

Health and Social Care Committee

Oral evidence: Sexual health, HC 1419

Tuesday 5 February 2019

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Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Rosie Cooper; Diana Johnson; Andrew Selous; Dr Paul Williams.

Questions 1 - 82

Witnesses

I: Councillor Ian Hudspeth, Chairman of the Community Wellbeing Board, The Local Government Association; Dr Olwen Williams, President, British Association for Sexual Health and HIV (BASHH); Dr Anne Connolly, Clinical Champion for Women's Health, Royal College of General Practitioners; and Dr Asha Kasliwal, President, Faculty of Sexual and Reproductive Healthcare.

II: Ian Green, Chief Executive, The Terrence Higgins Trust; Marion Wadibia, Chief Executive, NAZ Project London; Laura Russell, Head of Policy, Stonewall; and Dr Anatole Menon-Johansson, Clinical Director, Brook.

Written evidence from witnesses:

- [Local Government Association](#)
- [British Association for Sexual Health and HIV \(BASHH\)](#)
- [Royal College of General Practitioners](#)
- [Faculty of Sexual and Reproductive Healthcare](#)
- [Terrence Higgins Trust](#)
- [NAZ Project London](#)
- [Stonewall](#)
- [Brook](#)

Examination of witnesses

Witnesses: Councillor Hudspeth, Dr Williams, Dr Connolly, and Dr Kasliwal.

Q1 **Chair:** Welcome to the Health and Social Care Committee inquiry into sexual health. Before we start, would each of you introduce yourself and who you are representing today?

Dr Williams: I am Dr Olwen Williams, a consultant in sexual health and president of the British Association for Sexual Health and HIV.

Dr Kasliwal: I am Dr Asha Kasliwal, a consultant in community gynaecology and reproductive health in Manchester, and also president of the Faculty of Sexual and Reproductive Healthcare.

Dr Connolly: I am Anne Connolly, a GP in Bradford, and I work in the contraceptive clinic and local gynaecology department. I am also on the CCG commissioning board, but I am here representing the RCGP.

Councillor Hudspeth: I am Councillor Ian Hudspeth, chairman of the Local Government Association Community Wellbeing Board, and leader of Oxfordshire County Council.

Chair: Before we get started, Ben Bradshaw would like to make a declaration of interest.

Mr Bradshaw: Yes; I redraw people's attention to my interest as a trustee of the Terrence Higgins Trust.

Q2 **Chair:** Thank you. To start off, could each of you set out the key points that you feel this Committee should know about trends in prevalence, as well as any key points that you feel we should focus on during the course of our inquiry?

Dr Williams: My background is in genitourinary medicine, which is the major specialty looking after people who have sexually transmitted infections. We are very aware that we have seen a significant increase in the number of sexually transmitted infections, especially gonorrhoea and syphilis. We would like to congratulate ourselves on reducing the number of genital warts due to HPV vaccination and on reducing chlamydia through the chlamydia screening programme, and, more recently, on the drop that we have seen in HIV, probably due to the use of pre-exposure prophylaxis, or PrEP.

However, I draw your attention to the nuances around the two venereal diseases, and I call them venereal diseases because they are the Dickensian diseases for which we established our venereal disease regulations 101 years ago. We have seen a 22% increase in gonorrhoea and a 20% increase in syphilis over the last couple of years, much more than we had anticipated for the 21st century. The background is possibly some behavioural change; we are aware that there is more condomless sex, for oral, anal and vaginal sex. We are aware that people are not



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negotiating safe sex in the first instance; data tell us that about 47% do not use a condom on their first sexual experience with a new partner.

Within that, we see other things that are really worrying, around antimicrobial resistance in the field of gonorrhoea. Over the last 35 years, we, as experts, have been very aware how gonorrhoea can mutate in the presence of different antibiotics, but last year was the first time we saw a case for which no drugs were available. Latterly—in the last three months—we have seen another two cases where there were major issues around treatment.

AMR is a major issue for us; we are at a point where, if we do not use or have the right antimicrobials, we will land up in a situation where a simple disease that is treatable and curable with one injection will become an in-patient event of three days, and the cost to the organisation hosting that will go from £250 to £1,500. If we do not address the issue of AMR in gonorrhoea, our costs in the next four or five years for antimicrobial resistance will go up into the region of about £3.5 million, just for the treatment of anti-resistant gonorrhoea. The antimicrobials available to us at the moment are few and far between. There are some exciting things in the forerun, but that will be in five years' time.

Q3 Chair: We will have some specific questions on that shortly. Asha?

Dr Kasliwal: Our biggest concern is around women's health. Women comprise 51% of the population, and we find more and more that they are not getting access to services, not just contraception, which we think is a basic need. Most women need contraception at some time or other in their lives. However, it is across the life course, so we are talking about menorrhagia contraception as well as menopause management. We have over 15,000 members, and they are finding that access is reducing to all those services, not just contraception.

Some £700 million has been cut from the public health budget, so the local authorities are not to be blamed, because they are passing on these cuts. What happens then is that the very vulnerable in our society suffer; the woman with the pram cannot navigate her way through the system and get access to her needs. As a consequence, the use of long-acting, reversible contraception—there is good NICE guidance suggesting that it is the best form—is decreasing. Public Health England has data suggesting an 8% decrease. I am sure that Anne Connolly will agree that GPs are doing less LARC provision as well. Very sadly, abortion rates are slightly increasing, more so in the over-30s. Some commissioners are trying to protect young people's services and do their best with the moneys they have, but that means that older women are not getting good access to any of that.

Q4 Chair: We will have more questions specifically on access, but thank you for highlighting that as a key concern for you. Anne, do you want to tell us about your key concerns?



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Dr Connolly: I go back to two reports that I am sure you have seen. One was written in 2015 and highlighted the problems with accountability across the system, and fragmentation, and there has been no progress on that. More recently, there was the “Time to Act” report from the RCGP.

The biggest concern for us as GPs is the loss of the holistic healthcare we give, particularly to women. Separating sexual health from the rest of women’s health has an impact not only on abortion numbers but on more complex women going through maternity services; there is separation of the care that we as GPs give our women all the time.

I work in the centre of Bradford, where the cuts hit the most deprived most severely, because they cannot always navigate the social, cultural or financial factors; they cannot navigate the hurdles put in their way when access is changed. We know that increased inequalities are occurring across the system, with reduced access. From the point of view of the RCGP specifically, it is about payment for services. Payment has been reduced or stopped, or it is inadequate, or there is no promise of future funding, so nobody can plan, which has problems for training a future workforce.

Councillor Hudspeth: Obviously, with health coming over in 2013, there were some opportunities and major challenges. The challenges we have already heard about, with the reduction in funding, which has meant that we had to make some really difficult decisions.

There have been opportunities to look at local government, which has been stepping up to the mark in places, perhaps making sure that things are more accessible in different units, bringing them in with other council services to make it more part of the holistic approach. But we cannot get away from the fact that there has been a reduction in funding, which means that we have to make some difficult decisions. Overall, local government spends about £600 million on those services, but, obviously, if cuts come in, we have to make sure that we spread them, because each different service has a particular priority that we should be funding. We should be making sure that we are delivering the best possible.

There have been some good working arrangements; there has been an increase from five days to six and seven days. We have been looking at using technology, so that people can book services online and through apps. Ultimately, it comes down to the funding we have, and the increase in appointments as well, from 2.9 million to 3.3 million. With that upward curve and the reduction in funding, we are rising to the challenge, but it is difficult, and we would appreciate the cuts being reversed.

Chair: Thank you for those clear opening statements.

Q5 **Mr Bradshaw:** Dr Williams, could you analyse for us in a bit more detail the reasons for the very worrying increase in syphilis and gonorrhoea, particularly on the groups most affected?



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Dr Williams: We have been very aware of the increase over the last five or six years, and in syphilis since probably about 1997. These are highly infectious STIs; some people do not have symptoms, but the majority of men will probably have a symptom around an STI. The prevalence is higher in groups of men who have sex with men, and in black and ethnic minority groups, and we are aware that social deprivation and issues around access to services contribute to the rises.

It is also around education and people having a knowledge base so that they think about getting tested if they have condomless sex. You could argue that the more testing there is, the more you are going to pick up, and therefore the more you will see. If people do not present to services promptly, do not have good partner notification and leave things a little while, there is the capacity for onward transmission from that person, quite unwittingly.

Among the challenges we have as clinicians is that we rely on health advisers and partner notification, with patients self-notifying, via an app or face to face with a healthcare professional. If you cannot bring a partner in for treatment and testing, it means that that person is compromised. Part of the growth is how people access their sexual partners. I won't blame the internet or apps, but it is often due to the fact that a profile disappears; someone meets up with someone, hooks up, and then the profile disappears. It is impossible for that person then to inform the person they have had sex with about their condition, which means that they can go on unwittingly to transmit.

Q6 Mr Bradshaw: Is it possible for you to quantify how much of the increase is the result of behaviour change, which could be addressed by better education and information, and how much is driven by poor access to services? You mentioned both.

Dr Williams: It is quite difficult to do that. The other thing is that we know there has been a drop in condom use as well; less than 50% of people use them at their first episode. It is multifactorial. The drive is to warn people, and do campaigns about condom use and accessing services. Of course, some people have extremely good health-seeking behaviour and try to get into services. We have seen a 13% rise over the last couple of years in people accessing services, with a huge demand from people for online testing, not just from NHS Online but purchasing their own tests as well. People are aware that they need to be tested; it is about where they go once they get a positive test.

Q7 Mr Bradshaw: Is there any evidence that the huge success of PrEP, which you highlighted in your evidence, as have others, could have had the unforeseen consequence of reducing condom use and, therefore, exacerbating the problem?

Dr Williams: If people are using PrEP appropriately, they were not using condoms prior to that, so I do not think it promotes lack of condom use; the fact is that it is complementing it. In my own practice, I witness



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people on PrEP actually using more condoms than they were prior to being on PrEP. They are coming in and having three-monthly checks, so that is also quite good.

