

Health and Social Care Committee

Oral evidence: Sexual health, HC 1419

Tuesday 26 February 2019

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Rosie Cooper; Diana Johnson; Andrew Selous; Martin Vickers; Dr Paul Williams; Dr Philippa Whitford.

Questions 83 - 212

Witnesses

I: Professor John Newton, Director of Health Improvement, Public Health England; and Professor Jim McManus, Vice President, Association of Directors of Public Health.

II: Steve Brine MP, Parliamentary Under-Secretary of State for Public Health and Primary Care, Department of Health and Social Care; Professor John Newton, Director of Health Improvement, Public Health England; and Dominic Hardy, Director of Primary Care Delivery, NHS England.

Written evidence from witnesses:

- [Public Health England](#)
- [Association of Directors of Public Health](#)
- [Department for Health and Social Care](#)

Examination of witnesses

Witnesses: Professor Newton and Professor McManus.

Q83 **Chair:** Welcome to the third evidence session of our inquiry into sexual health services. I would like to start by putting on record the Committee's thanks to everyone who hosted our visit to Plymouth.

Before we get started, could I ask our first panel to introduce themselves and say who they are representing, for those following outside the room?

Professor Newton: I am John Newton, the director of health improvement at Public Health England.

Professor McManus: My name is Jim McManus. I am the director of public health for Hertfordshire and vice-president of the Association of Directors of Public Health. That is who I represent today.

Chair: Thank you both for coming. My colleague Andrew is going to kick off with the questions.

Q84 **Andrew Selous:** Good afternoon. Could I start by asking you what evidence there is about recent changes in sexual behaviour and the causes of those changes?

Professor Newton: From the point of view of the epidemiology, we have trends in instances of sexual infections that are going in different directions. We have a very welcome decline in HIV new diagnoses, down by 28% since 2015. We have a sharp fall in genital warts; and in sexual health, rather than in infection, we have a gratifying fall in teenage pregnancy. On the other hand, as you have heard, we have significant increases particularly in gonorrhoea and syphilis. We have had a 20% increase in syphilis in the last year, between 2016 and 2017, and we have a 27%¹ increase in gonorrhoea.

Q85 **Andrew Selous:** I will come on to what we need to do about those two in a second.

Professor Newton: You were asking about causes. Concentrating on those two, which are going in the wrong direction, we think the causes are largely to do with behaviours. There are three things driving high-risk behaviour in the people affected. There is so-called sero-adaptive behaviour.

Q86 **Andrew Selous:** Could you describe that?

Professor Newton: When people know their HIV serology, they may adapt their behaviour: if they are having sex with somebody who is also sero-positive, they do not take the same amount of precaution as they would otherwise. That is sero-adaptive behaviour.

¹ Note from witness – The correct number for gonorrhoea is in fact 22% not 27%.



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The other two causes that have been identified are use of various geospatial apps and chemsex. I believe you have heard that in evidence from others. How much evidence there is to support it, I am not sure. I suppose it is soft information. We know that the increase is greater in people who are HIV positive than in the group who are—

Q87 **Andrew Selous:** When you mentioned apps just then, were you talking about online pornography?

Professor Newton: They are more the geospatial apps that allow people to meet each other for casual encounters.

Q88 **Andrew Selous:** Tinder and Grindr, and that sort of thing.

Professor Newton: Yes.

Q89 **Andrew Selous:** Professor McManus.

Professor McManus: I will try to avoid duplicating what John has just said.

Andrew Selous: That would be helpful, thank you.

Professor McManus: The area that is probably most promising for me is the social, scientific and psychological studies that are focused on both social psychology and individual psychology. What we see emerging is a complex number of different social trends. They are different not just by age but by sexual orientation and by perceived gender; young gay men are forming relationships and having sexual relationships in different ways from gay men of perhaps my age, and it is the same for younger people. There is also the importance of subculture, in terms of chemsex, which started off as a phenomenon among some gay men and is now a phenomenon among some heterosexuals. There is a lot more sexual bridging going on in bridging networks with behaviourally bisexual men, facilitated an awful lot by the geospatial apps that John was talking about.

My slight worry is that you need to put together a composite picture of both what the epidemiology says and what social science can tell us. In some ways, we still do not have social science and epidemiology talking to one another as fruitfully as they might on the issue, and certainly not as fruitfully as they did in the early days of the 1990s when we had a significant European social science programme on HIV and sexual health.

Q90 **Andrew Selous:** Can I ask about the effect of young people learning about sex through pornography? Is that leading to different types of sex and to sex perhaps happening more outside longer-lasting relationships? What is your comment on those areas? It was something the Committee picked up on its visit to Plymouth, for instance; it was reported by front-line practitioners. What effect does that have in terms of how public health responds?



Professor McManus: My reading of the evidence is quite mixed. In some cases, young people are experimenting more and in others young people experimenting less. The mostly qualitative studies on this say that there are issues about respect, boundaries and taking care of yourself, and the leach-over from that into mental health, particularly with younger people, and poor states of mental health, is quite significant in a lot of research. It is one of the reasons why I say that sexual health services are not just treatment services: they are a system that needs to link to school nursing, health visiting, drug and alcohol services and a range of other things if we are to deal with a very different kind of phenomenon of sexual health where psychological sexual health is far more important than it used to be. I think it is massively under-studied. There are an awful lot of nostrums talked about it, but I am in no doubt that it is the cause of significant amounts of distress for some young people, whereas others will navigate it very quickly.

Q91 **Andrew Selous:** The one word that neither of you has mentioned yet is relationships. The Government made what were broadly welcomed announcements on that area yesterday. What impact does that have on the area we are looking at today?

Professor Newton: It is hugely important. To pick up Jim's point about the importance of seeing sexual health in the round so that it can be integrated with other supportive services in education, we have been working on a programme called Rise Above, which is done with PSHE teachers. That gives young people a range of skills to withstand the challenges that they get around use of modern technologies, pornography and all the other issues they have to deal with. Those are changing so quickly that our traditional approaches to public health need to adapt. We need to be more aware of the fact that they are changing. The importance of teaching first about relationships and then about sexual health in the context of relationships is crucial.

Q92 **Andrew Selous:** Is Public Health England fully engaged in that area and assisting with it?

Professor Newton: Yes, we are. Jim and I have both worked in public health for many years, and looking at the history of the control of teenage pregnancy, a lot of that was around promotion of relationships and education. For example, another initiative from the area some five years ago was the You're Welcome initiative where young people were invited to help design sexual health clinics to make them accessible. There is a whole range of things that have to be done, not just diagnosing and treating sexual infections.

Professor McManus: I agree with that. The glaring omission in our system is educating young people in such a way that they have a strong sense of the preciousness and the dignity of what it means to be them—I do not use those words lightly—and a strong sense of what it means to be in a relationship, or not to be in a relationship, as they choose, and to make intelligent choices.



Teaching people from a life or psychological approach—that is where I would come from, wouldn't I?—is something we still lack, and the longer we focus sexual health on treatment alone and not on that wider system issue, the more we will have issues that sideswipe us, such as chemsex?

Q93 Andrew Selous: Are you saying that public health and the health service will play its part alongside education in that quite important area, Professor McManus?

Professor McManus: I do not think this is an issue that the NHS can solve because it is geared up to deal with clinical systems.

Q94 Andrew Selous: I asked if you would play your part alongside others.

Professor McManus: Yes. I would identify that there are probably about 20 or 30 different parts to play, and we are up for playing our part. I could point you to programmes running in my county where we take young people who are questioning their sexuality, identify who they are and take steps in a safe environment. I could also teach you about relationship assertiveness programmes for young women to counter some of the behaviours young men who have grown up on pornography and got some of the wrong social cues will deliver. Those are happening across the country, but we need to make them systematic.

Q95 Andrew Selous: Excellent. That is very helpful. Finally from me, what action do we need to take in respect of the worrying increases in cases of syphilis, congenital syphilis and multi-drug-resistant gonorrhoea, which you referred to earlier? What do we need to do about those concerns?

Professor Newton: Public Health England is developing a syphilis action plan, which will be ready in spring, but the essential elements of controlling both those conditions are to get testing done as early as possible and get people treated as soon as possible to reduce infectivity. It is more of the same but intensified, and then, of course, addressing the underlying behaviours, which is what we have been talking about. That is more difficult.

In relation to HIV, we fund prevention exercises through charities, and they are tailored to the groups who engage in the high-risk behaviours that we think are driving up rates of gonorrhoea and syphilis.

Professor McManus: I agree with everything John says. In relation to congenital syphilis, the system was fragmented on the first day I worked in sexual health in 1990. To me, it is quite clear that we have to make the system work; we have to make the pathway work. That is about making sure maternity services and sexual health services work together. It is not about moving the deckchairs around. It is about making people do their job, setting quality standards and being very clear what we want to achieve.

Some of the recent evidence on congenital syphilis shows particularly that people are now beginning to bridge sexual networks between



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heterosexuals, behavioural bisexuals and men who have sex with men. We are only going to see sexual mixing risk of infection increase, if we do not get the whole system right by every service playing its part.

Chair: Thank you.

Q96 **Diana Johnson:** In terms of recent trends, I noticed in the briefing we received that there was a reference to geographical areas and trends. What interested me was that Yorkshire and Humber saw a 55% increase in demand. Can you say anything about that? What is that about?

Professor McManus: I have not seen that page of your brief, but I think there are a number of things. First, nationally we have seen demand increase by 13% since transfer of public health to local authorities in 2013. We have seen testing of people increase significantly and general positivity decline. In a number of regions there have been concerted campaigns to get people in to test in their local area. Yorkshire and Humber have had a number of concerted campaigns. They have also had a number of outbreaks where contact tracing was driving people into services.

