we don’t take a public health perspective, what sort of perspective are we to take? That’s why I’m so disappointed by these reforms and successive governments. By taking our eye off the ball, we spend money in the wrong place.

How did you come to specialise in psychiatry?

I didn’t go into general practice straight from qualifying because I don’t think you should. It’s the sort of profession, a bit like psychiatry, that you grow into as you mature as a doctor. I did nine months in A&E and then did a medical rotation for two years and went back to A&E. Psychiatry really drew me in. I loved every job I did at the Maudsley, from child psychiatry to care of the elderly, and I thought, I must be a generalist. So I went into general practice.

My last job in psychiatry was caring for drug users. I set up a barefoot service, for drug users who did not have access to a GP, and loved the work. Working with drug users epitomises my relationship with patients. You come up against everyday sexism. It’s not the groping, because that doesn’t happen any more. Some of it was things like you’d have a meeting, but the real meeting would happen afterwards over a bottle of whisky. And you just couldn’t be there, because you had family. Or discussions on the football terraces, which still happens to a certain extent.

I have experienced racism. I think more, though, I’ve just faced it with an elderly patient who I’ve known for 25 years. She’s now blind. I can sit down in front of her and she recognises my voice because of our relationship. That’s what general practice is about.

I had an expertise in mental health, substance misuse, general practice, clinical governance and the regulatory framework. So, when the tender for running a new sick-doctor service was put out [in 2007] it cried out for me to apply. I got the contract and have been running it ever since.

If money were no object and you could do one thing tomorrow to help the GPs you support, what would it be?

The one thing I would do would be to establish a lead for mental health and wellbeing for all NHS staff, not just GPs. Under that I would put together a whole programme, with mindfulness and thematic reflection at one end, right through to a confidential mental health service for those who can’t access mainstream services. I would also tackle some of the toxic structures that are causing great ill-Health in the NHS, such as the regulatory process, the Care Quality Commission and the name-shame-blame environment.

I would start to inspect around compassion. I’d triangulate it and use metrics to tap into the experience of staff in an organisation, sickness absence rates, records of bullying and whistleblowing and complaints. Those are hard measures of a service in distress. We know that where we have a compassionate organisation where staff feel attended to, you will get better patient outcomes and you could save millions of pounds because you wouldn’t need the inspectorate process.

How would you like to see general practice shaping up in 10 years’ time?

I don’t think there’s been another specialty where others have done [so much] to them without asking them what should be done. One thing that hasn’t changed is people: they want a doctor who is there, they can trust and who knows what to do.

As a GP, I want to be able to work in my local community, have relationships with patients that are intergenerational, have fast access to specialists and have enough time in the consulting room. It’s not very much to ask, is it? I went to do a home visit today with an elderly patient who I’ve known for 25 years. She’s now blind. I can sit down in front of her and she recognises my voice because of our relationship. That’s what general practice is about.

The absolute mark [of success] would be if I can name my GP. I might have to wait to see them if it’s an emergency, but I would know who they are.

What’s been your proudest moment, professionally, so far?

If I’ve had a bad day, what invariably helps is thinking about how I’ve helped a patient. Career-wise, I’m not one to dwell on successes. Even when I was Chair of the [Royal College of General Practitioners] Council, I couldn’t believe that I was. I’m pleased that if I died tomorrow people might remember who I am. Recently Professor Aidan Halligan died. He was an old loss of mine, and an amazing man. I would love it if, when I’m long gone, people remembered me as someone who stood up for what was right about our health service and the most deprived people in our communities.
Sexual healing

The subject of sex is so elaborate and entangled that it can be hard to pick out the key issues. But it is central to the subject of wellbeing, says Alan Maryon-Davis

There are 25 health benefits from a happy, fulfilled sex-life

Sexual healing is not just about STIs and unplanned pregnancy

The National Surveys of Sexual Attitudes and Lifestyles (Natsal) are large probability surveys of the British population undertaken approximately every decade since 1990. The advent of HIV/AIDS, and the urgent need for population data to inform prevention and prediction of HIV transmission, provided the impetus for the first survey (Natsal-1), conducted in 1990-91. In the second survey (Natsal-2), carried out in 2000-01, the focus was expanded to include broader aspects of sexual and reproductive health.

The most recent survey (Natsal-3), conducted in 2010-12, was the most ambitious to date. The age range extended to 74 years and the scope was expanded yet further, a decision informed by the World Health Organization definition of sexual health. This moved away from thinking about sex solely in terms of the prevention of adverse health outcomes, and widened the remit to include “the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.”

Taken together, the three Natsal surveys provide rich data from more than 45,000 people, analysis of which has revealed changes in sexual behaviour over time and through the life course, and also advanced our understanding of the factors affecting sexual health and the interplay between them. Three big themes emerge from the data.

