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Health and Social Care
Committee

Sexual health

Fourteenth Report of Session 2017–19

*Report, together with formal minutes relating
to the report*

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Health and Social Care Committee

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Contents

Summary	3
The current situation	5
Our inquiry	6
Overview – a new national strategy	8
1 Funding and commissioning	10
Introduction	10
Funding cuts	10
Fragmentation of commissioning	13
Tendering and procurement	17
Structural changes	18
Conclusions and recommendations	19
2 Services	22
Quality of care	22
Accessibility	22
Vulnerable groups	25
Conclusions and recommendations	26
Testing and screening	27
Cervical screening	27
Long Acting Reversible Contraception	28
Pre-Exposure Prophylaxis for HIV	30
3 Prevention	32
Behavioural trends	32
Prioritisation and funding	33
Education and information	34
Conclusions and recommendations	36
4 Workforce	37
Morale	37
Retention and recruitment	37
Training	39
Conclusions and recommendations	40

Conclusions and recommendations	41
Annex 1: Visit to Plymouth	45
Annex 2: Sexual health focus groups–frontline experiences of commissioning and providing services	48
Engagement	53
Formal minutes	54
Witnesses	55
Published written evidence	56
List of Reports from the Committee during the current Parliament	59

Summary

Good sexual health is a vital aspect of overall health and wellbeing. That is helped by easy access to high quality information and sexual health services. Although the top line figures for sexual health appear positive at first glance—overall sexually transmitted infections and teenage pregnancies are falling—they mask a number of seriously concerning underlying trends and inequalities as poor sexual health outcomes fall disproportionately on certain groups.

An enduring theme in evidence to this inquiry was geographical variation in access to the highest standard of sexual health services, worsened by the impact of greatly reduced funding and increased fragmentation of services.

Sexual health must be sufficiently funded to deliver high quality sexual health services and information. Cuts to spending on sexual health, as with other areas of public health expenditure, are a false economy because they lead to higher financial costs for the wider health system. Inadequate sexual health services may also lead to serious personal long-term health consequences for individuals and jeopardise other public health campaigns such as the fight against antimicrobial resistance.

Looking forward to the Spending Review, the Government must ensure sexual health funding is increased to levels which do not put people's sexual health at risk. We are concerned that cuts have fallen particularly heavily in the area of prevention. The message to this inquiry was clear: inadequate prevention and failure to ensure early intervention increases overall costs to the NHS.

We welcome the Minister's indication that prevention as part of sexual health will be a central part of the prevention Green Paper, and we expect the Government to set out in the response to this report how that commitment will be followed through into action, including the funding required to put it into practice.

A recurring theme in evidence to this inquiry was the complexity caused by fragmentation of both commissioning and provision, as well as the variation in the level of services available to patients. We also heard evidence of the considerable time, energy and money that can be wasted through repeated procurement and tendering processes. We were given examples of how this complexity and variation is having a direct and unacceptable impact on patient care in some areas, for example women being denied cervical screening and having to undergo a separate examination elsewhere for a test that could and should have been completed in a single visit.

Some areas have managed to negotiate their way around the bureaucratic obstacles and work more effectively together. This needs to happen everywhere in order to put patients first, and more should be done to make joint working easier.

Witnesses to this inquiry told us that a new, national strategy is needed for sexual health, to help both providers and commissioners to deliver sexual health services to a high quality and consistent level, in the face of the challenge of fragmented structures.

We recommend that Public Health England should provide clear national leadership in this area. The strategy should set out one clear set of national quality standards for commissioners to adhere to, encompassing all aspects of sexual health.

Recognising the complexity of the provider and commissioner landscape in sexual health, we recommend the establishment of a broad-based working group of representatives drawn from all sectors involved in commissioning and providing sexual health services to help draw up the strategy. This national sexual health working group should include senior representation from PHE, NHS England, local government, CCGs, as well as different provider and patient representative groups.

The working group should bring new impetus to work to drive forward change and improve services for patients, delivering effective, joined up sexual health commissioning. That means both identifying and disseminating best practice, and working supportively but robustly with services where improvement is needed. The national sexual health strategy should set out a clear framework through which local areas will be assessed against the quality standards, with the findings made public both to ensure best practice is widely shared, and to increase public accountability.

Based on the evidence we have received in the course of this inquiry, we identify a number of priority areas which the national strategy must address, including access, the provision of services which meet the needs of vulnerable populations, cervical screening, testing for the full range of sexually transmitted infections, access to long-acting reversible contraception (LARC), access to pre-exposure prophylaxis (PrEP) for those at risk of contracting HIV, and preventative interventions within all aspects of sexual health. We call for immediate action on the provision of cervical screening and the availability of PrEP.