Q8 Mr Bradshaw: It is helpful to have that on record. If you analyse the extent of the funding cuts to public health and sexual health, has the biggest reduction been in prevention and education?

Dr Williams: Yes, there has been a significant amount, but there are some very subtle changes as well. I discuss this with my colleagues in BASHH. There are little things. Everyone has access to dual nucleic acid amplification tests for gonorrhoea and chlamydia, but quite a lot of clinics do not have access to culture for gonorrhoea, so they treat someone with gonorrhoea blindly, in a way, not knowing what their antimicrobial sensitivities are. That feeds some of the issues we have around governance and around infection prevention. Little things like that have caused issues as well.

Q9 Mr Bradshaw: How much do you think chemsex has contributed to the growth, from your experience?

Dr Williams: It is interesting. Chemsex died a death in Wales a while ago.

Mr Bradshaw: That is good to hear.

Dr Williams: I would not like to comment, because I do not have explicit data that would link STI rises with chemsex.

Chair: Thank you.

Q10 Diana Johnson: I want to ask about demand for contraceptive services and how they have changed, through GPs or specialist services. Also, could you, Asha, say a little bit more about the comment you made about abortion rates going up slightly, and the particular issue of women over 30?

Dr Connolly: We submitted some evidence from a Primary Care Women's Health Forum survey about increasing demand for contraception from primary care. There is an expectation that women can access everything, whereas we know that there is a reduction in the number of practices providing LARC; we know that from absolute numbers. Women are being directed to primary care for a service that they then often cannot access; the most vulnerable or chaotic are the ones who do not make the time to try to find another service, because they do not have the money or the cultural wherewithal.

I work in the centre of Bradford, and we know that it particularly affects certain cultural groups. Women with busy lives, either working or with children, cannot go from one service to another because they just do not have the time. They neglect their own health and go back to playing normal, as they now call it in Bradford, which is withdrawal. We are going



back quite a long way from the good benefits we were seeing from good access to all contraception.

You will know yourself that it is hard to get a GP appointment these days. There is less trained workforce. Clinicians of my age are struggling to get GP positions, although we have all the right badges. Now we have a shortage of GPs, because lots of GPs are choosing to move, and they do not necessarily do the extra training to get the enhanced skills because it is not required in the same way. We are losing a workforce at the moment.

Because there is no planning and we do not know what the future funding is, GP partners are saying, "Why are you doing a service like this? You are not getting enough money; we need you on the frontline. We cannot get the backfill." We are watching access to better methods of contraception going, alongside the fact that specialised services are reducing in numbers. They cannot do the same amount of training because they do not have the capacity, or they are training a different workforce. Then there is the whole issue of mentoring support and ongoing provision. We have put out the figures, although I cannot quite remember them. There is a significant move to the expectation that primary care can pick up the extra work with no extra funding in GMS, unless we can work it out with the new moneys that have come into primary care, which may be possible.

The other example of our problems is with cervical screening. Women had a choice of where they went for their cervical screening, and for me it is an insult that a woman has to be examined so many times—that they have a coil fitted and cannot have the smear done at the same time, because it is not funded. I think that is an assault, actually.

Q11 Diana Johnson: So that I understand that, why can't they do it at the same time? Is it because there is no specific funding to do that test?

Dr Connolly: Because of fragmentation, there is commissioning with different responsibilities, and some SRH services are not funded to do cervical smears. Even though the woman is in the position, and trained clinicians could do that, they are being told not to. The woman is told that she can have a coil fitted and have her swabs done, but she has to go somewhere else to have another examination. Those of us who have had smears know that it is quite intimate and quite an assault.

Dr Kasliwal: To give you an everyday example, in my clinic last week I saw a patient for a complex coil fitting. She was due her smear, but I could not do it. I am able to do it, because I am a trained colposcopist, but the commissioning arrangements are such that that service is unable to provide the smear; God help her if it is a difficult smear. She can go back to her GP, and we know how hard that access is. If that smear is difficult, she will be referred to my community gynaecology clinic for me to do the smear at an extra cost. That is what the fragmentation of



commissioning is causing, and one of the many reasons why cervical screening is going down.

To continue with the question you asked, the Advisory Group on Contraception did a freedom of information request, and we know that two thirds of councils have reduced their spending on contraception, which means that 8 million women now live in an area where funding to contraception has decreased. That has a major impact on access.

If we are not getting the money to provide cervical screening, how will we be able to afford it? That is the question. That is what we are seeing on the ground. We also see that long-acting reversible contraception is not available, and it is not just choice of method. Take emergency contraception, for example, where we are innovating and doing new things; we are doing online bookings, and pharmacists are providing emergency contraception, which is great. But what is the best form of emergency contraception? It is an intrauterine device. That is in the NICE guidance; there is good evidence behind it, and it is Faculty guidance, but not all women, especially young women, can get access to emergency contraception.

We are doing a lot of innovation, and that is okay, but unless you see the patient face to face, you cannot do a cervical screen or an emergency IUD, or any IUD fitting for LARC. Innovation is very important, and it will take away some of visits for repeat pills, and so on; but every visit for a repeat pill is a chance to talk about long-acting reversible methods and a chance to talk about infections and offer sexual health screening. That is getting lost.

Also, there is no training, which Anne alluded to. Sexual and reproductive health consultants are system leaders; they provide leadership to a whole network and system. Because the money is not there and the training is not there, we are not training the consultants of the future. We have registrar posts, which we could appoint people to, and we have an 80:1 ratio of applicants, but we do not have the money to train, because there is no money in the system to do that training. Pharmacists, GPs and physician associates could have been delivering a lot of the contraception, supported by governance from the system leaders, the SRH consultants, but that cannot happen.

Chair: We will come on more specifically to the workforce shortly. Thank you very much.

Q12 Diana Johnson: On the issue of abortion and the over-30s, could you say something specifically about why that is happening?

Dr Connolly: A lot of the focus has been on young women, rightly so—the under-25s and teenage pregnancy reduction. Some services are focused only on young women; older women, or those over 25, cannot always access that service, and they have to go to a GP, who may or may not fit a long-acting reversible method.



There is societal change, as well, but we know that older women are finding it harder to get the contraception care they need. It is not just about abortion. In the bigger maternity picture, we are trying desperately to work better on our maternity outcomes, but we are giving the hospitals women who are less and less fit; they are not planning their pregnancies in the same way, because they cannot control contraception in the same way. It is often the women who need more preconception care who are not accessing it, so that is a bigger holistic care challenge.

Q13 Luciana Berger: You talked about fragmentation, but can you be specific about what the situation was before the Health and Social Care Act? What would make a difference if it was applied today to the challenges that you have highlighted in your contribution?

Dr Williams: One of the things that disappeared with the Health and Social Care Act was the fact that there was a 48-hour target for access to sexual health, which had actually transformed how people could access all their needs, both the STI side and their contraception needs. On the back of that, the innovators came in. We changed the way workforce worked, we empowered people, and there was a lot of amazing work. Taking away that target, which most clinicians and system leaders still work to, allowed an erosion to happen in some of those things, because people did not have to meet it. There was an expectation that you would be seen in 48 hours, and that went. That was a big step.

A lot of the commissions are specifications developed with the Department of Health, based on British Association for Sexual Health and HIV and Faculty guidance and standards. They are just put together, and it is up to people to pick out what they want to commission from that, and that has lost a little bit. From a BASHH perspective, most of the relationships between our members and commissioners were found in our survey to be good, but the tendering process has completely sidetracked service delivery and changed management for them.

Dr Kasliwal: I agree with everything Olwen said. We have noticed that tendering hurts. A local public health consultant did a health needs assessment recently for Greater Manchester. I have the report with me. It is quite stark that, every time there is tendering, access to all the services we were looking at, such as contraception, goes down dramatically. We have an excellent relationship with our commissioners. It is not about the relationships; everybody wants to work better and get it better. But every time there is tendering, it hurts, and it hurts the youngest the most, the under-18s. That is what the Greater Manchester report shows.

Another thing is that the burden moves to somebody else. We do not provide post-partum or post-abortion contraception, and the burden of managing that moves to another commissioner. Abortion is commissioned by somebody else. Every pound spent on contraception saves about £10. Those are Public Health England's figures, not ours; it is



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their data. That takes time to show, and it is somebody else's £9. That is perhaps one of the other problems with the commissioning issue.

The biggest problem is with training. The mandate did not have training, so we are losing registrars. We cannot develop registrar jobs, because training is not even in the package.

Q14 Chair: We are shifting around a bit. We were hoping to focus on services and access, and then look in more detail at commissioning and fragmentation. Anne, could you stay with that?

Dr Connolly: I have two points. It has particularly affected holistic care for women, because they cannot get the Mirena put in for one thing, whereas they could get it put in for something else, and then there is the cost, and the hurdles.

The other point is about the loss of guaranteed funding for primary care. It is very much a postcode lottery; in some areas it is there, and in some areas it is not, or not that much. We cannot guarantee a primary care workforce. Those are the two biggest issues for the RCGP.

Chair: Luciana, do you have any other questions about service access and quality? We will come to more questions about commissioning later.

Q15 Luciana Berger: You have touched on the issue of the 48-hour target being removed, and there is evidence of people waiting longer, but what evidence can you provide as to people actually missing out on necessary appointments, or does that evidence not exist? Is it not a problem?

Dr Williams: We collect evidence. One thing we know is that everyone who attempts to get in contact and actually speaks to someone gets triaged over the telephone or face to face. Some services across the UK are turning away more than 50 people a week; they cannot physically see them in the department, because there is no capacity.

Q16 Luciana Berger: Is that nationally?

