

Women and Equalities Committee

Oral evidence: The prevalence of sexually transmitted infections, HC 1249

[Wednesday 3 September 2025](#)

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[Watch the meeting](#)

Members present: Sarah Owen (Chair); Alex Brewer; David Burton-Sampson; Kirith Entwistle; Natalie Fleet; Catherine Fookes; Christine Jardine; Samantha Niblett; Rebecca Paul; Rachel Taylor.

Health and Social Care Committee member present: Danny Beales.

Questions 1 - 51

Witnesses

[I](#): Dr Amanda Doyle OBE, National Director for Primary Care, Community, Vaccination and Screening Services, NHS England; Cathy Morgan, Director of Secondary Prevention, Department of Health and Social Care; Kate Folkard, Head of Programme Delivery and Service Improvement, Blood Safety, Hepatitis, STIs and HIV Division, UK Health Security Agency (UKHSA); Kat Smithson, Chief Executive Officer, British Association for Sexual Health and HIV (BASHH); Richard Angell OBE, Chief Executive, Terrence Higgins Trust.

Written evidence from witnesses:

Examination of witnesses

Witnesses: Dr Amanda Doyle, Cathy Morgan, Kate Folkard, Kat Smithson and Richard Angell OBE.

Chair: Good afternoon and welcome to the Women and Equalities Committee. Today we are holding an evidence session on the prevalence of sexually transmitted infections, and I am delighted that we have such an experienced panel in front of us. We will hear from Dr Amanda Doyle OBE, national director for primary care, community vaccination and screening services at NHS England; Cathy Morgan, director of secondary prevention at the Department of Health and Social Care; Kate Folkard, head of programme delivery and service improvement, blood safety, hepatitis, STIs and HIV division—that is a mouthful—at the UK Health Security Agency; Kat Smithson, chief executive officer of BASHH: the British Association for Sexual Health and HIV; and Richard Angell OBE, chief executive at the Terence Higgins Trust.

Welcome all. I am going to hand straight over to Catherine.

Q1 **Catherine Fookes:** Thank you everyone for coming this afternoon and appearing before the Committee. My first question is to Kate: could you outline the recent trends in STI prevalence, and tell us where you have concerns?

Kate Folkard: Yes, of course. Just to give you a sense of scale, the most recent number of new STI diagnoses is 365,000, which is slightly down on the previous year, but that overall figure hides a lot of variation.

With chlamydia, we tend to see between 150,000 and 200,000 diagnoses; with gonorrhoea between 70,000 and 80,000; and syphilis just under 10,000. The populations that experience the highest rates of STIs are young people, those living in the most deprived areas, gay men, bisexuals and other men who have sex with men, and people of black Caribbean ethnicity.

There is some good news in terms of genital warts, which continue on a downward trend. That speaks to the very successful HPV—human papillomavirus—vaccination programme, both the adolescent programme and the GBMSM programme in sexual health services. We have seen an over 80% reduction both in genital warts and cervical cancer since the start of those programmes, so that speaks very much to their effectiveness.

We have also seen decreases in chlamydia, but that is not necessarily the direction we would like to see things going. We have a national chlamydia screening programme which is about identifying asymptomatic infection in young women and a lot of the decline has been due to less testing in that population.



The two areas that we are particularly concerned about are gonorrhoea and syphilis. There were around 70,000 gonorrhoea diagnoses in the last year, which is slightly down on the previous year but still historically high levels. Of those gonorrhoea diagnoses, 50% are in GBMSM but we have also seen very steep increases in young heterosexuals. We saw a decrease in 2024, which was very encouraging, but it is still at very high levels. The issues with gonorrhoea are around the harm that it causes to reproductive health and, in rare instances, what is called disseminated gonococcal infection, which affects the body more widely. It is rare but still very serious. We are also seeing antimicrobial resistance in gonorrhoea; it is becoming increasingly resistant to antibiotics and difficult to treat.

Moving on to syphilis: again we are seeing historically high levels, with 9,500 diagnoses in the last year. The majority of those—66%—are in GBMSM, but again there are steep increases in heterosexual men and women. Syphilis is easily treated, but does not clear if it is not treated and again can lead to very serious complications in the individual that affect the wider system.

We are also concerned about cases of congenital syphilis, where syphilis is passed from mother to child. We have had 55 cases since 2015 in the last report, and that is despite having very high levels of antenatal screening. Many of those women contracted syphilis during pregnancy.

There is some good news, however, in terms of the introduction of the use of doxycycline post-exposure prophylaxis for the prevention of syphilis, and the introduction of the 4CMenB vaccine for the prevention of gonorrhoea.

Q2 Catherine Fookes: Just to follow up on that, Kat—if this question is appropriate for you—what steps are the Government taking to address disproportionately high rates of STIs in the most deprived communities?

Kat Smithson: Obviously I cannot speak on behalf of the Government, but in terms of the way that my members working in sexual health services would be working with the Government and with local commissioners in England or authorities elsewhere, probably the most significant piece of guidance since the last time this Committee heard evidence is the publication of the STI Prioritisation Framework. At BASHH we collaborated closely with colleagues in the Department and UKHSA on this. It is focused on trying to target scarce resources in all the right places and making sure that we are developing effective services at a local level.

What it does not do though is strategically set out the higher level of what we are trying to achieve: what is our national goal? What are our strategic aims? It is more focused on how we make sure that we are targeting the right population groups in the most effective ways, and the risk is that people get left behind. We are targeting broad population groups and there are always more marginalised communities who maybe



do not get captured within that prioritisation. That is something that we all acknowledge.

My members are repeatedly talking to me about resource constraints at a local level, which mean that there is often a drive for cost saving over what they would deem to be cost-effectiveness. There is also the fragmentation of services: the fact that, in a session with a person, they cannot necessarily do everything they want to do because of the way the funding and system flows get in the way. That is leading to inefficiencies, so there are significant gaps in the ability of the system to meet the needs of those who are disproportionately affected and to address these inequalities.

Q3 Catherine Fookes: I assume the target of the Government should basically be to eradicate, or to work towards the eradication, of all STIs. Should that be the target?

Kat Smithson: The public health aim should absolutely be, where possible, to eliminate the transmission of STIs, but that is not necessarily always going to be possible. New STIs will emerge over time and sexual health issues will always exist. But yes, when we have preventable and treatable conditions, we should be aiming to prevent and treat them.

We can see that with HIV that is absolutely an aim that is set out by the Government, and syphilis should be an aim as well. We long thought that syphilis had been eradicated and now we are seeing a resurgence; it is vitally important that we take every action that we can to make sure we are turning back the tide.

Q4 Chair: Before you come on to your last question, Catherine, I just wanted to come back to Kate and Kat. You said that you had seen a drop in gonorrhoea and chlamydia cases in 2024. Was any work done as to what the driver was behind those drops? What is driving the increase in syphilis?

Kate Folkard: It is complex. Some is due to changes in testing, particularly with chlamydia where we saw an 11% drop in testing in under 25-year-olds but an 18% drop in diagnosis. A good proportion of that drop is due to testing activity, but there is something else going on as well and we are trying to understand what it is and why it is happening.

Likewise with gonorrhoea, we saw very steep increases after covid then we saw a drop-off and more of a levelling out. That may be due to the impact of covid, but we do not know for sure. Longer term trends are about testing activity, the sensitivity of tests, changes in sexual behaviour and the social context.

Kat Smithson: With syphilis, it is obviously very difficult for us to determine the exact cause and driver of the increase. We have seen dramatic cuts to sexual health services and prevention services over the past decade and more, and there has been an increased focus on syphilis



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prevention activity in recent years. We are seeing a slight decrease among gay and bisexual men and other men who have sex with men, although it is far too early to be able to tell if it is sustainable. We are still seeing slight increases in the heterosexual population.

It is important to note that having well-integrated services is key. A lot of the expertise in syphilis, for example, is in the genitourinary medicine space, so largely within sexual health services and clinics, but some heterosexual populations may not be as aware of syphilis and we might not have targeted prevention activity focused on those groups; they may be presenting in other settings and therefore it might not be picked up in quite the same way.

We are also seeing presentations of syphilis in other parts of the NHS, and again that is often not picked up when it should be. They do not necessarily have the right links and connections to genitourinary medicine services in order to get expertise in at the right time, although different services and trusts are working on that.