The Government must take a strong line on participation in Relationships and Sex Education (RSE). Public health arguments are overwhelmingly in favour of ensuring that all children have age appropriate RSE. Relationships and sex education should be high quality, delivered by appropriately qualified people, and linked appropriately and usefully to local health priorities and local services.

Fragmented arrangements for the commissioning and provision of services have meant that workforce planning, development and training have suffered. There are very serious concerns about the pipeline of future specialists in sexual health. The Harding review should set out a deliverable plan for the workforce needed to deliver sexual health services across England in the next 10 years. Meanwhile, the national sexual health strategy should include a clear programme of further action to re-establish training and development for both the current and future sexual health workforce at the heart of commissioning and provision arrangements.

The current situation

1. Good sexual health is a vital aspect of overall health and wellbeing. That is helped by easy access to high quality information and sexual health services. Although the top line figures for sexual health appear positive at first glance—overall sexually transmitted infections (STIs) and teenage pregnancies are falling—they mask a number of worrying underlying issues and inequalities. Some concerning trends have been highlighted to us, as has the tendency for poor sexual health outcomes to fall disproportionately on certain groups.

2. Overall diagnoses of sexually transmitted infections (STIs) fell by 7% from 2013 to 2017.¹ There has been a significant decline in new HIV diagnoses, thanks to a sustained long-term effort and more recently the introduction in some areas of PrEP.² There has also been a fall in genital warts, due to HPV vaccinations, and chlamydia, since the introduction of the chlamydia screening programme.³ There are worrying trends however for the diagnoses of syphilis and gonorrhoea, which have increased by 20% and 22% respectively from 2016 to 2017, in line with significant rises over the past decade.⁴ Dr Williams, President of the British Association for Sexual Health and HIV, described this increase as “much more than we had anticipated for the 21st century”.⁵

3. Poor sexual health can lead to serious personal long-term health consequences for individuals. As Ian Green, Chief Executive of the Terrence Higgins Trust, told us, “sexual health is an issue for most people, but there are clear groups that are disproportionately affected.”⁶ The impact of STIs is greatest in young people. Among those aged 15 to 24, men are twice and women six times as likely to be diagnosed with an STI than their counterparts aged 25 to 59.⁷ Men who have sex with men (MSM) are also disproportionately affected by STIs. In 2017, 84% of syphilis diagnoses and 64% of gonorrhoea diagnoses in men were in MSM.⁸ Over half of those diagnosed with HIV in the UK in 2017 were gay or bisexual men. There are also disparities in the impact of STIs on minority ethnic groups. The rates of gonorrhoea and chlamydia in black and minority ethnic (BME) populations are three times that of the general population, and the rate of the STI Trichomoniasis is eight times higher.⁹ Minority communities constitute 14% of the UK population but have a burden of late HIV diagnoses of 52% and 40% for people accessing HIV services.¹⁰ Although rates of HIV are declining in MSM overall, this is not the case in all communities.¹¹ The situation is worse for BME women. 80% of women living with HIV are BME, and 62% are of African heritage.¹²

4. Anti-microbial resistance (AMR) is becoming a major issue in the treatment of gonorrhoea. Last year there was the first case globally of gonorrhoea for which no drugs were available, and in the last three months two further cases have arisen for which we

1 DHSC ([SLH0044](#))

2 [Q2](#)

3 [Q2](#); [Q84](#)

4 Public Health England ([SLH0087](#))

5 [Q2](#); [Q84](#)

6 [Q61](#)

7 PHE – [sexual health statistics](#)

8 PHE – [sexual health statistics](#)

9 PHE – [sexual health statistics](#)

10 Marion Wadibia [Q63](#)

11 Marion Wadibia [Q63](#)

12 Marion Wadibia [Q63](#)

heard there were significant issues around treatment. If the issue of AMR is not addressed, gonorrhoea will no longer be a disease that is curable with one injection.¹³ Public Health England told us that “resistance to the antimicrobials used to treat gonorrhoea is a global public health concern.”¹⁴ BASHH point out that the cost of treating a resistant gonorrhoea infection is around six times higher than a standard gonorrhoea infection.¹⁵