Dr Williams: Yes, that is nationally. The shift to online testing has been reasonably successful, but it is not appropriate for everyone—those who are digitally excluded, for example. There are people who actually have multiple concerns about their sexual health, and going down a questionnaire and being sent an online test is not the most appropriate thing for them. There are people who have language barriers, and all sorts of things. We know that there is unmet need. BASHH did some work last year looking at that, and we are about to analyse some data.

Q17 Luciana Berger: Councillor Hudspeth, do you have any concerns about the capacity of your local authority members to deliver the services required by the populations they serve? I reflect on the answer I got to a parliamentary question, which showed a 13% reduction in local authority spend on those services.



Councillor Hudspeth: Given the context of the financial restrictions that have come on us, we cannot turn around and say that it is not happening, because we have to take some very difficult decisions to balance the books. The funding reduction since 2013 has been an actual £531 million, which means that we have to make tough decisions.

Q18 **Luciana Berger:** To be clear, that is to the public health budget overall.

Councillor Hudspeth: Sorry, yes, that is the cut to the public health budget overall. The sexual health budget is about £600 million out of that. Over the period of time, it has been £531 million. In percentages, my information was that it was about 7%. That means that you have to make really difficult decisions just to balance the books.

We are in a situation whereby we are working with our colleagues to try to better things, and there are improvements in certain areas. In Oxfordshire, prior to the service coming over to local government, we had three particular units; now we have nine units, which are open longer and give us more ability. One really good thing that I am determined to protect is having a school nurse in every secondary school, which gives the ability for young people to go along to a school nurse and not having to talk to a teacher. They are getting understanding, so that starts off bettering life, which has to be the way to prevent things, but it is always very difficult to protect preventive budgets.

Q19 **Luciana Berger:** Can the doctors on the panel share with us any of the health consequences of the delays in access to sexual health services, both on the STI front and in respect of contraception?

Dr Williams: We are seeing neonatal syphilis for the first time in decades in the UK, and neonatal deaths due to syphilis.¹ That probably reflects some of the issues we have. We are seeing an increase in women presenting with infectious syphilis in pregnancy, and that has dire outcomes.

Q20 **Luciana Berger:** Can you put a number on that? How many babies are affected?

Dr Williams: It is in double figures, not much higher. But the fact that it is actually happening is extremely worrying.

Q21 **Luciana Berger:** Do you know when we last had it? You said decades, but when was it last recorded?

Dr Williams: On neonatal deaths, no, I couldn't tell you, but we had one in the last year.

Q22 **Luciana Berger:** Are there any other consequences?

¹ Dr Williams and BASHH provided supplementary evidence to explain this point further. This can be found following this [link](#).



Dr Williams: The consequence of the increase in gonorrhoea is that there will probably be an increase of pelvic inflammatory disease in women. The consequence of syphilis and gonorrhoea is morbidity and mortality between 88% and 45%, in a variety of general health conditions. To some extent, early prevention, treatment and management prevent long-term morbidity and mortality.

Dr Kasliwal: Contraception is by its nature prevention, isn't it? This is where disease management is easier to see than contraception, but it is actually prevention. There is cervical screening and management of menorrhagia. We know about the long-term health consequences; that is why each pound that we do not spend on that will cost us £10 in the long run. It is not just through abortion, which in itself is an issue; there will also be poorer neonatal outcomes if women cannot space pregnancies because they are not getting access to contraception. That creates a smaller interpregnancy interval, leading to poorer outcomes for the mother and the baby. There are women working today with menopause problems and menorrhagia who cannot get access to management of that. They may not be able to lobby or shout it out from the rooftops, but those are daily issues that women are dealing with.

Dr Connolly: The figures we are seeing for teen pregnancies are for women who got pregnant two and a half years ago. We know locally that our teen pregnancy rate is on the increase again, specifically for more deprived groups than we have seen for a while. Locally in Bradford, we have seen a significant increase in our looked-after children leaving care pregnant, which is a real exposure of the most awful complexities.

Dr Kasliwal: In Manchester, it takes a couple of years to get the teenage pregnancy figures, but we now see a rise in teenage pregnancies after a drop. That is very concerning, and our commissioners are getting together with us to look at that and see what we can do to improve it.

Chair: Thank you. Andrew has a follow-up point.

Q23 **Andrew Selous:** I apologise for coming in late, but I was speaking in the Chamber, and I have a European Committee to go to shortly as well. I wanted to come back to Councillor Hudspeth on the local authority delivery of public health in this area. You mentioned a £531 million reduction in funding, but then you gave us examples of some quite good outcomes. In Oxfordshire, you said that you had gone from three to nine units, which were open longer. Are there any learning points for local authority delivery in this area? Is there best practice that the LGA is getting around? Are there any tips for local authorities that you would be keen to share and promote?

Councillor Hudspeth: The reason for the Local Government Association is to share best practice, and we try to share it. More importantly, as I was trying to say, there are good outcomes that we have achieved through efficiencies, being a bit tighter and a bit different and making sure that the services are there for people to access them. The Local



Government Association is all about best practice and learning from each other to make sure that we can assist in other areas.

- Q24 **Andrew Selous:** To press you on your Oxfordshire example very briefly, I imagine that Oxfordshire's funding went down, so how did it manage to spread the service to nine units that were open longer? I imagine that some were existing facilities.

Councillor Hudspeth: Some were existing facilities. It is co-location, so they were using different buildings. It is not about setting up a completely new unit; it is about saying, "Can we provide that facility there?" Having nine across Oxfordshire, which has a population of about 680,000, means that there is better accessibility.

It is difficult—I am not saying that it is easy—but the team has raised expectation. School nurses in particular play a key part in making sure that young people can access services and advice as soon as possible, in a very compassionate way. It is not easy, and there is another £85 million reduction in public health grants for this year, which obviously means that we will have to make some challenging decisions. But where possible we try to work with our partners to make sure that we can deliver better services.

- Q25 **Mr Bradshaw:** You have already talked about some of the challenges that you faced over fragmentation in the post-Lansley world, so I do not want you to repeat what you said earlier to Luciana. Can I take it from what you say that you would all want everything brought back under the NHS banner? Tell me what your solutions would be.

Dr Williams: From my perspective, and that of my colleagues in BASHH, we want adequately funded services, regardless of where they sit. Rearranging the deckchairs is not the issue; it is about fundamentally putting in the right package of money to ensure that we deliver fit-for-purpose high-quality standards that are led appropriately and meet our organisation's specifications, and that we do not have this continued liposuction so that we are a body with just a bag of bones. We are at the moment falling over because we cannot cope with the number of issues—it is about capacity.

- Q26 **Mr Bradshaw:** I shall come to you in a moment, councillor. Do the other medics agree?

Dr Kasliwal: Partly. It is very important that there is joined-up commissioning. Fragmentation has, in many ways, made us unable to provide holistic care to a woman; that cannot be right. It needs to be patient-centric and, for us, it needs to be woman-centric.

I agree totally that the funding cuts need to be reversed, and we need adequate funding within the public health budget, irrespective of where it sits, but we also need joined-up commissioning. We cannot have silos working in silos; there needs to be a mandate or some kind of accountability. You cannot say, "Oh, yes, it's very good. You need to talk



to each other and commission jointly.” Where is the mandate for that? Who is going to check that it is actually happening so that when, as a woman, I walk into a service, all my needs can be met and I do not need to be examined three times by three different people for the same thing? That would be our viewpoint.

Q27 **Mr Bradshaw:** Dr Connolly?

Dr Connolly: The RCGP position is that it should come back under health, so that we can offer holistic care across the system, recognising that women spend a lot of their time either trying to be pregnant or trying not to be pregnant. Fragmentation, whereby funding is cut on one side and the expectations of managing the consequences are on the other side, is not working.

Q28 **Mr Bradshaw:** That is interesting. Can I take it from what you said, Dr Williams, that in an ideal world you would like it to be as it was before, but your priority is money, which is why your answer was slightly different?

Dr Williams: There are reasons for sitting within an NHS portfolio for clinicians. When I say clinicians, I mean nurses, doctors and health advisers. That is where they historically are comfortable. If managed and commissioned services are appropriate, sometimes the NHS was not the best place for some services; they were not commissioned well there. It could be that there was more innovation when they were commissioned outside the NHS. Personally, from a doctor’s perspective, I think most doctors would say that they wanted to be back in the NHS, but our first line is about having the appropriate package of funding to deliver appropriate services, regardless of where they sit.

Q29 **Mr Bradshaw:** Councillor Hudspeth, you would say that you want to keep it in local government, wouldn’t you, because you are a local government man? What would you say to these three professionals, and all the user groups we have had evidence from, which are almost universally critical of the fragmentation we have now?

Councillor Hudspeth: First, I would not immediately jump to say that it has to be in local government because it is local government; it is about having the best systems in place. You heard from the other three panellists that the funding is not there, so we have to make sure that the funding is in place, and then that the system is working right through. Of course, with health and wellbeing boards and an integrated care system, we are moving towards a much more streamlined system right across health and social care.

We have to be clear that simply moving the deckchairs, as Dr Williams said, is not going to fix the problem. We have to understand what it is, and the key issue, as we are all saying, is that the funding is not there. If the funding were to be reversed, would that provide a better system, and make sure that we are fully integrated across that system? Most importantly, we have the ability through health and wellbeing boards and



integrated care systems to make sure that locally it is accountable to local decision-makers.

- Q30 **Mr Bradshaw:** The fact is that, if the services were still under health, they would—I imagine—have benefited from the non-real-terms cut in funding that the NHS has had, whereas in local government you have had huge cuts. Do you not sometimes feel that you have been taken for a bit of a mug, with someone of your own party in Government putting the responsibility on you for these services and, at the same time, cutting the funds, which means that you get the stick? You get the blame from local organisations and users because those services are not available or are disappearing.

Councillor Hudspeth: As I said, some of the services are there. Obviously, it would be better to have more funding, but we have to be realistic about where we are with the funding stream and make sure that we get the best from what we have, rather than trying to change the whole system and imagining that with the funding we currently have it would deliver different results. Personally, I do not think that that would be the case, because we are in the situation with the funding we have, and that is the baseline you have to look at, rather than saying, “What if?”, because we cannot be in that position.