Q5 Catherine Fookes: Richard, a high incidence of STIs has been observed among some gay and bisexual men using PrEP. Why is that, and what work is being done within the community to address this?

Richard Angell: PrEP is a drug that people can take if they test negative for HIV; they will stay negative for HIV as long as they continue to take it as prescribed. It has been hugely effective at reducing the risk of HIV and the number of HIV transmissions. It has however continued to mean that people do not use a condom when having sex and there is some increased STI transmission around that.

The figures seem to bear out that those people who are on PrEP, however, are taking an active part in their sexual health and are quickly finding out if they have an STI then getting it treated quicker and therefore passing it on to fewer people. In that sense, the R rate is lower in this group and it evens itself out across the numbers of those who are PrEP users.

It is important to remember that people need choice to be able to exercise their sexual health. PrEP has been a brilliant addition to our toolkit and has really allowed people to take charge of their sexual health. The challenge is that in most parts of the country there is an average 12-week wait to start PrEP. That is three months. Asking a gay man to go without sex for three months is quite a big ask, and it is not reasonable. We also see with long-term contraception that people are waiting up to 18 weeks. So there are waits baked into the system and that of course compounds health inequalities.

While there is a network among gay men and a crowd factor that is educating others in the community about the value of PrEP—how to use it, how to be effective with it—that is not happening in other population groups. We have seen a really great take up in gay men and we want to



see more, particularly in queer men of colour and younger LGBT populations, to help get rates of HIV down and tackle health inequalities. But work needs to be done for those communities where PrEP is almost completely unknown, both to know that it exists and what the benefits might be, and then whether they might choose to use it.

Q6 Chair: I should say that we have specific questions for everybody else as well, do not worry, but we are expecting votes around 3 pm, so we will take a break then and be back as quickly as possible to restart. If there is anything that you would like to give the Committee more information on or go further into detail about, do not feel you have to do it here; you can also submit it as written evidence afterwards.

Kat, coming back to the national guidance on the use of DoxyPEP for the prevention of syphilis, can you set out how it will be implemented and among which groups? What impact do you hope it will have, and when will you start to see those impacts? You said that you are starting to see impacts, but could you elaborate on those, please?

Kat Smithson: The DoxyPEP guidelines have very recently been published, so it will take some time to see an impact. DoxyPEP is specifically suggested as an intervention for the prevention of syphilis; it will potentially have an impact on other bacterial STIs, most notably chlamydia, but it is not being targeted for that use. It is targeted specifically at those who are deemed as being at higher risk of syphilis, specifically gay and bisexual men, other men who have sex with men, and transgender women who have been identified in sexual health services. In terms of how it will be implemented, that will be a combination of public health messaging, making sure that people are aware of it.

One of the reasons why BASHH chose to publish this guidance in the first place and to go through the guideline writing process is because we knew there was already a lot of informal DoxyPEP use happening within certain population groups. This is about providing some strong guidance for clinicians to enable them to work safely with their patients, inform them of the risk of antimicrobial resistance, and practice good antibiotic stewardship with them.

In terms of how we will see the impact, that will depend on supply and availability. At the moment clinics are really trying to get it out. There are apparently some supply issues relating to the over-labelling of doxycycline; doxycycline is not normally provided for this purpose, so it has to be over-labelled. We need to make sure that we can get supplies to clinics and that clinics are actually in a position to be able to meet demand at a local level as well.

Q7 Chair: What does informal use of DoxyPEP mean?

Kat Smithson: Informal is probably not the best term to use, sorry. When I say informal I mean, for instance, someone who might have doxycycline left over from a completely different infection, or who might



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be purchasing it online, borrowing it from friends, or sharing it with friends.

Chair: Self-medication?

Kat Smithson: Yes.

Q8 **Chair:** Is there anything that Parliament should or could be doing to ensure that the supply chains are effective and drugs are coming in a timely manner?

Kat Smithson: We would like to work with NHS England and the MHRA to make sure that those things are moving quickly. However, I will follow up on that and let you know if there is anything we think Parliament should or could be doing.

Q9 **David Burton-Sampson:** I have a very quick question on DoxyPEP. Individuals are using this as a preventative if they think they may have been exposed. If someone is using it multiple times, is there any evidence that they could start to become resistant to the antibiotic and that it therefore stops serving its purpose?

Kat Smithson: It is not the individual who becomes resistant to the antibiotic; it is the pathogen that becomes resistant, so resistance is not necessarily promoted by an individual using it multiple times. It could be promoted by usage across the population, but my understanding is that on an individual level that would not necessarily impact its effectiveness as a prevention tool.

Q10 **Samantha Niblett:** Are there any trends by age group? I had heard—this could be a complete lie—that second-time-rounders, divorcees, are experimenting with sexual liberation and that there has been a surge in the spread of STIs in that age group. Is that complete and utter rubbish?

Kate Folkard: The groups that I described at the beginning are the ones where we see the highest rates; age wise, they are predominantly young people as you would expect because young people have more sexual partners at that stage in their lives. Whenever we publish the official stats in the summer, there are quite often headlines about older people. The numbers—I am talking about the over 65s—are very small. There are some slight increases, but they still represent a small proportion.

You get different age profiles for different infections; chlamydia and gonorrhoea mostly affect younger people, and syphilis is more across the population as a whole, more the 35 to 40 age group.

Q11 **Chair:** Kat, looking at another really vulnerable community at the moment, the guidelines note that members of the transgender community might be at elevated risk of acquiring syphilis. What is being done to reduce the risks of STIs such as syphilis among that community, who already face a huge number of barriers when it comes to accessing health?



Kat Smithson: One of the things we really wanted to do with these guidelines was to make sure that we considered the needs of transgender women and other gender-diverse people as well, following the evidence that we have of effectiveness. In terms of the wider work that is happening, there are many highly skilled and expert people in sexual health services who are working really hard to make sure that we have targeted services that feel safe and inclusive for people to enter.

It is also really important that public health messaging co-produced with trans communities is prioritised; that co-production element is important for a lot of the populations who are disproportionately affected by STIs. At the moment, because of the social and cultural issues that you are noting, it is especially important to acknowledge the wider impact of the landscape that we are in and how that might affect someone's access to services as well.

At a service-based level, wherever possible we are developing expert targeted services and messaging, but we also need to be working with our communities and our organisations where we have the resources to do so. A lot of the time this does come down to resources and people being really pushed; in those circumstances, sometimes services that target the most marginalised populations end up being the ones that go.

Q12 **Chair:** In terms of co-production and user experience, is that also true for black, Asian and minority ethnic people as well?

Kat Smithson: Absolutely. It is important to note that black African and black Caribbean women in particular are disproportionately affected by increased STI rates. We are seeing increasing levels of HIV among black African women, even though we have seen decreases in other populations. So it is really important that we are co-producing messaging with those populations and groups. This is not a one-size-fits-all thing; thinking about the different context and experiences of people within those groups is critical here.

Q13 **Chair:** Do you think you have the resources to be able to produce that support at the moment? If not, would you be prepared to write to us as a Committee and say, "This is where we have the gaps and this is where we would like to see more resources"? That goes for everybody on the panel.

Kat Smithson: I certainly think that if you asked my members who are delivering sexual health services, they would say they absolutely do not have the resources. When you are being asked to cut your budget, sometimes by half, it is going to be outreach services, health adviser services and health promotion or co-produced services that will go first.

Colleagues on the panel might be able to comment further on national initiatives, but at a national level we are generally seeing a significant decrease in funding for national public health messaging, which again



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makes it much harder to deliver targeted messaging. I will let Richard come in on that though because I am sure he will have more to say.

Chair: He will have to be very quick as I have noticed that the new Minister is on his feet.

Richard Angell: What Kat has just said should be the answer: we should be co-creating this stuff and we should be working with communities to make this happen, but—with the notable exceptions of Clinic T in Brighton, Clinic Q in London, some brilliant work in Manchester, and some individual clinicians in Kat's membership and network that are going above and beyond—that is not the case. It is certainly an issue for the trans community, and Kate shared the numbers within black Caribbean communities. The Government are doing nothing to overcome that, other than to hand over money to local authorities through the public health grant and hope that there is enough resource locally to be able to innovate. The simple fact is that when the public health grant has been reduced to the levels that it has, there is not the resource for that. Most are just keeping the lights on, but it is really important work that needs to happen.