5. *Mycoplasma genitalium* (MG) is another emerging threat to sexual health. This newly discovered STI has often been wrongly diagnosed as chlamydia. Diagnostic testing for this condition is not routine within sexual health services, and where not properly identified and treated it can develop resistance to antibiotics. Some of the antibiotics used to treat mycoplasma genitalium are already ineffective due to AMR. The British Association for Sexual Health and HIV warned that “if current practices do not change, Mgen will become a superbug, resistant to 1st and 2nd line antibiotics, within a decade.”¹⁶

6. Whilst the teenage pregnancy rate has fallen consistently since 2007, we heard from witnesses that in some areas, including Bradford and Manchester, it is beginning to increase, particularly amongst deprived groups.¹⁷ After over a decade of steady decline, the abortion rate increased from 16.0 per 1,000 women in 2016 to 16.7 per 1,000 women in 2017. Abortion rates in the over 30s, however, have increased throughout this period.¹⁸ Within this overall trend, there are regional inequalities and a north-south divide. The three northern regions of England have the highest rates of teenage pregnancy, and rates in the North East are 64% higher than in the South West.

Our inquiry

7. We received over 90 submissions following our call for evidence, from a broad range of groups and individuals. We held two oral evidence sessions in which we heard from a range of stakeholders working in sexual health, including national organisations representing providers and commissioners and charities, along with senior officials and the Minister. We are very grateful to all those who gave oral and written evidence to us.

8. We were particularly keen to hear from individuals with experience of using sexual health services, as given the sensitivities around sexual health, it is an area where services users may have particular issues having their voices heard:

One of the issues around sexual health and contraception access, of course, is being brave enough to stand up and talk about it. If you have a bad experience with your hip replacement, you complain to your GP, the CCG board, the hospital, or whatever. If someone feels exposed and vulnerable because of their cultural or social background, they will find it much harder to stand up and say, “I had a really bad deal. I had to go through these hurdles and I could not get that contraception, and I had to have an abortion” with the embarrassment of all that. There isn’t a local voice in local areas saying that they need to get the service sorted out better.¹⁹

13 [Q2](#)

14 Public Health England ([SLH0087](#))

15 [Q2](#)

16 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#))

17 [Q22](#)

18 Office for National Statistics, [Conception statistics, England and Wales](#)

19 [Q38](#)

9. We therefore ran an online survey, from which we heard directly from nearly 400 service users about their experience of using sexual health services and improvements they would like to see. We have used quotations from service users to illustrate our points throughout the report, which can be found in ‘case examples’ boxes, and are indebted to those who took the time to share their experiences.²⁰

10. We are also extremely grateful to the service providers and commissioners who contributed to the inquiry. On Monday 11 February 2019 we visited two sexual health services in Plymouth—Sexual Health in Plymouth (SHiP), a hospital-based clinic, and The Zone, a community based, young people’s service. We also held a roundtable with a range of people working in sexual health in Plymouth. More information about our visit can be found in Annex 1.

11. Plymouth was also the venue for a series of highly informative focus groups we held with 20+ people working in sexual health drawn from across England. We are extremely grateful for the time they gave, the distance they travelled, and the frank and thoughtful contributions they made. More information about the visit and focus groups can be found in Annex 2.

Overview – a new national strategy

12. Sexual health services are part of public health services, and therefore funding and commissioning falls within the remit of local authorities' public health departments, rather than the NHS. However some aspects of sexual health (including, for example, contraceptive services provided by GPs, which is where the majority of women access this type of care) are commissioned differently, by CCGs; and other aspects (such as cervical screening) are subject to still different funding and provision arrangements.

13. An enduring theme in evidence to our inquiry was geographical variation in access to the highest standard of sexual health services. Variation is not an issue which is unique to sexual health, but is a problem shared by many services which are commissioned locally, as highlighted by a number of our previous reports, including Public Health Post-2013, Suicide Prevention, and the First 1000 Days. Local authorities have experienced large budget reductions in recent years; also in common with other services funded by local authorities, sexual health services have therefore faced significant funding cuts - of up to 40% in some areas - in the face of rising demand for their services.