The first relates to major changes in the timing of sexual health events (see figure). There has been a progressive decrease in the median age at first sex from 19 years among women and 18 years among men aged 65-75 years, to 16 years among both men and women under 25 years at interview in Natsal-3. The age at first live-in relationship and first child, however, has increased especially among women. The widening of the interval between these events means that the proportion of ‘young people’ may be at higher risk of adverse sexual health outcomes, and in greater need of services, has increased dramatically.

The second relates to the strong associations we have found between the different domains of sexual health, i.e. sexually transmitted infections (STIs), unplanned pregnancy, sexual violence and sexual function, and between poor sexual health and poorer mental and physical health. The former challenges us to think of sexual health in a more holistic way rather than in ‘silos’, and the latter to think of sexual health alongside physical and mental health.

Third, our findings related to the life course. The stereotype of sexuality in older ages is not borne out in our data. Conversely, sexual problems, such as lack of interest in having sex, feeling anxious during sex, pain during sex, vaginal dryness, and problems getting or keeping an erection, are not exclusive to older people, but affect young people too.

Two common threads run through these examples. One is the need to adopt a broader concept of sexual health that includes outcomes relating to the quality and sensuality of sexual experience, not only as risk factors for adverse outcomes, such as STIs and unplanned pregnancy, but as important ends in themselves. The other relates to the need to challenge assumptions about sexuality and age. Both have important implications for how sexual health services and prevention activities are conceived and delivered.

Wendy Macdowall

Lecturer in Sexual and Reproductive Health

London School of Hygiene & Tropical Medicine

Member of Natsal study team

Where to go looking for human traffic

The subject of human trafficking is vast and crosses many areas of work and circumstances, so, when Active Communities Against Trafficking (ACT) approached the Chichester District Joint Action Group (JAG) to raise the profile of human trafficking among organisations, the JAG set up a task and-finish group to specifically look at the areas of labour and sexual exploitation. To ensure that it was focused and to raise its profile, it was felt that training for frontline staff was key and would be the initial drive for the campaign.

Officers from environmental health, housing and communities teams were trained on spotting signs of trafficking and how to report any suspicions. We also supported the “no smoking, no human trafficking in this vehicle” stoker campaign with signs. We visited a large caravan park in the district and gave a presentation to managers about human trafficking, particularly focusing on grooming. It was felt that this type of location could be used by grooms or by people trying to hide trafficked people.

A project tackling the street community’s vulnerability about exploitation was also undertaken. Key partners for this were ACT, a local homeless charity, Sussex Police, West Sussex Fire and Rescue Service and Crimestoppers. The charity received training in raising awareness of the signs of trafficking, supporting clients and referring them on. Before the training had even finished, one of the support staff had to leave to speak to one of their clients as they believed he was potentially at risk of being trafficked for work. We held a poster campaign in the day- and night-centre warning clients of the dangers of being trafficked and making them aware of the tactics traffickers use to engage with them. This project ran across Chichester and Arun districts.

The group was keen to work with the hospitality industry to prevent sexual exploitation, but hotels proved difficult to engage. However, the group has been working with the Child Exploitation and Online Protection (CEOP) group and, as part of the action plan, these locations will be revisited and their part in preventing CSE explored.

Pam Bushby

Communities Intervention Manager

Chichester District Council
DEBATE: Should the age of consent be lowered to 15? Richard Wingfield says the law criminalises a third of 15-year-olds, while Anne-Marie O’Leary fears sexualising children

This law leaves young people vulnerable

CHILDREN’s rights, including their right to the “highest attainable standard of health” (as guaranteed by Article 24 of the UN Convention on the Rights of the Child), are not protected by criminalising them for having consensual sexual relations. Whilst, as a society, our motivation to protect children from abuse and exploitation is admirable, using the criminal law to set an age of consent for sexual relations at 16 does not achieve this aim. Instead of focusing on the exploitation of 15-year-olds by older persons, the current law criminalises both persons with sexual relations involving a 15-year-old take place, even where no abuse or exploitation takes place and even where both partners are aged 15.

A 2006 survey found that 30% of all 18- to 24-year-olds in the UK had had sexual relations under the age of 16. The vast majority of these experiences are likely to have been with partners around the same age. Few, if any, parents would want to see their child arrested, charged and punished by the law for this. Indeed, for the children concerned, knowing that they had broken the law might have made them reluctant to come forward when they felt that they had not fully given their consent, or where there were unintended consequences to their health such as pregnancy or sexually transmitted infections. Reducing the age of consent to 15 would also make it easier for the NHS, other health providers and teachers to provide important sex and relationship advice, including advice on sexual health, free from any fear that they were encouraging or condoning illegal behaviour.