- Q31 **Mr Bradshaw:** We have made repeated attempts on this Committee, haven’t we, Chair, with the Secretary of State and other Health Ministers and the head of the NHS, Simon Stevens, to persuade them to stop cutting public health, as it is a false economy, but with absolutely no luck? Are you talking to those people? Are you lobbying and having equally fruitless conversations with them?

Councillor Hudspeth: One of the good things about the NHS long-term plan is the focus on preventive, and if we are going to focus on that, we have to make sure that it is not just in one area but right across the health agenda, which should mean that we make sure that public health receives the appropriate amount of funding so that we can deliver the outcomes that everybody requires.

- Q32 **Mr Bradshaw:** That is exactly the point I made to the Secretary of State, but he does not seem to think that public health and prevention are the same thing.

Councillor Hudspeth: I met him last week and put forward the case.

- Q33 **Mr Bradshaw:** What did he say?

Councillor Hudspeth: He said that he would look at it and consider it. But we have to make that link, because public health is about providing better preventive services for everybody. Just giving them information first of all can save money in future.

- Q34 **Mr Bradshaw:** Dr Kasliwal?



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Dr Kasliwal: One of the things that has suffered is training. I know I made this point before, but it has, and that is where being back with the NHS might be of value. There are all kinds of training. The brilliant initiative where nurses are placed in schools is good, but who will train that school nurse? You need training. Who will train the consultants of tomorrow, or the pharmacists or GPs or anybody who needs to provide that service? That has been lost over the last few years; it has been decreasing.

- Q35 **Dr Paul Williams:** Councillor Hudspeth, on commissioning of services, it is true that a local authority will lead the commissioning of sexual health services, but it seems that in some areas local authorities, NHS England and CCGs are working together so that a full holistic package is commissioned on behalf of people who access services, whereas, in other areas, it appears more fragmented. What is the magic bullet? What makes it work in some areas and not in others?

Councillor Hudspeth: It is about the relationship between local authorities, CCGs and the acute hospitals. If you all have the ability to work together to provide the right outcome, and focus on that, rather than people saying, "This is our domain and our silo," that is where the benefits are. Everybody has to think about the funding they have, which will always be limited, and make best use of it, by saying, "Actually, if it's over there, it's slightly better than if it is in this box."

- Q36 **Dr Paul Williams:** That's right. In some areas, NHS England and local authorities are working together, for example, to make sure that cervical screening is commissioned from sexual health services, whether or not they are provided by hospitals; Virgin is the provider of sexual health services in the area I represent. In other areas, NHS England and local authorities are not working together. Why is that? What stops them saying that they need to commission cervical screening as part of that approach?

Councillor Hudspeth: It is a system approach. That is where everybody has to focus on the best outcomes; people have to forget about who they are working for, or what organisation. It is about the outcomes for the residents in their area.

- Q37 **Dr Paul Williams:** And the outcomes that we are seeing are falling coverage of cervical screening, and some of the people who are at highest risk of cervical cancer are those who might have sexually transmitted infections. It is so obvious.

Dr Kasliwal: That is why there needs to be some accountability. It is not good enough for us to say, "Okay, you need to talk to each other and commission together."

Chair: That brings us neatly to Diana's question.

- Q38 **Diana Johnson:** I want to ask about accountability. The King's Fund has highlighted in one of its reports the lack of accountability at national level



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for the local decisions that are being made. Does any member of the panel want to talk about how they think that could be remedied?

Dr Kasliwal: We have a good example with teenage pregnancy—the engine room approach, as some people call it. When there was accountability at Public Health England, by managing, monitoring and giving consistent messages, we were able to bring down teenage pregnancy. Something of that approach is essential around commissioning. If Public Health England is given that kind of authority—there is no point in having responsibility without authority—and a mandate to manage that, we know that kind of co-ordinated approach can work.

Dr Williams: From an STI and sexual health point of view, Public Health England did not actually do any health promotion campaigns for eight years, until 1997. An organisation that has a remit around primary prevention and education was lacking in that area. It has been only in the last year or 15 months that we have had a certain campaign. PHE has had some responsibility around promoting HIV testing in a more targeted manner over the last four or five years, with things like “Take the Test,” and supported pinprick.

Sometimes doing something has unintended consequences, such as saying that sexual health clinics are not commissioned to do cervical cytology. People go to a level 3 sexual health service where no one is examined, and where cervical cytology is not in the skill mix of the people delivering that service. When someone comes to them and says, “Can you deliver this service?” they can’t, because they do not have the skillset. It is things like that—not thinking outside the box—doing one thing in one place and not checking somewhere else.

Dr Connolly: One of the other issues around sexual health and contraception access, of course, is being brave enough to stand up and talk about it. If you have a bad experience with your hip replacement, you complain to your GP, the CCG board, the hospital or whoever. If someone feels exposed and vulnerable because of their cultural or social background, they will find it much harder to stand up and say, “I had a really bad deal. I had to go through these hurdles and I could not get that contraception, and I had to have an abortion,” with the embarrassment of all that. There isn’t a local voice in local areas saying that they need to get the service sorted out better.

We tried to do some work locally with our health and wellbeing board, to bring out the issues around a system-wide need to look at things, recognising the fact that it is not just about abortion or maternity costs; it is about the whole education issue, and how to look at the system. There seems to be a lot of buy-in across the system, but a lot of it is so complex. For our local women, a lot is about stress, debt and social factors, which are not health measures. It is such a complex problem, and we have the funding cuts and no accountability over the system, as



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we said in the report in 2015. I cannot personally understand how it can continue to be so fragmented, because there is no responsibility.

Q39 **Diana Johnson:** Do you want to say something, Ian? What about political accountability?

Councillor Hudspeth: Political accountability in local decision making is a good thing, and it should provide best practice, as was indicated earlier. That is the key; it should not be about simply cuts, cuts, cuts. What can we do? What can we innovate, and how can we make things different? But the root cause comes down to the fact that, if we are having the accountability and responsibility, we need the funding. If we switch the responsibility back to another area, and the funding does not flow with it, we will still be in the same situation. It comes back to having the right funding. Having accountability locally gives the ability for the differences between different areas to be targeted, to make sure that they deliver the best service for their residents.

Q40 **Diana Johnson:** If you bring information together from all the local areas, do you think there should be accountability at national level, perhaps a Minister responsible for making sure that there are services across the country that actually deliver for patients?

Councillor Hudspeth: The thing is that there is a Minister responsible, and it is his or her duty to make sure that the appropriate funding is there. It is then for the commissioning organisations to deliver the best services possible within the financial constraints they have.

Q41 **Diana Johnson:** That sounds like you are saying that, as long as there is money, it does not really matter what the outcomes are.

Councillor Hudspeth: No, no. I said that one of the key things is that giving local accountability allows you to be innovative—I gave a couple of examples—and actually change different things to try to have that nudge difference. It is about having the ability to innovate, but we cannot ignore the fact of the reduction of £531 million in funding.

Dr Connolly: The accountability has no recognition of workforce planning, so we are seeing GP numbers being reduced, with GPs doing their diploma falling off the radar, and specialist service numbers being reduced. There is no accountability nationally to look at a workforce that will be delivering these services in 10 years.

Q42 **Chair:** Are you going to feed into the workforce programme that is part of the long-term plan being led by Dido Harding?

Dr Connolly: It is interesting, because the RCGP is going to challenge a letter written on behalf of the RCOG, our Faculty and the RCGP to Steve Brine a little while ago, recognising the problems of workforce. A piece of work was done by Health Education England that took many hours to look at the workforce going forward. There was one recommendation: considering that the majority of contraception is done in primary care,



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the RCGP should update its e-learning package. That was it. There was nothing at all for practice nurses, who do the majority of contraception.

Chair: We will return to workforce in more detail in a minute.

Dr Connolly: One last point is that there is no money in the long-term plan for the workforce.

Q43 **Chair:** Thank you. Can I return to the really concerning example that you gave, whereby someone is having a complex coil fitted, and you are not able at the same time to carry out a cervical smear? That is an issue about fragmentation of commissioning, yet we have heard that in some areas they are managing to move to joint commissioning, or co-commissioning. It is not only about saving money, although it is clearly a huge waste of money for someone to have to come back; it is also enormously distressing for the patient at the heart of that to have to come back. It is totally unacceptable that they are being subjected to it twice. What is it in your area that acts as a barrier to co-commissioning that looks at patient's needs first?

Dr Kasliwal: It is difficult to know, because I come from an area where DevoManc is one of the first areas to have a system to get better at commissioning.

Q44 **Chair:** Why isn't it happening, given that there is such a good reputation for that sort of integrated approach?

Dr Kasliwal: It is certainly not percolating down to the commissioning yet. We hope that it will eventually.

We went out to tender in the initial phases of DevoManc and, at that time, there wasn't joined-up thinking, although a plea was made for it. It is very easy afterwards to say, "Okay, now you do everything," but you need a structure for safer cervical screening, for example. We did 5,000 screens a year, which is quite a lot, and we had an administrator who made sure that there was a failsafe, and that we got the results. We had nurses who were trained, and we were training GPs and practice nurses to do cervical screening. In the initial phases of tendering, under the Health and Social Care Act and the local authority commissioning that came out of it, there was not even the understanding that it would fall through the crevices at that time. It was not commissioned, but then we lost the infrastructure.

Q45 **Chair:** Who have you taken it up with? Who is stopping you?

Dr Kasliwal: He has moved on to Public Health England, but we had an excellent commissioner. He went with me and the public health director to NHS England at that stage, before the service spec and the tendering, to ask whether money could be put into the system now so that we did not lose those 5,000 smears.

Q46 **Chair:** Who tells you that you cannot do it?