14. Many stakeholders have told us that a new, national strategy is needed for sexual health, to help both providers and commissioners in their attempts to deliver sexual health services to a high quality and consistent level, in the face of the challenges of fragmented structures and reduced funding. The British Association of Sexual Health and the British HIV Association both call for “a new long-term strategy”, with the National AIDS Trust describing the need for ‘a comprehensive strategy for sexual health and HIV that links up stakeholders across the system’. Similarly, the Royal College of Nursing argue that “an updated Strategic Framework, with action and funding behind it and prevention at the core is necessary”.²¹ Jim McManus of the Association of Directors of Public Health put a national sexual health strategy as one of his top policy recommendations in oral evidence to us,²² and the Terrence Higgins Trust add further detail on why this is needed:

What I think we are lacking, and this is a responsibility of Public Health England, is an overarching piece of work around a sexual health strategy for England. The last document came out from the Department of Health was in 2013. It was just for the Department of Health, but what we need is a systems approach with Public Health England having a responsibility to lead, with the Department, clinicians and third sector organisations, so that we have a clear and ambitious sexual health strategy that will respond to some of the issues as to why we are seeing an awful increase in gonorrhoea and syphilis. We have the highest rates of syphilis since 1949, which is shocking. We have to make sure that leadership is provided, because currently we are operating in a bit of a vacuum.²³

15. We recommend that Public Health England, in collaboration with a broad-based working group of representatives drawn from all sectors involved in commissioning and providing sexual health services, should develop a new sexual health strategy,

21 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#)); NAT (National AIDS Trust) ([SLH0055](#)); Royal College of Nursing ([SLH0078](#))

22 [Q106](#)

23 [Q73](#)

to provide clear national leadership in this area. The rest of this report—covering funding, commissioning, services, prevention, and the sexual health workforce—sets out the key areas that this strategy should focus on.

1 Funding and commissioning

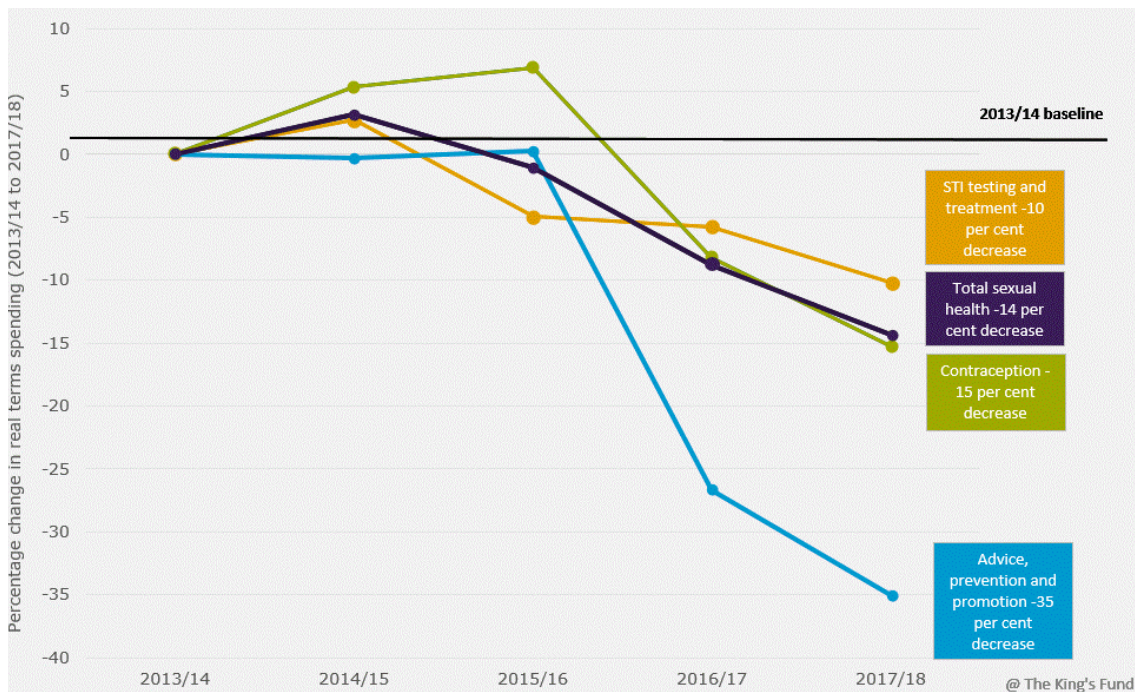
Introduction

16. Adequate levels of funding, effective commissioning and provision mechanisms are key to facilitating the delivery of services and other activities that enable people to have good sexual health outcomes. The evidence we have received indicates that both the level of funding and commissioning arrangements fall short of what is needed: funding is insufficient, and commissioning is fragmented. Notably, the extent of this insufficiency and fragmentation is variable across the country: some local authorities have invested in sexual health and some areas have worked collaboratively to overcome commissioning challenges, but in neither case is that the norm.