Catherine asked a question about whether there should be an aspiration to bring down and eliminate STIs. There is a World Health Organization goal to eliminate STIs as a public health risk, but we would just like to see numbers sustained in the right direction. That would be a pretty radical ambition for where we are now.

Q14 **Samantha Niblett:** You have already stated that resistance to antibiotics is proving a problem, particularly for gonorrhoea; that caught my attention in your answer to the first question. To what extent is antibiotic resistance becoming a concern more broadly, particularly for infections like gonorrhoea and Shigella?

Kate Folkard: Gonorrhoea, Shigella and Mycoplasma genitalium are the STIs of concern when it comes to antimicrobial resistance. The first-line treatment for gonorrhoea is ceftriaxone; the first case of ceftriaxone-resistant gonorrhoea was seen in 2015, and to date we have had 52 cases. So far this year we have seen more than we did last year; we are now seeing one or two a month. The UKHSA and sexual health service clinics are very adept at responding to that. Clinics will identify if there is resistance and feed that back to UKHSA, which will then confirm it and provide treatment advice.

We then have a very intensive management of that case, with contact tracing, partner notification and treatment for cure to ensure that we have managed it effectively. The vast majority of those cases are related to travel in the Asia Pacific region. So yes, we have strong systems in place. Gonorrhoea is on the WHO priority pathogens list so it is absolutely an area of concern, but we are well-placed to respond to that.

Q15 **Samantha Niblett:** This might be a rhetorical question, but are the



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Government making sufficient funding available to develop new antibiotics for those STIs, and/or how close are we to creating them?

Kate Folkard: I am not able to comment specifically on the creation of new antibiotics. It is really important that we use the existing antibiotics we have judiciously so that we sustain their use for as long as possible. We also have a surveillance system in place where we look at how resistance is developing over time, which again feeds into the clinical guidelines around treatment, to make sure that we are using the available antibiotics as effectively as possible.

Q16 Samantha Niblett: Amanda, what impact do you foresee the vaccine having on rates of gonorrhoea, and what is the strategy to ensure take-up by those most at risk?

Dr Doyle: We launched the meningococcal vaccine for gonorrhoea on 1 August alongside the routine mpox vaccination, and over the month of August we have rolled it out so that all the relevant providers are now on board.

This is the Meningococcal C jab that we use in the infant vaccination programme, so it is the same vaccine, but because meningococcus and gonococcus are very similar bacteria, it has about a 40% protection rate against the development and transmission of gonorrhoea. It is not like the HPV vaccine, which completely prevents transmission, but it significantly reduces the risk not only of transmission, but of the development of antimicrobial resistance within gonorrhoea. It has dual benefits.

Obviously, we do not have any figures about take-up yet; we only started rolling it out last month. We have a target high-risk population which is gay and bisexual men and men who have sex with men, then a very small number of people who are deemed to be at equivalent risk, and we are targeting those populations.

We are learning from the roll-out of the mpox vaccination, when we had an outbreak and learning from our experience of delivering services to the at-risk population, largely through sexual health services, which is an area where they trust those services to roll it out. We will be closely monitoring both the effectiveness and the uptake.

Q17 Samantha Niblett: On the topic of trust, when you have your target groups, how do you overcome vaccine hesitancy?

Dr Doyle: Vaccine hesitancy is a recent phenomenon that we are seeing across all vaccine formats. It is fuelled, as you know, by a lot of misinformation or social media information. We have to target it by hitting back and promoting the benefits and risks of vaccination to everyone, not just those in the high-risk population.

We are employing what we have learned through other vaccination programmes about how we most effectively identify and target at-risk



populations, how we convey messages, how we can better use social media, and how we can use digital routes to share information and enable people to access both information and services. But it is a constant challenge.

Richard Angell: I would like to briefly come in on that. It is important to say that vaccine hesitancy among gay men has been much lower than in other populations. If you look at the mpox outbreak, people were literally queuing in the street to get their vaccine, supporting others to do it and donating to help people get to that point.

The challenge is access. We have seen this with the HPV roll-out for gay men; of those who have not already been vaccinated, only a third get offered the HPV vaccine when they have an appointment at a sexual health clinic. There is still a lot of work in making that appointment work for people.

Another thing we have seen through the cuts in services is that 51% of people leave a sexual health clinic having either not been offered or not taken up an HIV test. We know that only a third of gay men in this particular programme are being offered an HPV vaccine; we do not know what that means for gonorrhoea yet, but we have to get that pushed up across the board and make that contact work. The truth is that to manage the number of appointments—which local government has done brilliantly—they are having to make them very brief in order to see the numbers and volumes of people they need to see. That is the biggest challenge: it is not hesitancy, it is access.

Q18 **David Burton-Sampson:** Just very quickly, perhaps for Kate or Amanda, you mentioned the resistance of antibiotics to certain strains of gonorrhoea. What does that mean to an individual in the long term if they find themselves with a resistant strain? Do you have any figures on the percentage of people currently catching gonorrhoea who are resistant? *[Interruption.]*

Chair: I am just going to pause the session while we go and vote; we will resume when we come back. You have plenty of time to think of an answer to David's question.

Sitting suspended for a Division in the House.

On resuming—

Chair: Thank you for your patience, everyone. We are back. David had asked a question; I hope you can all remember it, or do you want David to refresh it?

Q19 **David Burton-Sampson:** I will just rephrase it slightly, because the bell going off in the background was distracting me. Basically, say I catch an antibiotic-resistant strain of gonorrhoea: how do I get rid of it and what long-term impacts will it have on my health? Do you have any facts around how many people are currently catching these resistant strains of



gonorrhoea and Shigella?

Dr Doyle: I was going to pick that up. The antibiotic-resistant strains for gonorrhoea specifically—but it also applies to the other diseases we mentioned—are a very small proportion of the total number, but it is always something that causes alarm bells in the clinical community when we identify it, because there is always a risk that if that strain is resistant to our usual treatment and it goes unidentified, it is more likely to spread and therefore numbers will grow.

It does not mean it is resistant to all antibiotic treatments. When we talk in this case particularly, what we mean is that our usual first-line treatment does not work, so what we do is resort to stronger, more powerful antibiotics. We like to keep those antibiotics in reserve; they are the second and third-line antibiotics we use for very seriously ill people in the intensive care units. If we start having to use those antibiotics commonly for what are usually more easily treatable infections, they become less of an effective weapon for a whole range of other antibiotic-resistant infections, which makes us less able to treat people more widely. It is really important that we identify those strains, but for an individual with one of those strains, it does not mean we cannot treat them or eradicate the disease.

Chair: That is really important to try to put people's minds at ease, as well as highlighting the serious issue around antimicrobial resistance: people can be treated and should reach out.

Q20 Danny Beales: Back to vaccinations and the gonorrhoea vaccine: what lessons have been learned from the roll-out of the mpox vaccine programme in terms of tackling equality issues? Often, in that roll-out, it was again health literate people accessing services who navigated them, booked and got their mpox vaccine. What are you doing to reach communities that might not be accessing service—for instance, perhaps gay or bisexual men, or men who have sex with men but do not define themselves as gay or bisexual, in ethnic minority communities.

Secondly, again with mpox, we saw a much lower uptake of the second dose. Are you confident that we will see an equal uptake of all the doses of this vaccine, and what will you do to ensure that we see continued uptake?

Dr Doyle: As Richard described, we learned from the mpox vaccine that once we had effectively shared the risk and the actions people needed to take, people who already knew how to access services—largely gay and bisexual men and men who have sex with men—were very keen to access and get vaccinations, and that remains the case.

That was a response to an outbreak. We have now launched routine mpox vaccinations for the same group. We can give that vaccination concurrently with the gonorrhoea vaccine, so reaching out and giving people information, making the services available and taking the opportunity to offer more than one vaccine at a time is very useful for us.



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As Richard described, there is a large community of gay and bisexual men or men who have sex with men who are very health-literate and educated, and they share information and support each other, which helps engage people. But there are subgroups within that who we have to be very specific in targeting, particularly where it is quite a cultural challenge to access some services. The way to do that is to attempt to destigmatise, use digital means as much as possible to share information widely, and allow people to access our services.

Q21 Danny Beales: Are you doing that as part of the gonorrhoea vaccine? What funding is available for that activity, outreach and public messaging?

Dr Doyle: Sexual health services are commissioned by local authorities.

Q22 Danny Beales: Is there no particular national funding for that?