In areas I have seen across the country where demand has gone up, there are usually the following key factors: first, the result of a campaign or the result of education; secondly, the result of outbreaks; thirdly, a culture of people taking more care of their sexual health more regularly; and, fourthly, obviously, contact tracing. Those, to my mind, are the key drivers, as far as I can see, wherever I have asked people. Does that answer your question?

Q97 **Diana Johnson:** Yes. Perhaps afterwards we could let you have that information about the increases and if there is anything else you can think of it would be helpful to know. It stands out when looking at areas; in the south-east there is a 20% to 26% increase, so Yorkshire and Humber being twice that is concerning.

Professor McManus: I will investigate that for you.

Q98 **Mr Bradshaw:** Given what you have just said about RSE, Professor Newton, I wondered what you thought of the calls from some campaign groups to allow parents to withdraw their children from those classes.

Professor Newton: It is a difficult one. My tendency would be to resist it, unless there are very good cultural or religious grounds. I believe it is suggested that they would not be able to withdraw from the elements that are in the national curriculum, so presumably the more biological aspects of sexual education, which I think is absolutely essential. I urge whoever is making those decisions to allow as many children as possible to benefit from it.

Q99 **Mr Bradshaw:** On what evidence do you urge the Government to resist those calls?



Professor Newton: All the arguments—you will have heard them from others presenting evidence here—are that providing good, solid age-appropriate relationship education at a young age is essential for laying the foundations for sexual health and good decisions later in life.

Q100 **Mr Bradshaw:** Without putting words in your mouth, is it your concern that parents, although they might think so, are not necessarily always the best people to communicate that education to their own children?

Professor Newton: I am not sure what the valid argument would be for a child not receiving education, if it was correctly provided. The public health arguments are overwhelmingly in favour of providing that sort of education for all children.

Mr Bradshaw: Thank you.

Chair: We are going to look at services now, particularly access and quality.

Q101 **Dr Williams:** John, you referred in your evidence to some concerns about access, or the decline in access, to sexual health services. I have read the BASHH survey that suggests that one in five clinics turn away at least 50 people per week. How concerned are you about the decline in access to sexual health services?

Professor Newton: We will probably talk about this more in the next session, but, overall, we are pretty pleased with the way local government has provided comprehensive sexual health services to their populations. They have a lot to be proud of. We are seeing really high-quality services provided; they have extended the availability of services, integrated them with other services and made some efficiencies. Take, for example, chlamydia testing: where the number of tests has gone down, the number of positive diagnoses made has gone down by less. Tests have gone down by 8% but positive diagnoses have gone down by only 2%. There is some evidence that local government is using its resources wisely and providing good-quality services. There are gaps and anomalies in the access.

Looking again at your own survey, which I thought was very interesting, it is by no means all bad news; quite a lot of people were pretty pleased with the service they got. Since Jim and I have been doing public health, and I worked clinically in GU medicine many years ago, there has always been some limitation in access. What we are seeing now is by no means perfect, but, overall, the picture is generally positive.

On the gaps and anomalies, the thing that concerns me is that there are certain services that people are not getting adequate access to. You have heard quite a lot about LARC, and you have heard about cervical screening in sexual reproductive health clinics.

Q102 **Chair:** For those following this, we should clarify that LARC is long-acting reversible contraception.



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Professor Newton: Thank you.

Certain groups are not getting adequate access. The people who are most vulnerable find it most difficult to get access—intravenous drug users, rough sleepers, recent migrants and, perhaps, victims of sexual violence.

Q103 **Dr Williams:** Would you include sex workers in that group as well?

Professor Newton: Yes. Indeed, sex workers would fit into a number of those categories.

Q104 **Dr Williams:** In the current model, where services are put out to tender, how do you encourage the most vulnerable people to be the most valuable people? How do you encourage targeting and services being built around the needs of vulnerable groups?

Professor Newton: I will hand over to Jim in a second, but it is like any service provider; you start with a needs assessment. Local government is very aware of how you do that. You need to do a needs assessment that looks at the generality and the specific needs of certain groups. Then you have to try to design services to meet those identified needs.

Professor McManus: I agree with that. There are multiple mechanisms. The best commissioners I have seen deliberately sought to engage groups that may experience the greatest inequalities or the greatest lack of access, and involved them. In my area, we involve people in co-designing the service and we involve clinicians in co-designing the service. That is the first thing.

Setting quality standards is the second thing. The third thing you need to do is this. I know you have the message about public health funding, so I will not bang on about that, but sustainable funding would allow much longer-term contracts. The sexual health contract in my area is eight years and there are a number of other places that can do that. We need to build up good commissioning practice.

It was no better in the NHS. I have a very long memory of that. The contracts I inherited for sexual health services were on one page of paper, and I can point to others who have the same. You need robust contracts and good quality measures. Your own survey identifies moving services out of hospital sites into the community. Put them in the community and start online testing so that there is a range of measures that really good commissioners are using. The challenge is first to make sure that we are using them consistently; secondly, that we have the money to do it long term; and, thirdly, that the quality of commissioners, and the quality of behaviour between partners, is such that it builds additivity—if I might strangle a word—into the service with outcomes for everybody.

We have sexual health services across the country in drug and alcohol services and we have them in some schools. We have them offered in a



variety of places. That is the kind of richness of access that you are looking for as a minimum quality standard.

Q105 **Dr Williams:** I am hearing that when it works well the local authority assesses need, co-designs services, particularly with vulnerable groups, then commissions to meet those needs, and funding probably is not adequate. What about when it works badly?

Professor McManus: There are usually several mechanisms when it works badly. I do not know what John thinks, but my take on it is that sometimes commissioners behave like they did in the NHS, just rolling contracts over and not delivering things. You still, in 2019, have providers who do not know how to tender, which is a skill. That is a crucial thing. You have communities that are either very difficult to get to, or there are traditional entrenched positions in one community or another.

I presume that you have heard of sector-led improvement, which is local government's continuous improvement. A number of regions are doing sector-led improvement around sexual health to improve how we do that and improve standards of commissioning. Model contracts, which ADPH and PHE wrote together, are a good help, so there are a range of things you can do. The key issue is to have the capacity to look right across the system and say, "We think you could do better here." We are up for that.

Q106 **Dr Williams:** Is there a need for a clearer national strategy and perhaps clearer national accountability?

Professor McManus: I promise I will shut up and let John answer in a second. I would do several things if it were me, which probably would backfire spectacularly. I would produce a national strategy.

Mr Bradshaw: Hear, hear.

Professor McManus: I would have quality standards. I would not move any more deckchairs around, because that is just counterproductive to delivery. It took us 18 months to settle down after reorganisation. I would put a duty on everybody to work together. I would make everybody create a pathway for every population. Then I would set about doing peer challenges on how those are going and give them long-term funding.

The evidence from health quality improvement science is that where that has been done in other countries it works. You also need good relational and sexual education in schools—that goes without saying—and good mental health. Those are the things that could build a far better sexually healthy society than the one we have now.

Dr Williams: That is very helpful, thank you.

Professor Newton: You asked where it works well and where it works badly. It is about the level of collaboration between commissioners. We



are evaluating some commissioning pilots; you are probably familiar with them. Where there is good collaboration, the problems can be solved, but collaboration is not easy, and it requires work and leadership.

Q107 **Dr Williams:** And it is not mandatory.

Professor Newton: It is not mandatory. It is quite hard to mandate collaboration. Collaboration requires work and leadership.

You mentioned funding. There is no doubt that funding is an issue, and the thing that concerns me about local government funding, which I do not think has been discussed with you recently, is that there has been a fall in the amount of money spent by local government on sexual health overall of 4.3%, but the amount spent on prevention and advice has fallen by 9.6%. Local government has spared spending on the diagnosing and treatment of infections and has made major cuts in the others.

Q108 **Dr Williams:** Presumably, it is often voluntary and community sector organisations that are doing that kind of education, prevention and advice, so it is their funding that has been cut.

Professor Newton: It will be very variable around the country. It will have fallen in different places I am sure, yes. The one in the middle is contraception, which has fallen by 5.9%.

Q109 **Dr Williams:** A final thing I want to ask you about is quality. The majority of people who responded to our survey said that they find the service compassionate and caring, but a significant minority of people felt that they were very judged, and that perhaps enhanced stigma. What do you think needs to happen to reduce some of the stigma around sexual health services?

Professor McManus: Avedis Donabedian, who was the inventor of healthcare quality science, described healthcare as an exercise in love. You have to start from absolute, non-judgmental acceptance of the person in front of you as a vulnerable human being who is in need. That has to be the absolute foundation of the whole reason we are in this game. If you cannot do that, you need to work in another specialty.

My experience of my providers, and many providers up and down the country, is that they absolutely go the extra mile. Where people do not go the extra mile, it is because they are either burned out or exhausted. It is that old thing of "Hurt people hurt people." It is a cultural thing, and it needs to be part and parcel of what we do.

Chair: We are running a bit behind. We are probably going to need short questions and answers, if that is all right, moving on to funding and commissioning in a bit more detail.

Q110 **Dr Whitford:** We have already touched on funding and commissioning, with the reductions in funding, and particularly the fragmentation of commissioning between NHS England, local government and CCGs, the



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commissioning groups. Which do you think is the bigger issue—the drop-in funding or the fragmentation, considering you were talking about collaboration? Which is the bigger problem?

Professor Newton: It is very difficult. The one that we are more able to address is fragmentation. There will never be as much money as we would like, I am sure, for these sorts of services, so it is essential to address the fragmentation. As you know, we did a survey of commissioning and we put forward a five-point approach to tackling it. We are making some progress—or the commissioners, I should say, are making some progress towards that. Fragmentation can be addressed, but it requires, as we mentioned, work and leadership.

