

Health and Social Care Committee

Oral evidence: Sexual Health Services in England, HC 1394

Wednesday 22 October 2025

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Alex McIntyre; Joe Robertson.

Questions 1-105

Witnesses

[I](#): Richard Angell, Chief Executive Officer, Terrence Higgins Trust; and Laura Domegan, Head of Nursing, Brook.

[II](#): Professor Matt Phillips, President, British Association for Sexual Health and HIV; Dr Zara Haider, President, College of Sexual and Reproductive Healthcare; Rob Bacon, Strategic Lead for Sexual Health, Hertfordshire County Council, and representative for the East of England, English HIV and Sexual Health Commissioners Group; and Tim Elwell-Sutton, Deputy Regional Director of Public Health for South East England, Department of Health and Social Care.

Examination of witnesses

Witnesses: Richard Angell and Laura Domegan.

Q1 Chair: Welcome to this one-off session of the Health and Social Care Committee on sexual health services in England. We have a wide-ranging list of questions on this important area of the health service. The purpose of today is to shine a light on where we are now and what needs to happen, and to help the Government do an even better job. We start our first panel with Laura Domegan and Richard Angell. Richard, can I ask you to introduce the organisation you are from, followed by Laura?

Richard Angell: The Terrence Higgins Trust is the UK's leading HIV and sexual health charity. It was founded in 1982 when our namesake became the first named person to die of an AIDS-related illness.

Laura Domegan: I am here on behalf of Brook. We are originally a young people's charity that focuses on sexual health clinics and education, but we have recently branched out into all-ages services as well.

Q2 Chair: Thank you both. Can we start with the lay of the land: what are the latest trends in lifestyle and behaviour that you are seeing and that we need to be aware of and respond to?

Richard Angell: The public are having sex, which is good news. An important part of our public life is that people have sex, and it is an amazingly under-appreciated part of our health and social care system. One of the things we were pushing for in the 10-year plan was for it to acknowledge sex as one of the social determinants of health. It is often named, but never explored, and when it is funded, it is, "We will treat your gonorrhoea when you have it."

If you think about the things we do with smoking as a social determinant of health—or if you think about weight or some of the other issues—a whole series of interventions are right, but we focus only on the very medicalised ones right at the end of that process when you have a disease in that sense. There is a real challenge with that. There are lots of things that could come from embedding that approach going forward.

When people turn up and use the system as it is, they really struggle because the system is under strain. Our friends in local government have done an amazing job of localising services; they have taken the transfer out of the NHS very seriously and put a high priority on trying to deliver good services. They have done an amazing job to maintain a high number of appointments across the country, but lots of things have had to go on the scrapheap to afford the maintenance of those appointments, particularly some of the stuff around health advisers who often do partner notification, which is your best chance of finding the next positive in the system. That is not being prioritised across the board in the system. That means that we have the highest level of STIs that we have seen in the



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country since the second world war, and people are having a poor experience when they experience them.

My team did some mystery shopping in all your constituencies. They took your constituency office and, as the crow flies, tried to find your nearest sexual health service and book an appointment. They were a 27-year-old straight male who'd had three sexual partners in the last six months, had had condomless sex and had no previous bacterial STIs.

The result was not very good, basically. Layla, you will be pleased to hear that your constituency is the only place where you could book an appointment on 4 November—which, if you have an itchy willy, is pretty inconvenient and is not a great service. This was an asymptomatic person, but it is still not a good service. In the rest of your constituencies, there were no in-person appointments.

Alex, your constituency's sexual health service was the only one that gave a date for when services would be available, which was mid-November. Most had postal services available, except in Jen's constituency, where by 2.30 pm yesterday, they had run out of kits for the day. This is a system across the country where services run out of postal kits almost every day, and people are shopping themselves, booking from their partner's place and trying to hack the system to get the appointments that they need. Some people were sent to drop-in services—very few exist now across the country—but were told they would have to arrive early because the appointment slots go incredibly quickly.

One thing that we will talk about throughout this hearing is that the people who disproportionately experience sexual health problems and STIs are younger people, but—with a very few exceptions—there aren't any services open on a Saturday. You as parliamentarians have compelled our young people to be in employment, education or training in the working week, but if our services are organised around the producer and when it is convenient to provide those services and not around the population who need them, it is no wonder that people are not getting seen the way they need to and, crucially, the way they want to.

Q3 Chair: Are there any new behaviours that have emerged and that we just do not have responses to yet?

Richard Angell: There are a couple of things there. People are less likely to label themselves and the sex that they are having. People will define it by saying they have sex with their friends—people they want to have sex with. It is not about a male or a female in that process. Younger people in particular are changing how they talk about and how they define the sex that they are having.

People are much less likely to use condoms. Some of that is because we have the lowest spend on condoms we have had since the 1980s and people obviously cannot use things they cannot get. Equally, people are choosing not to use them. There are some things, like HIV PrEP and Doxy-PEP, that mean that you can have sex without a condom and feel that you



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have taken charge of your sexual health. So some people are taking those up, and particularly in the LGBT community those trends have been exacerbated.

But you see the largest percentage rises in STIs among people over 50 and often among divorcees. Broadly, gay men use condoms to stop HIV and straight people use condoms to stop pregnancy. So if you are post-menopausal, the reason why you have traditionally been using a condom is not there.

There are also some innovations that we are not doing and that should be trends that we are—

Q4 Chair: We will come back to those, so if I may, I will stop you there. Laura, from your perspective, what behaviours are you seeing in the populations that you deal with that we need to be aware of and respond to?

Laura Domegan: Brook recently did a study called the EASY study, which sampled young people across all our services, education pathways and online services as well; and basically what that showed was that condom use is going down among young people. STIs have gone up. Emergency contraception use has risen. But also young people are not accessing hormonal methods of contraception. What we saw from the study was that, basically, social media has a big impact on them. It is where they get their information from. They don't know where to go to—

Q5 Chair: Are they just not getting the information, or are they getting disinfo?

Laura Domegan: They are getting the information, but they almost can't work out what is factual—what is correct. You tend to get a lot of negativity. Influencers also have a big impact. Obviously, if a big influencer has recently said, "I had a coil fitted; it was a horrendous experience," that has a massive impact on young people and you see it in the services. You then get lots of phone calls. If somebody has said, "Hormonal contraception is dangerous," you get loads of phone calls; you get people wanting to come off hormonal contraception. So we have seen a big downturn in that. They don't want the hormonal methods; they start asking about the non-hormonal methods. We have, obviously, the copper coil, but they start talking about the rhythm method and things like that, which we would not advise.

The other big thing is education. We have pushed it back to the schools, but across the country young people are not getting a consistent message. They are getting very different messages, depending on what schools they go to. Church schools tend to restrict it more. That is also confusing for young people. We have to make these services open and accessible, and people have to have RSE from a young age. We have to be giving them the correct information and telling them where they need to go for it.

Q6 Chair: I used to do the sexual health talks when I was a teacher, and there would be about three of us who were willing to even start to have



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that conversation with young people, so training is important, I am sure. What have you seen that works? Do we have any good news stories of where you have seen these changes in the trends and services have adapted successfully to them? Do you have any examples, Laura?

Laura Domegan: I think it is just a case of being open—the door has to be open. There have to be all different ways of doing this. There have to be the digital methods, where people can go online and order the kits. But the door also has to be open, because digital and telephone appointments do not replace face-to-face appointments. The digital and telephone services tend to see the worried well, so the door has to be open for young people to access.

Where we see more success is where the service is young people-focused. In a lot of cases, young people's services have been absorbed into the level 3 sexual health services, and then we are seeing a trend of young people disappearing. One of the studies we are looking at is asking why the under-16s have disappeared, because in our data we are not seeing the younger cohorts who we were seeing, particularly before covid.

Q7 **Chair:** Can you talk me through why a physical face-to-face meeting would be better for people who are actually unwell, versus a digital one where they do not have to travel in?

Laura Domegan: For a young person, sometimes they do just want to see someone. Especially if they are not sure, quite often they will just walk past, and if they see the sign, they will walk in. There is an increase in mental health concerns in young people. There are increased safeguarding concerns as well. Sometimes they might come in just saying, "I want an STI kit," but actually they have been sexually assaulted, they might need EC, or sometimes they just want that person to speak to—to just listen to them. I think that for the young people the doors have to be open.

Richard Angell: Adding to that—and I agree with everything that has been said—some people cannot receive the kit at their home. You might live in a multi-generational household where the matriarch opens the post, and this is not something that you want to share. You might be living with your wife and having sex with other people.

We run a postal testing service for HIV and we provided a click and collect element to it, with 4,000 sites across the country. One in 10 used the click and collect; one in four of the black gay users used it; and one in three of the Asian gay users used it. For some people it is vital that it does not come to their home, and we make that happen.

Despite some brilliant innovations and some brilliant companies trying to deliver the best services, the tests are also quite difficult to do. I often have a plaster on my finger because I show people how to do them—not least the Prime Minister during last Testing Week, which was an amazing thing for him to do. The test can sometimes fail—getting enough blood out can be really difficult if your hands are not warm enough or whatever, and when you do the pee bit, you have to not do the first bit of your pee, and then do the rest of it. Getting it right is a bit technical, and if you are



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trying to do those things in a house where there is not a lock on the bathroom door—you know what siblings are like—or whatever it might be, it can be really intimidating, so some people need that service. But crucially, as was said, some people want to talk about wider things and this is their route into the system.

One thing that austerity has done is change some of the clinical decisions. We did a mystery shopper report. It showed the numbers of people—particularly asymptomatic people—unable to get appointments. I presented it to the sexual health doctors and got a pretty hard time. One of them said to me, “Why should we even make our service available for asymptomatic people?” It was a moment, and one of the clinicians on the panel was like, “I think the absence of resource has changed our clinical judgments over this period of time.” Crucially, the Health Secretary keeps saying, “The patient is king”—or queen, or a non-gendered version—and the patient’s experience, and how they want to use the service, really matters. We want to make sure that online is available for everyone who can get it. It is an important modal shift.