Dr Doyle: The national funding is for the actual delivery of the vaccine: the vaccines themselves and paying and commissioning the services to deliver the vaccine.

Q23 Danny Beales: Is it realistic for local authorities to deliver national messages to quite small population groups for a national vaccine?

Dr Doyle: No, but it is absolutely important that some messages are very local and targeted, because with the picture across different communities and the targeting of groups within those communities, it absolutely helps for it to be local. There is something about saying, "Nationally, this is now available and this is who is at highest risk.", but it is really important that local messaging and local information on where and how to contact and access services is delivered as part of local sexual health services.

Q24 Danny Beales: Richard, do you have any thoughts about the effectiveness of the current approach from the voluntary and community sector, or what else is needed to reach those groups?

Richard Angell: There is nothing happening and no additional resource for that to happen. Most local authorities are not in a position to respond to a new thing and educate people about the gonorrhoea vaccine, or the mpox vaccine that was made available beforehand.

There is a really good model in the system run by HIV Prevention England, which is a programme that has evolved in different ways and been funded by the Government since the Thatcher era. It is a mechanism that was put in place for the voluntary sector to run a national campaign and then work with local activation partners to do that really good work, which we have done very successfully. THT has had that contract for the whole life of that work, has been competitive at every stage, and we really pride ourselves on running that well.

So the model is there for doing it, but whenever the model is applied to another STI area, it seems to come at the expense of HIV funding



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because they basically want to come out of that HIV Prevention England pot to make that happen. If we are going to get to ending new cases by 2030, that clearly has a massive opportunity cost on that desire, but the voluntary and community sector has that model in place.

Just quickly, if I may, on lessons learned for mpox, this is a really important point and Pat McFadden and Wes Streeting both deserve some credit for it. The funding for the mpox vaccine in the middle of the outbreak was just £15 a person, which is what they pay for HPV where basically you go to a school, line up pre-sex teenagers and give them all a vaccine. That is very different from giving a vaccination for mpox where you need to take a sexual history and people might be asymptomatic or symptomatic or need other interventions there. The new Government, who have implemented this, have raised what they are paying sexual health services to implement the mpox vaccine.

That was a really important lesson: NHS England did a disservice in the outbreak in terms of how little it was paying sexual health services, but that point has been listened to and the system has had a really good learning, which is also reading across for gonorrhoea. But in making that decision to fund the vaccine, what we have not done is fund the promotion of that vaccine, and that is going to be really important because, if you do not, that is when health inequalities take over.

Q25 Chair: I just wanted to come back to clarify one point, not just in terms of resources around funding, but about time. Ultimately, one of the main reasons people are not being offered these vaccines is because of the time constraints within an appointment. Is that correct?

Richard Angell: Totally. What local government has done brilliantly with the devolution of the public health grant is to try to increase the number of appointments that there are for people, whether through online or in-person testing. It has done that exceptionally, but essentially everything else in the service has been put on the bonfire to afford that, so there are far fewer health advisers.

We do partner notification very brilliantly with the 51 cases of antibiotic-resistant gonorrhoea, but if you have general gonorrhoea, nobody sits down with you and says, "Who were your last sexual partners? They're most likely to be the people who have it as well." That has all gone in the system, and those appointment times are more and more pressured to make that happen. We have almost no sexual health services open on a Saturday. When do young people use a sexual health service? Kate talks about the burden that young people have on sexual health. They are in school, education or training, and if they are not they lose benefits and entitlements while doing that.

We have organised the service around not just the producer, but often the commissioner, not the patient. We have lost weekends and are losing other days of the week to make it happen and keep a service going in an area. There are almost no walk-ins across the country. We mystery



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shopped the sector 18 months ago and found shocking results: deserts where you could not get postal testing and huge waits to get treatment or appointments; it is a real challenge.

Chair: If you are able to share those results from that survey with us—if you have not already—that would be really useful. I am going to move on now to Alex and we are going to talk about HPV vaccine take-up.

Q26 Alex Brewer: Cathy, in the last three years more than 400,000 children left school without receiving the HPV vaccine. What work are you doing to increase the take-up both in schools and for those who have already left school?

Cathy Morgan: As you know, the Government remain really committed to the HPV vaccine. As Kate has already said, it has been hugely successful in making a difference. I am sure Amanda can talk a little about the take-up that we are doing using the NHS.

Something that Richard and Kat have talked about is the importance of opportunistic vaccines. Although there are pressures in sexual health services, we know that there are also a lot of opportunistic conversations and that there is definitely commitment on HPV.

Dr Doyle: Shall I pick up? NHS England is responsible for the delivery. As you say, the bulk of our HPV vaccination comes through school-age vaccination services. We offer the vaccination to all children in Year 8. When we first started, it was just girls. Since 2019, it has been both girls and boys. Everyone is offered it in Year 8, and then we have a catch-up in school: every year that you are still in school after that, if you missed it once, it is offered again, and that is available through the school service for anybody still at school.

Last year, about 76.7% of girls and 72% of boys were vaccinated by the time they were in Year 10, so age 14 or 15. Our peak vaccination rate—not just for this, but for lots of vaccines—was 2018-19. Things dropped during the pandemic and did not pick up, for the reasons we have talked about. It has started to pick up again; we are not quite back at our peak yet, but things have risen.

Any young person up to their 25th birthday can access a catch-up HPV vaccine through their general practice if they have missed it. Each year we ask GP practices to focus on a vaccination campaign as part of the contract and really push an increased uptake, depending on what our priority is in a given year or what we might want to push. This year, it is HPV vaccination catch-up, so all the GP practices across the country are really pushing that.

We are also looking at how we expand the use of things like the Community Pharmacy England network—which is starting to commission to offer lots of routine vaccinations—for people to be able to use those



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other routes. We are starting work on how we can roll out access to HPV vaccination further.

For the higher risk community that we have been talking about with regard to the gonorrhoea and mpox—the gay and bisexual men and men who have sex with men—that group is eligible for the HPV vaccine until they are 46. Again, they can access that vaccine not only through sexual health services, but GP practices. It is really important almost to publicise the difference. In an ideal world, everybody would be vaccinated at school and we would not have to then worry about chasing specific groups.

We have done some real work around looking at what is stopping that take-up, and one issue we have found is consent processes. Something as simple as that is messy; if you are vaccinating children, you need parental consent, but a note in a bag for your mum or dad to sign a form is not always something that comes back in an orderly way, so we have rolled out a digital consent process called Mavis that is much more streamlined, quicker and easier for parents. That is now rolled out because we know that is an issue. It is not that people do not want it; it is just that they do not get around to filling the form in.

Q27 Alex Brewer: When was that rolled out?

Dr Doyle: We have been developing it and are rolling it out.

Q28 Alex Brewer: So there is no dataset to compare it yet?

Dr Doyle: We do not have any data that says, “We rolled out on this day and this is the uptake that has increased,” but we will have quite soon.

The other thing we have asked, and cross-Government teams have been very supportive in, is that we need every school to see this as a real, important priority. It is not that schools are obstructing, but some schools are very enthusiastic about ensuring that this happens and that everybody recognises its importance, so there is an ask around making sure that happens consistently. Again, it is back to information, but we are improving and are very successful.

If you look in more global terms, we are doing very well with regard to HPV compared to many comparable countries. This is tied up not only to reducing sexually transmitted disease, genital warts and so on, but it is part of our commitment to eliminate cervical cancer in women by 2030 as part of a WHO commitment. It is obviously really important in boys because of the incidence of genital and oropharyngeal cancers in men, but also in as far as transmission of HPV goes.

Q29 Alex Brewer: I am mindful of time, but I have a couple of quick follow-ups. Regarding the age limit of 25, is the vaccine not effective over 25 or are there other reasons why it is not given, apart from obviously in that one specific group you talked about?



Dr Doyle: We deliver vaccines according to recommendations of the Joint Committee on Vaccination and Immunisation. It almost becomes a diminishing return. You have the group that you are going to get, but the reason we offer it to 12-year-olds is that we want to vaccinate people before they have been exposed; the later you leave it, the more likely they are to be exposed.

Q30 Alex Brewer: You talked a little about take-up. This really varies across the country; I can see in some areas it is really excellent and in other areas it is really low, such as right here in Westminster and just across the river in Lambeth. Is there a particular part of the system that is failing in some areas or is it multiple factors? What are they?