Professor McManus: They are of equal importance. There are things you can do without money, and local government has demonstrated that. We have managed a 13% increase in take-up. You still wait less long on average for sexual health services in England than you do for a GP, despite the cuts. We have managed transformation, but we absolutely have to address commissioner behaviour.

Some of my members cannot get some parties to the table for love nor money. Page 8 of the PHE/ADPH review last year is one I commend to you. You could have written that about fragmentation 20 years ago or you could have written it yesterday. I absolutely reinforce what John says.

Q111 **Dr Whitford:** What about the impact of competitive tendering? You mentioned earlier that tendering is a skill that providers should have. It is almost like writing a business case, but equally the people at the frontline do not always have that kind of skill. You mentioned short-term contracts, which obviously destabilise, and there is the sheer length in the use of the time of frontline consultants trying to bid for something. Do you think there is something that could be done centrally? You talked about some people who use very long contracts, and we know from the Committee that there are others that are really short.

Professor McManus: We have to recognise that the NHS is an artificial market. It is a market when it wants to be, and it is not a market when it does not want to be, and many people do not pick up tendering skills. There are things you can do. You can work with organisations. Tendering can be seen as a quality mechanism or it can be seen as a mechanism to achieve cuts. It needs to be a quality mechanism while achieving savings.

First, my advice is to start by designing the service you want with your provider in the room, because they know what they are doing. Secondly, support them in understanding tendering rules and OJEU, because I cannot imagine that we are going to get rid of OJEU—I will not mention the “B” word. You cannot get rid of OJEU; you have to tender. Then you can support commissioners nationally. We run programmes at ADPH. We run a course on local government law practice and tendering specifically to help directors of public health. In my experience, some people came



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over from the NHS with the very NHS model of year--on--year contracts, not recognising that local government has a wider range of choices and a wider range of lengths, so we need sophisticated commissioning right across the board in health and social care.

Q112 Dr Whitford: You were talking about having the provider in the room as you design the service, but how can you do that when you are putting it out to tender? You do not know that it is that provider who will provide it. We see all the time with tendering that someone says, "We will do that at half the price," and then they turn up and they cannot, or they do not deliver the thing you designed with the other provider.

Professor McManus: You can include quality. You can weight quality in tendering, and good commissioners will weight quality, not just price.

There are many myths about tendering. I would not expect a consultant physician to know the first thing about tendering. Why on earth should they? I do not know a single NHS trust that does not have a commercial department where people know about tendering, and they need to do that work. For me, there is a cultural thing. Sexual health was always the Cinderella in the NHS and it still is to some extent in some organisations. How much access to corporate time do those services get to help them build good tenders? I find the same with school nurses in a number of areas in the country. There is a systemic answer. It is not that tendering is an evil, but that tendering well done, done sophisticatedly, intelligently and with good behaviour, can deliver good outcomes.

Q113 Dr Whitford: Do you think the contracts should be longer so that there is time for relationships to get a result and to turn something around?

Professor McManus: Yes. I do not know any director of public health who does not want a contract of a minimum of three to five years, and most of my contracts are eight years. It is possible to do that.

Q114 Dr Whitford: John, you mentioned earlier access to long-acting contraception. The Committee has heard about the issue around testing for mycoplasma genitalium and the fact that it can be missed and thought to be chlamydia. Obviously, that then can lead to increasing antimicrobial resistance. How do we get away from that only being available in PHE reference labs and get it out so that it becomes a more routine thing for services to do?

Professor Newton: Indeed. There are a number of gaps in testing. The other one is testing of sensitivities for gonococcal infection. Sometimes that is not available, so you do not get the right treatment straightaway. We would very much stress that good-quality sexual health clinics need to provide access to testing. That is for the commissioners. We have made clear what we think would be effective, including the things you mentioned. LARC, if we can use the acronym, is an example where collaboration is required; I understand that, while local government will be paying for the contraceptive itself, GPs feel they are not always able to be reimbursed for their time, which is a different commissioner.



Having said that, again seeing things in the round, although there has been a decline in the number of patients receiving LARC—it has gone down from 1.3 million to 1.2 million—there are still an awful lot of women receiving LARC. It is just that we would like the trends to go in a different direction. All these things are possible, but they need to be given impetus.

Q115 Dr Whitford: Is the issue of being able to access cervical screening at the same time also being recognised and taken forward?

Professor Newton: It is, and it has come up in the commissioning pilots. There are successful pilots where the NHS has been able to commission cervical screening in sexual and reproductive health clinics in Liverpool and Merseyside. NHS England has addressed it, and there are a number of ways it could be done. Again, we could discuss that more in the next session when NHS England is represented.

Professor McManus: There are some very simple mechanisms called section 75s. I could point you to areas where HIV treatment is being commissioned by the local authority on behalf of NHS England and you could do the same with cervical screening. It is perfectly possible.

Dr Whitford: Some of the model contracts you referred to might help to ease out the variation.

Q116 Diana Johnson: Could you explain to us or update us on the progress that has been made from the recommendations set out in the review of commissioning of sexual health services, particularly whether you feel that there might be a need for a more radical approach than the recommendations in that review?

Professor McManus: Is this paragraph 2.4 in the NHS plan? Is that what you are referring to, or are you referring to the five?

Q117 Diana Johnson: This is the PHE committee. They have the six actions, yes.

Professor Newton: The first one is resolving barriers to commissioning. We have the pilots and I think they are going well. We are learning a lot from the processes. There is a lot of good practice in different parts of the country that we are evaluating. We will be publishing our evaluation this spring.

On supporting commissioners, we have produced service specifications. There are a lot more resources for sexual health commissioners. The third one is building capacity. We have been promoting various networks, running workshops. We fund a commissioning group, which has done good work.

The fourth one is data and evidence. Apart from producing sexual and reproductive health profiles, we have produced various toolkits on the evaluation of services. We have produced return-on-investment tools. I



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think you heard about the strong evidence that investing in contraception and sexual health has a very positive return. We have done a survey of women's reproductive health.

The fifth one, I think, was that sexual and reproductive health should be considered in any future considerations around commissioning. That is the paragraph 2.4 discussion.

Professor McManus: From our perspective, we have a national English commissioners group that meets regularly and shares good practice and documents as well as toolkits and tenders. We have, through sector-led improvement, a number of areas where they are doing sexual health commissioning and joining up sexual health commissioning approaches. We have a range of models for NHS England to delegate commissioning to local authorities and work together. We have piloted in a number of areas a kind of whole-system sexual health commissioning group, which seems to work, which is complementary to the approach that John has taken with the pilots.

We are providing mentoring to commissioners and to directors of public health. We have done master classes on system redesign, in-service redesign. We have been working very closely with a lot of the sexual health provider groups, people like BASHH and FSRH, to make sure that we understand one another better and build a culture of greater collaboration. Those are the things that are under way from an ADPH perspective. I could go on, but I won't.

Q118 **Diana Johnson:** You mentioned earlier a duty to work together. I guess within some of what you have just been saying that is implied, but do you think it needs to be more explicit? Do you think it is something that needs to be set out very clearly in regulation?

Professor McManus: There are precedents. This is a cultural and behavioural thing: people will not work together unless they want to work together. I worked in crime and disorder for a number of years, and there was a duty on a number of partners to attend crime and disorder partnerships. Quite a lot of them rarely turned up. You need to get hearts and minds, but you also need to have a duty.

I am a great believer in Government giving us the powers and the money and getting out of the way while we get on with it, and then holding us to account for whether we have done it. That tends to be my way to run a system. Require us to work together and to share. Paragraph 2.4 of the NHS long-term plan is going to look at whether the NHS should have a greater say in commissioning. No, look at the whole system and look at how we do the system better together, taking our respective parts and working with one another. Why will NHS England not in some places put cervical screening in? Why can't we have sexual health services in drug services? That is the place to start, and it has to start from a culture of working together and a requirement, I think. I would like a requirement



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on school headteachers to work with directors of public health at national level. We have to force the system to behave in different ways.

Chair: Thank you. Finally, we have a question on action at national level.

Q119 **Rosie Cooper:** John, our evidence has called for Public Health England to develop new service specifications to monitor standards in sexual health and to step in and take action if they decline. That is as well as a national prevention programme. How do you see that? What are your views on that?

Professor Newton: There is an interesting question about the role of Public Health England as opposed to the local role. This would be Public Health England looking at standards of services commissioned by local government and intervening if we thought they were not up to the medical standards.

Q120 **Rosie Cooper:** When we took evidence last time, it was very clear that there was fragmentation all over the place: people were putting money into different pots in local government, in health services, and it enabled people to fall through the gaps, to be perfectly honest. If our evidence is saying that you should look right across the board, do you think that would work?

Professor Newton: It could be very difficult. We provide what we call system leadership, which provides various tools and evidence, and we try to share good practice and so on. That is a co-operative model, whereas local government is a self-governing organisation, as you all know very well. Particularly from the LGA, when we have had similar discussions around, for example, suicide action plans, we get a strong reaction from local government if Public Health England attempts to performance-manage them.

We do not performance-manage local government. We do not really have a statutory basis to do that. What we can do is put quite a lot of pressure on people who may not be performing. Equally, we can encourage those who are doing well. We would much prefer a collaborative model to a performance-management model. I think local government would say the same.

Q121 **Rosie Cooper:** That is okay if you are sitting in Public Health England or in local government, but if you are somebody trying to use the services, all this sounds like, "Everyone is accountable, nobody is responsible," yet again. Really it is an à la carte menu: pick the bits you like and don't do the bits you don't like. Who the heck gives a damn really? How are you going to make sure that the service you are getting taxpayers' money for is being delivered? Why should it matter which area of the country you live in, and who likes which bit and who splits it all up and fragments it? Is there a regulator anywhere? Does anybody care?