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Dr Kasliwal: They said, "We don't have the money. We won't be giving you anything."

Q47 **Chair:** If it is not happening in Manchester, that is very concerning.

Dr Kasliwal: In Manchester, we made an effort before that tender came out, the service spec, to approach NHS England. We have had a 30% budget cut; that is massive. To expect us to absorb something that is not part of the service spec is not possible. We need to make sure that women get contraception and STI treatments, and that men get STI treatments. If we are paid for that, we need to make sure that we do it. We could not do a freebie for anybody. NHS England said, "No, there is no money in the system." Now there is an understanding that that needs to come back.

I went to a meeting the other day with NHS England, where they were looking at putting some money into it and trying to get sexual and reproductive health services to do cervical screening. The problem has been that they said, "No, there is no money and we are not giving you anything."

Q48 **Chair:** Even though it is costing them more in the long run. That is extraordinary.

Dr Kasliwal: We predicted that.

Q49 **Chair:** A related issue that has been raised with me by clinicians in my area is the sheer burden of the time around procurement and tendering, and that it takes them away from their clinical responsibilities. Is that widely felt?

Dr Williams: Having been a senior manager in the NHS as well as a consultant, I think our training helps us with leadership and business planning. It usually takes one consultant out of the service pretty much for two or three months to do a tender and get everything spot on. The added burden for the individual looking at the package they are tendering for is that it might mean losing a colleague. We are very aware that looking at the tendering process has had quite an impact on people leaving genitourinary medicine—the STI side of things. We lost about 10% of the workforce as a result of tendering, either before or directly after, in the last year.

There is an emotional input. It is also making sure that you are doing the right thing for your population and your patients, and that they are getting access to those services, but the fallout is potentially what happens to your team.

Q50 **Chair:** Rather than its being about designing best services, and sorting out issues such as those Asha raised, it tends to take a huge amount of time without feeling that it is about service design. Would that be your assessment?



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Dr Williams: Where sexual health has been really innovative over the last year is in adopting modern technology. It has embraced and empowered the patient group to take self-testing on board and to get text results. The innovation is there, but there is a point where actually you have to have manpower delivering a service. You have to be able to see people.

Asha was talking about complex patients. Our complex patients are people who experienced child sexual exploitation who present with an STI. They have multiple needs and psychological problems, and in the past, possibly, would have been able to access a whole cadre of services on one visit. They would have had health advice; they would have had referral to psychological support, but that has been unpicked. It is fundamentally, "Well, this is all we do. We deliver an STI testing service." That is fine for some people, but the complexity of what we now see with regard to STIs—gonorrhoea and syphilis—involves a lot more time. The patients have to have injections. It is not, "Here, take these pills and go away," or, "Buy them from the chemist." It is time in clinic, making sure that they are fine as well.

Q51 **Rosie Cooper:** In some of the answers to the questions, I heard you talk about the difficulties of commissioning, fragmentation budgets and all of that. I heard about the training element. How would you describe the key issues facing the sexual health workforce at the moment? What are the big issues?

Dr Kasliwal: Clearly, those are two separate specialities so I am talking about sexual and reproductive health. We have several issues. One is that we need X number of consultants to be able to train the workforce of the future and to be system leaders. We have not been able to get the numbers to fill those sorts of post.

As I said earlier—I do not know if you were here—we have 80 people applying for one job. We do not have a problem with people wanting to be trained in our specialty; we just do not have the jobs. The reason we do not have the jobs is that, even though Health Education England is willing to give us the numbers, it only provides 50% of the funding. The rest of the 50% comes from the service, and, because there have been cuts, there is not the 50% of funding for the training posts. If we do not train the consultants of tomorrow, we cannot train the nurses, the GPs, the pharmacists, the physician associates or the consultants of tomorrow. This is one of the problems. It is not people not wanting to do our specialty but the fact that the public health cuts mean there is not the money in the system to provide 50%. Health Education England will only give 50%.

The other problem is that there is no time for training. Because of the cuts, there is not enough manpower. We are trying our best just to provide access to patients. There is no time to train people. We are likely to lose that element.



Dr Williams: In genitourinary medicine, we have a very structured training programme. We have around 350 people on ESR registered as GUM physicians, and at any one time we have between 16 and 30 trainees coming up for completion of their specialist training. They do two diplomas around STIs and HIV, and they also do their training in contraception. They come out with a very rounded package of training.

We found that commissioning the training has been an issue for some areas, but we have not had major issues with delivering that side. Our challenge now is the fact that morale within the specialty is quite low, with people seeing the cuts and people leaving. There was a big expansion about 30 years ago when I came into the specialty. We are all now getting a little bit grey and frazzled, and leaving, but we have no issues with there being jobs for the people coming through in the GU aspect.

Q52 **Rosie Cooper:** The invisible word we have been using all afternoon is commissioning. Who commissions which bits? I know you have done it before, but let's nail it down. Who are these invisible commissioners who do all this invisibly?

Dr Kasliwal: Two things happened in our specialty. It used to be part of obs and gynae training, with sub-specialty training in community gynaecology and reproductive health. At that time, the posts were there and it was part of the NHS. There were no problems.

In 2010, CSRH became a separate specialty. That new specialty was in its infancy and developing at the time of the Health and Social Care Act. Basically, it has fallen foul of two things together. It became a specialty in its own right by Act of Parliament, which was great. That was good, but then the Health and Social Care Act came along. The NHS already has a system whereby it has to have registrars who undergo training and become consultants. GUM is an established specialty. Ours was established as part of obs and gynae in the past. It was okay, but at the time it separated, sadly for us, the commissioning structure changed and local authorities were not given the mandate to train the consultants of tomorrow, and the money was cut.

I am ready to take another registrar. We know the numbers we need for the future, but I do not have 50% of the funding because my funding has been cut. In the previous era, it would have been automatic. Also, if we had been well established as a specialty 10 years back, we would already have those registrar posts in place.

Q53 **Rosie Cooper:** Are you saying that all your budget is done by the local authority?

Dr Kasliwal: For the contraception element and sexual health. The GUM and contraception element is all done by the local authority. I also have a community gynaecology service on which I report to the CCG and which is monitored by the CCG. We have an HIV service that is again



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commissioned separately. Three bits of our own service are commissioned separately.

Q54 **Rosie Cooper:** Does NHS England directly commission any of it?

Dr Williams: Cervical cytology.

Dr Kasliwal: Cervical cytology, which they do not commission from us.

Dr Williams: They are also specialist services. HIV is a specialist service that is commissioned. Our training programme is to bring up clinicians who are rounded in all aspects of sexual health, including HIV. What I think Asha was alluding to but has not actually said is that several of our colleagues across the UK are employed by up to four different employers because of the way their services are delivered.

Dr Connolly: NHS England would, in theory, be commissioning the core contraception and primary care, but there is no standard set in primary care for core commissioning, and the LARC provision is very dependent on whether or not there is funding and whether there is a commitment to time. That comes from the public health budget, which may or may not be subcontracted out from the specialist service.

Rosie Cooper: I am sure this is music to the ears of all our constituents. We are making it so complicated that it is ridiculous. The reason I was trying to get to that is that it almost reminds me of the prison health service that is directly commissioned by NHS England. That was just a race to the bottom, and I can see that here.

How should the problems you have outlined be tackled and whose responsibility is it? That is why I was asking you about the level of commissioning and the ridiculousness of it. Councillor Hudspeth, you talked before—

Chair: We did that, Rosie, before you came in. We addressed some of those points.

Q55 **Rosie Cooper:** Can I leave you with a thought then?

Councillor Hudspeth: Certainly.

Rosie Cooper: My apologies. How does the situation that Dr Kasliwal described, where a woman ends up having to visit three different services, because one cannot do it and it is in bits and pieces, actually meet the best practice, innovative, integrated vision you were talking about? If you are allowing that to happen today, you cannot be making the best use of what you have.

Chair: There is one final quick question from Paul and then we must move on to our next panel.

Q56 **Dr Paul Williams:** We will have to make some recommendations to Public Health England and the Government. What actions do you think are needed at national level? Do we need a strategy? Do we need better



enforcement and accountability powers? Do we need new targets? What do you think we need nationally?

Councillor Hudspeth: Nationally, we have to address the issue of the funding situation and say, "Is there sufficient funding for the services we want?" That has to be the key.

Q57 **Dr Paul Williams:** Funding is a given. Are there any other suggestions for what we need nationally?

Dr Connolly: Accountability and an acknowledgement at the top that this is creating inequalities. HEE needs to be mandated to make sure that there is proper training across the whole system, including primary care.

Q58 **Dr Paul Williams:** Better accountability and better training. Anything else?

Dr Kasliwal: I agree with that; those were my points.

Q59 **Dr Paul Williams:** Do we need a national strategy?

Dr Williams: We probably need a 10-year plan where we look at some of the challenges and how we do the joined-up thinking around prevention, promotion, treatment and management. We need to tackle some of the access issues that everyone has described so that everybody has the ability to go to a one-stop shop and get all their sexual health needs in a high-quality manner from trained staff who are competent in delivering quality care.

Dr Kasliwal: Health Education England needs to be core to any recommendations and plans, because training is important.

Chair: Thank you very much, all of you, for your evidence this afternoon.

Examination of witnesses

Witnesses: Ian Green, Marion Wadibia, Laura Russell and Dr Menon-Johansson.

Q60 **Chair:** Thank you for your patience. For those following from outside, could you introduce yourselves and who you represent?

Ian Green: I am Ian Green. I am chief executive of the Terrence Higgins Trust and also chair of HIV Prevention England responsible for the delivery of the national HIV prevention service.

Laura Russell: I am Laura Russell. I am head of policy at the lesbian, gay, bi and trans charity Stonewall.

Marion Wadibia: I am Marion Wadibia. I am chief executive of the NAZ Project London. It is a sexual health charity led by and designed for minority communities to enjoy better sexual health.