You asked about the exciting things that are happening and where there is good news. HIV is clearly one of those areas. We have a very clear goal. We could end the onward transmission of HIV by 2030 and we have all the tools to do it. We could be the first country in the world to do it. If we do it, it will be the first time we stop the onward transmission of any virus without a vaccine and without a cure.

The system is working together. We have an action plan and another being refreshed now. The Committee has called for a sexual health strategy on two occasions. The Government have accepted that recommendation; we still have no strategy. Susan Hopkins at UKHSA has done a brilliant job with the sexual health prioritisation framework, which has been a stopgap for a strategy, and we welcome it in lots of ways.

On HIV, the system working together to try to achieve that goal is really working. Online testing has been a massive improvement. Online PrEP provision is doing really well, and you are seeing people modally shift out of clinic appointments if they do not need them, which is freeing up appointments. In Brighton, we have a service that has created 1,000 appointments a year for outreach. We now go out to trans communities, to sex workers and to migrants new to the area. Some really good things are happening and, crucially, that digital service has opened that up. In the rural area where it was piloted, 40% of users were new to PrEP altogether, so it was a brand new service for nearly half the users.

Q8 Jen Craft: Good morning. I would like to look a bit deeper at the declining use of condoms, particularly among young people. I note that over the eight-year period when spending on contraception fell, spending on prevention, advice and promotion also fell by about £20 million. Do you think that the lack of spend on prevention is driving the behaviour change, or are other factors at play?



Richard Angell: It must be; the two things are clearly related. We as a charity ended up deciding not to provide a number of local services. I had £4.5 million of local government contracts to do prevention, which is normally about 10% of the local budget for sexual health, but I was finding that it was costing me £5.5 million to service those contracts. Inflation has been a real challenge in the last few years, and obviously our friends in local government experience it—not just as much as anyone but often more—and they have had their budgets restricted in every area of funding that they receive.

The pressure on the public health grant has been very real. Over that time you have seen some of local government direct it to things that have not traditionally been public health spend in that area. There is a real pressure on that budget, and we have been expected to provide increased KPIs and more performance for the same money. At the system level, the clinic then has less money for condoms.

We are not seeing the system as a whole, which is really troubling. A lot of people will go to have a coil fitted and not get a chlamydia or gonorrhoea test, let alone a syphilis or HIV one, which is completely bizarre. This is a service that you have to proactively go and use, but 400,000 people left a sexual health appointment last year without an HIV test. That is not good. That means that they are definitely not having a conversation about PrEP—if they are not even being offered an HIV test, they are not having a proper conversation about what will prevent future disease.

Laura Domegan: It is definitely true. There is pressure on the clinics' finances. We used to provide condoms to chemists and school nurses; we used to give them out across all areas where we have clinics. We have had to restrict that because of the costs. Contracts are coming out; we are being commissioned for the same value that we were commissioned for previously, but we are expected to do a lot more. That puts pressure on the ready availability of condoms.

With young people, there is also a stigma. Going back to RSE, I think we have almost gone a different way with condoms. They are not being promoted as much, and there is a stigma. That came through with the young people who spoke to us in our recent study. We have a lot of work to do to put condoms back on the agenda for young people.

Q9 **Jen Craft:** What is the stigma? What is the reticence?

Laura Domegan: They tend not to want to speak to partners about it. They do not want to say anything. Obviously certain sexual trends tend to get promoted. There is embarrassment.

Chair: Like what?

Laura Domegan: Different trends—without going too much into it—

Chair: It's okay.



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Laura Domegan: They do not want to use condoms. Quite often people just do not want to ask the question, and they will put themselves at risk to save embarrassment.

Q10 **Jen Craft:** Are the conversations that young people are having driven by social media?

Laura Domegan: It can be social circles, social media or different groups. Those were some of the trends we saw in the study we did. Stigma was still a big thing around condoms.

Q11 **Jen Craft:** What are the effective strategies to encourage condom use? Spend is obviously one of them.

Laura Domegan: I think it is about education from a young age, bringing condoms back on to the platform and promoting them again. It is about having them readily available, if the funding is there, so they can just be picked up. We have had the C-Card scheme, but that seems to have disappeared in recent years. For young people, condoms are expensive to buy in a supermarket. They need to be more readily available.

Q12 **Jen Craft:** Part of it is about having things readily available and part of it is about behaviour change. Are there examples of anyone having been able to address those different behaviours and make a real difference? Are there things in place?

Richard Angell: Not really—very little has happened. The last time the Department of Health tried to commission a national sexual health campaign, it did one with emojis covering people's faces and stigmatised the issue more, so it is good for the voluntary sector to be the lead partner in lots of this in the same way that it is, for example, with HIV, really rooting communities in their experience. We do not want to exacerbate the stigma in making that happen.

C-Card has been a real backbone of doing this, and it was a really successful part of the teenage pregnancy strategy 20-odd years ago, but it has been fragmented in different places. Pharmacists are, crucially, the main provider, and they do not get any pay at all for being part of the C-Card system, so it often feels quite onerous for them. Crucially, there isn't a national campaign overriding that.

You talked about your experience as a teacher, Chair. It has got worse, because the provision of sexual health education has been controversialised in the last eight-year period. We have had Members of Parliament saying things that were not true in the Chamber about how sexual health education was being provided, so it is a tougher thing to do. Schools then went through a phase of contracting it out to people, but all those organisations were then controversialised, so fewer of them now exist to do that work, partly because of the wider crisis in the voluntary sector making it unable to do that work.

It is a real challenge. Ultimately, the way the message works is repetition, but nobody is even saying it once, let alone repeating it to get the message out. It feels to me that this is one of the things you could do



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nationally. If there was a national postal condom service, so that you could order from anywhere in the country and get it sent either to your home or to one of 4,000 click and collect sites across the country, that would totally change the dynamic. You could go to a pharmacist and show your QR code—you would not have to say any words—and there could be absolutely anything in there. You would just get a little envelope with some condoms and some lube in it. We could make that quite easy, and it would not be expensive in the scheme of things.

Jen Craft: It's about beginning a conversation and then—

Richard Angell: Sustaining it.

Jen Craft: Those are the two main drivers.

Q13 **Chair:** On schools, what can we do now, from this point onwards? Is it about more guidance and training? Is it about clearer direction from the Department for Education? What would you recommend to Government to reverse the trend?

Laura Domegan: It is about ensuring that everyone is getting good quality at the same level, because there is such a difference throughout the country. There are vast differences in what children and young people are being taught. Some are getting amazing RSE, but others aren't. It is about a standardised approach and promoting prevention—things like condoms and PrEP—and then PEP, Doxy-PEP and partner notification. They are the keys to reducing STIs and, hopefully, eradicating a lot of where we have got to in this day and age. We need a standardised approach where everybody gets good quality to the same standard.

Q14 **Danny Beales:** On condom use, I remember being young once—

Josh Fenton-Glynn: Do you?

Danny Beales: Once. When I was coming into sexual awareness, you couldn't really move for free condoms. Every time you went to a clinic you left with a bag, whether you liked it or not. Every bar that I went to had free condoms in baskets everywhere. It was so easy to access affordable condoms. Even in some schools at the time, you could go to the nurse, or they were left in places.

Now, I never leave a sexual health clinic being offered condoms, or being asked. Most bars and locations now do not have them. Have you assessed how availability has changed? How much unmet condom need is there? How many free condoms are available in places? Is there any information about that and how it has changed over the last 10 years?

Laura Domegan: From what we can see, people are not as interested in condoms, so they are not as readily available and they are not being promoted. They are not as wanted as they were. Every time I see a client I say, "Do you want some condoms? Do you want testing?", and the answer is "No. No." We need a two-part approach whereby we have got to encourage condoms again and push education and promotion, while also—



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Q15 Danny Beales: Should we be asking people whether they want them? I got told, "Here's your bag." They were everywhere. It was so easy to just grab some and have them.

Laura Domegan: People refuse if you just give it to them. They will say, "No, I'm not interested."

Q16 Danny Beales: I suppose we have moved to opting out, on the basis that we should not say, "Do you need a condom?" or "Do you need a HIV test?" because of the stigma associated with that. Do you have any data on the numbers of free condoms that are available, or on the number of people who would like a condom but cannot afford to purchase them in the shops?

Richard Angell: I do not have the latest data on this, because we have not run the service for some time, but when we were running local services, postal condom services was part of the offer. One of the challenges was that the conversation with the commission was about how you restrict them. Even though there is that trend, there is still serious demand for condoms, particularly in lower socioeconomic postal codes. Often, we were restricting take-up. We made sure that everyone could get one a year, or whatever, but if you needed repeats, we were limiting them to certain postcodes, for example. People for whom cost is a factor but from whom there is demand want that service, but the system is struggling to afford it and to make it happen.

Certainly when I was growing up, you could not go into a gay bar, let alone leave, without condoms being everywhere. That is much rarer these days, partly because the sexual health contracts that were focused on gay men have been merged into more broad services. Availability is a really crucial part of it, and there is a demand. Also, to find the local service—to find the particular thing—you have to know about where you live, because it is so bespoke, place by place.

Q17 Chair: Who should we ask to get that data? Is it ICBs?

Richard Angell: It is an interesting question. No, it definitely will not be ICBs. The best bet is probably to FOI each of the local authorities. I do not know whether even DH would have that these days.

Q18 Josh Fenton-Glynn: Laura, you spoke to Jen about condom use going out of fashion, and you mentioned social media. Not to put too fine a point on it, but is the problem that people do not use condoms in pornography?

Laura Domegan: I think it has an effect, yes. Social media and pornography are much more readily available now, particularly to younger people, and that does have an effect, and influencers obviously have a massive effect on young people as well.

Q19 Josh Fenton-Glynn: What are the influencers saying? I am obviously old and do not understand social media that well, but I am trying to imagine what an influencer is saying about not using condoms.