Funding cuts

17. Cuts to spending on sexual health have been severe. Sexual health is predominately funded through local authority public health budgets, and in recent years this spending has fallen significantly: there has been a 14% real terms reduction in local authority spending on sexual health between 2013/14 and 2017/18 (figure 1).²⁴ On our visit to Plymouth, we heard a sense of injustice that, unlike the NHS budget, local government public health spending was an “easy target for cuts”.²⁵

Figure 1: local authority spending on sexual health has decreased



Source: The King's Fund

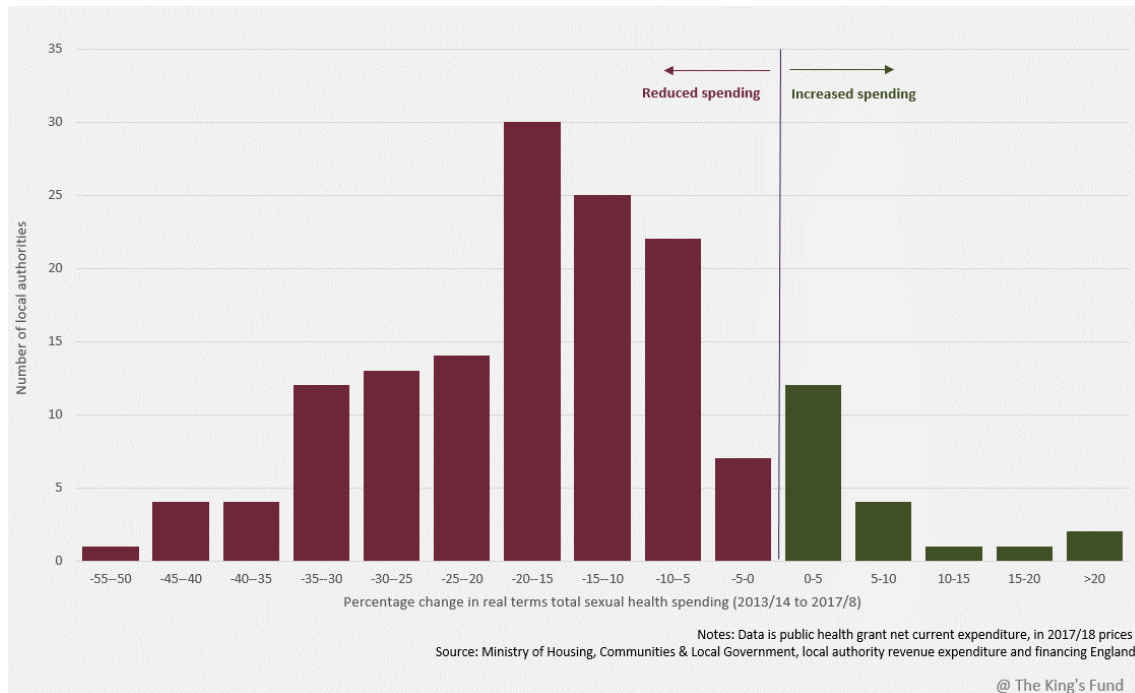
18. As the graph above shows, advice, prevention and health promotion have been particularly hard hit, with a 35% reduction in funding.

²⁴ The King's Fund, [Sexual health services and the importance of prevention](#)

²⁵ Annex 1

19. There has been significant variation in funding decisions taken by local authorities across the country. Whilst some have prioritised sexual health, and protected or increased spending, others have cut spending by considerably more than average (figure 2). Troublingly, this variation often does not reflect local need,²⁶ and there is a lack of national accountability for these local spending decisions.²⁷