Professor Newton: They do care. Accountability is clearly with local government. They are accountable for the services in their local area,



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accountable directly to their population. We are accountable for some of the things that we do, but some of the things you are talking about sit within either local government or indeed local NHS accountability, which, again, is separate. The accountability is there, but it just does not happen to be through Public Health England.

Q122 Rosie Cooper: It just feels like a bit of a feather; it does not make any blessed difference.

Professor Newton: You would need to talk to the people in those areas about whether they feel accountable. I think they do.

Q123 Rosie Cooper: The people who gave evidence here were very clear that it is fragmented; it is all over the place; everybody blames everything—this is my interpretation of it. At the end of the day—

Professor McManus: It has been fragmented since I came into sexual health in 1990.

Q124 Rosie Cooper: Does that make it okay then?

Professor McManus: No, it does not make it okay. Quite the opposite. I think sexual health has been more transparent since it has been in local government than it ever has been. I could not point you to a single local authority that does not care about sexual health, but there are a number of systemic issues.

The first systemic issue is that there is no single joined-up view that everybody shares of what good looks like. There are myriad action plans, some of which, frankly, are contradictory. The second thing is that there is no single national set of quality standards, which would go some way to addressing the issues you raise, or minimum service specifications. The third thing is that there are mechanisms to work with local authorities where things are not going well. I won't go into detail about them now, but this will not be solved just by regulation. It needs to be solved by a number of mechanisms, of which good-quality monitoring and good feedback to the system to make it work are just two, in my view.

Rosie Cooper: I surrender. It is not going to make a great deal of difference.

Chair: Thank you both very much for coming. I understand, Professor Newton, that you are staying on for the second panel. Thank you very much.

Examination of witnesses

Witnesses: Steve Brine MP, Professor Newton and Dominic Hardy.

Q125 Chair: Minister and Mr Hardy, thank you very much for joining us. We are all familiar with the Minister, Steve Brine. Dominic, perhaps you could introduce yourself for those following from outside.



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Dominic Hardy: I am the director of primary care and system transformation for NHS England.

Q126 **Chair:** Thank you very much. Following on from some of the points we heard earlier and from our previous two sessions, it is clear that there has been a significant increase in demand accompanied at the same time in most areas by a very significant fall in funding. We have heard that, while most areas have tried to prioritise services, it has particularly hit the prevention side of sexual health services. Steve, would you be happy to start by commenting on that?

Steve Brine: Good afternoon. I think it is very important that you are doing this inquiry. Of all the important things that go on in Parliament today, as ever, it proves to the public that there are other things going on here that matter, and this really does matter. It is one of the most interesting bits of my brief.

I want to say at the outset, Chair, that it is important to recognise that everybody has sexual health in the same way as everybody has mental health. It is just that some people have good sexual health, some people have poor sexual health and some people are disproportionately affected because of their circumstance or their place in society. The inequalities within those groups—the disproportionately affected—are complex, as I suspect you have heard from other witnesses. It may be about the messaging we give them or about behavioural change, which I am sure we will get on to and I have certainly seen when I have visited clinics; sometimes it is cultural and sometimes it is stigma.

There is no getting away from the fact that you allude to, and I have seen in previous evidence: we are still living with a 2015-2020 spending review. The Red Book does not lie. The figures are what they are. Since 2013, when the House made its decision to pass, by and large, the commissioning of sexual health services to local authorities, local authorities have been responsible for doing that with reducing budgets, and that has been difficult for them. But, as I suspect Professor Newton has already said to you, more people are attending sexual health services. The most recent data suggests that there were 3.3 million attendances in 2017, which is an increase of 3% from the previous year.

Q127 **Chair:** Indeed. That was my point—that those services have been prioritised through the funding but the area that we heard has been hardest hit is the prevention side. We heard in the 10-year plan and from the Secretary of State that he wants to prioritise prevention. There is very little evidence of that happening in sexual health services. Is that something that you are going to be addressing as part of your role?

Steve Brine: Most certainly. One of the most exciting parts of my job right now is the fact that I am leading work on the prevention Green Paper. If you are the Minister for primary care, public health and prevention, and you have a new Secretary of State who says that prevention is one of his three priorities, happy days. I have a great team



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of officials across NHS England, Public Health England and DHSC working behind me to whom I have given pretty much a blank piece of paper when it comes to prevention.

When it comes to sexual health, in prevention, I know we are going to come on to various things; we will be talking about online, quality of services, the long-acting contraceptive for different vulnerable groups and the education side. Perhaps you saw the stuff that the Department for Education laid in the House yesterday. There was a big statement from the Secretary of State yesterday about sex, relationships and health education in schools. That is a critical part—

Q128 **Chair:** We are going to come to that specifically later.

Steve Brine: I am sure.

Q129 **Chair:** I am talking about the next spending review that is coming up. We have heard that funding for the prevention side of this important agenda has been hardest hit. What are you going to be saying to your colleagues in the Treasury about the importance of that?

Steve Brine: I am going to be making a very robust case for public health spending in the forthcoming spending review conversations as long as I am still in this post. I do not think anybody would doubt that. We have the HIV prevention programme, and there are very good examples going on.

Fragmented is obviously a loaded term. Yes, the system has changed since 2013, but, as you heard Jim say about the idea that when sexual health was fully NHS-commissioned it was a brilliant service, it was a Cinderella service then. As for the idea that prevention of sexual health will not be central to the prevention Green Paper, it will be very much part of the prevention Green Paper, and, I would suggest, the HIV prevention programme is a good leader for that.

Q130 **Chair:** Thank you. The other area we heard about was particularly making sure you are not leaving behind vulnerable groups, so that you do not have a one-size-fits-all service. Is that something you are going to be looking at?

Steve Brine: Yes, definitely. That is why I said in opening that everyone has sexual health, but there are those who are disproportionately affected.

If you look at some of the different projects that are going on around the country, I know some members of your Committee would be interested. Luciana is not here, but there is a programme that Addaction is running, for instance, in Liverpool for men who partake in chemsex called the chemsex open access support team. There is the community conversations programme in London among the black and African community, and a programme in Cumbria where they do HIV testing in



pharmacies. That is all part of different communities responding to their different populations.

I sat on the Bill Committee for the Health and Social Care Act for 13 long weeks that I will never get back, but one of the conversations we had then around passing public health to local authorities was that they would be able to respond in a more nuanced way to their local populations. That is one of the positives of it, but it does have negatives and I do not doubt that we will get on to that when we talk about commissioning.

Chair: Indeed. We are going to talk now about some of those particular services and treatment.

Q131 **Dr Whitford:** Minister, you mentioned long-acting reversible contraception. Provision of that has dropped by 11%. What should be done about that?

Steve Brine: In some areas, Philippa. Within sexual and reproductive health services, prescriptions of LARC methods increased by 25% between 2012-13 and 2016-17, from 272,000 to 342,000, but in primary care prescriptions have dipped. Public Health England—John may wish to add to this in a minute—took a big survey and had focus group discussions with about 7,500 women about their experience of reproductive health and making future positive choices. The most important topic for most women was preventing pregnancy, particularly those in the younger age group. I am pleased to see that those prescription figures have gone up by a quarter.

My colleague in the Department, the Minister for mental health, inequalities and suicide prevention, Jackie Doyle-Price—Thurrock—set up a women's health taskforce. She works very closely with me and PHE on that. At its most recent meeting, there was a lively discussion around unplanned pregnancies and the actions being taken to address them. I suggest that I might get her to send the Committee some information on that. We have some of the lowest teenage pregnancy figures that we have ever had in our country. That is a success in this area of policy.

I want PHE to talk about their reproductive health action plan and online contraceptive prescribing, and then I might touch on maternity outreach clinics, which are mentioned in the long-term plan and are a really positive thing. John, did you want to add something on the reproductive health action plan that PHE is doing?

Professor Newton: Yes, and on LARC.

Q132 **Dr Whitford:** I am trying to focus on working through some of these quite specific services.

Professor Newton: There was a NICE evidence review of LARC, which clearly showed its effectiveness in preventing teenage pregnancy, so it is an important choice available for women. For women who have very disorganised lives, it is particularly effective. The evidence is striking; as



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the availability of LARC increased, teenage pregnancy went down. That trend is continuing to go down. There is no problem with the trend and the outcomes.

Q133 **Dr Whitford:** But most women access contraception within primary care.

Professor Newton: They do.

Q134 **Dr Whitford:** That is obviously where we are seeing the fall, and primary care physicians are saying, basically, that the tariff, the remuneration, does not cover the cost.

Professor Newton: We mentioned the review that will be going on, and it is mentioned in paragraph 2.4 of the long-term plan. That is exactly the point: we need to look at the current arrangements and see where we could make relatively modest changes that would solve a problem like that. Everybody knows it is a problem. Everybody realises we should do something about it. It is a question of people sitting down and talking about it. In this case, we need to draw in the NHS as well because there are NHS commissioning issues.

Q135 **Dr Whitford:** It is very much primary care.

Professor Newton: We should be able to solve that problem. That is on LARC.

On the reproduction action plan, recognising that reproductive health is a public health issue has been quite transformational. We are very pleased with the consensus document we produced. The plan is in train at the moment and will be published in, I think, spring this year. It will look at the issues in the round.

We have mentioned several times the complexity of sexual health, reproductive health and HIV, which is another subset of these issues. In any attempt to simplify them, you usually end up in the wrong place. They are complex issues and we have to address them together.

Steve Brine: Philippa, coming back to your point about primary care, it is undoubtedly tied up with where the money flows, it is undoubtedly tied up in the contract, and obviously there is an annual contract for negotiation that goes on. Dom from NHS England might wish to add to this, but I take your point. I have heard the evidence you have already received; I have heard that evidence directly from primary care practitioners. As the Minister, I spend time sitting in GP surgeries watching—with permission, I might add—the good work that goes on, and I have heard that directly.