Dr Menon-Johansson: I am Dr Anatole Menon-Johansson, clinical director for Brook, a young persons' charity.



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- Q61 Dr Paul Williams:** We will start by talking about inequalities. I am going to ask you to describe inequalities and then Luciana is going to move on to work out how the needs of those groups are being met.

From your organisation's perspective, and from the people you know best, can you tell us about the extent of inequalities both within sexually transmitted infections and unwanted pregnancies, and perhaps whether or not things are getting better or worse?

Ian Green: First of all, sexual health is an issue for most people, but there are clear groups that are disproportionately affected by poor sexual health and HIV. From our perspective, some of those key groups are gay and bisexual men, and in that broad definition there are some specific demographics within men who have sex with men; black Africans and BAME groups are disproportionately affected by poor sexual health, and struggle to access some services.

We increasingly see challenges around gay men and bisexual men from south Asian communities, and particular needs as to how they access services, and similarly, in relation to HIV, how women are in a position to access preventive services around HIV. Trans women are 50 times more likely to be at risk of HIV than other women.

It affects young people. What we are also seeing with the first generation of older people with HIV is that they are struggling to access advice and information, and wider sexual health services. Some of my colleagues will have other examples, but from the groups we are working with those are the key groups I would bring to your attention.

- Q62 Dr Paul Williams:** It is an essay question, but why do those inequalities exist?

Ian Green: It is very difficult to pinpoint one reason why those inequalities are there. Sometimes it is about how we communicate with people in our prevention messages, to make sure that those prevention messages are accessible to people. It is about making sure that our services are provided in different ways so that the people who need to access services feel that they are welcomed, and that the services are accessible to them.

I would love to give you a clear and cogent answer, but I do not think there is one.

Laura Russell: I completely agree with what Ian has just said. We know that gay and bi men are at significant risk of poor sexual health outcomes. We also know that we do not know enough about other members of the LGBT community. We think that trans people are at higher risk of poor sexual health outcomes. We know about poor rates of HIV, but we do not know much about other sexually transmitted infections because we do not have data collection in that area.



Lesbian and bi women are at slightly higher risk potentially of some sexually transmitted infections. Young lesbian and bi women are at higher risk of unplanned pregnancy, which was found by a Public Health England systematic review. Again, there has not been enough research into that particular group to explain why that is happening.

We know that women in the LGBT community are less likely to access sexual health services, and when they do they are less likely to have a good experience of those services. That could be an element, but again we lack the research. We are glad that there is going to be a national LGBT health adviser. Hopefully, they will be able to look into some of this, but given the fragmentation of sexual health as a service being provided it will be quite tricky to know how they can best influence that for the LGBT community.

Q63 Dr Paul Williams: When you say that people are less likely to have a good experience, do you know what they say about that?

Laura Russell: Again, we are not entirely sure. I would not want to speculate particularly. We know from Stonewall's own research that LGBT people are likely to report being discriminated against by healthcare professionals. That is across the healthcare service, not specific to sexual health.

The Government's own national LGBT survey found that people are more likely to have a good experience in sexual health services than, say, mental health services. Again, it is different depending on which part of the LGBT community you are from. If you are a gay or bi man, you are more likely to report having a positive experience than if you are a trans person or if you are a gay or bi woman.

Marion Wadibia: I agree. There are some flavours to this that we need to unpick or understand. When we think of inequalities, for me, it is not just a group, as in BAME. We need to name where the disproportionality lies.

In reproductive health, we have seen a rise of three times more abortions. We have seen a rise in poor health in minority communities. If you then go over to sexual health, much has been said today about gonorrhoea and chlamydia. I am sure I am going to pronounce this wrongly; Anatole can correct me. Trichomoniasis is a bacterial affection that is eight times more likely in minority communities; it does not affect the rest of the population in the same way. If we look at HIV and persistent late diagnosis, 62% of women living with HIV are of African heritage. If you put that together with the other 18% who are non-white, 80% of women living with HIV are BAME. The inequalities are across the system.

One of the challenges is how we adequately support individuals to access help. Ian touched on the south Asian story around HIV. One of the challenges we have seen is that there has been a reduction in HIV in men



who have sex with men, which is a good story, but not in all communities. Part of the challenge is that in a public health framework we have looked at HIV as a whole, but, if we start looking at it in relation to what it means to individual communities, that is where the disparities begin to lie.

Minority communities constitute only 14% of the actual UK population but have a burden of late diagnosis of 52%, and of 40% for people accessing HIV services; it gets worse when you look at women. Those inequalities stand out across the piece. It is not just a sexual health piece, a reproductive piece or an HIV piece; it is failure across the board, and minorities are impacted.

Dr Menon-Johansson: Young people are particularly at risk as they begin to become sexually active. They are put at risk to start with because of the lack of good relationship and sexual education in schools. That does not set them up correctly in terms of engaging with their new-found freedom as adolescents and then young adults.

In Brook, we specialise in supporting young person-centred services. We are finding that the inequalities have been exacerbated recently as all-age services are being commissioned because of lack of funding. Consequently, young people find that services are not responding to their needs.

Important things like safeguarding for young people do not come from a one-stop-shop service. You have to build a relationship with the young person before they will be able to reveal where they have specific needs. We know that child sex exploitation is a problem. We know there are problems in relation to gangs. Those things do not come out on the first consultation. We need services that go out, which is why third sector services are so important. We need to go out to groups that have not been able to access services that are getting leaner and are unable to work with the people they are meant to be serving.

I have just been looking at some data from last year. In Brook, we had a chlamydia positivity rate from those we tested of 12.9%. Two years ago, it was 6.9% when we looked at all the testing. There has been a reduction in the number of services that have been involved in the screening we have, but that is a significant jump in STI rates in young people. Clearly, there is a lot of work to be done.

Sexual relationship education and sex education for young people is something that we would obviously like to support schools more in delivering. Young people need to be able to understand consent and biology. They need to understand where services are, and they need to feel comfortable going to those services.

Q64 **Dr Paul Williams:** We will ask a few more questions about education a little bit later.



I know that there are geographic inequalities. In the north-east of England, teenage pregnancy rates are the highest in the country and there is a lot of variation. Presumably, there are other particularly vulnerable groups, such as sex workers and IV drug users. Are there socioeconomic inequalities in terms of unplanned pregnancies and sexually transmitted infections? Is that something anybody can speak to?

Dr Menon-Johansson: There are. Poorer areas with poorer schools have higher pupil to teacher ratios. They do not have access to the education. There are fewer services in poorer areas. That is easy to map out. I have done previous work across London looking at where services are, and the south-east and the north-east did not fare as well across London. There are geographical differences in access to services.

There are also differences in how services adopt new technology. That may be because of the clinicians in those areas, or the relationship between clinicians and commissioners. Sometimes, it is a collaborative process; sometimes, it is a hostile process when services go out to tender, and that does not engender services that are responsive to the local population.

There are many reasons why there are geographical differences, but we know that poverty is related to all sorts of determinants of poor health. Mental health, drug taking and smoking levels all correlate with socioeconomic status. This has been well described not only in our country but in many other countries.

Marion Wadibia: Anatole is right on the money. There is another layer, especially for vulnerable minority communities, and that is the story of immigration and how migration plays a part in how people understand sexual health and how they access services. In terms of deprivation and access, we have seen a huge rise in the shifting of our casework. Traditionally, we provide HIV care and support services. As caseworkers, much of my staff's time is now taken up in challenging decisions on benefits. It is directly linked to poverty. One of our ambitions this year is to talk more about poverty in the HIV system. While it has been absolutely necessary to concentrate on the fragmentation of services, we have not concentrated on what that means to ordinary people on the streets, and the compound impact it has had in what has become normal.

Sofa-surfing is not normal, yet my clients think that it is. Having to choose whether you pay the electricity bill or whether you feed your children is not normal, yet that is what they think. If you wrap that up in an environment that says, "Migrants go home," reaching out and asking for help can be very difficult. It can sometimes be completely demoralising. It is not just about poverty. It is about all the other aspects and the knock-on effects.

Q65 **Dr Paul Williams:** And fears around charging can be added to that as well, I am sure.



Marion Wadibia: Absolutely. When you have to make the choice between, "Do I actually go and get medical support for something that is needed?" and, "Do I look after my family?" it is not hard to understand why there is a social hierarchy of, "What are we going to do to get through this week?" rather than, "What do we do to get through the year?"

Laura Russell: Because of cuts to services, we are seeing a cut in the community outreach services that support people who may be in poverty prior to accessing clinical services. Quite a lot of the time, bigger, integrated sexual health services are moving away from certain areas. People who are from disadvantaged socioeconomic backgrounds are going to find it more difficult to travel to those big services as well, so all of those issues will be compounded by the way that sexual health services are moving and the way they are currently being commissioned.

Ian Green: We did a report last year about people growing old, and the sexual health needs of older people, particularly around HIV. Many people who were diagnosed with HIV in the 1980s sold their pensions. They now have the prospect of growing old in poverty and struggling to chart the social care system. There are some real challenges, but it is complicated.

Q66 **Luciana Berger:** You have in part answered this, but I am checking whether you want to embellish or expand your answers to share with us the extent to which you believe the needs of the particular groups you represent, who are vulnerable to poor sexual health, are currently being met, if at all.

Dr Menon-Johansson: One aspect of our service that I mentioned before is safeguarding, which actually is not funded. It is being delivered. It is very important. In a sexualised society, young people are getting their education through porn and not through schools. Young people are being groomed. It is not widespread but it exists, and, when we find it, we need to support those young people. That work, when it escalates to social services and the police, is not properly paid for in terms of the clinical staff it takes out. That is one area where we find it is difficult. Of course, it needs to be recognised that that work is going on and needs to be supported. That is one big ticket item for us.

Marion Wadibia: For NAZ, one of the challenges is that not only are needs not being met but there has been a complication around how we can advocate for services to be met. Let me explain. One of the consequences of cutting budgets has been that prevention work has been cut. We have seen a real reduction in the number of sexual health agencies able to deliver across the piece on sexual health, HIV and reproductive health.