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Laura Domegan: It can be different things. Where I have seen that more with influencers is when they talk about things like contraception, such as the dangerous side effects of hormonal methods—"This happened to me when I had my coil fitted." I have not seen it so much with condom use, but the young people in our study reported that condoms were just not high on their agenda any more.

Q20 **Josh Fenton-Glynn:** Young people under 25 have the highest STI diagnosis rates, and Richard has talked about what is driving the over-50s. From your work at Brook, what do you think are the things driving that trend?

Laura Domegan: I think it is that sexual health clinics have had to prioritise where the funding goes. Like Richard said, we cannot just be giving tests to everybody. You have to prioritise people who are symptomatic. You have to cap test kits online, because we have seen in most of our contracts that it just spirals. Even if you have 60 kits a day, they are gone by lunch time, and sometimes earlier. Whereas we used to be able to test everybody, we are now able to test only those who need it. For young people, it is also about partner notification, which we are still not great at. That is why STIs spread more readily as well.

Q21 **Josh Fenton-Glynn:** So it is not that young people are having more sex; it is just that they are having sex with asymptomatic STIs.

Laura Domegan: Yes, they can be asymptomatic, or they do not know they have an infection. For example, in Manchester our test kits used to be available up to 25, and we had a really high positivity rate. When that was cut to 19 and under, we saw the positivity rate drop. Kits should be more readily available so that more people can be tested.

Q22 **Josh Fenton-Glynn:** To move on to a slightly more difficult area, NHS Digital shows that, in 2020, girls aged 13 to 15 living in the most deprived areas were three times more likely to access emergency contraception than those in the least deprived areas. Obviously, there is no such thing as consensual sex with an under-16-year-old, so what is going wrong here? What more can we do to protect those girls?

Laura Domegan: I think it is about education when people are young, encouraging contraception and looking at what the barriers are. People in the more deprived areas tend to have more barriers to accessing sexual health services, which tend to be under higher pressure in more deprived areas as well. Education is the key with young people—education about contraception, and even going back to basics with consent, and sex and the law. It is all of that. It is about protecting young people, and particularly the ones in the more deprived areas.

Q23 **Josh Fenton-Glynn:** Is something particularly driving why this is affecting young people? Is it that the education is not happening in the home?

Laura Domegan: I think it is both—it is about at home and in schools. We have also seen a reduction in clinics, which are not open as long as they used to be or staffed as well as they used to be. We are not seeing

the promotion of contraception in some areas. It is about education and having the contraception and the advice readily available for them.

- Q24 **Josh Fenton-Glynn:** To go back to the conversation with Richard earlier about the emoji campaign and so forth, one thing I have picked up, both from this evidence and in my reading around this, is that misinformation is playing a huge role in some of these problems. What is the best way to counter that misinformation? How can we play an active role in that?

Laura Domegan: It is about ensuring that we've got that positive information out there, and getting influencers on board to promote the positive sides. You only see the negative stories. It is like childbirth: you only hear the negative side. It is about getting more positive experiences with coil fitting and implant fitting out there, and getting the influencers on side, because that is what the young people seem to follow. It is about putting things back on the agenda, and empowering young people to know where to get the good, factual information from. That can empower them to make decisions about their sexual health.

Josh Fenton-Glynn: It reminds me a bit of the vaccine misinformation. It is really easy to point to some of the negatives around hormonal contraception, but what you are not seeing is that a lot of women have far greater bodily autonomy as a result of it.

Richard Angell: The only way to deal with misinformation is to overwhelm it with the right information. At the moment, there is a vacuum that people are filling.

We also have to acknowledge the fact that, for example, in 2010 we were spending £4 million a year on the national HIV prevention programme; 15 years later, we are now spending about £1.1 million to £1.5 million, and that is essentially just focused on the two communities that are most likely to acquire HIV. There isn't that broader conversation. You are going to need something in those volumes to get out those kinds of messages to people. There was a recent attempt to try to expand that programme on HIV, from a 1 million audience to an audience of 10 million young people, with a £1 million budget. I thought, "This is really not going to go very well if you do that!" You have to commit serious resources to fill that space.

Also, young people have a really bad experience when they try to use the service. I know our friends in local government will say, "The service is full, so it must be provided at a time when some people can use it." I cannot believe that we legally require young people to be in education, employment and training at the same times at which we make the services available. If you have a reason why you cannot be there—and those young people reliant on their EMA or that job are much more likely to be from lower socioeconomic backgrounds—the trepidation and consequences are real.

Twenty years ago, when I was young and doing these things, I knew my rights. I knew that I was entitled to an appointment within 48 hours. It



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was really clear. The NUS did a massive national campaign back then—with the Terrence Higgins Trust and Brook, I believe—and it was a thing that young people knew. We demanded our appointments within 48 hours. Obviously, all that target stuff was got rid of in 2010, and now people do not know and get fobbed off. I was talking to a sexual health doctor the other day about somebody who had tested positive for gonorrhoea, but the next appointment for treatment was in two weeks. That is not that doctor failing; that is the system constraining them constantly.

Q25 Josh Fenton-Glynn: On that, I think 10% of chlamydia tests in 2024 took place in GP settings. Can't we just get people to access health services where they can find them?

Richard Angell: Wouldn't it be amazing if, when you registered with a GP, you were given a kit that you could return in the post, so that you could do chlamydia, gonorrhoea, syphilis and HIV? It would be absolutely massive. If you just did it for people joining a GP service, you would disproportionately find that it was younger people, students, migrants and people from lower socioeconomic groups who move around the country for work. If you made it a universal offer to everyone who joined a GP, you would be targeting exactly the right people you wanted to. You could go on the same care pathway for sexual health, so it would not be more work for the GP. They would just hand you over the kit. They are doing this brilliantly in Wales. They are locating kits in a number of community settings. You can take away the kit there and then, and you return it. You do not know that you are a sexual health service user when you go there; you might have picked it up at a different service. We could adopt that elsewhere.

Crucially, about four years ago the national chlamydia screening service went from testing everyone to testing only young girls. This does not help with the misinformation and the stigma. If you are a girl who has had a chlamydia test, that must be because you have chlamydia, not because you are taking charge of your sexual health. WhatsApp is so pernicious in school environments. If you are the kid who does pick up the condoms, is that because you are an S-word, and all the things that go with that? This is part of why we have to fill this space quite actively. If we do not, bad actors will.

Q26 Chair: What is the return rate on test kits like?

Richard Angell: Really good. There are a few examples of where it is not, but it is really good generally.

Chair: You say a few—why?

Richard Angell: Some people will order a test and not use it. You think something is itching so you order the test, and then it is not itching two days later and you think, "Maybe I'm not going to do it." It is about the urgency of why you ordered it.

Chair: Right, I see. But it is still an efficient way to run these services.

Richard Angell: It is a really efficient way to run them.

Josh Fenton-Glynn: It seems like an obvious recommendation—to give a test to new registrants at GPs.

Chair: Absolutely.

Q27 **Alex McIntyre:** Thank you very much for your answers so far. On tackling some of the health inequalities in this space and thinking about the positive outreach we need to do, what groups need more of a targeted focus at the moment? Other than social media, how can we target them?

Richard Angell: The community who are clearly being left behind the most are black Caribbeans. You see very high rates and disproportionately increasing rates of STIs among that community. Because of the nature of breaking up the public health grant by local authority, there is almost no one authority where that is a big enough issue that they go, “Right, we’re going to do a concerted effort focused on black Caribbean community influencers,” and some of the stuff around that, so it always falls between the gaps.

There are some good practices, but even when there are, it is not a big enough issue in the neighbouring local authority to pick it up and scale it up. Partly because we think, “Every local authority is so different,” we always focus on what is different. I am a bit more of a Jo Cox person and think, “Well, what’ve we got in common?” Often, people do not care what London borough they live in, or what part of the country.

Q28 **Alex McIntyre:** Where are the examples of good practice? If we are looking for a good example of what we should be doing nationally, what would you say?

Richard Angell: Lewisham have done some really good stuff, really focusing on health inequalities. They work with PrEPster—who were due to be here today, but Will is unfortunately unwell—and with Africa Advocacy Foundation, who have done some really brilliant stuff with their PrEP and Prejudice campaign, focusing on the experiences of black communities. That is a really good example.

Liverpool have done some really good stuff and are co-ordinating their outreach across the service. There are some really good examples. I could go on and on about things that people are doing. They are trying to hack the system. Bristol is trying to find a way to get PrEP in pharmacies. Sadly, it has not done so, but it has found a really good way of providing a different route for people to access PrEP in the community.

Chair: What is the barrier?

Richard Angell: Yourselves, if you don’t mind me saying. Primary legislation means that a community pharmacy cannot provide PrEP at an affordable cost. Basically, it costs the NHS £7 a month to give me 30 PrEP tablets, but it would be recharged at £360, I think, if pharmacies were charging it back. Obviously, the public and sexual health grant cannot afford that massive multiple.

Chair: We can look further into that. Thank you.

Richard Angell: It would be a great thing to do.

Q29 **Alex McIntyre:** Laura, do you have any views on that?

Laura Domegan: What we are seeing more of, and what we are being asked to do in the areas where we are, is issues in the migrant communities. They tend not to know where to access services. They are not given the information and do not know what is available to them. Quite often, they come from countries where PrEP might not be available, or they might have been put on PrEP but have not had it for a number of years. It is about focusing on the migrant communities and what information they need, and doing some targeted work with some of the charities that focus on those groups.

Q30 **Alex McIntyre:** Are there opportunities to use providers outside traditional sexual health services to promote service engagement?

Richard Angell: Massively—Danny talked about the opt-out testing we do in A&Es for HIV and hepatitis. It is hugely beneficial: 85% of people who have been tested and 75% of people who have tested positive have never used a sexual health service, so it is a great intervention. Why not add syphilis to that testing, when we are seeing historically high levels of syphilis across the country? It would be a really easy thing to do. There are some complications to adding syphilis—the care pathway is not quite as clear—but it would be a really good thing. If you have 14-hour waits in A&E, why not provide a pot for patients to pee in and put that through the process?