I want to live in a country where young people have the confidence to know that they are emotionally mature enough to have sex, free from any pressure or manipulation, and with excellent and age-appropriate sex education empowering young people to make the right choices. I also want to live in a country where young people are protected from sexual abuse and exploitation. But far from protecting children’s rights and their health, our current age of consent leaves 15-year-olds vulnerable, criminalised and unwavering to come forward when something harmful happens to them.

We should follow the examples of countries such as Denmark, France and Sweden and lower the age of consent to 15.

Richard Wingfield
Advocacy Officer
The Equal Rights Trust

YES

Like other people

It is everyone’s right to be able to enjoy a fulfilling sex life, but the sexual needs of the disabled are being ignored, says Tuppy Owens

It would send the message that it’s OK

CHOOSING to start having sex is a life-changing decision. Done well, it can set you on the path to a lifetime of mutually fulfilling and respectful relationships. Done badly, it can devalue sex and lead to toxic relationships and feelings of low self-worth.

Would you leave a hormonal teenager barely cut of childhood to make such a huge decision? Probably not, but that’s the view being put forward by some who are seeking to slash the age of consent to 15. While few parents are comfortable with the thought of their child becoming sexually active, it’s a debate that needs to be had.

Studies show around one in four UK teens currently lose their virginity before they hit 16. Worryingly, many of these are the most vulnerable in our society, with children in fractured, low-income homes or in care most likely to have underage sex. Tellingly, 40% go on to say they regret having sex so young.

Choosing to have sex involves a myriad of problems. Firstly, it may well exacerbate the problem of underage sex. We could end up with the disturbing prospect of a society in which a quarter of 14-, 15- or even 12-year-olds are having sex.

Secondly, by insinuating that younger children are ready to have sex, we cut short childhood and increase the already prevalent problem of society sexualising children. Recent official reports, such as the Bailey Review of the Commercialisation and Sexualisation of Childhood, have shown that UK children are “being pressured to grow up too quickly”. If the law told them that it is acceptable to have sex at 15, this pressure would only increase.

Very few 15-year-olds are mature or emotionally strong enough to resist ongoing pressure from their peers, let alone an older adult wanting to have sex with them.

Thirdly, it is right to be telling 15-year-olds that it is fine for them to have sex and even a baby – the biggest responsibility of all – when they are years off being seen as responsible enough to vote, buy an alcoholic drink or drive a car.

As a society we need to work together to decide exactly why some teens are having sex early, and adopt strategies to help those who feel forced to have sex as pressured into it. People will always break the law, but let us retain laws that are designed to keep our children safe.

Anne-Marie O’Leary
Editorial Director
Netmums

NO

Debated may be lacking in confidence because their sex education was worse than useless

Disabled people may be lacking in confidence because their sex education was worse than useless

AFTER survival, sex is the strongest human drive, so it is inhumane for health and social care professionals to ignore the sexual needs of clients. It’s especially inhumane to ignore the sexuality of disabled people because sex might be one of the few pleasures they can enjoy – as they may be unable to see, hear, walk, talk, taste, move, feel or fully understand. In any case history, care plan, policy or service provision, it is important to address all of an individual’s needs, including their sexual needs.

There are 25 health benefits of a happy, fulfilling sex life, according to the American white paper the Health Benefits of Sexual Expression. This makes it even more important, when services are commissioned, that they should address sexual needs.

Because many professionals may avoid the subject due to shyness or prudishness, contracts must require them to ask disabled clients routinely if they are having sex and even a baby – the biggest responsibility of all – when they are years off being seen as responsible enough to vote, buy an alcoholic drink or drive a car.

As a society we need to work together to decide exactly why some teens are having sex early, and adopt strategies to help those who feel forced to have sex as pressured into it. People will always break the law, but let us retain laws that are designed to keep our children safe.

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Financial provision for sex is not an extravagance or a risk for scandals but is as necessary as food, housing and transport. Public opinion is positive about it. Disabled people may need a rail to steady themselves on the bed, a sex toy, condoms or a sexual service. This is their right. It will be your right and my right too, sooner or later.

You may like to join our group, the Sexual Health and Disability Alliance for health and social care professionals. We are a self-help and pressure group and are currently conducting a freedom of information request to determine what local Health and Wellbeing Boards are doing to address the sexual needs of their disabled residents. Improvements will not happen unless public health identifies them as major determinants of the mental wellbeing of disabled people and promotes action to facilitate their implementation to stop disabled people being disadvantaged. It is actually illegal not to support disabled people in enjoying the same pleasures as other people in the privacy of their own homes – so, legally, you have no choice.