Can I add this thing about maternity outreach clinics? It is a relatively small point. If colleagues are interested, it is under 3.16 in the long-term plan. What we say there is that it is about “increasing access to evidence-based psychological support and therapy, including digital options, in a maternity setting.” The new maternity outreach clinics “will



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integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.” That is really for high-risk women. We talk about making every contact count in the NHS, but for high-risk women for whom another pregnancy would—a polite way of putting it would be “not advised”—often be disastrous to their physical and/or mental health and their family setting, that is very important. I wanted that on the record.

Q136 **Dr Whitford:** So that is being looked at and taken forward.

Steve Brine: Definitely.

Q137 **Dr Whitford:** We also heard, and it came up in the earlier panel, about women not being able to access cervical screening in sexual health clinics. We already have 30% of women who do not take up their screening invite, and it is slightly higher in the 25 to 29-year-old group. It is the third who probably are the age group that is more likely to use sexual health clinics. What is happening to address that?

Steve Brine: This is one for NHS England. We had a very interesting debate on cervical screening in Westminster Hall, which you were at, Philippa, and the Member for Rotherham, who obviously has a lot of experience in these matters, raised the issue that women who had been victims of sexual violence are falling behind in the cervical screening stats. You will remember the point that was made. I said then that we would connect her to the screening review that is going on in DH at the moment. That point had not been raised with me before, but it struck me when she said it. There is a lot of sense, a lot of truth, in what she said. Obviously, those women would potentially interact with the sexual health services, so I thought that was a good point.

I want to bring Dom in on the task and finish group, which is working with different agencies, and Jo’s Cervical Cancer Trust, around cervical screening in sexual health units, which is the point you rightly raised.

Dominic Hardy: It is a really important issue to address, and I understand how distressing it can be to have to make multiple appointments in various clinics to access simple screening. We firmly believe at NHS England that commissioning needs to be integrated around patients, so on this issue we have set up a task and finish group, at the Minister’s behest, to look at exactly how we can provide a standardised service.

We are actively considering including that standardised service as part of our commissioning agreement with the Department of Health and Social Care for NHS public health screening services from 2020-21, and for this coming year, 2019-20, we have instructed our local teams to build on their current work and set out in a clear action plan how they will improve access opportunistically to cervical screening. Although only around 1% of cervical screenings are taken in sexual health clinics, it is often



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paradoxically those women who find it hardest to access services through their GP practice. We are keen to do that.

When we surveyed all our local teams last summer to baseline where they were in these commissioning arrangements, all of them had some arrangements in place. For example, in Cheshire and Merseyside, in all their nine local authority areas, they formally commission the service as part of one of the commissioning pilots that John mentioned in the earlier evidence session. There is some evidence of what works that we can aim to build on.

Q138 Dr Whitford: And try to share practice.

Steve Brine: As well as the point I made about women who are victims of sexual violence point, another point made in the debate that also struck me—I think it was one of your SNP colleagues who made it—was around trans women and their access to cervical screening. It is obviously tiny numbers, but they should not be discriminated against, and I am damn well determined that they will not be.

Q139 Dr Whitford: Obviously the numbers done within specialist sexual health are small in comparison with primary care, but it is about the fact that cervical screening has gone back down by half in that setting. There were concerns in the first panel regarding access to testing for mycoplasma genitalium. That seems to be partly due to an insufficient tariff. There is no funding at all for trichomoniasis vaginitis. How do we get the testing moved closer to services? You commented on that, John. How do we ensure that these organisms are being tested for and recognised, and that we are not actively cultivating antimicrobial-resistant infection?

Professor Newton: This goes back to Jim's earlier point about having some standards and good practice. There is variability. There are many clinics where those tests are available, but they are not available everywhere. It is about understanding the clinical arguments that they should be provided everywhere. There may be reasons why it is not possible to provide them everywhere—I am not sure—but it is about understanding the clinical arguments, making sure we have standards of good practice and that those can be adhered to as much as possible and incorporated in commissioning contracts.

Ultimately, of course, the more tests you do, the more costs are associated with it, so it will be a choice about how money is invested, and whether there are large numbers of tests. Equally, there are clinical movements against over-diagnosis and over-testing, which we need to be aware of, so we need to use the tests appropriately. A lot of local councils are introducing more remote access, remote sampling—not necessarily remote testing—which is a very popular approach for the people who use it. It is for low-risk people who can have a large number of tests done quickly. Of course, that releases capacity for those who need to be tested in the clinic.



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Q140 Dr Whitford: But it is also regarding the funding. Part of the increased expense is because it is going to a reference laboratory, but the funding for the mycoplasma genitalium testing is not sufficient, and the problem is that it was not being recognised and was thought to be chlamydia. Therefore, it can be treated inappropriately and we end up with antimicrobial resistance. And there is the fact that trichomoniasis does not have funding at all. As you are moving forward, is that going to be looked at? Are we looking at these newer infections that are being identified so that they are identified and treated correctly?

Professor Newton: I cannot comment particularly on that example, but I remember reading it in the evidence that was provided to you. Clearly, the whole approach to providing good quality advice about testing is to understand the benefits of testing and ensure that testing is available if it will make a difference to clinical outcomes. If, as you described, it would in that case, those sorts of tests should be available, but clearly our microbiologist would be able to advise on that. I am afraid I do not have that advice to hand.

Q141 Dr Whitford: It would be useful for the Committee to know what the direction of travel is; if we are incorrectly treating, we are wasting money. Similarly, if we are breeding resistance, we are setting up a huge problem for the future.

Professor Newton: I am very happy to ask our colleagues to provide you with specific advice on that one.

Steve Brine: What we should probably tag on to that is the point about super-gonorrhoea, which is not dissimilar to the point you are making. The CMO announced in November some £5 million for new tools in the diagnostics of super-gonorrhoea. I am sure, Chair, that you do not want to go off down the cul-de-sac of AMR. I am sure that the Committee is well aware of the AMR strategy and the refresh we just published.

Chair: Yes, thank you.

Q142 Diana Johnson: I want to ask about cervical screening. When we were in Plymouth, we talked to clinicians there and they had made arrangements so that there was funding available through sexual health services for cervical screening to take place. You also mentioned Cheshire, I think, Dominic.

Dominic Hardy: Cheshire and Merseyside, yes.

Q143 Diana Johnson: Overall, around the country what is the percentage of arrangements in place? Is it less than 10%, or more than 10%?

Dominic Hardy: When we did the baseline review in July last year, we established through all our local teams that everywhere has some arrangements in place, but they are by no means standardised. That is what we are now looking at, to be able to replicate across the country the



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most standard services like, for example, the one you appear to have seen in Plymouth.

Q144 **Diana Johnson:** Are you saying that most places have something in place?

Dominic Hardy: Most places have something, but by no means at a standard level. That is what we want to try to tackle.

Q145 **Chair:** So the next time the Committee looks at that, we will find that we do not have parts of the country where women need two separate visits unnecessarily because of poor commissioning arrangements.

Dominic Hardy: Subject to the outcome of the work we are doing, and with the Minister's agreement, we would aim to standardise that from 2021, I think.

Q146 **Chair:** In 2021? Is there no way you can bring that forward? That is quite a long way away.

Dominic Hardy: We are already saying that for 2019-20, for which we already have a section 7A public health commissioning agreement in place, agreed by the Department of Health and Social Care, we aim to have an action plan for all our local teams, to make sure they raise the standard and move towards a standard approach, but we will include that in the whole of the agreement for 2021, assuming that is where we get to as part of our current piece of work.

Chair: Thank you.

Q147 **Mr Bradshaw:** What happened to the expansion of the PrEP programme to deal with the inequity around England, Minister? You said it would all be in place by March, and it doesn't look that way, does it?

Steve Brine: Do you want to do that, Dominic?

Dominic Hardy: We have the Impact trial running at the moment, as you know, and that is important to us in providing answers to some of the key questions—what proportion of those attending sexual health clinics will be at high risk and eligible for PrEP in the future, for example, and what length of PrEP duration attendees are on. We have already expanded the trial once, or agreed to expand it, from 10,000 places to 13,000. On a recommendation from the research team, we have agreed to allow up to a further 13,000 men to enrol on the trial, and we are in the final stages of discussions with local government at the moment to ensure that the places are there when people enrol.

As I am sure the Committee knows, NHS England funds the drug costs and the costs of people attending trials, and we need sexual health clinics funded by local government to fund those placements in capacity in order that people can participate in that trial.

Q148 **Mr Bradshaw:** Does that represent the doubling that the Secretary of



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State committed to on 30 January?

Dominic Hardy: Yes. It is from 13,000, which was the first point at which we increased the number of funded trial places, and a doubling from that number to up to 26,000.

Q149 **Mr Bradshaw:** Are you going to fulfil the commitment that Minister Brine gave in a written parliamentary question, that most sites will be full by March?

Dominic Hardy: We certainly aim to begin enrolling at as many sites—clinics—as we can as soon as possible. That is why we are in the final stages of discussions at the moment.

Q150 **Mr Bradshaw:** I understand that five of the trial sites have not even started recruiting yet.

Dominic Hardy: Is this for the expansion?

Mr Bradshaw: Yes.

Dominic Hardy: That is because we have not reached a final agreement on that point.

Steve Brine: The oversight board is meeting when—next week?

Q151 **Mr Bradshaw:** I thought it was meeting on Monday.

Dominic Hardy: They met yesterday. They had some discussions, and I think they are still to agree finally which local authorities are going to provide funding—

Q152 **Mr Bradshaw:** What is causing the hold-up?

Professor Newton: There is a significant pressure on the sexual health clinics to provide this additional capacity, and to do it very quickly, particularly in a place like London that has a heavy concentration of the PrEP places and could be destabilising to the rest of the sexual health service. It needs to be carefully managed.

Mr Bradshaw: We are catching up very slowly with Scotland on this, aren't we?