There is a whole series of ways in which people are waiting in our health services. They are unwell and the system is not seeing them as a whole person. I think this is a great place to put these kinds of interventions. Particularly for young people, leaving with an STI kit every time they engage with a service would be a really transformative way of improving their sexual health. We found that people don't not want it if you provide it for them. You say, "It's just standard," so it's not picking people out. If people feel they have been isolated when they are talked to about some of these things, particularly in reproductive health services, it is not routine; they feel that something has been seen in their behaviour.

Also, you still get lots of practitioners saying, "You won't need an HIV test, will you?" That is a hugely pejorative thing to say to somebody, but, sadly, it is custom and practice. I say to our sexual health and reproductive health colleagues, the truth is we have higher take-up of HIV testing in A&Es than we do in sexual health clinics. That is not good.

Laura Domegan: I totally agree with Richard. It is about having testing more readily available—in A&E and with GPs. We do not see school nurses much any more, either. Support the school nurses back in and give them the test kits. It is just about having the kits and testing more readily available in areas where people do not have to come to a sexual health service.



Q31 Joe Robertson: Richard, when you opened, you talked about alternatives to in-person services, the challenges, and not making assumptions that people would be comfortable with testing kits delivered to their home. How can we do more to design better alternatives to in-person services?

Richard Angell: Digital is a really good option for lots of people; it is a system that works for them, and with everyone it works for, you take pressure off the in-person appointment, so that it is there for those who need it. I would like to see it integrated into the NHS App, for example. If somebody is looking over your shoulder, they will not be able to tell what is in the blue app. They will not know whether you are checking a GP appointment or ordering a kit online. It could be very discreet.

You could have one national system. Jen's constituency would not have run out at 2.30 pm yesterday if we had got the system right. You can do that and take that pressure away from local authorities who are really focusing on the areas where they need to do outreach to the community. They know about migrants falling behind and going into sex-on-premises venues and those other things that need to happen.

The crucial bit is integrating it with the system. We do not have click and collect services with most of the state-commissioned postal kit testing services, and that really is exacerbating health inequalities, particularly among black and Asian populations, who are much more likely to live in multi-generational households. We can design that into the system. There is a big case for being digital-first in sexual health, but you have to have the clinics there for people for whom digital does not work, or where somebody has tested positive and needs to go and see one of our absolutely amazing sexual health doctors across the country.

Q32 Joe Robertson: Can I go back to some of the comments around awareness of HIV and using condoms? Is there a role here for public health campaigns? I am thinking of previous decades. I hope that in schools we have not gone backwards but have advanced in terms of sex education and sexual health. Is there a role for public-facing campaigns that capture people who are already in the adult population? I am not aware of the sorts of campaign that we had perhaps a decade or more ago.

Richard Angell: There is, and we will be coming to you in February next year to ask whether you will do a test and set an example locally. We have been running the National HIV Testing Week for 11 years. That was a response to the fact that there was so little resource in the sector that you could not run it all year round; you had to focus it on a week.

We have seen brilliant things recently. Prince Harry led the way early in the campaign, publicly talking about having had an HIV test. He has done it on a number of occasions, and it has been global news. Last year, the Prime Minister became the first global leader in office to take an HIV test, which was really good. With that, we get 20,000 people testing for HIV, and most of them are first-time testers. It is a really successful initiative but, as I said, in 2010 funding was £4 million and now it is about £1.1



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million or £1.5 million, depending on how you draw around the campaign. There is less resource for doing the same thing, so we have to get more and more inventive. We love the challenge, and hopefully we embrace it year on year.

You are probably not in the main target audience for the campaign; we have to focus it to keep the positivity rate up and make sure the right people—first-time testers—are in that group. There is a lot of work to be done there. It is the only thing that the Government does centrally to fight stigma around HIV. The campaign that we run is called I Test. It is a person saying, “I test for HIV. You should too.” We think that is a really good way of dispelling stigma so that people say, “Yeah, I’m fine with it.” We have had the Prime Minister and various other famous people do that, and that is a really important way of not just promoting testing but fighting the stigma around it. There really is stigma: people fear the result.

Q33 Joe Robertson: And the same goes for the role of condoms as being about more than just pregnancy and HIV?

Richard Angell: Totally, but you would have to be actively in that space, and I don’t think you could do it for anything less than £10 million. You have to start in that kind of space. If you are talking to 10 million young people, you need a concerted effort to be in that space.

Q34 Chair: Thank you very much. We are nearing the end. You get to be Prime Minister for just a minute, and you are allowed one policy change—

Josh Fenton-Glynn: Don’t let Richard do that.

Chair: Just one and no supplementaries—no, I might be kind to you. What is the top thing that you wish the Government would do now?

Laura Domegan: For me, let’s get a sexual health strategy. We need a good-quality strategy that ensures good-quality services that have the funds they need.

Richard Angell: I would have a national, always-on, postal testing service that initiates PrEP use. I would have that as one service, commissioned by NHS England. That is what happens in Wales, and it is really effective. That would be my legacy from my one minute as Prime Minister.

Chair: Thank you very much for your time this morning; it is much appreciated.

Examination of Witnesses

Witnesses: Professor Matt Phillips, Dr Zara Haider, Rob Bacon and Tim Elwell-Sutton.

Q35 Chair: Good morning, panel. We are really pleased to have you with us. We have a bumper crop of witnesses. It might be easier if you introduce yourselves and the organisations you are from.



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Professor Phillips: Good morning. My name is Matt Phillips, and I am the president of the British Association for Sexual Health and HIV, which came into existence in 1917 and represents the specialties of genitourinary medicine and HIV.

Dr Haider: Good morning. I am Dr Zara Haider. I am a jobbing consultant in sexual and reproductive healthcare, working at Kingston in Surrey, but I am here in my capacity as president of the College of Sexual and Reproductive Healthcare, formerly known as the Faculty of Sexual and Reproductive Healthcare, which represents 14,000 multidisciplinary members who work across sexual and reproductive healthcare, including doctors, nurses, midwives, pharmacists—the whole gamut of the profession.

Rob Bacon: Good morning. I am Rob Bacon. I am here as a rep from the English HIV and Sexual Health Commissioners Group. In my day job, I am the strategic lead for sexual health at Hertfordshire county council, and I sit within the public health team.

Tim Elwell-Sutton: I am Tim Elwell-Sutton, deputy regional director of public health for the south-east. I work in DHSC, which hopefully needs no introduction.

Chair: Thank you very much. As you can see, there are several of you on this panel. Please do not be offended if certain questions are directed at just one or two of you. If you are dying to come in on it, just indicate that, but we may not finish if everyone answers every single question.

Q36 **Dr Cooper:** Thanks so much for coming this morning. I want to dive straight in and look at the commissioning and provision of sexual health services. A number of organisations have submitted evidence and opinions to us, and perhaps unsurprisingly, we have heard that split commissioning is not always giving us the best results. For example, the LGA has said that split commissioning between local authorities, NHS England and integrated care boards has resulted in a fragmented system, which has resulted in inconsistent access, gaps in services and poor co-ordination. As the Chair said, we may not have time for all four of you to reply, but perhaps Rob would like to go first. What aspects of this fragmentation are the biggest priorities to address, and how would you like them to be addressed?

Rob Bacon: Exactly as you said, the system is fragmented. One of the key areas that we need to address is understanding that we all work to a whole-system approach. It is very ingrained in us, in local authorities, that we cannot do this alone, and examples have been given this morning of the importance of a whole-system approach. It is about using the evidence around local need and working consistently to deliver high-quality services.

Q37 **Dr Cooper:** To try to get to the heart of this, there are now several different organisations acting as commissioners. Is that ideal, or should we think about one specific commissioner moving forward?



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Rob Bacon: Ideally, there is a place for each one of those organisations to deliver. I do not think it can be done by just one organisation. The key thing is to make sure that everybody understands their role in that system.

Q38 **Dr Cooper:** Forgive me, but is it worth having the gaps resulting from split commissioning to have the benefits you are talking about?

Rob Bacon: As we talked about earlier, if we had a very clear strategy around sexual health that had very clear governance and very clear outlines about whose responsibility it is to do that commissioning, it would be very clear. At the moment, for example, integrated care boards are under extreme pressure. That has a knock-on effect on local authorities. Some areas have very good relationships with their local integrated care boards. The majority do not.

Back in 2014, we had the “Making it Work” document from Public Health England, which had the commissioning responsibilities clearly listed. As the years have gone on, we have gone from clinical commissioning groups to ICBs, and ICBs are now being reconfigured. Local authorities go through restructures in various different forms. Some of these guidelines are up for interpretation, so the interpretation can be different in each local area.

Q39 **Dr Cooper:** Yes, fair enough—it sounds like a tumble-dryer of a mess, frankly. Before public health is split from the NHS, is there a case for sexual health services to be commissioned via the NHS—in other words, a national commissioning service, rather than one splintered at local and regional level?

Rob Bacon: One of the key areas for local authorities is the evidence-based approach. We know our local area. We know what is going on at locally. We work across the sector. We commission drug and alcohol services, school nursing, children’s services and adult care, so we understand the different complexities around that.

Q40 **Dr Cooper:** Absolutely, but with respect, the NHS should be doing that as well—it should be evidence-based and data-driven. It is great that public health is doing that in local authorities—that is amazing—but the NHS should also be doing that at an ICB level and, arguably, at an NHS England level. Should sexual health service provision be all in local authorities or all in the NHS, or are you making the case that, as long as there is a strategic document or clear guidance from the NHS, it can, in effect, be commissioned through both arms—through local authorities and the NHS?