Tuppy Owens
Founder and coordinator
The Outsiders Club, the Sex & Disability Helpline, the Sexual Health & Disability Alliance and the TLC Trust
Collaboration needed on child sexual abuse

Despite the fact that child sexual abuse has increasingly been seen as a public health problem, relatively little progress has been made in any country in dealing with the issue using a public health approach. We can stop child sexual abuse before it occurs (primary prevention) using a public health approach, but it will require effort from all areas of society. Those responsible for forming public opinion must urgently spread the message that all sexual abuse is wrong, and promote the importance of healthy, equal and consensual relationships.

In our report, Preventing Child Sexual Abuse: Towards a National Strategy for England, we outline a wealth of knowledge about effective programmes and primary prevention interventions. Based on this evidence, we want to start an active discussion about what a strategy for child sexual abuse (CSA) prevention in England should look like. Actions, across all levels of society, could include:

**Government**
- Including sex and relationships education (SRE) as part of a statutory entitlement to personal, social, health and economic (PSHE) education.
- Funding a national CSA prevention resource centre similar to the National Sexual Violence Resource Centre in the US.
- Regularly teaching CSA prevention classes throughout primary and secondary education as part of the curriculum.

**Parents**

**Professionals (including health professionals, legal professionals, social workers, teachers)**
- Training and learning in dealing with potential CSA.
- Voluntary sector
  - Providing services for young people and adults at risk of committing abuse.
- Community
  - Community members, eg. trained NSPCC School Service volunteers, helping to raise awareness about CSA and CSE (child sexual exploitation) in the community.
- Media
  - Signing up to and following a code of conduct when writing about CSA.
- Agreeing and implementing a national strategy will require significant collaborative working across organisations. This will be challenging, but with such an important goal, it is vital that we start now, building on some great work by a number of organisations and individuals.

**Jon Brown**
Head of Strategy and Development
(Sexual Abuse)
NSPCC

**Keeping happy and safe**

We can stop child sexual abuse before it occurs using a public health approach.

**Savile-style abuse just thin end of wedge**

There has been a recent string of high profile cases of sexual abuse against patients within the NHS, covered in the national press. Most people respond to such stories with horror and disbelief. Healthcare organisations, by their very nature, have a duty to protect their patients from harm. Cases involving famous people or unusual circumstances are at one end of a spectrum of sexual abuse against patients. Sadly, the spectrum is populated by many more cases that are not newsworthy but nevertheless cause considerable physical and psychological damage to the victims. Despite many inquiries and policy changes, some fundamental lessons have not been learned. Those responsible for healthcare need to move away from seeing sexual violence against patients as a freak event to seeing it as the consequence of a lack of governance, poor supervision and a lack of power held by vulnerable patients. Despite a common belief that abuse is always conducted by sexual predators, evidence is emerging that situations and environments can generate abusive tendencies in people who did not set out to abuse. Creating healthcare systems where power is actually and structurally concentrated and unchallenged in a small number of individuals can precipitate sexual violence and other abuses.

Lessons learned from previous cases show that perpetrators will abuse victims precisely because they are less likely to be believed or defended by others. Risk factors making a person more vulnerable to abuse include having a mental health problem, having a learning difficulty or disability, having a speech difficulty, being dependent on others for care, being elderly or being outside mainstream society. It seems that society has yet to learn how to believe and defend those reporting sexual violence regardless of their social circumstances.

The Department of Health is currently working with other sectors, such as those working in criminal justice and education, to change the perception of sexual violence against those receiving health and care, and to develop a better understanding of how health systems can be strengthened to prevent its occurrence.

**Stella Botchway**
Public Health Speciality Registrar
Health Education Thames Valley

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The Education Act 2002 says that every state-funded school must offer a balanced and broadly-based curriculum which promotes the spiritual, moral, cultural, mental and physical development of pupils and prepares them for the opportunities, responsibilities and experiences of life. The voices who want sex and relationships education to become a statutory requirement for schools are growing. We must heed them, says Joe Hayman.

**The Education Act 2002** says that every state-funded school must offer a balanced and broadly-based curriculum which promotes the spiritual, moral, cultural, mental and physical development of pupils and prepares them for the opportunities, responsibilities and experiences of life. The voices who want sex and relationships education to become a statutory requirement for schools are growing. We must heed them, says Joe Hayman.

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As a non-statutory subject, there is virtually no coverage of PSHE in teacher training, while in school PSHE teachers are not given the curriculum time or professional development they need. Too often, PSHE falls off the agenda in schools; this needs to change.