Dr Doyle: It is multiple factors. Certainly in London there are pockets of communities or whole communities themselves where there is a significant degree of vaccine hesitancy or cultural issues that make people resistant to accessing vaccines. But across the country more widely, there is variation in how effectively school-age vaccination services deliver.

Obviously, we have parts of the country where school absence is more of a problem than others, so you are not going to get vaccinated at school if you are not at school. We have an offer for children who are not in mainstream education. But we recognise what those issues are, and those are the things we need to address by reaching out through schools to parents and communities to enable this to be supported and encouraged.

Q31 Alex Brewer: Do you have sufficient resource to be able to do that? That is a lot of work in outreach, comms and building a digital consent system as well.

Dr Doyle: We are resourced for the vaccine programme. Obviously with things like outreach communications programmes—both national and local—the more resource you have, the more you are able to do. But the issue is not resource; it is often tackling the individual issues that block our ability to deliver to certain groups within the population.

Q32 Chair: I have a couple of follow-up questions. Professor Whitty said, “We have the potential to almost eliminate cervical cancer in this country; it would be tragic to let that slip through our fingers.” While the average is on track hopefully to reach that stage, as Alex said, we see areas in constituencies such as mine in Luton where below half the children are taking this up. It cannot be left to do more of the same.

What different approaches are you looking at to increase uptake, whether it is language or community leaders taking a lead in the same way that we saw with covid vaccines, for example, to overcome vaccine hesitancy there? I guess it struggles with its image, because the name HPV does not ring in people’s minds that this is going to eventually be anti-cancer for their children. Is there anything that you are thinking about around the communication strategy and vaccine uptake of HPV for areas that



have particularly low uptake?

Dr Doyle: Both Cathy and Kate might wish to come in. We have done quite a lot of insight work with communities, as simple as, "What messages make you more likely to vaccinate and what messages put you off?" It is interesting, and some of it feels counterintuitive; frightening the life out of people does not always work, or things that are perceived as us trying to force the message on people or control people's actions.

The most effective strategy is a one-to-one conversation with a trusted health professional. It makes a difference across the board where there is hesitancy, particularly with childhood vaccines, although obviously this is older children. It is taking the opportunity at every contact that the NHS or other services have with families, and it will be apparent in a GP practice if a child has not been vaccinated; all that information is on their Single Patient record. When they see a health professional, we have to take the opportunity to have a conversation with people.

Q33 **Chair:** Cathy and Kate, as Richard said, it takes time to talk this through. It takes time to be offered a vaccine and talk about the positives of this and why it is needed. Are there the resources to be able to see the improvements not just across the board but particularly in low uptake areas?

Cathy Morgan: The Government fund local authorities on the basis that local authorities are best placed to take those sorts of decisions about how to best engage the populations. We know that there have been really good examples of individual local authority outreach services. It is also important to work really closely with the school nursing service so that you can explain to the young people themselves using the new relationships, sex and health education curriculum that was published back in July so that people are able to take an informed decision. There is evidence that it works, but as Amanda has said, it takes time to have those conversations and help people to understand what it is that you are asking.

As you said just now, Sarah, understanding that HPV equates to cervical cancer is not an obvious thing, so being able to help people to understand that that is why we are asking them to have the children vaccinated and that it is safe to do so is really important.

Q34 **Kirith Entwistle:** My first question is for Cathy and Kat. The Government's Plan for Change talked about shifting care from hospitals into more community-based settings. I wanted to know to what extent this has meant an increase in resources for sexual health services. If you could talk a little about the impact that you think the spending review might also have on long-term funding for sexual health services as well, that would be really useful.

Kat Smithson: This is a really key question. What does the 10-year plan for the NHS actually mean for sexual health services? The short answer is, so far, very little: as you have heard today, sexual health services are



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commissioned directly by local authorities in England. One of my asks to this Committee would be to support us in asking questions about what that means and what this shift to community can mean for public health and local authority-delivered services.

Increasingly, my members are telling me that they feel quite separate from their NHS colleagues and the rest of the system, and that is having an impact. What we really want to see is a constructive conversation about what the 10-year plan might deliver from a public health perspective when it comes to sexual health, and how sexual health services—which really should be looked at as a fantastic primary example of community-delivered services—are actually being included and integrated into this plan. There is so much potential there for sexual health services to become a key touchpoint for lots of populations, to bring them into health services and intervene much earlier on things as well.

In terms of the spending review, we had a slight uplift in the public health grant. Again, it is too early to tell, but the message that I am getting back from my members and early indications from conversations I am having, both with commissioners and people on the ground, is that that is not being reflected in the contract figures for sexual health services in any way. If anything, the message that is being given is that there is more pain to come, and current tenders that are happening at the moment seem to be working on the basis of needing to make cuts and further savings. There is a lot of instability and insecurity in the system, with people feeling that they do not know where their service is going to be in the next six to 12 months, let alone in the future. It is taking some time to see any benefits from that.

Cathy Morgan: The public health grant that funds local authority commissioned sexual health services increased by quite a significant amount in real terms in '25-26; there was a real terms increase of 3.4% and a 6.1% cash increase. The budget is now over £3.8 billion. Clearly local authorities are best placed to determine how they spend that, based on the needs that they see in their local areas. They need to obviously make trade-offs and choices, based on what needs they have and how they would like to prioritise those.

In terms of longer-term outcomes, the Chancellor's spending review statement included overall departmental allocations, but that is yet to be broken down. The Government have said that they intend to publish a three-year settlement for the public health grant allocations alongside the local government finance settlement, so there will be more certainty over the next three years than there has been previously when there have been annual updates.

Q35 **Kirith Entwistle:** Kat, aside from more funding, are there any other steps the Government could take to improve the ability of sexual health services to carry out their functions? How do you think the abolition of



NHS England will affect sexual health services?

Kat Smithson: Obviously resources are a key factor, but it is also about how the system works with those resources. What the STI Prioritisation Framework should be helping us to do is think about how we can spend resources most effectively. In terms of the barriers that my members are telling me about to delivering really good care, I hear about fragmentation of the system, which is a term we use all the time. It is about the impact of that on, for example, a consultant sat with a woman where they can identify that there might be safeguarding risks, but they may be limited in what they can do. They can identify that there might be a cytology need, but they may not be funded or directly commissioned to deliver that service, so they have to send that woman away or refer her on. That is a barrier, not an enabler.

What we want to do is try to make sure that whoever is commissioning the service enables a more joined-up approach, because we are not maximising the skills that we have in our services. What we have is a workforce feeling that they are not able to use the skills that they have. What that is leading to in some cases is dilution of expertise and knowledge as well, and they are focused on trying to find savings or going through contracting processes rather than delivering care to the patients. There are things that can be done that could support really good, patient-led care, working with the clinicians and healthcare professionals that you have in the system, that do not necessarily require more resources, just a different use of the resources and more joined-up and integrated thinking.

Q36 **Kirith Entwistle:** Maybe thinking a bit more about the process itself and where there might be—as you mentioned—barriers in place that could be easily removed or tweaked to speed up the process a bit?

Kat Smithson: Absolutely. In terms of the NHS England abolishment, it is again really difficult to say. A key thing to remember as well is that NHS England directly pays for some vaccines that are delivered through sexual health services and some of the drugs that are prescribed, and it is commissioning HIV treatment and care as well. A lot of people working within sexual health services are also delivering HIV care, although it is commissioned from a different service.

I suppose a question I would like to be asking the Department going forward is how we make sure that this transition can potentially have a positive impact on co-location of services, for example, and lead to better integration of those services for people living with HIV. Can we make sure that there are not any unintended consequences?

Richard Angell: Collaboration is also something that does not cost money, but can be really successful. Of the 33 London boroughs, 30 commission Sexual Health London services, which is a postal STI service. It is 25% cheaper than tests provided elsewhere and has a higher take-



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up and diagnosis rate of putting people on emergency contraception and other kinds of services, so there is a crowd mentality for that.

In Manchester they run out of tests most days, because each local authority in Manchester is commissioning its service and closes its services off to other people in other bits of Manchester, but people in Manchester do not have sex on the basis of their local authority. Grindr did not open up and only apply to Salford. If we commissioned a sexual health service in Greater Manchester, for example, to a very clear conurbation, that might be a way and a unit in which you could have a better spend of that money, use the expertise of the voluntary sector exponentially, get better outcomes for the patient, and they would not have to know what council tax they pay, but what services they need to use.

Kirith Entwistle: I will take that on board as a GM MP.