Chair: Philippa wanted to come in on that point.

Q153 **Dr Whitford:** Is it, therefore, only available within the Impact trial? It is not available on a needs basis for an individual; they would have to commit to the trial, which obviously for anyone who might have a slightly more destabilised life is something they may struggle with.

Steve Brine: You cannot have a trial and roll it out. You do a trial with a view to rolling it out. I have made no secret publicly that I fully hope and expect that that is what will happen, but the whole idea of the trial is to assess the full potential of PrEP by gathering evidence through the trial. The trial ends in 2020 and the results will be in 2021, and—we were



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discussing this yesterday—it is the gap between those two places, that A and that B, that I am interested in and concerned about. I want to make sure that no one falls into that gap. PrEP is one of the most exciting advances in healthcare and preventive healthcare in a long time.

Q154 Dr Whitford: What is the particular question that Impact has to answer? Is it about the behaviour of those who are on it? There is quite a lot of clinical evidence already.

Steve Brine: It is behaviour and side-effects, isn't it?

Dominic Hardy: There are a number of questions we are seeking to answer at the scale of England, and the size of the trial reinforces that. What proportion of those offered PrEP would accept it, for example? What proportion of those attending sexual health clinics will be at high risk and eligible for PrEP? Those are the kinds of questions that commissioners seek to answer.

Q155 Dr Whitford: Could you not have answered both of them with an audit rather than a trial? A trial implies that there is a degree of randomisation, or is Impact actually only an audit?

Professor Newton: It is not a double-blind trial.

Dominic Hardy: I think the trial implies a degree of rigour that allows us to get at answering those questions.

Q156 Dr Whitford: It is only an audit. It is not a trial of the drug.

Dominic Hardy: It is a significant trial to understand the behaviours of people eligible for and using PrEP provided—

Q157 Dr Whitford: But there is no control group. You are simply signing people into Impact and following how they behave.

Dominic Hardy: I think I am right in saying that the trial is led by the Chelsea and Westminster Trust and overseen by a clinical panel. It is their advice that we take on how that trial runs.

Q158 Dr Whitford: But it is an audit-based trial. It is not a clinical trial. There is not a control. It is collecting—

Professor Newton: It does not have a placebo control. There is not a group who are receiving a placebo. That is the point. The effectiveness of PrEP was proved in previous placebo-controlled trials. This is a pragmatic trial of how it works in practice, so it is a research trial.

Q159 Dr Whitford: You could be following that in audit without limiting the numbers.

Professor Newton: Audit would be the next step.

Q160 Dr Whitford: You would still know at the end of the year what percentage were willing to accept it, what percentage kept taking it, and, as you are following them up, you would know what happened to their



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behaviour. You are actually limiting the numbers who can get it, which is not intrinsic to an audit-based trial.

Dominic Hardy: Far from it. We were not, as commissioners, routinely funding this before—

Q161 **Dr Whitford:** I am well aware of the debate we have had.

Dominic Hardy: It represents an expansion of places for people enrolled on the trial to be able to access the drug in a way that allows us meaningfully to understand the behaviours of those using the service.

Q162 **Dr Whitford:** But is it not a better public health approach to be decreasing the risk of spread? It is a little bit like the new antivirals for hepatitis C. If you invest in them, you start having less spread of the virus.

Professor Newton: There are two points. First is the 28% drop in new diagnosis of HIV that preceded the PrEP trial, so that is down to testing and putting people on treatment if they are positive. That is going on. Secondly, the trial is there to generate the evidence required for people to commission PrEP effectively in the future and cost-effectively so that the right people get it, commissioned in the right way. The trial is there to generate the evidence required for the next step.

Q163 **Dr Whitford:** It is evidence for commissioning rather than clinical evidence.

Professor Newton: It is evidence to drive commissioning decisions. We have talked about the resource situation we are in; commissioners have to make difficult decisions and they need evidence, otherwise they cannot justify those decisions. Audit comes afterwards. Once you have decided what you are going to do, with the audit you decide whether you are doing what you intended to do. This is about the stage before.

Steve Brine: It is of course related to the commitment the Secretary of State gave at the end of January around getting to zero HIV infections by 2030, which was a point that Mr Bradshaw raised in Health questions the time before last, if I remember rightly, and we responded to that. The role of PrEP as part of our combined HIV prevention efforts will be part of the action plan that we are working on right now in order to get to that ambition—the zero.

Q164 **Dr Williams:** I am going to talk about access, but I will start with access to PrEP. When are my constituents going to be able to access PrEP?

Mr Bradshaw: And mine.

Dominic Hardy: We have 143 clinics, I think, enrolling men at the moment. My understanding is that they are providing 13,000 places at the moment. They have been selected, I think, in consultation with Public Health England looking at HIV prevalence and attendances at sexual health clinics.



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Q165 **Dr Williams:** There are 672,000 people in Teesside and they have their sexual health services provided by Virgin, who at the moment have no people enrolled on the PrEP trial. Why not?

Dominic Hardy: As I said, I think the clinics were selected on the basis of the data that PHE—

Q166 **Dr Williams:** The clinic was selected but they have not enrolled anybody.

Steve Brine: Clearly, we cannot give you an answer to that immediately, but I have a feeling that Mr Hardy will be looking at it after today.

Q167 **Dr Williams:** I thought there would be a theme. Are there other private providers of sexual health services that have enrolled people?

Dominic Hardy: Are you saying that the clinic is part of the trial?

Q168 **Dr Williams:** The clinic is part of the trial, but it has not enrolled anybody yet.

Dominic Hardy: I am happy to take a look at that.

Q169 **Dr Williams:** There are 672,000 people, of whom many will be eligible, and would love to be able to access PrEP.

Dominic Hardy: I am happy to look at that.

Q170 **Chair:** You will look at that and respond to us in more detail about variation in uptake. It is a big concern.

Professor Newton: In general, enrolment in the trial has gone very well.

Q171 **Dr Williams:** Not for the people I represent.

Professor Newton: Sadly. But we will look at that particular one.

Q172 **Dr Whitford:** Is there a clinic in every area? I understand that that clinic has not enrolled everyone, but is there a clinic in every health board area or health area?

Professor Newton: As Dom says, it is based on the epidemiology of the indication for PrEP. There is a pretty limited group of people for whom PrEP is indicated.

Q173 **Dr Whitford:** But they do not all live in one place.

Professor Newton: No, but they are not randomly distributed around the country. There are certain parts of the country where we have a much higher concentration of people who would be eligible for and benefit from PrEP.

Q174 **Dr Whitford:** In the cities.

Professor Newton: Yes, in the cities.

Q175 **Dr Williams:** Can I ask about access to general sexual health services?



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The BASHH survey told us that more than half of clinics are turning away patients on a weekly basis. A fifth of clinics are turning away more than 50 patients per week. In our first panel we heard evidence that it has always been this way. Is that good enough, Minister?

Steve Brine: Always been this way? No, of course it is not good enough. I think what you have to understand—you do understand; you know this—is that there are different areas that do things differently. Local government has recommissioned services in different areas to make them more integrated, more accessible and available in areas that people go to. I think you heard from Councillor Hudspeth, in Oxfordshire, that since we made the change in 2013 they had gone from three centres in Oxfordshire to nine centres, through commissioning differently and smartly.

In Hertfordshire, we moved to two new hubs with another on the way. I visited the service at Watford myself last year. They are all in community and town centres, they have a new online system for testing and triage, and test kits are sent out to home, which I know we will come on to. The one I went to is right next to an FE college, which may be coincidental, but it is certainly useful. In Leicester, I am particularly interested in what they are doing. There is a new city centre hub in the Haymarket shopping centre where they are spending £1.5 million on a new sexual health clinic in the shopping centre, which Leicester City Council are spending money on. It is going to be called the Discreet Centre. It is in a former TK Maxx shop. Students from the De Montfort University were involved in the design; it will be laid out to be useful while sensitive and private, to get people through quickly. There are lots of good examples of sexual health services being procured by local authorities.

Q176 **Dr Williams:** What about the fifth of services where clearly supply is not meeting demand?

Steve Brine: Underperforming demand?

Dr Williams: Yes.

Steve Brine: But you also have to look at behavioural change. I think it was Mr Bradshaw who asked the question in your session on 5 February around behavioural change and how that has led to the number of people coming into sexual health services. It is not a straight line. It is not a simple picture. It is different in different areas. It is different in cities; it is different in areas that have bigger BME populations or bigger MSM populations. There are lots of good examples of where it is going on, but, as I said at the very start, there is no ducking the facts; if anybody thinks that the coalition Government in 2010 had a golden economic legacy, I would challenge that view, obviously. Yes, we had to make really difficult decisions and we had to pass on savings to local authorities, who then passed that on to their services. You cannot make those kinds of savings without it having an impact. That is part of the fact that we crashed the economy.



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Q177 **Dr Williams:** But we have heard that it has always been like this, even prior to 2010. We have heard that people were waiting too long, waiting for hours in a drop-in service, and were not able to book appointments when they wanted to book appointments. What is the ambition and what tools should you have as Secretary of State in order to be able to realise that ambition?

Steve Brine: I think—

Dr Williams: Sorry, not Secretary of State, Minister of State.

Steve Brine: Thank you for the promotion.

The ambition has to be to give young people and older people confidence that they can get high-quality, trusted and reliable advice when they need it. That could be through walking in. It could be through walking into a pharmacy. I am also the community pharmacy Minister and, as you know, I have great faith and trust in community pharmacy. I was in a community pharmacy earlier today asking the pharmacist about sexual health services when a fellow Health Minister walked in, and I immediately said I was asking on behalf of a friend, of course, but I was just doing my research ahead of your Committee today.