In February this year, the Commons Education Committee completed an inquiry into the status of PSHE education, including SRE. The committee, having received 431 written pieces of evidence and heard from 25 experts, recommended that PSHE, including SRE, should be made statutory. Statutory status is also backed by more than 100 expert organisations, including six medical royal colleges, two royal societies and the Faculty of Public Health. The chief Medical Officer called the subject “a bridge between education and public health”. The vast majority (88%) of parents support a move to statutory status and hundreds of thousands of young people have been involved in the UK Youth Parliament’s curriculum for life campaign. It is time for these voices to be heard.

**Joe Hayman**
Chief Executive
PSHE Association
Partnerships and Communications Manager

Mario Christodoulou

As long as campaigns about safe sexual practices remain almost exclusively focused on teenagers and younger adults, opportunities continue to be missed to engage with older people. Research among older people continues to show that this age group does not feel they have received much advice or information about STIs. Although healthcare professionals recognise that older people are at risk of STIs, there remains an unwillingness among clinicians to discuss sexual health with this age group. Interestingly, ageist assumptions seem to be working in both directions here with health professionals feeling offending their older patients if they raise issues of sexual health, and older people themselves believing that sexual problems aren’t important ‘at their age’ or waiting to see if problems get better on their own.

Ultimately, messages advocating safe sex and sexual health should target all sexually active people. Age-appropriate educational materials, delivered via general media, GPs or GUM professionals, shouldn’t continue to overlook older men and women.

SOPHIE looks to the ceiling, her lips begin to tremble, tears start to flow down her cheeks. In her hand she holds a life-changing piece of paper – the results of her HIV test. Her tears are of joy; thankfully, her test results are negative.

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HPV is not a women-only problem

THE inclusion of boys in the national human papilloma virus (HPV) vaccination programme has become a live issue in the UK. While the government’s vaccination advisory body considers this, 36 patient and professional organisations (including the Faculty of Public Health) have joined together as HPV Action to make the case for gender-neutral vaccination.

HPV causes disease in both sexes. HPV Action estimates that the virus caused almost 5,000 cancer cases in women (cervical, vaginal, vulval, oral and anal) and over 2,000 cases in men (oral, anal and penile) in the UK in 2011. HPV additionally causes 39,000 new cases of genital warts in women and 48,000 cases in men. Immuning girls against HPV will not protect all men. They can still acquire the virus if they have sexual contact with someone outside the vaccinated ‘herd’. The group most obviously at risk is men who have sex with men (MSM). The solution to this cannot be to try only to vaccinate MSM – there is no way of ensuring that enough of the MSM population will be reached. Heterosexual males also remain at risk from a girls-only programme: not all girls will be vaccinated and many men will have sex with women from countries where there is no HPV vaccination programme for girls or where uptake is relatively low.

It would cost an estimated £22 million a year to add boys to the UK’s HPV vaccination programme. The cost of treating genital warts alone was over £52 million in the UK in 2010. The government’s decision on vaccinating boys is expected in 2017.

Peter Baker
Campaign Director
HPV Action

The drugs don’t work – but they do make money

BY THE time you’ve read the title of Peter Gotzsche’s book, you won’t be in any doubt about where he stands on big pharma. However, he is well placed to comment on some of its morally questionable techniques of marketing and research having worked in the industry in the late 1970s and early 80s. He left to train in medicine and went on to co-found the Cochrane Collaboration, making him the ultimate poacher turned gamekeeper.

Gotzsche is admirably candid about his background in the drugs industry and the nature of some of his own contributions. He admits to co-authoring a paper which used ‘fishing expedition’ analysis to support claims for a drug’s anti-inflammatory effect on sports injuries, when the reality of the study data appeared to be that it was no better than aspirin.

The impact is at times undermined by awkward sentence structure, haphazard arrangement of paragraphs and excessive use of hyperbole, but it is difficult not to share the author’s motives, and support his call for revolution.

Alex Hawley

Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare
Peter C Gotzsche
Published by Rod & Haze
ISBN 978-1846198847
RRP: £24.99

SPECIAL FEATURE: SEX

Services must be fully inclusive of sexuality

ESTIMATES for the size of the lesbian, gay or bisexual (LGBT) population in the UK vary from 1.6% to 7%. However, the number of people engaging in same-sex sexual activity is higher than those reporting LGBT identity; the most recent National Survey of Sexual Attitudes and Lifestyles (Natsal) survey found that 5% of men and 8% of women had ever had a same-sex experience with genital contact.

Prevalence of HIV remains high among men who have sex with men, who continue to be the group most affected by HIV infection. What is less well known is that 40% of women attending genitourinary medicine clinics who had exclusively female partners received a sexually transmitted infection or other diagnosis, compared to 18.5% of women who had sex with men.