Richard Angell: I thought you might.

Q37 **Kirith Entwistle:** I have a final question around the reproductive health inquiry that we are doing. We found that there needs to be a better use of women and girls' interactions with healthcare settings—for example, visits to sexual health services—to detect reproductive ill health. To what extent is that something that sexual health clinics are able to support, and have sexual health services been brought within the women's health hub model at all? Kat, I guess that is for you to answer.

Kat Smithson: We have two different specialities that are often working within integrated sexual health services: community, sexual and reproductive health and genitourinary medicine. When we are talking about women's health hubs, it is really important to consider the potential role of genitourinary medicine expertise in delivering some of that—not just thinking about tacking on, for example, testing around STIs, but actually thinking whether there are proper links into GUM services, because women need GUM. That is really important and is something that is consistently raised by my members.

Conversely, it is also making sure that we are not missing opportunities in reproductive health appointments to test for HIV, for example. We know that women are leaving sexual health services without testing. Some will be reproductive health-based appointments where it is not necessarily standard to offer the HIV test; it depends on the area. What can we do to make sure that we are consistently offering HIV testing, or even have HIV testing on an opt-out basis, are other key touchpoints for women when they are attending sexual and reproductive health services such as in abortion services and in cervical cytology and things like that?

There are lots of examples of where we can be better joined up in making sure that we are offering the right screening in the right places, directing people to the right expertise, and making sure that they have access to what they need, when they need it.



Kirith Entwistle: The point that you made about not just tacking on services, but really thinking about using those opportunities, utilising them well and establishing those links is really important.

Chair: David has a quick follow-up question on this section, and then we will go on to the next section, which is around testing.

Q38 **David Burton-Sampson:** Sorry, I am being very greedy with my questions; I am going to put this one to you, Cathy. Richard has implied a couple of times that access to services can sometimes be quite difficult for people. I have heard from a variety of different sources that the type and level of access you get to sexual health services depends on where you live, especially when you really need it, say if you think you might have some sort of infection. I hear how it is funded through local authorities, but clearly that is leading to a postcode lottery for some people. Is any thought being given by the Department to how we can address that to get a more standardised level of service across the country and more access to more people?

Cathy Morgan: Yes, absolutely. As I have mentioned, the public health grant has funded sexual health services. We have been working with colleagues—including UKHSA—on the STI Prioritisation Framework. That looks at how you take decisions locally to understand both your need and what services should be provided. That does not change the funding situation, but it means that local authorities can best understand what the needs of their population are and how to respond.

Others have also done quite a lot of work: the ADPH reissued its “What Good Looks Like” guide for sexual and reproductive health services earlier this year, which again, is designed to help local authorities think about the services that are best meeting the needs locally.

It is really important that there is a needs assessment and then a decision on which services should be prioritised. That is much better than a one-size-fits-all approach, but that is not to say that a good standard should not be reached throughout.

Q39 **Samantha Niblett:** I am hijacking David’s questions, as I have a couple of things to ask. It is really interesting to hear you talk about the responsibility being with the local authorities. I have offered my constituency office up for sexual health clinics; the NHS loves the idea, the local public health service at Derbyshire County Council loves the idea, but the main challenge is no resource. I continue to press for that.

The reason I actually wanted to ask a question was I recently met with the CEO of Grindr. You mentioned this programme in London, and he was saying that one of the great things about the online community, predominantly with gay and bisexual men, is that sense of community. You might not just go to hook up with someone or meet someone; it is also a great way to communicate. He said that Grindr was partnering with Sexual Health London to help deliver HIV tests at home.



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We are talking about pressure on sexual health services. When it comes to that collaboration between not just different health authorities, but thinking-outside-the-box organisations, such as me as a constituency MP saying, "Come and use my office," do you have any examples of where that might be working somewhere else that we could perhaps propose as suggestions?

Richard Angell: Grindr For Equality has worked with us on National HIV Testing Week, and we put out an activation through that. That gets a significant number of HIV tests ordered through it, and it is a really effective means of getting to the target population to make that happen. We appreciate that it partners with us as part of National HIV Testing Week to make that work. Ultimately, the reason why National HIV Testing Week exists is because local authorities have so few resources that, if you did something to promote testing outside that time, you could bankrupt local authorities.

The problem that we have not really got to is the problem with the public health grant model: there is a zero-sum game in sexual health. The more tests you have online, the fewer doctors and nurses you can afford. There is a small budget that is limited. The NHS is an ecology; it is a significant proportion of our GDP turnover, so this sliver of £3.8 billion sounds like a lot of money, but in health services it is not. Every additional test we promote online is something that is not happening somewhere else in the system. That is the real challenge, and it is why the public health grant system is not working for service users.

Local governments have done a brilliant job, with two hands tied behind their back, running that system. This year we talked about it going up, and it is the only time it has gone up by more than inflation. The financial year we are in now is the only time since it was created that the public health grant has gone up by more than inflation. People are doing really well with that tough system. But the truth is, if I received a grant funding at another point of the year to do a big push on testing, or we convinced Grindr to do an activation at another point of the year, those tests would get ordered, but the budget for those tests would just get saturated earlier in the year.

The thing about testing week is the Department of Health and Social Care pays for those tests in that week so that we get that activation. It is the only thing we do all year on stigma reduction for STIs or HIV, the only time nationally where we talk to the public and "The Prime Minister is doing a test", or "Prince Harry is doing tests"—Gareth Thomas was leading this year. There are all the things we have done there.

The problem is we could be too successful. "It's a Sin" came out, and we got rid of the tests in six days. We potentially could have had to turn off the tests, but thankfully DHSC found some money down the back of sofa—plus it was covid times and health money was not really restricted in that sense. But if "It's a Sin" had come out in a non-pandemic environment, it could have been very different.



That is the challenge with the model as we have it now. If we accept that model, we are accepting that we are robbing Peter to pay Paul if we do really well in nurses in schools, or really well in sexual health by increasing access. That is the challenge that is just fundamentally baked into this system. It is not just money. Ultimately, the Lansley reforms led to such fragmentation and this important part of the system being funded in this opportunity cost environment. The NHS is almost an economy in its own right; it finds a way and it makes its own savings within the system. But, if local government does a really good job and prevents people getting HIV, the NHS saves money, not that local authority. That is the problem.

Q40 David Burton-Sampson: I am going to come to you, Kate. The STI Prioritisation Framework states, "There is a lack of evidence that widespread screening reduces STI prevalence and harm." What is the latest advice on getting screened, and what has changed or is changing in the approach following the publication of the STI Prioritisation Framework?

Kate Folkard: There is a lack of evidence that widespread chlamydia screening reduces prevalence, which is why there was a shift from reducing prevalence to reducing the reproductive health harms that chlamydia causes. There has also been some other work that shows that asymptomatic screening for gonorrhoea has not reduced the prevalence. That is a statement of fact.

There is an international debate about asymptomatic screening for chlamydia and gonorrhoea—this does not touch syphilis and HIV at all—and a debate about the balance of benefits and harms for that, because many of those infections will resolve and not cause harm. Some countries have made changes to their screening and testing recommendations. BASHH sets the advice around testing frequency, with support from evidence from UKHSA. That has not changed, so our position is still the same in terms of the recommendations to the public. But we are continuing to keep that evidence under review, as other countries have done as well.

David Burton-Sampson: So nothing has changed at the moment, but it is under review?

Kate Folkard: Yes.

Q41 David Burton-Sampson: Concerns have been raised that the current test and treat strategy for chlamydia and gonorrhoea among gay and bisexual men "may be an inappropriate use of resources and doing more harm than good" when it comes to antimicrobial resistance. Are there any plans to change the advice? From what you have said, I do not think there is, but, based on what we are hearing, are there plans to change the advice on testing for gay and bisexual men, for example from three months to annually?



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Kate Folkard: BASHH and BHIVA recently published their revised PrEP guidelines. That had previously always been three-monthly testing. It now states—others may correct me if I am wrong—three-monthly testing for most, but if somebody is in a stable relationship and does not require that, there is more flexibility around that.

As I have said, other countries have reviewed that evidence and made changes as a result of that. For example, Holland has stopped doing any asymptomatic testing for chlamydia and Belgium has stopped asymptomatic chlamydia and gonorrhoea testing for gay men on PrEP. There are countries that are making shifts in those recommendations. As I said, we have not made any changes as yet, but we are keeping that evidence under review. There is a thorough process by which BASHH would review guidelines that would take that evidence into consideration.