Rob Bacon: It is about partnership working—the medical side and the social care side have to work closely together. Sexual health is not just a medical issue to address. As we heard earlier, there is the educational side of things and meeting the needs of different groups. We are now seeing issues relating to migration and homelessness, and to drugs and alcohol. That will not be addressed solely within the NHS, so we must have that clear working arrangement where we bring the public health element—

behaviour change, understanding local need—alongside the medical support.

- Q41 **Dr Cooper:** Forgive me, but the idea of integrated care boards and their broader partnership working is to bring that more holistic way of looking at things into the mix. Is there not a place at regional level—we talk about devolution—to look at something like sexual health? Rather than have separate commissioners, might we have commissioning in one place and bring the expertise to that one place?

Rob Bacon: A regional footprint does make absolute sense. The reconfiguration of ICBs may help us across. We won't be duplicating or trying to do something at the local level; we can do it regionally. So I fully support that, but unless the ICBs and other colleagues understand their role in the commissioning arrangement—what is their responsibility and what is the local authority's—we are never going to move forward.

- Q42 **Dr Cooper:** Zara, what lessons can the Committee learn from the work that you have been involved in to improve co-ordination of services?

Dr Haider: Let me give an example: if a 55-year-old woman comes to my service wanting a hormonal coil fitted as part of her HRT regime, I can't fit it for her because I am not paid for it. So that woman, with her perimenopausal symptoms, will get bounced back to her GP. GPs are less inclined to fit older ladies; they are often more tricky fits. In my service I have lots of coil-fitting appointments. I have trained my senior nurses to fit coils and we have lots of appointments. I literally could fit that coil the same day or within a couple of days. But no, I can't fit it because I am not paid to do it. So she gets bounced back to her GP, and the GP then bounces her back to gynae, where she will sit on a waiting list for 18 to 24 months—unless she can afford to go privately—waiting for that coil to be fitted. That is the reality of the fragmented service that we have.

- Q43 **Dr Cooper:** Thank you, Zara; that is a very clear example. I am not sure I have anything to add to that except to hold my head in my hands and say, "Dear God, help us." That is a clear example of where we are absolutely failing patients and we are not, as the previous panel said, putting patients at the centre of our care.

Dr Haider: We need to wrap the care around the patient. Women's health hubs are a very good example of where that is happening. So it is possible, and there are some great examples around the country. But yes, that is a typical example.

- Q44 **Dr Cooper:** That goes back to understanding commissioning—who is doing what, where the needs are—

Dr Haider: And where the money is flowing; absolutely.

- Q45 **Dr Cooper:** Thank you; that is very clear and, unfortunately, it is not a theme that we have not heard before. Are there any further opportunities to better integrate sexual health care with reproductive health care? Matt?



Professor Phillips: I had the same experience as Zara described in clinic last week. Fragmented commissioning means you have the skills, the knowledge and the ability, but you can't do it; it is not funded, and the queues are set up wrong. Sending the woman back to gynae so she is on that list for two years is a nonsense and it does need addressing urgently. Strategic intent may help. It is not that the doctors and the nurses seeing the patient don't know what to do and can't do it; it is about ensuring that commissioners ensure that the money follows the needs of the patient. The time spent in duplicating the conversations to get this simplest thing done! A woman is being examined by me. I could do her smear, but I am not commissioned so she has to undergo that invasive speculum again elsewhere. I completely agree with Zara that we have to move commissioning in a way that maximises the benefit to the patient and reduces wastage throughout the system.

Q46 **Dr Cooper:** Thank you, Matt. We will put you in charge; it sounds great.

Tim, may I move on to you? Do you think that merging NHS England into DHSC provides a possible opportunity to address some of this fragmentation issue, if not all? Where do you think NHS England functions relating to sexual health should fit in the future?

Tim Elwell-Sutton: That merger is subject to legislation being passed; that is the expectation. Things commissioned at regional level in NHS England will in future be done by ICBs, so, as you said, Rob, there is an opportunity in ICBs' new role as strategic commissioners. Their key need is to understand local population needs.

I link this to the implementation of the 10-year health plan, because that structural change is part of a broader strategy ultimately to produce more joined-up services. Think about the neighbourhood health agenda, which is part of the 10-year health plan: it is very much about having neighbourhood health plans agreed between ICBs and local authorities, led by health and wellbeing boards. There is an opportunity there for better join-up locally between ICBs and local authorities.

Q47 **Dr Cooper:** Where there is opportunity, there may also be threat. In this ongoing organisational restructure and merger—the ICB regional footprint and NHS England going into DHSC, in whatever manner that ends up being done—do you identify any threats to sexual health services?

Tim Elwell-Sutton: We are aware that there needs to be a smooth transition of commissioning responsibilities from NHS regional teams to ICBs, which I think will happen in 2026-27. We need good joint working, which I am seeing in my region, between regional teams and ICB colleagues. Really, it is an organisational change risk, which I believe is being managed at present. It is not unique to sexual and reproductive health services; it is part of the wider system change.

Q48 **Danny Beales:** Thank you for joining us. I have some questions about funding, prioritisation and service resilience. In one sense, sexual health services doing far more with much less is a success story. Their productivity with real-terms reductions in funding is a lesson for the NHS



about doing much more with constrained budgets, but that comes with trade-offs and challenges. Rob, how have decisions on how providers prioritise what to do with budgets that are shrinking in real terms panned out? What is your experience of prioritisation?

Rob Bacon: As I mentioned, the key is to look at local need and to adapt to meet the complexities of the different types of service user that come forward for sexual health services in particular. You can look at the digital solution we discussed earlier—various apps and so on—as well as placing services in the community and especially outreach models, to try to take the burden off frontline services. I think sexual health services are very good at responding in terms of clinic and appointment times in an effort to meet that need.

Sometimes, we forget some of the complexities in the patients who sexual health services see. You do not know from one day to the next who will walk through the door. There are issues of sexual exploitation or domestic abuse—highly complex cases that take a lot of time in a very stretched, pressured service. If some of the pressure can be alleviated through online, outreach and community work, that will help us to make sure we see people with the greatest needs.

- Q49 **Danny Beales:** The Committee has seen in evidence and on a visit capacity being freed up through the channel shift online, but we have had feedback that the increased complexity of the patients being seen has not been reflected in the provision of extra resource or even the level of resource being maintained. If anything, health educators and specialists who might help with complex issues have disappeared from services. In your experience, how is the increasing complexity that services are seeing being reflected in what services are available?

Rob Bacon: You are absolutely right: what we saw, especially with digital, was huge numbers of STI testing and contraception being introduced, but actually we did not start to see the decline in the presentations coming to sexual health. The pressure on funding comes from balancing the two. It is about trying to look at some of the examples given earlier—those special nuances—and working with communities locally, skilling up the workforce in other services, such as drugs and alcohol or mental health, and making them more aware of how they can interact with sexual health services, for example by offering chlamydia and gonorrhoea kits at point of care. We need to take an “every contact counts” approach and use other local examples where it is working.

- Q50 **Danny Beales:** You talked about assessing and responding to need. Do you have a sense of what the unmet need is at the moment? We heard from the first panel about mystery shopping in our constituencies. It seems that, rather than responding to needs, a lot of our constituents who are symptomatic in a walk-in sense just cannot access services. Is that responding to need, or is that services being restricted and resourcing being cut?

Rob Bacon: I think everyone would be clear about what the unmet need is and, as I mentioned before, those groups that we need to reach out to.



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Yes, there is a lack of resource, and additional funding would reach out to that. I think we would all agree that one of the key things is that, as soon as pressure hits the system, the first things to go are the prevention elements, because we have to make sure that our frontline services are strong and robust. Rising rent costs, staff costs and pathology costs are adding to that difficult mix.

- Q51 **Danny Beales:** Looking at the funding reductions, we saw in excess of £200 million of real-terms cuts from 2013 to 2022, as well as quite a substantial drop in the spend per head on sexual health services. The whole health and care system has faced constraints, with increasing demands and budgets not increasing in line. Do you feel that sexual health services in the health sphere, and specifically the public health sphere, have been disproportionately affected by spending reductions?

Rob Bacon: Yes, I think they have.

- Q52 **Danny Beales:** Why do you think that would be?

Rob Bacon: It mainly goes back to that issue of sex and the awkwardness that we sometimes face when we need to have those conversations with elected members, or people like yourself, to try to move those conversations forward. Also, other priorities seem to hold greater responsibility or receive more of the limelight. Actually, sexual health, including reproductive health, is a key element to that. Women in particular are disproportionately affected because they need to use those services much more. I totally agree that it is something we always battle with in sexual health, as it is sometimes just not flavour of the month, or there are bigger issues that NHS England or other colleagues have to deal with, and gradually, sexual health gets pushed down the list.

- Q53 **Danny Beales:** Do you feel that the challenge of maintaining support—or relative support—for sexual health services would be less if commissioning had been maintained in the NHS, rather than shifting to local authorities?

Rob Bacon: The fragmentation widened, and I feel that there will be some benefits on the clinical side that probably will have been strengthened or maintained, but people are being pushed around the system for their medical needs. Again, it is about going to that whole-system view; this is not just a medicalised issue that we need to deal with. Sexual health and reproductive health still carries on in the NHS, and it is not just the local authority. We deal with the specialist clinics, but the other elements of sexual health can and should still happen within primary care and secondary care. I think the emphasis is always placed just on those specialist level 3 clinics, when actually the whole system has a responsibility to look at that as well. I think that has suffered in some way because of that fragmentation.

- Q54 **Danny Beales:** Thank you. Tim, looking at leadership and co-ordination at a national level, what do you think the Government, or the Department of Health and Social Care specifically, could do to better co-ordinate and support sexual health services to carry out their functions?



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Tim Elwell-Sutton: I will comment on funding to start with, because that is obviously the foundation on which it rests. We have not mentioned the one good news story, which is that after about 10 years of real-terms reductions in the public health grant, in this year of 2025-26, there has been a real-terms increase of 3.4%.

Q55 **Danny Beales:** How much of that has flowed to sexual health services?