It may be that people walk in, it may be that they are referred by a GP, it may be that they are referred by a pharmacist, or it may be that they access it online. Some people may sniff at online, but SH:24 is a really excellent online service, developed with funding from Guy's and St Thomas' charity. I am sure you have looked at it, Dr Williams. It is a brilliant website; it has brilliant information. You can put in your information and it sends you directly to a service.

Q178 **Dr Williams:** There are some brilliant online resources.

Steve Brine: It also sends out self-testing kits. I am sure John can give the numbers. The numbers of online testing kits we are sending out in London are really impressive. Services are changing and that is how people want to access those services. The idea that it is all about bricks and mortar and walking in—

Q179 **Dr Williams:** I have not said that.

Steve Brine: I did not say you did.

Q180 **Dr Williams:** It is about the people who want to access services and who are not accessing them, and my question was about what tools you need. The people you need to be fighting for are the ones who are not accessing the services. What tools do you need to make sure they get the services they need?

Steve Brine: I need primary care, in the wider sense of the word, to grab them and to make every contact count. This is part of primary care. I consider pharmacy to be primary care, and I need that part of the NHS system and the NHS family to grab them and embrace them when they



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come into contact with it, because that is what making every contact counts means. Whether that is in bricks and mortar or clicks and mortar, I am not prissy about it. I just want it to be the right service for them and I want them to get a service that they are confident in.

I know that the Committee did a small survey. When I look at other survey data, I hear the access arguments all the time and I understand that there always have been those arguments, but I also hear people give great endorsement to the service they receive when they receive it. There are very high satisfaction levels when they access it.

Professor Newton: The context is that there has been a 13% increase in the number of people seen in sexual health clinics since 2013. There are more people being seen. As the Minister says, the key is to open up a number of channels so that the right people are seen in the right place at the right time and they do not have to wait. Those who would benefit from the specialist sexual health clinics need access to them, and to have access to them quickly, but we need to provide other ways in which other people can get advice or testing.

Q181 **Dr Williams:** What if people are not getting access? Will you know about it and what can do you about it?

Professor Newton: You either have to increase capacity in the specialist clinics, which is difficult because it is expensive, or you have to open up other channels, which is what we have been talking about, such as online access or the use of community pharmacy. Something like 1.3 million people visit community pharmacies every day. People have got used to being able to go to a sexual health clinic whenever they want to. I worked at St Mary's, which was the second largest clinic in the world. We used to have 50,000 new diagnoses every year in one clinic alone. There is a tradition of open access for sexual health clinics. That is still provided; it is still what local government is asked to do, but, as demand rises, we have to support it by providing alternatives for people who do not need to be seen in those clinics.

Steve Brine: I know you talked in the previous session about the pilots, and I suspect that John talked a lot about them. There are some additional areas, one of which is in the north-east, in Tees Valley, which is partly where you represent, isn't it, Paul? Four local authorities, two CCGs and NHS England have commissioned a range of sexual health services for years. In classic NHS Minister and officials talk, we talk about 2.4, the long-term plan bit that talks about commissioning, which we may come on to. There are some areas that have been doing that for years.

My ambition is not small, but I have to recognise that society is changing and that the number of clients coming into the system is going up, which is partly through behavioural change. I have sat in sexual health clinics, as I know that as a Committee you have done. I am pretty broad-minded, but what goes on is an eye-opener.



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Chair: Thank you. We are going to come on to funding and commissioning.

Q182 **Martin Vickers:** Minister, we have been told that, wherever sexual health commissioning is located, it should be commissioned from one single funding pot, and competitive tendering should not be compulsory. What view do you have on that?

Steve Brine: That competitive tendering should not be compulsory?

Martin Vickers: Not compulsory.

Steve Brine: I do not want to sit here and criticise competitive tendering because sometimes it can lead to a better service. Maybe Councillor Hudspeth expanded on that when he talked about his three units into nine. If you as a local authority are responsible for the sexual health services in your area and you decide to combine other services, and combine hubs as they are doing in Leicester, and go out to competitive tender to get better value for your ratepayers, what is wrong with that? Ultimately, you as an upper-tier authority councillor in England are responsible. That is what the democratic accountability of the Act was about. Ultimately, you are responsible to that population, and I do not have an issue with that. Why should I have an issue with competitive tendering?

Q183 **Martin Vickers:** That is what I was asking—whether you did or not.

Steve Brine: I am sorry.

Q184 **Martin Vickers:** Professor Newton, do you want to comment?

Professor Newton: Making a link with the earlier discussion, the point is to use tendering for what it is good for and use it intelligently. That was the point that my ADPH colleague made. I know that you have heard clinicians say that tendering is very time-consuming. The experience is that tendering drives quality up, but it needs to be done in a way that does that, and does not just take up time.

Q185 **Martin Vickers:** Minister, what factors will you take into account in making decisions about whether there should be a stronger role for the NHS in commissioning services, as proposed in the long-term plan?

Steve Brine: Let us be clear about what the NHS long-term plan proposes, to use your word. Sexual health is the third biggest thing that local authorities commission. I do not want to let horses run wild with the idea that what we are doing in the long-term plan is saying that local authorities have failed and it has all been a disaster, even though people who work in those services, who are among the most committed people I have met in the NHS, do a very difficult job. I do not want the message to go out that that is what we are saying because that is not what we are saying at all.



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If you look at the 2.4 bit, it says, "Action by the NHS is a complement to, but cannot be a substitute for, the important role for local government." I gave the example in the north-east where that collaborative work has been going on for a long time. The long-term plan talks about a stronger role for the NHS. I am going to bring Dom in on this in a minute on that. Councillor Hudspeth—I know I keep quoting the man; it is like I am obsessed with him—talked about deckchairs, an unfortunate analogy in some ways, but his point was that just rearranging the deckchairs is not necessarily the answer. That is not what we are saying in the long-term plan at all.

We are talking about a collaborative approach for commissioners and the NHS maybe having a stronger role in that. If you look at the long-term plan as a whole, you will read about primary care networks, for instance, where we have done the vanguards and proved the concept of vanguards, and now we want to see primary care networks taking more responsibility for primary care in their area, potentially including sexual health, and maybe where it is not working in certain areas, because in some areas it jolly well is working and I am content with it.

Dom, do you want to add to the point about NHS England's long-term plan, the point about the stronger NHS role? It is not replacing it, is it?

Dominic Hardy: Indeed. It is worth saying that NHS England was asked to focus by Public Health England in the long-term plan on the things the NHS can do with the funding that the Government have allocated to us. That is what we focused on—smoking cessation in hospitals, for example, and enhancing the cancer screening programmes. Clearly, we want to play our part in making sure that sexual health services are effectively commissioned. We greatly value the work that local government colleagues do to commission high-quality sexual health services, and we want to be clear that, just as our fellow commissioners in clinical commissioning groups do, we have a role to play to support that and work collaboratively to get the best outcomes for the communities that we all serve.

Q186 **Martin Vickers:** Minister, I will move on to accountability. Is more action needed at national level to drive improvements, or perhaps more emphasis at local level?

Steve Brine: I used to hate it when I was on the Select Committee and Ministers gave this answer, but I think the truth is, Mr Vickers, that it is a bit of both.

Martin Vickers: I thought you might say that.

Steve Brine: There are things that need a national lead. You have the national policy document on sexual health and HIV, which was published in 2013, and the different points within that around scrutiny of commissioning arrangements and development of an action plan on getting to zero HIV infections. That is stuff I expect to set.



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When I was sitting at the back listening to your previous session, I was pointing at myself when you talked about accountability. Local authorities are accountable to their populations—rightly so. That was the intention of the Act and that was right. PHE is accountable to me. The Secretary of State and I set the mandate for PHE, and therefore it is directly accountable to Parliament and to the public through me.

If we made a change around commissioning, it would be what works in the area, and it might not be the same for every area. I do not want to get to a position where Ministers are prescribing what sexual health services look like in Cleethorpes or what they look like in Winchester and for it to be exactly the same. That would be a mistake and a regressive step.

Martin Vickers: I am pleased to hear that.

Chair: Thank you. We have two further sections to address, one on education and one on workforce. Ben will talk about education.

Q187 **Mr Bradshaw:** Minister, do you agree with Professor Newton—

Steve Brine: Almost certainly.

Q188 **Mr Bradshaw:** —that parents should not be allowed to withdraw their children from compulsory RSE when it is finally introduced?

Steve Brine: Yes, I do. Parents have the right to request that their child be withdrawn from the sex education but not the relationships or health education part of RSE. The new subjects that the Secretary of State set out yesterday in the House, and I am sure you were there, will form part of the basic curriculum. There is no right to withdraw from teaching on sex at all as part of the reproductive and biological education part of the national curriculum for science. That is absolutely right.

Q189 **Mr Bradshaw:** You are confident that parents would not be able to deprive their children of the sort of education they would need to help them avoid contracting sexually transmitted diseases later in life.

Steve Brine: Yes, I am confident. The Secretary of State had 30,000 responses to his RSE consultation, and he has taken a long time to come up with yesterday's announcement, and rightly so. On another level, I was heavily involved before I was a Minister in lobbying for this change because it has been a long time coming; the regulations are well out of date.

What we announced yesterday as a Government is really important. I know the Labour party was very supportive of it when the Secretary of State made his original statement, and that is really great. I am a parent of young children. I want them not just to know the mechanics. I want them to know the implications of smoking for their health, and I want them to know the implications of poor, bad behaviour for sexual health



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and the implications that will have on their life chances. The new RSE curriculum will be important in that.

There is a television programme that I am sure the Committee has seen called "The Sex Clinic", which is on E4. I saw it last night. I have seen a number of episodes, and it is quite shocking how many people come into that clinic with very basic misunderstanding about personal hygiene and the impact that can then have on one's sexual health. Without getting into details, if you parent young boys there are certain things you teach them, and the same for young girls. The people who come into the clinic on that programme—I mean, honestly, why you would go on a programme and do that I do not know, but—

Q190 **Mr Bradshaw:** Would the bits of RSE that parents would not be able to take their children out of include bits on transgender and LGBT+ rights?