Figure 2: changes in spending on sexual health varies between local authorities



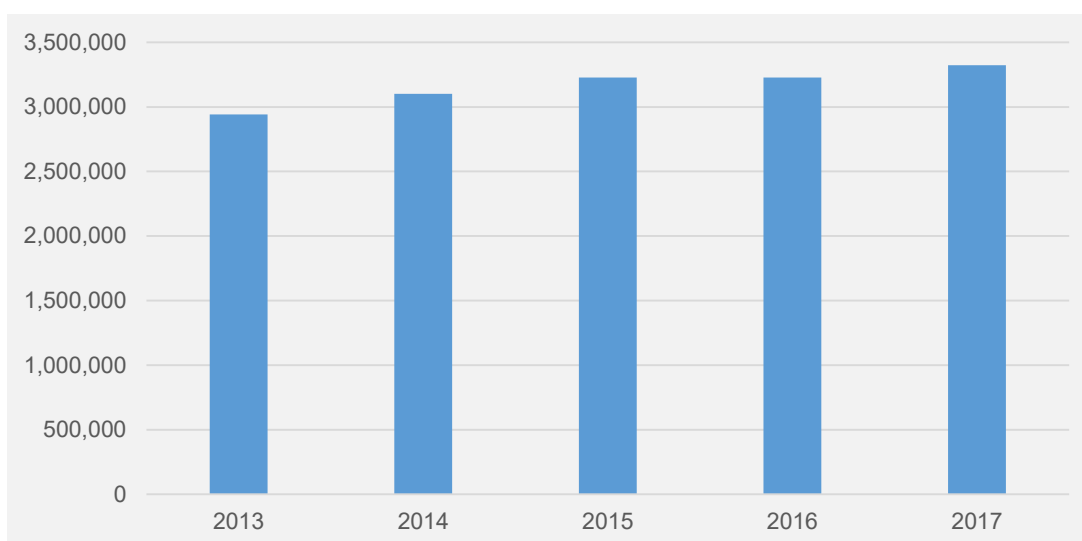
Source: The King's Fund

20. Compounding difficulties, budget decreases have happened in tandem with increasing demand: attendances at sexual health services in England have increased by 13% from 2.9 million in 2013 to 3.3 million in 2017 (figure 3).²⁸

26 British Medical Association ([SLH0005](#))

27 The King's Fund ([SLH0082](#))

28 Local Government Association ([SLH0050](#))

Figure 3: attendances at sexual health services have increased

Source: The Local Government Association

21. Councillor Ian Hudspeth, Chairman of the Community Wellbeing Board of the Local Government Association, stressed the challenge posed to local government:

Ultimately it comes down to the funding we have, and the increase in appointments as well, from 2.9 million to 3.3 million. With that upward curve and the reduction in funding, we are rising to the challenge, but it is difficult, and we would appreciate the cuts being reversed.²⁹

22. Providers and commissioners have also emphasised the challenge of reduced funding. The clear message we received was that persistent funding cuts have already had a negative impact on services. We heard that services are at risk of being cut back to the extent that they are unable to deliver fit-for-purpose, quality provision.³⁰ At our roundtable in Plymouth we heard that funding cuts are particularly affecting the ability of providers and commissioners to focus on anything beyond the minimum that is required of them - mandated STI testing and treatment services and contraception services. The funding for prevention activities and wider supportive services has reduced considerably, meaning that outreach services for vulnerable groups have been stripped back.³¹

23. The service users we heard from have told us that funding cuts are affecting both the quality of and their ability to access sexual health services (case examples 1).

29 [Q4](#)

30 [Q25](#)

31 Annex 1

Case examples 1: service user views on funding

Sexual health is so crucially important and funding is just being cut and cut. I would be on the phone trying to reach sexual health clinics that I didn't know had actually been closed down. (homosexual woman aged 25–35)

More funding is desperately needed. I am a student nurse and have been on the professional side from having a sexual health placement and also the patient side. Budget cuts mean Staff shortages and in turn means there are limited appointments available. (heterosexual woman aged 25–35)

It makes no sense to cut funding and expect infections to stay the same. If people don't get treatment in time infections will increase. More funding and more staff are needed. (homosexual man aged 46–60)

Source: Summary of survey responses received

24. The Minister for Public Health and Primary Care acknowledged that cuts had had an impact on services:

[In 2010] 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.³²

25. We heard about the short-termism of these cuts: that current funding cuts and the consequential effect on services represent a “false economy”³³ and “will only compound acute pressures for the NHS and other services”.³⁴ For example, at our focus group in Plymouth we heard that reduced HIV prevention activities, funded by local authorities, will lead to more cases of HIV and increase pressure on HIV treatment, funded by the NHS.³⁵ The NHS Long Term Plan recognises that funding for services such as sexual health interplay pivotally with the NHS, directly affecting demand for NHS services.³⁶

26. We reiterate the findings of our predecessors' report *Public health post-2013*, that cuts to public health are a false economy. Cuts have a detrimental impact on the delivery of public health services. This affects service users, and risks widening health inequalities. They also increase demand for NHS services and jeopardise their sustainability, as preventable ill health is not adequately managed.³⁷

27. We were concerned to hear “real and justifiable concerns that additional cuts will be applied to a sector now at breaking point”.³⁸ Speaking to these concerns, the Minister told us he would make “a very robust case for public health spending in the forthcoming spending review conversations.”³⁹

Fragmentation of commissioning

28. Our evidence was clear that the challenge is not solely in the amount of funding; mechanisms for its distribution and use are complex and fragmented. Professor John