A lack of consistent sexual orientation monitoring in healthcare services means that the specific needs and experiences of LGBT people often remain unrecognised and unaddressed. Even in sexual health provision, women who have sex with women can go under the radar. The figures cited above only represent women who had recently had exclusively female partners and who disclosed this information to the clinic staff. Furthermore, there is a lack of knowledge in services about trans people’s sexual health needs, and little understanding of the interplay between gender identity and sexual orientation.

The National Lesbian, Gay, Bisexual and Transgender (LGBT) Partnership, with the support of Public Health England, published a companion document to the Public Health Outcomes Framework, bringing together evidence of inequalities impacting on the health of LGBT people and their experiences of the healthcare system. It makes recommendations across four key areas:

1. Recognition of LGBT needs in health strategies, including joint Strategic Needs Assessments
2. Engagement with LGBT communities in monitoring sexual orientation and gender identity
3. Service provision to LGBT patients, including specialist services to address specific needs locally.

The LGBT voluntary and community sector can support public health professionals to implement these recommendations, for example by consulting with the local LGBT community, providing staff training on communicating effectively with patients about sexual orientation and behaviours, and co-designing and delivering specialist services.

Independent cost-benefit analysis has shown that specialist services provided to the LGBT community can provide value for money. For instance, every £1 invested in the LGBT Foundation’s sexual health service produces £6 of potential savings in the budgets of public agencies as a result of fewer HIV and STI infections. In these challenging economic times, this adds further weight to the argument that public health, and sexual health, services should be fully inclusive of people’s sexuality and expressions of sexual identity.

Heather Williams
Policy & Research Manager
LGBT Foundation
In memoriam

Michael Warren Hon FFPMH 1923 – 2015

A man of quiet and unassuming demeanour, Michael made an exceptional contribution in the early years of FHP by his work on the training programme, curriculum, and a monumental task. He was the founding Academic Registrar, a post to which he was appointed on the basis of his record in the development of the master’s degree at the London School of Hygiene and Tropical Medicine where he was Reader in Public Health.

Previously, he held appointments on the Council of the Society of Medical Officers of Health and as Chairman of the Society for Social Medicine and was ideally placed to integrate the academic and practical components of the larger public health discipline. He also served as editor of the British Journal of Preventive and Social Medicine.

In 1971 he went to the University of Kent as Professor of Social Medicine and the first Director of the Health Services Research Unit. It was a brave move, as he joined the social science faculty of a new university and was the first medically qualified member of staff. He continued to play a vital part in the development of academic departments which helped develop FPM’s training programme. He acted as external examiner to the master’s degree courses in the various universities developing them, often from pre-existing courses of the formerly statutory Diploma of Public Health. He used this opportunity to assist and inspire those providing these programmes to ensure that they met and also helped develop FPH’s requirements for specialty training.

After retiring in 1983 Michael spent a long period reflecting and writing on this history and future of public health both as an academic discipline and as a professional practice. Two major publications for FPH were a thorough and scholarly history of its founding and early development, and a historical bibliography of major publications relating to state medicine, public health and social services development from 1066 to 1999.

Michael was an immensely civilised and scholarly man who was always ready to respond generously to a request to undertake tasks and duties relating to public service. Whatever he took on, he worked thoroughly and creatively. Although many of those who knew him best have long pre-deceased him, those who remain will all attest that he was not only a much admired but a very well-liked man.

David Allen

Anthony Hedley FFPH 1941 – 2014

Tony’s postgraduate (Abderdeen University) travels, often under World Health Organization (WHO) auspices, cultivated passions for public health and photography. He held the Henry Mecchan Chair of Public Health in Glasgow from 1984 following a senior lecturership at Nottingham and helped establish the Faculty of Medicine at Khon Kaen University, Thailand, receiving an honorary degree from King Bhumibol in 1983. From 1988, he led the Department of Community Medicine at the University of Hong Kong, staying until his retirement in 2010. He was for many years an examiner for FPH and a passionate go-between, ensuring a generation of Hong Kong trainees passed their FPH exams.

Tony’s interest in respiratory health was seen in dogged work on tobacco control. Concurrently, he established a world-class, air pollution research team, creating the Hedley Environmental Index of real-time air pollution costs in Hong Kong. He received the WHO Medal and the Hong Kong Bronze Bauhinia Medal. He was awarded Emeritus Professor in 2014 and 10 days before his death flew 8,000 miles from his beloved Isle of Man to Hong Kong for a sold-out forum in his honour.

Richard Fielding

From the CEO

I RECENTLY spent my first of two weeks on the Duke of Edinburgh’s Commonwealth Study Conferences rushing around Oxford, London and Surrey with 100 Commonwealth leaders from 23 countries, challenged by the topic ‘What makes a smart city?’ I interviewed five public health leaders in advance to get their ideas: an ICT approach, sustainability, connectivity, education, leadership and governance, culture and history.