Q42 **David Burton-Sampson:** It is interesting what you say about stopping asymptomatic testing for gonorrhoea and syphilis for people who are on PrEP.

Kate Folkard: Not syphilis, no.

David Burton-Sampson: Not syphilis, sorry.

Kate Folkard: Yes, that is really important. It is just gonorrhoea and chlamydia. It is really important that we carry on the testing for syphilis and HIV.

Q43 **David Burton-Sampson:** I am sorry, forgive me. Gonorrhoea and chlamydia. PrEP does not protect against those, though, does it? Where do you think the correlation is between that in Holland and what was its rationale for that? I would be concerned if that came in here.

Kate Folkard: As I said, it is going back to that balance of benefits versus harms of testing somebody who—this is only for asymptomatic infections—does not have symptoms. That infection may well clear of its own accord and not cause any harm. Having a test is not without its costs to the individual—not financially, but in terms of anxiety and taking antibiotics, if that infection would have cleared on its own. Those considerations and concerns around antimicrobial resistance are quite an important part of that consideration of the benefits and harms.

Q44 **David Burton-Sampson:** Kat, can I come to you briefly? Are there any interactions outside sexual health services that could be used—or used more widely—to help monitor and control STIs? For example, should STI screening be a routine offer at abortion clinics?

Kat Smithson: What we have seen with the opt-out testing in A&E for HIV and hepatitis over recent years is just how successful taking screening for some conditions outside sexual health services can be. Yes, I would say if the evidence is there to back that up—it certainly is for abortion services, for example—we would like to see screening, and



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particularly HIV testing, in those environments. We would follow the evidence with regard to that, but yes.

Chair: I am going to bring in Danny Beales, who is our guest on today's work from the Health and Social Care Committee. You are very welcome. I am going to hand over to you.

Q45 Danny Beales: First, I am just going to declare for transparency purposes that I used to work with Kat, and I am very close with Richard from when I was at the National AIDS Trust—it is nice to see a number of you again today. Turning to HIV and access to PrEP, first, I have a question for Richard. We have seen persistent inequalities in outcomes in terms of HIV, and in some cases increasing inequalities, whether in rates of late diagnosis among women or ethnic minority groups, levels of new diagnosis, or levels of uptake of testing. Why do you think we have seen those inequalities persist, and what more should be done to address them?

Richard Angell: The inequalities fundamentally exist because they exist in society. HIV is probably the most stigmatised disease area there is, certainly since leprosy, and it has an emotional charge. I often say that people think about hepatitis, but they feel about HIV. You have an emotional response to HIV because of the nature of the epidemic, how it was established, and of course, how it was publicly prevented in that era when there were no tools other than fear and condoms, basically. That is where it comes from.

PrEP as an intervention is quite a strong drug for people to take. You therefore have to have a sense that you might potentially acquire HIV to want to take that drug. Gay men are clearly disproportionately affected. While the numbers have gone down, when you look at the number of gay men living with HIV per 10,000 population, actually we have made very little progress in recent years. You really see in those numbers that gay men—obviously including men who have sex with men—disproportionately continue to take the brunt of the epidemic.

Regrettably, PrEP was essentially brought into the market as a gay men's product, and we have been evolving that service since. It has been put in sexual health services, in a system where you have to fight to get through the door; these are not proactive services that come out to you, they are services you have to seek out. Every week Dean Street issues 300 appointments, and 1,500 people are chasing them, and that is the best-funded sexual health service in the country.

From the work that you did when you were at NAT, Danny, we have not seen progress on that 12-week waiting list for starting PrEP. Even those who know about it, know the benefits of it and think they would benefit from it have a 12-week wait to get it. The initial guidance was essentially for gay and bisexual men. We now have guidance that says, "If you think you have a risk, then you are eligible," and we are seeing that going



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forward. What we have not then done is style the services around how women use the NHS.

One of the exciting things, though, was a very small trial by a group called Lavender that ran a gay men's service on online initiation for PrEP. It had more women come through the service than the local authority had had previously through all its other services. When it did focus groups, one of the things women said was, "Well, if it's a gay men's service, they're not going to be judgmental about what I'm doing. I'm very happy to use it." That was a really interesting learning; it was a really helpful thing.

The ability to take up PrEP digitally is a huge innovation. We are seeing two places in the country that are doing this at the moment. In Sussex we are seeing it, and about three quarters of the users of that service are new to PrEP. It is a brand-new service in a rural area for those people. In Hackney, where they are doing it alongside a trial that is funded by the Elton John AIDS Foundation and some pharmaceutical partners, three quarters of the people going through Hackney are modal changers. They were getting it from sexual health services, and they are now going online to do it. That is creating capacity. In Brighton, where we have had a digital app for some years helping people manage their ongoing PrEP needs—not starting but getting renewals, more drugs—that has released 1,000 appointments a year.

With those appointments we are now doing outreach services at Terrence Higgins Trust offices, in gay bars, at a trans community group, with migrant communities new to the south-east. That capacity is going out to people who would never come through to those services. That is the model we have to use. We have to build the NHS around the service user.

The Health Secretary keeps saying, "The patient is king or queen," but that is not true in sexual health services. They are often organised for the convenience of the producer; you have to seek it out, you have to be active, you have to be knowledgeable about the system. Lots of people, if they do not have something itching or burning when they pee, do not necessarily go back and persist to get that appointment.

That is fundamentally where the health inequalities in that system lie, but we have the tools to target them. The NHS England app and the equivalents in Scotland, Wales and Northern Ireland are a real opportunity to change that: a totally personalised and absolutely private service, where you could initiate an HIV and STI test screen sent to your home, or ideally to a click-and-collect service.

Our service has 4,000 services across the country where you can pick up an HIV test so nobody in your house knows. We know particularly those from ethnic minority backgrounds are much more likely to be in houses of multiple occupancy, or multi-generational households. Nobody wants Grandma opening their STI test, but that is how some households are organised.



If you can initiate PrEP through that as well, and essentially have a digital prescription for getting your repeat PrEP, that could totally change things. But that probably requires a change in the law from parliamentarians to allow PrEP into pharmacies; until we can make PrEP available in community pharmacies, we are not going to see some of the access that we need. There is a change needed there, and some people cleverer than me need to get around the table and work it out.

Danny Beales: My second question was about access to PrEP, and you have covered it quite well. In your view, digitalised access to PrEP and access to a community pharmacy are needed to address the gender-based differences in uptake and other inequalities—Kat, do you want to come in about the barriers to those changes, or are any other specific changes needed to widen access to PrEP?

Kat Smithson: I do not disagree with anything that Richard said. What is really important here is that creation of capacity in sexual health services, how online and digital platforms work in partnership with face-to-face services, and how they are parsimonious with each other. One of the things that we have talked about already today in relation to the public health grant is that it can become a zero-sum game. Some online services are seen as a cheap way of delivering testing, or a cheap way of delivering services. You see money coming directly from a sexual health clinic budget and going into online services, which then creates tension in the system as well.

For my members it is incredibly frustrating, because they feel like they are almost being pitched as those who are against online services and promoting their own face-to-face services, and actually what they want is to optimise online opportunities. They have often been at the forefront of developing these services and how they work, and it is really frustrating to be presented as someone who is standing in the way of innovation when what you want to do is work innovatively yourself.

It is important to ensure that the system you are developing works really well in partnership with a local service, and that you are not removing the capacity of that local service to be able to then deliver PrEP when it is needed. You do not want to just channel shift. If you end up then sitting in clinic with someone who needs PrEP, and you have to direct them online because you are not empowered to give them PrEP, that is not the answer. That is a really key thing. It is really about smart service design, to be able to maximise the opportunities and the potential of some things.

The other thing to say is around the delivery of new technologies as well; long-acting PrEP, for example, and whether that has a role specifically for women. We are looking at injectable PrEP options. Those are currently all under patent, so they are more expensive than the PrEP that we have accessible in pill form at the moment, but for some women who are at particular high risk of HIV, these really might be the most important,



effective options for them. My members want to be in a position to be able to prescribe them when needed.

- Q46 **Danny Beales:** Lastly, I will turn to the action plan process. Cathy, and potentially Amanda from an NHS England perspective, what lessons have you taken from the current action plan, or outgoing action plan, in terms of its success—or lack of—in reaching the 2030 goals? Where are we with the updated action plan?