Tim Elwell-Sutton: It is too early to say. Those decisions are made at local authority level.

Q56 **Danny Beales:** Should the Department of Health and Social Care be clear that that has to reach sexual health services proportionately, bearing in mind what we have just heard?

Tim Elwell-Sutton: That is not our policy. These are rightly local decisions. In my region, there are very different sexual health needs between, say, Brighton and Hove, which is one of my local authorities, and East Sussex next door. These are locally made resourcing decisions.

Q57 **Danny Beales:** Is it acceptable for one area to close all its services in sexual health? When we visited recently, we heard that Enfield, for instance, was considering closing its last service, on the basis that people could go elsewhere. Is that acceptable?

Tim Elwell-Sutton: No, it is a mandated service. It is absolutely part of the conditions of the public health grant.

Q58 **Danny Beales:** How is the Department holding to account commissioners for meeting population need, and assessing that properly?

Tim Elwell-Sutton: We do that partly through assurance of the public health grant. Directors of public health and local authorities have to give a formal assurance that they are meeting the conditions of the grant, which includes providing sexual health services. The regional team, where I work, works very closely with them to scrutinise the spend in all those areas. Where we see spending going down by an undue amount, we will ask questions of local authorities about that.

The other thing to mention is the local government outcomes framework, which is being put in place by MHCLG at the moment, which will be a different system of accountability.

Q59 **Danny Beales:** In terms of meeting that need, are you assured that that process is working, that areas are being scrutinised, and that commissioners and local authorities are investing to meet need in sexual health services?

Tim Elwell-Sutton: As I say, we have had 10 years of real-terms reductions. We will look very closely at how the new money is used, to ensure it is used appropriately for local needs.

Q60 **Danny Beales:** On that assessment and assurance process, we heard from the first panel that they feel that the centre—the NHS or the Department—could take a greater role in commissioning, for example, an



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online platform. Those things are not about meeting a specific local need, but about common needs, such as the need to access condoms and PrEP. Is it efficient to have tens—or hundreds—of different conversations about platforms and apps, and procedures for accessing PrEP at home or online? Or is there a greater role for co-ordination of commissioners, or centrally commissioning some of those aspects?

Tim Elwell-Sutton: A number of things are done by the centre to support what happens in local areas. There is the STI prioritisation framework that the UKHSA has developed. It works closely with commissioners to do that. We have model service specifications to ensure that what is commissioned locally is done really well. You heard earlier about HIV Prevention England, which is funded centrally but delivered by the Terrence Higgins Trust. The other thing I would point to is opt-out testing in emergency departments, which is done locally but pushed nationally.

Q61 Danny Beales: That is a success. Is that not an indication that more co-ordination could be done? We heard about GP testing potentially. The things that have been done have been quite successful. Should more not be done at a co-ordinated national level?

Tim Elwell-Sutton: Taking that example, it has been done in very high and high-prevalence areas, which is exactly what NICE recommended as an appropriate use of emergency department resources. Another thing to point to is that just last week saw the approval by NICE of injectable PrEP. We have had a gonorrhoea vaccine; we have had Doxy-PEP—

Q62 Danny Beales: Other colleagues are going to come to that. Before I move on, is your sense that more could be done nationally? Have you done any assessment of the efficiencies that could be achieved by nationally commissioning, or at least co-ordinating, online testing platforms? Presumably, the thing that most areas should have is not a population-based or needs-based decision. Is the system efficient at the moment? My area—one part of London—has completely different postal testing from the vast majority of other London boroughs. I believe ours happens to be quite slow and not as good a service. Should we make those decisions on an area basis, given that people are mobile and move around? Is it efficient to have so many different online postal testing systems and so many people looking at online PrEP systems? Is that an efficient system?

Tim Elwell-Sutton: I do not think we have done an assessment of the efficiency of that, so it is a fair question.

Q63 Danny Beales: On service resilience, Matt and Zara, Mpox was an extra pressure on the system, and the system responded. What is your sense of the system's resilience and ability to deal with the potential challenges from other new sexual health outbreaks or challenges in the future?

Professor Phillips: Current resilience is low. We are less staffed than we wish to be. We have talked a lot about funding, but we also need to talk about the experts who conduct how services work. The headcount of expert consultants in genitourinary medicine is now 10% lower than 10 years ago, so you have fewer experts to co-ordinate. Mpox was a vital



demonstration of what we can do when we need to, and BASHH worked hand in glove with UKHSA to co-ordinate work throughout the clinics.

Part of the importance of the experts in GUM is not only the resilience to sexual health things—I am certain that we are going to see more emerging infections. During covid, because our consultants and doctors are trained in general medicine as well, they were also able to oversee covid wards. A vital part of the GUM workforce provides resilience throughout the whole system—or could do, if it was sufficiently supported through resource and strategic intention to ensure that the workforce is there to conduct and orchestrate systems to respond.

Q64 Danny Beales: Zara, is there anything that you would want to see to make the system more resilient to future outbreaks of Mpox or similar things?

Dr Haider: I can certainly say what the system is like at the moment, which gives me concern. In my former life, I was the vice-president for workforce at the college, and we conducted a workforce survey that looked at things like—

Q65 Danny Beales: I am conscious that that is slightly straying into my colleague's question; we will come back to workforce challenges, because my colleague is going to ask you about that.

Very quickly, I want to ask about your and the system's understanding of the challenge around chemsex. Tim or Rob, from a leadership and a commissioner's perspective, what is your sense of the scale of challenge around chemsex, the number of people affected, the number of people potentially dying at the moment as a result of chemsex and the level of service provision available to respond to that challenge?

Rob Bacon: Because of the nature of chemsex, the data and information that we have can be patchy. In some of the bigger cities, like London, the footfall of people coming through and asking for services and support gives you a better overview of the types of need. In areas where it is more rural or harder to get services, that is a bit trickier. There is something about identifying what is going on, and about how we adopt the models that we have learned from in London and other big cities.

We also need to acknowledge the stigma that is attached to chemsex, which makes it difficult for people to come forward. There is an important role for sexual health, drug and alcohol services, and mental health services to work together. With the supplementary grant that was given around drug and alcohol services, we recruited a post to try to identify the need in Hertfordshire. We know it is there, but because we border London, we do not necessarily see it on our doorstep. It is about trying to build up a picture, so that we have a good, sound evidence base and can use funding efficiently or put applications in for further funding.

Without the evidence base, it is very difficult to justify trying to access the money.



Q66 Danny Beales: Should we have clearer national leadership and mandation of collecting information in A&Es and the coroner service on when admissions and deaths may relate to chemsex?

Rob Bacon: Sexualised behaviour associated with drug and alcohol use generally, including chemsex, would be a key area to look at. It is not just that in isolation; it goes back to my earlier point about the lots of other issues, social issues, around that as well. Definitely, looking at everyone's responsibility to step up to try to identify it is key.

Q67 Danny Beales: Is there a need for the national strategy that we have heard about to pick up this area and to provide the system with some more leadership? It is complex, we do not understand it and no one is routinely collecting the information. As you say, in that interrelationship between the many different services, they may or may not be working together.

Rob Bacon: I agree. That is one area of a very big area around sex and reproductive health that we need to look into. Colleagues who are here today will have much better experience, because they see it on a regular basis, while in other areas of England we might not see that.

Q68 Andrew George: My apologies for missing the opening section. I thank Danny for protecting the inevitable spillover between his area of very good questions and that of workforce planning. Zara, a moment ago you were going to refer to the 2023 survey of members and those working in the service. Can you say a little more about the state of the workforce, the pressures on it and what its needs are?

Dr Haider: We did a bit of a deep dive into what was going on in the workforce as part of the general workforce survey. There were some stark messages. For example, we found out that a third of our workforce was due to retire in the next five years.

Andrew George: That is three years now.

Dr Haider: Yes, because that was in 2023—even more worrying.

Q69 Andrew George: Exactly. Has it improved since?

Dr Haider: We have had a few wins in recruitment, but there is still a lack, there are still gaps, and things could still be better. I can talk about that if you would like me to.

Q70 Andrew George: The survey had a particular emphasis on retention of workforce. Is the issue primarily one of the retention of staff, rather than of having to step up recruitment in order to get numbers to levels that are sustainable?

Dr Haider: One of the issues is that the average age of people who work in sexual and reproductive healthcare—certainly of doctors—seems to be a bit higher. The average age is 47 or 48.

Andrew George: Sounds quite young to me!



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Dr Haider: Yes, they are young, but it is about retirement. They are retiring at the age that they should retire and, yes, some people will retire early, but we would very much encourage them to retire and return, maybe coming back not full time. Losing that wealth of experience, however, is a travesty when they have so much to give, and they might like to come back on reduced hours to keep on sharing their great knowledge and experience.

Q71 Andrew George: Since you have a view across the piece, is the pressure on the workforce in this area greater than that across the NHS as a whole?

Dr Haider: There are pressures on all the NHS workforce, are there not? Certainly for us, the levels of burnout and stress were quite shocking: 38% of people claimed that they were often or always feeling stressed; and 28% said that they were often or always feeling burnt out. That is not right.

Many of our members were saying that they have been asked to do more than they should be doing as suggested by their job plans, so proper job planning for my colleagues is absolutely crucial. That is sitting down with someone to work out, "What are you supposed to be doing in your day-to-day work?", and, "Is this accounted for in your job plan? All that training that you are supposed to be doing, is it adequately reflected?" For a lot of people, it is not, so it is no wonder that they are burnt out and stressed, because they are expected to do a lot more than they are meant to, or can do, in the hours of working.

Q72 Andrew George: Is that reflected from your perspective, Matt?

Professor Phillips: Yes, similar. We have not done a recent census of our workforce. As you will appreciate, there are two workforces that look after sexual health—on our side, it is more about infections and HIV—but we have equal concerns. A publication has shown a significant attrition rate in nurses after Mpox: they found it stressful and difficult, so there are significant attrition rates. As I mentioned, there are now 10% fewer consultants in our specialty—

Q73 Andrew George: Now in comparison to when?