Steve Brine: I cannot give you chapter and verse on that. It is not my policy. I am not the Education Minister.

Q191 **Mr Bradshaw:** Could you check?

Steve Brine: I will probably have to write to you on that because I do not want to mislead the Committee.

Q192 **Mr Bradshaw:** It would be very concerning, and I hope you would resist it if the Education Department was trying to allow it, for transphobic or homophobic parents to deprive their children of necessary education.

Steve Brine: I will check on it and give you the facts from a policy point of view. I can give you a personal view, as a Minister and a parent. You bring up children to face the society that exists, not the society that you want to exist. Teachers have a statutory obligation to teach the facts, not to teach opinion around that or anything else, political or otherwise. I think that young people should be taught exactly what there is out there in life and what they will face when they go out into the bigger wide world. If that includes trans, absolutely. That is my view.

Mr Bradshaw: Thanks.

Q193 **Chair:** Thank you. Can I come on to workforce? Two key areas have been raised with us. One was the recruitment and retention of the sexual health workforce and the other was access to training for long-acting reversible contraception methods, particularly, for example, Mirena coils.

Turning to the first area, one issue around fragmentation and commissioning is that often commissioning of the education of the future workforce appears to have fallen through the gaps. Which of you on the panel would like to touch on what is going to be done to address that? It is about recruitment and retention.

Steve Brine: I will start and then I will probably hand on to NHSE. We are very clear that a sufficient supply of well-motivated staff is central to



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making the long-term plan document live. That is why the Secretary of State has asked Baroness Harding—

Q194 **Chair:** This used to be a very popular specialty. Since the fragmentation issues in particular, we are hearing that it is becoming less popular as a choice.

Steve Brine: As a doctor, you may know that better than me, and maybe Professor Newton—

Q195 **Chair:** No. This is from those we have heard from. There is real concern about the pressures within the job, and the fact that there has not been the attention to training the future workforce that there was.

Steve Brine: I said it earlier, didn't I? It is definitely a challenging discipline to work in; you can face very challenging people.

Q196 **Chair:** It is a popular discipline, but we have heard that the training of the future workforce has fallen through the gaps.

Steve Brine: We are already increasing nurse training places by 25%. We have 5,000 additional nurse training places available every year from September just gone, and they then—

Q197 **Chair:** I am not talking about the general workforce; I am talking about the workforce within sexual health.

Steve Brine: A lot of the people who work in the sexual health workforce train as nurses, so they come through that training area. The point about retention, which obviously I am fascinated by in the wider primary care setting, is that people will stay, in my experience, working in the health service and working in their different disciplines if they feel pride in what they are doing and that they are making a difference. If they feel that they are constantly running to catch up and they are not able to do that, they will walk. In some ways, you cannot blame them for that.

If we have a properly resourced system, which treats people with respect, and, as I was saying to Dr Williams, they go to the right place to get the right treatment and do not all come in through the bricks-and-mortar door, that will help with—

Q198 **Chair:** You are not answering my question. My question is very specifically about—

Steve Brine: I am answering it.

Q199 **Chair:** No, you are not. It is a more general answer that you are giving.

Steve Brine: It is the answer.

Q200 **Chair:** I am asking you for a much more specific response on the issue of how you are going to make sure that we are training the future workforce and retaining them for sexual health services.



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Steve Brine: I already referred to the fact that Baroness Harding and David Behan, who you will know used to be with the CQC, have been asked by the Secretary of State to come up with a workforce plan to go alongside the long-term plan. That will report in the spring, and that will be a key moment, I would suggest, for the NHS and a key moment for the NHS long-term plan. Maybe that is too general an answer for you, but it is the answer.

Q201 **Chair:** Would you recognise that, at the moment, sometimes this is an area that is falling through the gaps? When you have, let us say, competitive tendering and Virgin, for example, providing a service, they are not actually taking part in training programmes for the future workforce.

Steve Brine: Sure, I would recognise that.

Q202 **Chair:** Everyone seems to be withdrawing from that, assuming that another area is going to pick up the training responsibilities. What we need is a much more joined-up approach to the future workforce. That is what I mean by falling through the gaps sometimes. Is that something you recognise?

Steve Brine: Sure, I recognise it; I would be a fool not to, wouldn't I? It is something I am sure the Harding-Behan work will take into account.

John, you worked in sexual health for a long time. Do you want to address the point that it has been a very popular discipline?

Professor Newton: Yes, it is popular for various reasons. It has a range of disciplines, nursing and medical but also health advisers. The non-clinical staff are crucial to those clinics as well. It is quite a specialised discipline.

Health Education England have done some work on this. They did some work following our survey of commissioning, so there is a consensus view about what is required. Again, I think it needs to play into the broader initiatives that the Minister mentioned around the long-term plan, to see what the opportunities are. In many ways, it is about flying the flag for this relatively small discipline alongside all the other demands at every level.

The question is whether something specific should be done on sexual health or whether it is a question of remembering sexual health in the more general approaches to developing the clinical and the non-clinical workforce. I think, with apologies, we probably need to do both.

Q203 **Chair:** Yes, both, but also, as I say, not allowing some areas just to opt out of the future training of the workforce, and to make sure that it is included.

Professor Newton: No. For the reasons we have said, we need coverage. It is no good providing perfect services in central London and—



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Q204 **Chair:** You need coverage. It is too easy for some areas to think, "I won't worry about that. I'll let somebody else pick up the training."

Steve Brine: It is a point well made and one that I will make sure, through officials, that the Harding review does not miss.

Q205 **Chair:** Thank you. It will be really important to address that. The other point I wanted to ask you about was making sure that GPs and others working in primary care have access to training opportunities for LARC methods. Perhaps, Dominic, that is something you would like to respond to.

Dominic Hardy: We discuss that with the college regularly, which I know issues guidance on it and provides general practice with the route into that training. We aim to make sure that we create capacity in general practice for people to have the headroom to access that training, because without the training you cannot keep up your competence.

Q206 **Chair:** Would you recognise that it is quite variable? There are some areas, again, where those training opportunities are falling by the wayside.

Dominic Hardy: Yes. As part of the long-term plan, we set out proposals to establish training hubs in every health system around the country, to give practitioners in primary care, working in multidisciplinary teams, the skills to care for patients and users of all kinds of services. I would envisage that they will have a holistic view of the training needs of that group.

Q207 **Chair:** We have already touched on the fact that you are looking at the commissioning arrangements to make sure that we do not have artificial barriers to people doing coil fittings, for example; it is also about having the training available to them.

Dominic Hardy: Indeed.

Q208 **Chair:** That is something you are going to pay some attention to.

Dominic Hardy: From the primary care perspective, absolutely, yes.

Chair: Diana has some questions about education.

Q209 **Diana Johnson:** I want to ask you, Minister, about pornography. When we were in Plymouth, we were told by one of the sexual health services for young persons that people who had been working in that service for many years were saying that they were really concerned about the effect that pornography has now on when young people start to have relationships, the idea of what a relationship is and the behaviours that are acceptable or normal. I wonder, Minister, whether you might want to say something about your view on that. Is it something you have come across in your discussions with officials, and, if so, what do you think we could do to challenge and tackle it?



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Steve Brine: Crikey, that is a big question. It is not a conversation that I have had with officials, but my view as a Minister and as a parent is that parents have a huge responsibility. My children are at little school. They love their time on the iPad, but through various apps and ways of controlling them, I am very tight on what they can and cannot look at. In a way, that is just a symptom. I am very strict in the way I try to teach my son about how to be a gentleman and how you treat a partner. I feel that we have lost that somewhere in society, and maybe that feeds into the way that some men—it usually is men—treat women in relationships. Ultimately, I do not think that can be a role for the state. It comes down to parenting, which comes in all shapes and forms these days, and that is fine. Whatever form it comes in, the values you teach your children about respect have not changed.

Q210 **Diana Johnson:** I think pornography when I was growing up was quite different from the pornography that is now available on the internet and that young people have access to. I am concerned that some of the practices that you might see in pornography, things like anal sex, will be expected to happen because it is what young people are seeing. You are saying that it is for parents only, but in fact there are questions about what, as a Government, or a health service we should be saying to people.

Steve Brine: I am not sure I agree, Diana. There is a limit to Government's intervention, and I do not say that as a Conservative; that is just my instinctive answer. You are right to mention anal, for instance, versus more traditional sex, but when I talk to people in the sector I am told that actually oral sex is more the sex of choice these days. One of the decisions I made around the HPV vaccine for boys was because the dental profession, which I also look after in my ministerial brief, were very clear with me that head, neck and oral cancers are on the rise, and they believe that the popularity, shall we say, of oral sex is a problem in that space.

Q211 **Diana Johnson:** Are you saying we should just accept that?

Steve Brine: No. I think it comes down to the way we parent our children. I do not think that it is Government's job to parent children. It is certainly Government's job, and the Secretary of State has been very active in this space, to look at what social media companies' responsibilities are, and I thoroughly endorse that as a parent and as a Minister, but we cannot get away from the fact that how we bring up our children has a massive impact on our society. I know my responsibilities in that space, and the vast majority of parents also know their responsibilities in that space. If they do not, they need to have a long hard look.

Q212 **Diana Johnson:** I just wondered if Public Health England might say something—

Steve Brine: He is champing at the bit.



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Professor Newton: This speaks to the point we heard before about the need to equip children to deal with the threats that are going to be there, whatever they are, and they are going to change. We need to recognise that the speed of change is probably increasing, and that services find it difficult to change at the same speed. We need to keep that in mind all the time.

Chair: Thank you all for coming this afternoon.