Cathy Morgan: The big learning is that we have to do this as a community. This is not just about Government doing things to people; it is about us working with many of those on the panel with me today. We have been working throughout the whole time that we have had an action plan, both to develop it and then to implement it. Government cannot do this on their own; we need to be able to pool together all that information, and that is what we have been doing.

We have had a stakeholder implementation group throughout the life of the existing action plan. That group has helped us to then start developing the action plan. Professor Kevin Fenton has been out running a range of different events, making sure that he is reaching into communities and understanding what works. We are working with our partners right the way across the system to look at what interventions might work.

- Q47 **Danny Beales:** What have you heard from that process, from the community and the range of stakeholders? What are the key messages you have heard?

Cathy Morgan: We have heard that we need to do more building on what has already been done. We need to do more in those spaces—testing and treatment, retaining people in care—and we need to do more about tackling stigma, which remains a really significant issue. Finally, we need to think about HIV in the broadest context, so that we are thinking about sexual health services in their totality and HIV as part of that picture.

Dr Doyle: It is possibly worth mentioning the opt-out testing in emergency departments, thinking more broadly than just sexual health services when people contact them. We have now rolled out further sites in emergency departments in areas where there is high or very high prevalence of HIV. People who are having a blood test anyway in the emergency department are offered a test. That has been successful both in identifying new cases and in identifying people who are not a new case, but may have become disengaged from treatment, or lost to follow-up, so it is an opportunity to re-engage.

We test for hep B, hep C and HIV, so it is broader than just HIV; it is other blood-borne viruses. We are finding that women make up a higher proportion of the people we identify through those routes, and older people make up a higher proportion, not surprisingly. These more generic



routes to access people are often finding cases in the groups who do not traditionally access our sexual health services. It is quite important that we properly evaluate how effective some routes are.

Q48 Danny Beales: When do you expect the plan to be published?

Cathy Morgan: The Government have committed to its being issued later this year.

Q49 Danny Beales: Just very briefly, Richard and Kat, from a community end provider's perspective, if there is one hope for the new plan, what would it be?

Richard Angell: Can I just clarify something? With the opt-out testing, we now have sites coming on board that are doing only HIV, and NHS England is not funding the testing of hep B and hep C in the latest iteration. That is a real worry, because it will be judged on the ROI of the intervention on its own, and HIV will then get defunded. We are seeing a huge number of tests happening for people who would otherwise be diagnosed with hepatitis B and C, who are going undiagnosed in those areas. That is a red flag in the system that needs to be noted.

When advocating for anything around the plan, three numbers always come to mind for me: 12 weeks waiting for PrEP, 5,500 undiagnosed people, and 12,000 people in England—1,000 in Scotland, 250 in Wales—who are diagnosed with HIV and do not take their medication. We are doing absolutely nothing about that last group. For me, it seems you have to organise around those things. How do we make an online service available all year round? Wales is doing that brilliantly: any time of the day, anywhere in Wales, you can order an STI kit, and you get tests for chlamydia, gonorrhoea, syphilis and HIV sent to your home. It is doing community testing and looking at doing click and collect with it.

We have to have that in England, in all parts of the country, all year round. We currently have £44 million, I think, being spent on HIV and STI testing in 100 different contracts. If you learn the lesson from London and pool that together, we could do that.

Danny Beales: I am in Hillingdon borough, the one that does not participate with the other 31 boroughs, so I feel your pain.

Richard Angell: You, Croydon and Greenwich are not participating. You could see the exponential benefits there, learn the lessons for opt-out testing, and put that in GP services. Particularly in very high prevalence areas—the places where we started the A&E testing—if GPs were doing that opt-out testing, we would see a huge number coming through. In opt-out testing, 73% of those diagnosed have never been tested for HIV before and never gone anywhere near a sexual health clinic. They might be expensive tests to do, but there are people who otherwise would never be found, and too often we are finding them very late in the day.



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PrEP in pharmacy would be a change that could come through. If we could just change the system so one pharmacy could do it, they will all follow suit. Crucially, there is this bit about the 12,000 people who are diagnosed and do not take their medication. It comes down to a complex set of issues, but fundamentally, it all comes back to stigma, whether internalised stigma about the virus, or community-based stigma, or stigma in the system where they have had a very poor experience when using the NHS previously.

The truth is that the place you are most like to experience stigma about HIV, if you are living with HIV, is in the NHS—not in an HIV service, but in all the services around it. That puts people off. We know 7% of people living with HIV avoid the NHS because they have had such a bad experience.

We need to have a programme. The Elton John AIDS Foundation, when it trialled opt-out testing in Lambeth, Lewisham and Southwark, also went through its rolls of people who had not been seen for more than 15 months. It re-engaged huge numbers of people. We need about £3 million a year for three years to turn the tide on that, to make that happen. That is a drop in the ocean in NHS England funding, and it will save money very quickly in the system. Croydon University Hospital alone identified that it spends £400,000 a year on late-stage HIV people coming into A&E. If we could get that upstream, we could change the dial, and we might have that bit of hope that we could get there by 2030. We are not on track at the moment, but if we apply that, we could be.

Chair: Kat, could your list be slightly shorter than Richard's, please?

Kat Smithson: Yes. As I said before, this is really about making sure that you are working with sexual health services on this. It is not STIs versus HIV, but how everything connects together and how sexual health services can work in collaboration with other initiatives, continuing the things that are working really well and making sure that we are not removing other potential touch points. Yes, hepatitis B and C being removed from the opt-out testing is a real concern to us, even though you would not necessarily think that that was our primary concern.

The other thing that it would be remiss of me not say is that we have huge inequalities affecting heterosexual women with HIV, particularly people of black African ethnicity, that have not been addressed yet. We really need to think about how we can work with sexual health services and sexual and reproductive health services more effectively to ensure that we can start addressing those inequalities, because the previous action plan has not done that.

Q50 **Chair:** Before I ask this last question, I invite Committee members, if you have any other questions at the end of this, just to indicate that to me please. During the previous Health and Social Care Committee's inquiry into sexual health, the Committee heard from young people at a community-based clinic in Plymouth and found that many young people



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were getting their education through pornography. Nobody will be surprised to hear that, but the Committee's report said that it was, "informing their expectations of sex and influencing what they perceive as acceptable. Condomless sex...and rougher sex have become increasingly normalised."

Cathy, I have two questions based on this. Are you happy and satisfied with the level of information given in schools as part of RSHE? Although it is a very small increase in the number of teenage pregnancies, are you concerned about it, and is there a clear factor leading to this slight increase at all?

Cathy Morgan: In terms of RSHE—relationship, sex and health education—we are hopeful that the new guidance issued in July will be really useful. It looks to set out factual knowledge for young people on sex, sexual health and sexuality, and to set that within the context of relationships, to try to move away from that pornography view of the world. Pupils will also be taught about contraception, sexually transmitted infections, developing intimate relationships, and resisting the pressure to have sex until they are ready. We are hopeful that, by providing the support that we are providing to schools, it will make a significant difference in the conversations that are being had in schools. That is a positive.

In terms of teenage pregnancies, the numbers are up slightly. As you say, it is not a massive trend as yet; it is a small uptick, but it is obviously not what we want to see. We are working with colleagues to try to understand what is going on and whether this is a blip in the data, or something that is more systematic that we need to take action on.

Q51 **Chair:** As you said, the new RSHE guidance has only just come into place for July. What will you look for as an indicator of whether that has been successful or not?

Cathy Morgan: We will be looking for feedback from teachers themselves, whether they are able to understand the guidance—it is statutory guidance, so they need to apply it—and whether that is being responded to positively by the young people in their care. We will also of course be looking at the data that comes from various surveys.

The Natsal-3 data tells us that the majority of people are still saying that they get most of their information about sex from lessons at school, followed by their friends, parents, and media. Although there is quite a lot about pornography, they are still looking to the lessons that they receive in school. We are doing a further survey; we will get that data soon, and that will give us a bit more of an understanding of how young people are responding and reacting.

Chair: If nobody else on the Committee has any follow-up questions, that leaves me to say thank you very much to you all, and to remind you that if you leave here and you are kicking yourself that you did not add something else—probably not you, Richard—or thinking, "I wanted to add



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this," or it would be useful for our committee members to know, please submit it in writing. I am grateful for all your time and your expertise. That brings this session to a close.