Lots of great ideas – some of which will get worked up more fully. But it was the journeys that colleagues went on that surprised me: an engineer offering to mentor an illegal immigrant towards her employment dream, a mining developer deciding to engage in community projects in his neighbourhood, a senior public servant vowing to support those born without the advantages they took for granted. And perhaps that is another strength of the public health message: the chance to use evidence to change people’s minds and create a healthier future for all.

I interviewed five public health leaders in advance to get their ideas: an ICT approach, sustainability, connectivity, education, leadership and governance, culture and history.

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Would you like to give the RCP’s prestigious Milroy lecture on public health?

The Royal College of Physicians is inviting applications for its annual Milroy lecture, founded by a bequest from Dr Gavin Milroy FRCP in the 19th century. Dr Milroy’s original aim was to ‘promote the advancement of medical science along with the interests of philanthropic benevolence and of social welfare’ but for today’s audiences the RCP’s interpretation is much broader and relevant to public health and hygiene.

For further information and to apply by the closing date of 4 September 2015, please see the RCP website: https://www.rcplondon.ac.uk

Richard Fielding

Deceased members

The following members have also passed away:

Gregory Dillaway FFPH
Victor Hawthorne FFPH
Mabel Mills MFPH
Elizabeth Timothy FFPH

Marko Petrovic MFPH 1963 – 2015

Marko was born in the UK to Serbian refugees and was immensely proud of his Balkan heritage. After graduation he worked in surgery then trained in public health in Wales where he made a significant contribution to the national MMR scare response. As Consultant in Communicable Disease Control in Greater Manchester, his great passion was TB, and he developed a deep and expert knowledge on all aspects of the disease. He worked tirelessly with clinicians, nurses and epidemiologists across the country to reduce the incidence of TB, improve patient care and control outbreaks. In recent years he undertook research for an MD into the immunology of TB. Although ill health meant he was unable to complete his thesis, he published several papers which have advanced understanding of the disease. He was diagnosed with an aggressive prostate cancer in the summer of 2013. Despite significant discomfort, he continued with his MD and worked part time, dialling into a TB strategy meeting only 10 days before he died. He was so committed and prolific that many colleagues outside the Health Protection Team were unaware how ill he was.

He was supported in his illness by his family, his faith and his colleagues. He leaves his wife, Danica, a son and a daughter.

Lorraine Lighton
Diane Fiefield
Barbara Isalska
**FPH in brief**

**Global Health Strategy**

This strategy sets out FPH’s aims for its global health and international work for the next five years and will be launched at this year’s FPH conference on 23 and 24 June. The work will build on FPH’s many existing international partnerships, as well as challenge it to work harder and with greater impact towards improved global health outcomes.

**Support us**

If you have a passion for public health and the significance of its contribution to the human condition, you may feel moved to donate to the further development of FPH as it embarks on the next stage of its journey. FPH’s ambitions include extending its reach and influence locally and globally, and extending its membership base and moving towards college status. You can donate to FPH using a debit or credit card by visiting the FPH online donation page at [www.fph.org.uk/support_us](http://www.fph.org.uk/support_us).

**Welcome to new FPH members**

We would like to congratulate and welcome the following new members who were admitted to FPH between January and April 2015.

**Fellows**

Ian Ashworth
Michael Caley
Daniel Carter
Ying Yang Emily Chan
Mariana Dyakova
Paul Fisher
Elizabeth Green
Katherine Harvey
Jorg Hoffmann
Richard Holmes
Soo Lim
Elizabeth Lingard
Yeung Wong
Emily Youngman

**Members**

Arun Aklussala
Simona Baracaia
Nicholas Bundle
Andraa Clement
Ian Diley
Clare Ebberson
James Elston
Louise Flanagan
Suzanne Gilman
Ruth Goldstein
Mary Hall
Catherine John
Peter MacPherson
Richard Holmes
Soo Lim
Elizabeth Lingard
Yeung Wong
Emily Youngman

**Fellows**

Melanie Roche
Caroline Rumble
Ashley Sharp
Louise Sigrid
Katie Smith
Emily Stevenson
Hayley Teshome Tesfaye
Tazri Tillmann
Gerald Tompkins
Kirsten Watters
Helen Webster
Nicholas Young

**Diplomate members**

Kathryn Cobain
Lucie Collinson
Kathryn Faulkner
Matthew Fung
Andrew Graham
Ali Hasan
Alexander Hawley
Emma Kain
Janice Lo
Orsolina Martino
Gerardo Javier Melendez-Torres
Helen Sikkov
Judith Stonebridge
Sam Williamson