Professor Phillips: Ten years ago. It is difficult to recruit people to train to follow us, and that is tricky. We need help with NHS workforce training and education, to build those numbers and get the next generation of experts. The greatest error is that we think about how to address the needs of today—I am delighted that this Committee is thinking beyond that—whereas our work is to begin to anticipate the needs of next year: the resilience, and the future emerging infections and outbreaks. That is certainly the work that sits with the workforce that BASHH represents.

Q74 Andrew George: That draws me into the 10-year workforce plan, which is anticipated but not yet published. A moment ago, you predicted that there will be a greater range of challenging diseases that the service will have to respond to. Looking forward, what does that mean for the service, at a local authority level and at NHS secondary and tertiary levels?



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Professor Phillips: I feel that it means that we need a stronger commitment to training, and to pulling new people through who are trained to be able to work with unknown and unanticipated diseases, such as the Mpox outbreak. No one in sexual health was training in Mpox five years ago, so we all had to be trained in the agility to deal with it. What I feel is really needed is to ensure that commissions are required to ensure that training occurs—not training on local low levels, but training on high-impact, important, high-consequence outbreaks, such as those we have seen.

Q75 **Andrew George:** Do you think, therefore, that there should be a greater emphasis on the clinical side within the workforce plan? Or should there be a greater emphasis at the public health end of the service?

Professor Phillips: If I may be so bold, I think there is some mistaken thinking there. If I see a patient for Mpox, I am also giving them the HPV vaccine, so I am doing the prevention too. And I am saying, “Put these condoms in your pocket, even if you don’t want them.” You would get that in my clinic, Danny. It is a mistake to say that the clinical is separate to the public health—that is a weakness in many strategies. If you see an expert, you will get the prevention done and the clinical intervention, reducing duplication for the patients in the system.

Q76 **Andrew George:** Are you satisfied that that level of integration operates throughout the country?

Professor Phillips: No.

Q77 **Andrew George:** Where and why? This goes back to Danny’s point.

Professor Phillips: It does, and to the evidence that Rob gave. It has to be run through elected members; if commissioners struggle to speak to their elected members about sex, then how can we expect sexual health services to be robust?

Q78 **Andrew George:** So does it come down to elected members making those decisions that cannot go forward simply by officer decisions in the public health service?

Professor Phillips: I think that is for other colleagues to answer.

Q79 **Chair:** On the point about elected members not wanting to talk about sex, how can we help with that? Is it that elected members themselves feel squeamish, push back and do not want to talk about it? What is your experience? I have not had these conversations with elected members—maybe I should do, to normalise it—but what do you think would concretely help? It sounds like this is a barrier that probably is not going to change very soon, so what do you think would help?

Professor Phillips: I am happy to talk to anyone about sex, but that is my job—I am the president. That is what Zara and I would do.

Dr Haider: That is what we do every day.



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Professor Phillips: But perhaps it would be facilitation to ensure that elected members get to speak to the experts on the ground—people like Zara and I—to understand the needs. Sex is fundamental to civil society, it is the greatest form of pleasure, and it is the way to create the next generation. It is vital for civil society, and for it to be deprioritised in such a way as it has been is as frustrating to Zara as it is to me, I am sure.

Rob Bacon: The Local Government Association produces some really excellent briefings for elected members, in a digestible format, providing case studies. That sort of evidence base, allowing for understanding by putting it in a framework that they can adopt and consider at the local level, does change that. Of course, talking about sexual health is a very specialist niche role, so I think that sometimes they are grateful that somebody else is dealing with it. Other things, like air pollution or potholes, are a little bit easier to understand. I think communication, continuing to be transparent, looking to the specialists and talking to local people will help that.

- Q80 **Andrew George:** Surely, at the local authority level, most local authorities have the strong leader model, so it is primarily just one local councillor who you need to be talking to, not the whole council. I do not understand why you cannot make significant progress without having to have a wider discussion. Is that true?

Chair: For the sake of the transcript, the panel are nodding.

Professor Phillips: Yes, agreed, but I guess the point was well made before about having to have hundreds of different conversations with hundreds of different people.

- Q81 **Josh Fenton-Glynn:** I want to come back to the question that Andrew asked about the sustainability of the workforce, Zara. How long is the training pathway for a doctor in your field?

Dr Haider: For a specialist in sexual and reproductive healthcare, so for a community sexual reproductive healthcare trainee, it is six years of run-through training from ST1.

- Q82 **Josh Fenton-Glynn:** So six years from after foundation.

Dr Haider: Exactly. You do two years of foundation and then you step in. The competition for our training is beyond belief. This year, 1,400 applied for 80 interviews and 14 posts.

- Q83 **Josh Fenton-Glynn:** One third of sexual health doctors are planning on retiring in the next five years.

Dr Haider: In the next three years—a bit sooner.

- Q84 **Josh Fenton-Glynn:** It simply does not sound like we have got the training places to replace them.

Dr Haider: No. We need more. We do have people coming through alternative routes as well to become a consultant, but they are few and far between.



Q85 Josh Fenton-Glynn: Is that like CESR?

Dr Haider: Yes, we call the portfolio pathway now. It is a struggle because it is such a hard thing to do. It is demonstrating in your portfolio that you have done the equivalent of somebody who has spent six years doing run-through training as well as doing your day job. It is a real graft, and it is incredibly expensive. We have had people who have been successful doing it, but they definitely need support and help, and the numbers are trickling through.

Q86 Josh Fenton-Glynn: But this is a five-alarm fire, isn't it? We are losing a third of the sexual health workforce and we have got 14 new training places this year. How ready are you to expand the training places?

Dr Haider: We are definitely ready. In the workforce survey we talked about SRH deserts: areas of the country where there is no CSRH consultant. There is nobody there to give leadership and direction to SRH. We would love to be able to put some of our trainees there, because we know that trainees tend to get consultant jobs pretty close to where they did their training. If we had the opportunity to do that with more trainees, that would be fantastic.

Q87 Josh Fenton-Glynn: They would be working to a trainer who was elsewhere.

Dr Haider: Yes, elsewhere, but perhaps doing some of their training within a clinic that was in the vicinity of the SRH desert where there is currently no consultant. We have plans; we just do not have enough trainees.

Q88 Josh Fenton-Glynn: In the NHS workforce plan, just to underline the point, we have to see more than 14 training places.

Dr Haider: Absolutely.

Q89 Josh Fenton-Glynn: And we have to see a method by which we are going to get a new generation of sexual health doctors.

Dr Haider: Absolutely. One of the small wins that we have had is that these training posts are fully funded. They did not used to be. You used to have to beg or borrow from an NHS trust, which made it even harder. So that was a win. But we still do not have enough trainees coming through, yet clearly there is a demand from people who want to do CSRH.

Q90 Danny Beales: I want to come back to you on the point about councillors because it is important to draw a line under that. I take your experience, but would you say it is not just councillors who are making decisions in this space? Ultimately, professionals are doing needs assessments and recommending services. A lot of programmes are commissioned nationally.

We have heard that those national programmes, such as HIV Prevention England, have also been cut significantly, so it does not seem to be just a councillor decision-making issue. Do you think it is also the case that, more generally, there is an undervaluing of sexual health, or a view that it



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is perhaps less harmful to cut in this area?

I remember distinctly conversations about the Mpox outbreak with national officials at national health organisations who were indicating that perhaps vaccines were not as necessary because people could just abstain from sex for the outbreak period, like abstinence was a solution to a public health issue still, in 2023—or whenever it was. Would you say that attitudes about sex and the prioritisation of sexual health pervade the NHS, public bodies and political bodies nationally and locally—it is not just a councillor problem?

Rob Bacon: Absolutely. I have worked in this role for 13 years, and it always feels that, as much as we are passionate—and we need to acknowledge that all the commissioners, the workers in sexual health, the youth workers and the teachers teaching in schools are all trying to do their best in a difficult situation—you are absolutely right. We live and breath it, but outside that it always feels as if we are struggling to get our point across.

The money does not go far enough, the workforce are stretched, people are being bounced around the system when they should clearly have been seen at their point of care. Why is it different from one local authority to another? There are all those struggles. We have said numerous times about that clear governance action plan around sexual health. We have one for HIV; why not for sexual health? We have one for women's health, but these areas are all interlinked.

If we had that overall umbrella, with that clear role, and a clear understanding of what you are responsible to commission, so that there is no confusion, then we could all work within that parameter and hopefully the funding would follow and we could use it and direct it in the most appropriate place.

Q91 **Chair:** You have teed me up well for the next bit, because you are talking about a strategy to pull together what currently exists. I think Dr Beccy Cooper described it earlier as a “tumble-dryer of a mess” and it is becoming clearer and clearer that that is true, but there is also new stuff coming down the line: injectable PrEP has just been approved, and we have Doxy-PEP and the gonorrhoea vaccine. There is innovation in this space, so we cannot just sort out the mess as it currently is; we also have to prepare for the innovations of the future. Matt, can you deliver those recent examples? Do you have the capacity to deliver the new innovations?

Professor Phillips: I am hesitating because I do not want to say no, but I have to say no. As the president, our services are telling me that they do not have capacity. They will find a way and, as Zara has described, they will do more. They will give that extra 10%, which takes them up to 150%. But actually, no—there is not capacity. It is underfunded. Mpox was really not well funded. However, we are delighted to see the innovations. We are caught between a rock and a hard place.

Chair: It is capacity, not desire, that stops you.

Professor Phillips: It is absolutely capacity. The desire is there for even more—as much as we can get.

Q92 **Chair:** So funding—what else do you need? Give me a shopping list.

Professor Phillips: Funding, supported staffing models and a strategy.

Dr Haider: I could not agree more. The desire and the willingness are definitely there. We are trying but we do not want to do it at the expense of something else—something that has to give or drop—because we are desperate to try to wrap the care around the patient.