32 [Q129](#)

33 Royal College of Nursing ([SLH0078](#))

34 Local Government Association ([SLH0050](#))

35 Annex 1

36 NHS, [Long Term Plan](#)

37 Health and Social Care Committee, [Public health post-2013](#)

38 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#))

39 [Q129](#)

Newton, Director of Health Improvement of Public Health England, and Professor Jim McManus, Vice President of the Association of Directors of Public Health, stressed that funding and fragmentation are of “equal importance,”⁴⁰ and that there is a particular need to address fragmentation given that it is the more readily remediable of the two:

There will never be as much money as we would like, I am sure, for these sorts of service, so it is essential to address the fragmentation.⁴¹

29. Since the implementation of the 2012 Health and Social Care Act, responsibilities for commissioning different elements of sexual health services have been split between local authorities, NHS England and clinical commissioning groups (CCGs) (figure 4).⁴² Breaking up interlinked services into different silos led to a greater number of system boundaries, relationships and funding pots to negotiate. Public Health England’s own review in 2017 recognised these failings and acknowledged that a more co-ordinated and collaborative commissioning model was needed.⁴³ Although efforts have been made to address these problems, our evidence was clear that fragmentation remains a significant obstacle to effective commissioning.

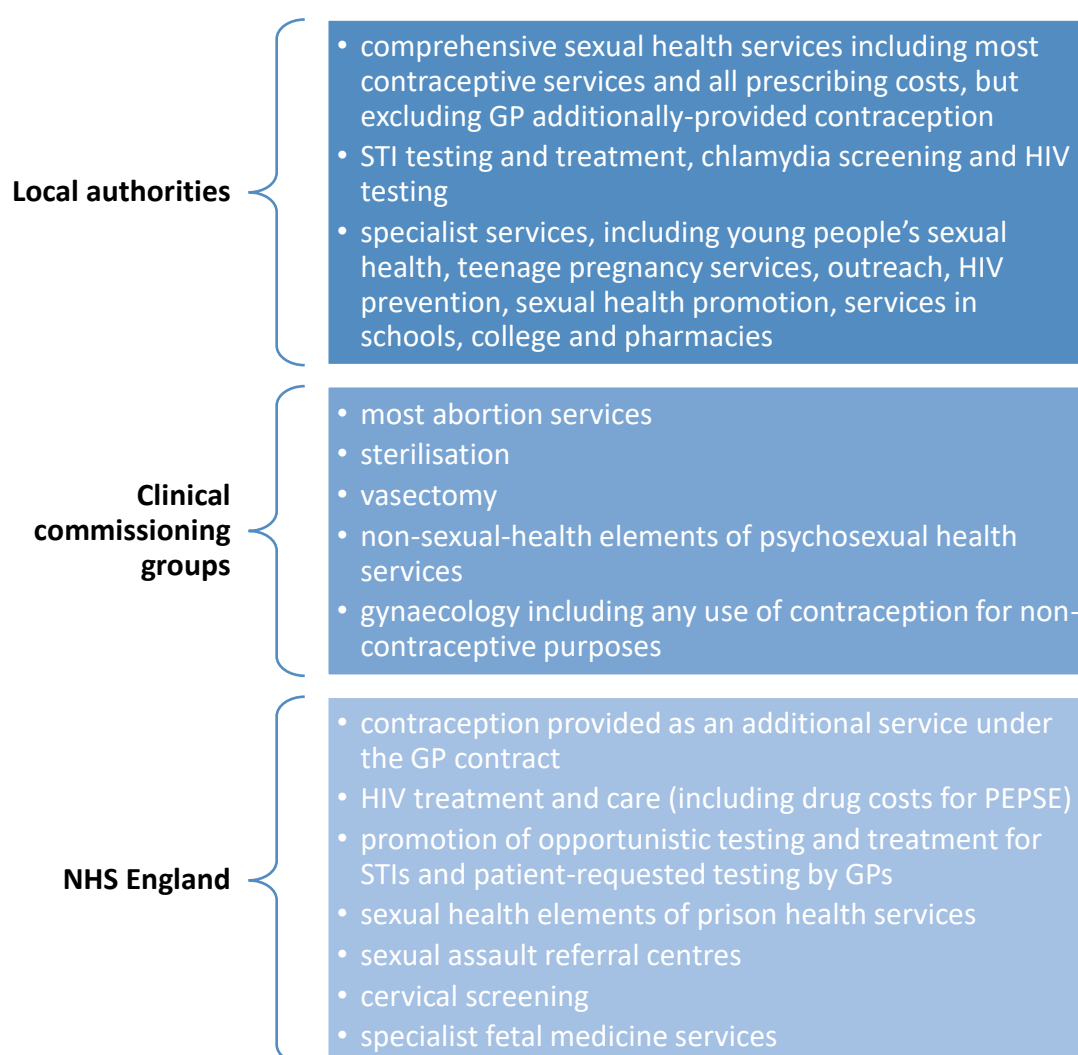
40 [Q110](#)