**Specialty Registrar members**

Suzanne Barr
Julia Bates
Lucy Devapal
Yannish Naik
Saran Shantikumar

**Letters**

CHRIS Boardman (The Final Word, Public Health Today December 2014) performs a valuable service in emphasising the most powerful ways of increasing the prevalence and safety of cycling and the potential counter-productive effect of focusing solely on helmets and high-visibility clothing. It seems inconsiderate of him, however, not even to mention the effect of high-visibility clothing on motorists. All drivers, even the most cycle-friendly, know the difference between following a grey-clad cyclist on a grey day and one in high-visibility clothing. The difference in confidence and stress is real. Doesn’t Chris consider motorists merit any consideration, except as potential cyclist-slayers? I should be interested if you have the opportunity to put the question to him: I’m sure he will find the right balance.

Paul Snell OBE

SHOULD not your item ‘Cut music to an hour a day’ [News in brief, Public Health Today December 2014] have said: “People should not listen to music for more than one hour a day on headphones”? I can see some people running off like they have with umpteen other Daily Mail headlines and making some of us feel guilty. Stoppy journalism in my humble opinion.

Irene Stratton (after 5.5 hours of music at Oxford Folk weekend including an hour of 18th Century dance music on fiddles, viola and piano) Honorary Associate Professor University of Warwick Clinical Sciences Research Institute

**Editor:** Yes, the one-hour limit in the WHO report did indeed refer to “personal audio devices”. Apologies. The BBC made the same mistake!
Doctors used to be the masters of the NHS universe with their medical gobbledegook. Then along came managers who spoke of ‘workstreams’ and ‘business solutions’. Here, Phil Hammond gives his prescription for the next stage of reform: the bidet revolution.

WHAT do doctors really think? Humans have evolved to lie to other people, all the better to lie to ourselves, but doctors are still just about trusted to tell the truth. However, there’s plenty we still hide from public view, particularly when it comes to how we feel about our jobs or working for the NHS. Doctors may look cool and composed on the outside, but we’re often as anxious as patients during consultations. We’re worried about missing an important diagnosis, not being able to give people the time they need and not being able to cope safely with the demands placed on us. Just as we shouldn’t blame people for being ill, old or overweight, we shouldn’t blame NHS staff for not being able to always provide the highest standards of care in a chaotic system that’s creaking at the seams.

Doctors once held all the aces in the NHS with our secret language. We used to be able to baffle the masses with silly Greek words: we spoke of menorrhagia, rather than heavy periods, or dysmenorrhoea, instead of painful periods. And let’s not forget oligomenorrhoea (infrequent periods), amenorrhoea (absent periods) and — wait for it — polycystic ovary syndrome. Travel an inch or so upwards and you can have dysuria (painful wee), haematuria (bloody wee) and polyuria (lots of wee).

But, thanks to mobile phones, anyone can have instant access to a medical dictionary to demystify their doctor. The power has shifted to managers who may speak in ways that no dictionary can help you understand. Of all the examples of NHS ‘work’ I’ve collected over the years, my favourite is this advertiment: “Applications are invited to become a Blue Sky Practitioner reporting to the Blue Sky Lead in the New NHS Modernisation Agency. The workstreams will work to a generic cycle based on a hypothesis driven, creative problem-solving process to create improvement products… You will undertake horizon scanning and futures research… creating curve leverages systems for rapid diffusion… helping customers articulate and understand mess.” How have we evolved to speak such drivel?

Doctors hate this new corporate language in the NHS but are generally too fearful to shout it out loudly. Turning healthcare into a market puts targets and profits above patients. A friend of mine resigned as clinical director of a mental health service when he was told that the “core purpose of your role is to drive the business development strategy, in line with the Business Proposition, scanning the mental health environment for new opportunities and identifying and stimulating new business solutions that fit with the corporate vision.” He said, rather warily: “All I want to do is help the mentally ill.”

The NHS is facing a £30 billion black hole in its finances in the next five years, and keeping it on the rails won’t be easy. I’ve had enough top-down reform. We need a bidet revolution, from the bottom up, with patients and carers leading the charge. What they need is the confidence, courage, tips and tactics to stay well outside the NHS and thrive inside it. I’ve written a book to kick it all off. Let me know what you think (@drphilhammond).

Phil Hammond
Doctor, journalist, broadcaster and comedian

Phil Hammond’s latest book, ‘Staying alive – how to get the best from the NHS’, is published by Quercus. Public Health Today readers can get a discounted copy for £10 with free P&P (UK only) by calling 01235 827702 and quoting reference ‘BOOKPOINT’.

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If you have an idea for an article, please submit a 50-word proposal and suggested authors to: news@fph.org.uk. The proposed subjects of 2015’s remaining special features are: Disasters & Emergencies (September) and Healthcare Public Health (December).

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