The BAME sector has been impacted terribly by that. We have seen almost a decimation. We do not have a national campaigning organisation in the same way as we did five years ago. We do not have the same number of organisations. Part of the challenge is not just about what we



can do and whether the need is being met. There is an infrastructure problem, and with that we have a lack of leadership. That needs to be addressed.

In addition to cuts to local authority funding, we have also seen a cut in income from big foundations around HIV support. It is not a single Government piece or local authority piece. Five or six years ago, there was a triangle of funding, from local foundations as well as from local authorities and Government. Because we have seen a reduction across the piece, the tailored and targeted approach that we know works with smaller groups and those who do not necessarily come forward has absolutely been decimated.

What we have is the response: "We will just do this vanilla thing." That is not to say that all vanilla things are terrible. It just means it is not an option of one or the other; it should have been done in tandem. The income is not there, and the system does not recognise that without a voice it is very hard to advocate for relevant interventions that can help.

Laura Russell: It seems that, with the reduction in funding, there is reduced ability to involve the communities you are meant to be serving in the commissioning process. That is something we have seen. Even though we know that particular members of the LGBT community are at risk, we do not have data about smaller communities, particularly trans people. There is lack of understanding that there is a need to provide those services—let alone reach out to those communities—and co-design and deliver them in a way that means that their needs are being met.

Ian Green: The highest population rates of STIs are among people of colour. You cannot be broad and say that it is BAME communities completely, because it is fairly low among black African communities. It is about being nuanced in how we respond. It is not a one-size-fits-all approach. That does not work, and it is really important that all of us, who have a responsibility as third sector organisations, play our part to make sure that we are holding the Government's feet to the fire, and that we are taking responsibility and targeting appropriately.

Dr Menon-Johansson: These are the things that are not funded. We heard Asha describe cervical screening. There is TV testing. The parasitic infection trichomoniasis vaginitis increases the risk of HIV acquisition in women where it is untreated. It is not funded to test that across the UK. Another organism is mycoplasma genitalium, which is another sexually transmitted infection. A lot of services have been asked by BASHH to test for that. They are not funded to test for it. Clinics are doing it without funding.

There is the HPV vaccination for young men and catch-up for young boys. It is really important that we do that and support clinics to do that for young men. These are things that we could do for the people we are representing and serving by making sure they have access to the tests they need.



Q67 **Chair:** On a point of clarification, are you saying that there is nowhere across the UK where they are funded to test for TV and MG?

Dr Menon-Johansson: In the integrated sexual health tariff, there are pathways to fund for testing for chlamydia, gonorrhoea, HIV and syphilis, also hepatitis A and B, but funding is not directly there for trichomoniasis vaginitis testing. There is a code now for mycoplasma genitalium testing, but no funding that follows it.

We are asked to do things and to serve people optimally with the highest quality of care. There are at least 50 million trichomoniasis vaginitis infections diagnosed on the planet each year. It is a very important infection, and we need to test for it. It is not part of the online testing service that is being offered in London, for example, yet they ask about the ethnicity of people who are testing. There is no reason why they could not target it at the BAME community.

Q68 **Dr Paul Williams:** Does it require a pH test? Does it require a slide?

Dr Menon-Johansson: It is the very same test that does chlamydia and gonorrhoea. It is just another molecular target that looks for that parasitic organism.

Q69 **Luciana Berger:** This is another question that you may or may not be able to answer. Within your client groups there will be some crossover, but can you share with us any insights you may have regarding difficulty for people with either long-term mental health problems or learning disabilities in accessing sexual health services for advice? Don't feel obliged to answer, but if you have any insights from your respective organisations it would be very helpful to hear what they are.

Ian Green: The only thing is that 50% of people living with HIV, from the Positive Voices survey from Public Health England, have some kind of mental health need. Some of those are quite significant. Many people who have been diagnosed with HIV for a long time suffer from post-traumatic stress disorder through grief and living with what was a fatal condition for a very long period of time.

Accessing mental health services directly impacts on whether they can access good quality sexual health services or broader health services. To put them into just one little bucket is a bit challenging. We need to be conscious of the crossover between somebody's mental health, sexual health and wider health needs.

Laura Russell: Some of the services that better meet the needs of those communities take mental wellbeing into account and are able to deliver that alongside sexual health services. There is a really good sexual health service called cliniQ that operates out of Dean Street. It provides services specifically for trans people. It is a holistic service, but that is not widely replicated around the country.



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There is not much research about access for LGBT people with disabilities. We know that women with disabilities who are LGBT are less likely to access sexual health screening, but that is about all we have.

Marion Wadibia: We have a counselling department, and within the last three years we have seen a fourfold increase in referrals. Not only do I agree with Ian about the link between mental health and HIV; one of the challenges we have been faced with is a reduction in adequate mental health support provision that is culturally specific. Let me be clear about that. We are funded to work in 11 boroughs. We see people from all 33 boroughs, as well as regularly seeing people from outside London coming to NAZ to use the counselling service. We provide counselling in seven languages. There is a wait time, unfortunately.

Part of the challenge is that we are talking systems, but we need to talk people. Many people who are impacted by poor mental health do not even recognise it because they have been waiting for such a long time, or it is difficult, or we have not quite got them over the barrier and seen in time. It is almost seen as normal, and it is not. While I encourage the discussion around systems, without people they do not make sense. We need to think about the compound impact that this is having on people.

Dr Menon-Johansson: We recognise that adolescence is a time of exploration, new learning and new experiences. Drug taking is a particular risk for young people, as is poor sexual reproductive health. Sometimes, it is very difficult to unpick that at the first consultation, as I mentioned earlier. We try to ask it of every client, but usually we need to build their trust before we can get that information. Mental health requires counselling and ongoing engagement, and a lot of those services no longer exist for young people.

Q70 **Luciana Berger:** You will have heard in the previous session about the health consequences of not accessing services or of delays in accessing services. You have already added to that in terms of some of the repercussions faced by your client groups. Is there anything else in particular that you want to raise about the health consequences of not being able to access services, or of delays to accessing services, beyond the issues around comorbidities that we heard about before and/or identification of sexual diseases? We heard about neonatal syphilis, for example. Is there anything else?

Ian Green: The only thing I want to add to what we heard earlier is about the public health imperative. People remain infectious if they are not treated. It is important that there is good access to sexual health services when people think they might have been at risk, or in some cases when they are symptomatic and have not had access to services.

There was research undertaken in south London over a two-week period; 10% of people with symptoms were being turned away and could not access sexual health services. That is unacceptable and should not be



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happening. It is not only about the welfare of the individual but about the public health imperative—the spread of infection.

Marion Wadibia: Part of the challenge is how we understand what the impact is. For me, when you look back on the data, minority and BAME communities have been disproportionately impacted by poor reproductive and sexual health and HIV for more than a decade. It is now intergenerational. Who joins up the dots around that? Who is responsible?

Going back to our mantra around people and not just systems, there is a lot of good will across the piece to ensure that minority groups have a voice and are represented, but one of the casualties is that there is no national adviser to the Minister who says, "You need to pick up late diagnosis of BAME people as an actual matrix." There is no national agenda that says, "Okay, we want to reduce chlamydia in vulnerable groups, but we also know that for BAME communities we are going to have to include TV." There is nothing that says we will have a strategy for women, especially BAME women, who are not just impacted by HIV and gonorrhoea and late abortions but something else is going on.

For me, one of the consequences is intergenerational, where it becomes almost normal to have poor sexual health and it almost becomes normal to sit in these types of Committees and have people nod, but no action comes out of it.

Dr Menon-Johansson: One of the things that came up earlier was the lack of funding being linked. If local government does not fund services that support access for young people, and a young person ends up being pregnant and having an abortion, the CCG pays for the abortion. If a young gay man is not given all the prevention advice that we have around vaccinations, and PrEP if reasonable in that context, and then acquires HIV, NHS England pays for that. It is a lifetime cost, and it is significant for someone acquiring HIV.

The people who are paying get the downstream consequences. Because the funding streams are not linked, people do not think about how prevention really does pay for itself. It is the best investment we have, and we need to make sure that the money comes back. Every time we stop another HIV, that money should be coming back into prevention services. We are talking millions of pounds over the country.

Q71 **Chair:** We know that it happens in some areas. It just does not happen in every area.

Dr Menon-Johansson: Actually, there is no funding link. If you stop someone catching HIV, and NHS England gets the benefit of that, there is no funding that comes back to the services doing a great job around HIV prevention. That saved money is just saved money. There is no way that we are putting it back into public health.



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It is the same with abortions. Abortion is prevented by putting a young woman on an implant, which is the most effective form of contraception, works for three years and is 90 times more effective than the pill. Every time you shift 100 women from the pill to the implant, you prevent at least nine pregnancies by the end of the year. That is £9,000 that the CCG is going to pay for abortions at NHS cost, as well as the impact on that young woman's life if she continues to have a child. Of course, that will impact on her education and work opportunities.

The people who are benefiting are the CCGs, but local government are the ones with the public health grant reduction and they are making the difficult decisions we heard about earlier. Every time some service is not delivered, someone else is paying downstream, and the Government pick up the total cost.

Q72 Luciana Berger: I want to come back to a point that Marion made earlier about services now being more vanilla, as you put it. I want to return to this debate about the tailored services that we are seeing less of. Do you think we should see a return to greater provision of those tailored services? If so, what needs to be put in place to make that happen?

Marion Wadibia: We need a return to some kind of balance. NAT in its report last year on HIV prevention pointed this out. It is not an either/or. We need to return to tailored provision across the piece. That is whether you are black, gay or a Latino woman. Something needs to be relevant to you.