Q93 **Chair:** Rob, from your perspective and the commissioning perspective, with all the new innovations that are coming down the line, what do you need to make sure that the commissioners are able to harness this opportunity?

Rob Bacon: We fully support the innovations. This summer there were the Mpox and gonorrhoea vaccines. Some areas are now introducing cervical screening within their sexual health service. As much as we want that and are supportive, it still puts pressure on the system. Again, there must be some funding attached to that. We are fully supportive of that joint working relationship moving forward.

Q94 **Chair:** Is the role of commissioners nimble enough to harness those things quickly enough to make a difference?

Rob Bacon: No.

Q95 **Chair:** What needs to change to make it more nimble?

Rob Bacon: There needs to be good lead-in time and notice that those things are coming and some capacity to put them into practice, as well as an understanding that some areas are going to get them up and running on a very different timescale. When it was advertised that “Doxy-PEP is now available from your sexual health service”, that was not actually the case for all sexual health services. That was announced across social media, but local authorities had not been informed, and our sexual health services needed to get that in place. There is that mismatch.

Chair: Where did that announcement emanate from?

Rob Bacon: I think it was NHS England.

Q96 **Chair:** Tim, over to you—how did that happen? How does it happen that an announcement is made but the local authorities meant to deliver did not even know it was possible?

Tim Elwell-Sutton: I do not know about that, but I can follow up in writing.

Q97 **Chair:** Yes, please come back to us with that. It strikes me as bizarre. On innovation, from an NHSE—and soon to be departmental—perspective, what are you doing to get out of the way of those innovations so that they flow down to Zara and Matt’s clinics?

Tim Elwell-Sutton: The national role here is partly around providing the evidence base—injectable PrEP is a NICE recommendation—and that is an important national role. It has given guidance on the appropriate cohort for that to be delivered to. We are working with NHS England to deliver the medicines needed for that. We have already talked about funding. Ultimately, a lot comes down to more local implementation.

Q98 **Chair:** Matt, thinking ahead to who is going to access that, let us pretend we have sorted the funding, training and everything else necessary. There remains the issue that the most at-risk groups are often not accessing that innovation. From your perspective, what is needed to make sure that the most at-risk get access to the latest thing?

Professor Phillips: Am I allowed another shopping list?

Chair: Absolutely.

Professor Phillips: First, any strategy would require services and local commissioners to engage with the local third sector. The third sector really understands the populations much better than clinics or local authorities. They are there and strategies should require engagement with them.

We should ensure that commissioning follows the patient, because if that patient turns up, you need to be able to do everything for them. Those young people—as we found during covid, and there was work done that showed it—really like that face-to-face service. They need to come in with their mates, then come in the next day and get condoms and build up that trust and reduce their fear. Part of it is having a physical open door; we need an open-door third sector.

We also need a strategic intent to address the needs of underserved populations. Richard rightly said in his evidence that we are seeing HIV rise in black women. That is absolutely terrible. It is terrible that in some areas, you are more likely to have an HIV test in your emergency department than in your contraceptive service. That is terrible and it needs addressing. The strategy must address the needs of underserved populations. Black women are very poorly served; the MBRACE study shows the risks to black women in pregnancy and that extends to our services.

Q99 **Chair:** Zara, I want to come to you about other at-risk groups. A lot of innovations have been targeted at men who have sex with men, but there are other groups that are underserved.

Dr Haider: Yes, absolutely. My colleague from the panel before talked about migrant populations and young people. We have thought long and hard about what we can do to help young people in my borough. We did a health needs assessment, and we opened a walk-in clinic at the hours that suit young people. There is lots of information around the clinic to help them learn a bit more about contraception and STI testing while they are waiting. There are plenty of clinicians around, so that they are not having to wait too long. This is thinking about young people's needs and making



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the service more accessible and likable for them, and then they tell their friends, which is brilliant.

We would love an advertising campaign, but that costs money. But we are definitely seeing the numbers rising, and we are also getting more men coming through, which is brilliant. Young boys are notoriously hard to attract to young people's services, but they are learning about us and are coming in.

It is also important to have information in different languages. This is something I have been battling for all the time I have worked in sexual and reproductive healthcare. There is just not enough information out there in different languages; there needs to be good, evidence-based information in alternative languages. We need to be thinking about black minority ethnic people who maybe don't speak English or people whose first language is not English—the migrant population. They are so disadvantaged, and the fact that they are unable to access information in their own languages makes things a lot worse.

Q100 Dr Cooper: Thanks so much for all that information. We are going to finish with strategy, you will be delighted to hear. This may be a rhetorical question at this point, but I will ask it for the record. Do you think a national sexual health strategy would be valuable for future commissioning and service provision? You can just say yes or no; you don't need to go into it. I will go down the panel. Matt, what do you think?

Professor Phillips: Yes.

Dr Cooper: Zara?

Dr Haider: Yes, definitely.

Dr Cooper: Rob?

Rob Bacon: Absolutely.

Dr Cooper: Tim? *[Interruption.]* Tim from the Department of Health—go on, let's hear it.

Tim Elwell-Sutton: Obviously, the Government recognise the need to improve health in this area. We are considering what to do next. The focus at the moment is on delivering quite a lot of other strategy in this field. We have the 10-year health plan. We also have the HIV action plan, which we have not spoken about much but which is important because it has implications for wider sexual health services. Part of the HIV action plan will be about stabilising and supporting system enablers, so that's an important bit of strategy. We have mentioned the women's health strategy. There is the men's health strategy and also the LGBT+ health evidence review that is being done by NHS England at the moment.

Q101 Dr Cooper: We have also mentioned the fragmentation of services, but perhaps the fragmentation of strategies might apply as well. Perhaps, Tim, we can talk about the most important strategy at the moment, which is



the 10-year health plan for England.

Our excellent researchers, our fantastic Clerks of the Health Committee, have been through it—with a fine-toothed comb, I presume. They tell us that there is one mention of sexual health in “Fit for the Future: The 10 Year Health Plan for England”, and it is—many thanks for doing this—on page 83. The plan speaks about “A new partnership with local government”—always a joy—and says: “The public health grant is a nearly £4 billion investment in local health outcomes.” It has already been mentioned that this is a real-terms increase. There is one mention, Tim, of sexual health in the 10-year health plan. What do we think about that in terms of prioritisation and how we are going forward here?

Tim Elwell-Sutton: Page 83 is the most important page of the strategy, just to be clear.

Dr Cooper: Good answer.

Tim Elwell-Sutton: More seriously, the 10-year health plan is not, was not, setting out to give strategy on individual conditions or for individual population groups. It is about creating a more joined-up, better health ecosystem, with the right incentives and structures in place. You could probably find something similar for a number of other really important health conditions. They do not come through in that strategy, because that is not its intention.

Q102 **Dr Cooper:** Matt, how reassured do you feel that the Department of Health is going to move forward with the sexual health strategy that three quarters of this panel have asked for this morning?

Professor Phillips: I was always taught to live in hope if you die in despair.

Q103 **Dr Cooper:** I suspect this Committee will be joining three quarters of the panel in the call for a sexual health strategy again—third time lucky—as we have not had a new one since 2013, but if there is not a strategy, we do have, as you say, the excellent Susan Hopkins at UKHSA, who has put in place an STI prioritisation framework. How is that working? Is that sufficient? Could we move forward from there?

Dr Haider: I am going to defer to you, Matt—it is definitely your field.

Professor Phillips: It is a help; it is a framework, and certainly action plans could be a kind of other part if a strategy is not on the table—a strategy ought to be on the table, though. I call to account that it has been recommended twice before. It is now 2025, and we are post an Mpox outbreak that was successfully contained only through the blood, sweat and tears of UKHSA, BASHH and our partners such as THT and the Love Tank, so it is time to make good on that. If we cannot make good on that, then an action plan and perhaps a national clinical director to prove how important and necessary it is to co-ordinate across this fractured system might be a second place.

Q104 **Dr Cooper:** Rob, let’s hope for a national sexual health strategy, but if we



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go back to the 10-year strategy, it is very much focused on the left shift approach—the move from treatment to prevention. I know all four of you will have heard of this for years and years. There is very much a strong preventive element of sexual health services, and this morning you have talked about the local authority role and the public health role in that space. Perhaps as Tim is sitting here listening about the 10-year strategy and its non-specific approach to this left shift, do you think there are lessons that could be learned in terms of how we can put together sexual health services moving forward in that prevention space to help the Government with their left shift approach?

Rob Bacon: Yes, I think there are—in the integrated pathways and how we can make it seamless, if we can, when people get on that journey. There is also engaging with the other organisations and services that are available, and that focus on equity in outcomes, not just throughput. Sometimes we lose that because we are so focused on the numbers—“How many people are we testing?”—but we need to get down to a high-quality role, what we can learn from that and how we can maximise some of the good practice that has been happening.

One of the things we do with the commissioners group is a climate check. We send out a survey of 10 or 12 questions to local commissioners to find out what is going on with the STI prioritisation tool. Not everyone is using that—a lot of that is to do with having capacity and time to go through toolkit—but among those who have, it is really informing planning. That is a good start. How do we build on those really good success models? How do we learn from colleagues who are here today and share that as part of that broader picture?

Dr Cooper: Great, thank you; that is really clear.

Q105 **Chair:** I am going to give you all the opportunity to answer: what is the one thing you would ask for from the Government in this space?

Professor Phillips: Strategy.

Dr Haider: For the money to follow the patient, so the fragmentation is not causing such an issue with my clinic, and I can give women the care that they need and deserve.

Rob Bacon: Sustainable funding and an emphasis on developing the workforce.

Chair: Tim, you are allowed one too.

Tim Elwell-Sutton: As I am speaking for the Government, I have to say that everything is excellent as it is. There is clearly a huge amount being considered in the innovation space, and I think that is an important area for us to push forward on.

Chair: Thank you very much to the panel and all our witnesses today. It is much appreciated.