Let me give you an example. We run a really small service. We have tested about 3,400. We had a phenomenal reaction rate, simply because we targeted specific communities. The will is definitely there across the piece from clinics and other sexual health providers to work in a targeted way, but funding is not available for that at this moment in time. The vanilla approach, where we say we will use a generic piece, definitely has a response. I am not saying it should not be there, but it should not be at the expense of targeted prevention. We know that the best way, not just to test people once but to introduce sexual health as part of a genuine change in behaviour, is to talk to people face to face. It still works as a model of engaging people.

Ian Green: I agree completely with Marion that we need to make sure that there is resource available for targeted services. We provide some of those. Some have been cut, but vanilla services have been cut dramatically. It is about making sure that there is an adequate level of funding for prevention services around HIV and sexual health. We have seen that cut substantially over the last five years as part of the overall public health cut. That is impacting on our ability to see the end of the HIV epidemic, which we can see. We can get to zero HIV, but we have to ensure that, as well as innovation, we have the funding to deliver an ambitious but realistic target.



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Q73 Mr Bradshaw: Can I go back to a question I asked in the earlier session about the big increase in gonorrhoea and syphilis? The two main groups worst affected in terms of the increase are men who have sex with men and the BAME community. Ian and Marion, could you explain why you think that is happening and what the solution is? You have already touched on some of the solutions in your answers to other questions, but what about this specifically?

Ian Green: I think Olwen Williams gave a very clear answer. It is complicated, but there have been changes in sexual behaviour. I do not think that is related to PrEP necessarily, because the increase in STIs began before PrEP was available. That needs to be taken into account.

What I think we are lacking, and this is a responsibility of Public Health England, is an overarching piece of work around a sexual health strategy for England. The last document that came out from the Department of Health was in 2013. It was just for the Department of Health, but what we need is a systems approach with Public Health England having a responsibility to lead, with the Department, clinicians and third sector organisations, so that we have a clear and ambitious sexual health strategy that will respond to some of the issues as to why we are seeing an awful increase in gonorrhoea and syphilis. We have the highest rates of syphilis since 1949, which is shocking. We have to make sure that that leadership is provided, because currently we are all operating in a bit of a vacuum.

Laura Russell: As part of that strategy, there needs to be some accountability between Public Health England and local authorities providing services, making sure that they are accountable for meeting the needs of all specific communities. Including models of how you best reach out and co-create community services as part of that is really important.

Marion Wadibia: I do not have a full stop; it is a comma. What is suggested is absolutely right, and you need an individual to do it. Part of the challenge we have is that many people subscribe to what we are saying, but unless we have that piece that says, "It is your responsibility to ensure that this system-wide approach actually filters down, makes sense and has engagement," it will still remain one of those things that everybody agrees to but nobody actually drives. That is the key for me. That would make the seminal difference in how we move forward.

Q74 Chair: Implementation.

Marion Wadibia: Yes, but implementation is not just across a system. It is somebody's job to make sure it is implemented.

Q75 Chair: So accountability for that.

Marion Wadibia: Absolutely.

Q76 Dr Paul Williams: Following on from that, I am wondering about



economic drivers as well. There are some local authorities and some commissioners that manage to reach out to the most vulnerable with a service by making the most vulnerable the most valuable to the providers. Are there any examples in sexual health where services are particularly commissioned and get a greater reward and greater income for those services when they are delivering to people who have the greatest need?

Ian Green: The Elton John AIDS Foundation is launching a social investment bond in three boroughs in south London around HIV testing, encouraging a wide variety of organisations and partners to focus on specific targets for HIV testing and getting to the 8% who are still undiagnosed. There is a financial reward alongside that. We are very interested in exploring that.

Apart from that, I am not aware of any other commission process that focuses specifically on how marginalised groups are approached, but it is something we would be very keen to explore and to see if it is happening. I am sure it is happening, but I am just not aware of it.

Marion Wadibia: It has happened in other areas. If we look at other disciplines, the idea of social investment bonds is not new to the charitable market at all. The key is that the investment needs to make sense. With certain bonds, you can see how it works really well with the bigger clinics because they have a nice throughput, or they have far greater throughput of people than we would normally see every day just in the community. It absolutely makes sense for those bigger providers. It also needs to make sense for the smaller providers like NAZ and other organisations that can provide an adequate service to meet these people but may not, because of the instrumentality or the process, be able to benefit as much from social investment bonds or those techniques.

Chair: I have just noticed that the Minister is on his feet, which means we may have a Division shortly. I am very keen that we should get on to education.

Q77

Diana Johnson: I would like to ask you about the opportunities that arise from the Department for Education finally—after years and years of a number of us around this table being involved in trying to get more up-to-date guidance produced—requiring all schools to provide good relationship and sex education. There were some issues with the draft that came out last year. What are your particular views on how helpful that will be in ensuring that the communities and groups we are talking about get good access to information to enable them to make healthy choices?

Dr Menon-Johansson: Of course, it is a welcome initiative to make sure that it is in schools, and it has been a long time coming. There is no exam at the end, and consequently it is very hard to understand what quality of education is being delivered by schools. There are some schools that are better at delivering it than others. There is a human right for



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young adolescents to have access to key information that will obviously support them going forward in their lives.

We need very good education for young people around relationships and sex, as well as drugs, how to use the internet and all the other skills for life. It is a welcome start, but we need to ensure that the quality is there across the board for all young people and that, if schools cannot avail themselves of it by doing it, they should bring in outside support. That is where the third sector does very well. There is no reason why Brook could not support a lot of schools to develop their programmes to make sure that they are age appropriate, high-quality education that supports young people to navigate the world.

Ian Green: The Terrence Higgins Trust has been campaigning for 30 years to make sex and relationship education mandatory in all schools, so we absolutely welcome the Government's commitment to make that happen. The devil is in the detail. The challenge is around making sure that the curriculum is appropriate and LGBT inclusive. It must be age appropriate of course, and the staff and the teachers who are going to deliver the curriculum must be properly supported and trained.

The curriculum must not be just set in stone. Up-to-date medical advances must be put into the curriculum. There should be flexibility. For example, we now know that somebody on effective HIV treatment, with an undetectable viral load, cannot pass the virus on to their sexual partners. That needs to be built into the curriculum because it will do a huge amount not only to educate that young person but to tackle the stigma associated with HIV. That is just one example.

It is absolutely vital. If we want a society where good sexual health is a right for all, it starts with good-quality relationship and sex education.

Q78 **Diana Johnson:** Did you think that the guidance produced last year was a good start?

Ian Green: There are some challenges in it around sexual health and HIV. We fed into the consultation. It is a good start but there is a long way to go.

Laura Russell: We agree on LGBT inclusion. One of the things that the guidance fundamentally misses at the moment is starting that from a primary age—introducing concepts like having same-sex parents. By the time that young person and that cohort get through to secondary education, and are asking for signposting to specific LGBT-friendly services, there is not the bullying, the stigma, the discrimination or the shame. That needs to be far more specific in the guidance.

Marion Wadibia: Much has been made of the guidance being inclusive, but what we have never spoken about is how the education needs to be culturally competent. That is going to be absolutely key in getting the right communities not only to take part in the education but to rehearse it



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at home and in local communities. That is something that has not been on the agenda, and it needs to be on the agenda to make sure that the education forms an intergenerational piece and is not just for one cohort.

Dr Menon-Johansson: It would be useful for the education system to work in tandem with healthcare provision as well. Young people should be shaping the services they may attend. There should be that engagement. At Brook, we spend a lot of time asking young people how we are doing and having that conversation with them, so that we can shape the services to what they need. We are building up our digital agenda because, of course, that is where a lot of young people are. If we are to have a good education system, we have to move with the times, as Ian said, and use the tools that are available to young people.

Laura Russell: To pick up on something Marion said, there are resources that are culturally specific, and they need to be championed a bit more. Specific schools guidance has been endorsed by the Chief Rabbi's office, for example, on providing relationship and sex education in Jewish schools. There is definitely some ground to build on.

Q79 **Diana Johnson:** What about when young people leave school? Is there more that could be done post-16 or post-18?

Dr Menon-Johansson: Absolutely.

Q80 **Diana Johnson:** What would that be? What do we need to do?

Marion Wadibia: Consistency of approach. You leave school; where do you go next, and what does that look like? Again, much of it is linked to funding. It is linked to the ability to provide sustainable education that is accurate throughout the course. That is a piece that needs further discussion.

Ian Green: Everybody, regardless of age, needs good, up-to-date sexual health information. It is the responsibility of all of us to provide that.

Dr Menon-Johansson: We meet university students who are clever enough to get into university but they have not had basic relationship and sex education. In a lot of access to services, there is a big educational component, and it is a shame that sometimes we have to start from scratch with individuals. There are a lot of university students who have missed out. There is a catch-up, not only for things like vaccinations but in education deficit out there.

There is a contraception deficit in the UK. If you look at the number of women who are trying to conceive and the number of pregnancies and abortions, you realise that we are in a three to one deficit in what women want and what is actually happening across the UK. That is not fair for those women. Having children when you cannot afford them, or you do not have the capacity to give them what they need, is something that has long-term repercussions.



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Q81 **Chair:** Dr Menon-Johansson, I want to ask you about confidentiality and trust in confidentiality. That seems to me to be a major barrier for young people I have met. What is the best way to build their confidence so that they can go to see a clinician without it being reported back to their parents?

Dr Menon-Johansson: When they come into a Brook service, they are told our confidentiality policy, which is that unless they or somebody associated with them is at risk, we are not going to break their confidentiality and we are going to support them to have the best possible sexual and reproductive health.

We are lucky in this country. We have legal support. We have Fraser rulings, and so on, to support young people.

Q82 **Chair:** Do you think that schools are doing enough to educate young people that they are safe to go to services?

Dr Menon-Johansson: They could definitely do more. There could be more services going into schools to talk about the pathways. We definitely could do more on that.

Chair: Thank you all. We have to break for a Division. We have heard a great deal of valuable evidence from you this afternoon. Thank you.