41 [Q110](#)

42 Public Health England, [Commissioning local HIV sexual and reproductive health services](#)

43 Public Health England, [Sexual Health, Reproductive Health and HIV: A Review of Commissioning](#)

Figure 4: commissioning responsibilities



Source: Public Health England

30. Collaborative, whole-system working between commissioners is essential to ensure robust care pathways for service users.⁴⁴ The difficulties caused by the current fragmented commissioning arrangements are well known to those working in this area and the national bodies that seek to support them. In 2017 Public Health England and the ADPH published a review of commissioning highlighting the difficulties posed and making recommendations to support commissioners in tackling them. Their recommendations included piloting more collaborative approaches to commissioning; developing further guidance to support commissioners; supporting commissioners through networks and workshops; and improvements to data.⁴⁵

31. PHE and the ADPH told us that 'some progress' had been made in implementing these recommendations.⁴⁶ The evaluation of the two collaborative commissioning pilots

44 Local Government Association ([SLH0050](#))

45 Public Health England, [Sexual Health, Reproductive Health and HIV: A Review of Commissioning](#)

46 [Q111](#)

is due to be published shortly. However, it is clear that there is still wide geographical variation in the extent to which local areas are able to commission and provide sexual health services effectively.

32. We heard that some areas have overcome systemic fragmentation to work collaboratively and deliver an approach that follows patient need. On our visit to Plymouth we saw an example of integrated working. We were told they “made it work” in the face of structural difficulties through close cooperation between providers, local authorities, the CCG and the NHS. Services were co-commissioned from pooled budgets. This level of collaboration had enabled services to be designed and planned in a way that spotted opportunities for services to connect.⁴⁷ In our focus group we heard that another area had similarly developed an integrated approach, operating a lead provider consortium model.⁴⁸

33. Our evidence has also been clear that, conversely, there are many areas where commissioning is not working well. In such instances, often, cooperation between commissioners is lacking. Professor McManus told us that “some of [his] members cannot get some parties to the table for love nor money.”⁴⁹

34. Difficulties with cross-charging were given as an example of commissioning challenges. Local authorities have a legal duty to provide STI testing and treatment, and contraception services, to someone whether or not they are a resident of the local authority. Patient flows are significant: in 2016 34% of first attendances and 29% of follow up attendances at sexual health services were by out-of-area residents.⁵⁰ Traditionally STI testing and treatment services have been charged by the provider back to the areas where the user is a resident (cross-charging), but contraception services have been absorbed by the host commissioner. The Department’s updated 2018 guidance on cross-charging states that it is a matter for local agreement whether cross-charging or host-funding is used for contraception, and “increasingly, areas are finding solutions that work for them.”⁵¹ At our focus group, however, we heard that areas are not finding solutions that work for them, and that guidance is “completely inadequate”. Some local authorities refuse to be cross-charged for contraception. One area anticipates a cost pressure of £230,000 to £250,000 if it is unable to successfully cross-charge for contraception. We also heard that this year some local authorities are even refusing to be cross-charged for STI testing and treatment. Cross-charging can also be taken as a demonstration of inconsistency and variability of approaches, as at our focus group we also heard that this was less of an issue in London as 31 boroughs worked together collaboratively on this issue.⁵²

35. Commissioning complexities mean services are falling through the gaps. This problem is exemplified by the potentially damaging commissioning arrangements around cervical screening. Cervical screening is the commissioning responsibility of the NHS. At our roundtable in Plymouth we heard that it is difficult to fund sexual health clinics to provide cervical screening because “the funding pots were split so resolutely” following the 2012 Act.⁵³ Troublingly, cervical screening in sexual health clinics has more than halved between 2013 and 2016, with many services restricting or removing their

47 Annex 1; Plymouth City Council ([SLH0023](#))

48 Annex 2; see also Derbyshire County Council ([SLH0020](#))

49 [Q110](#)

50 Department of Health and Social Care, [Sexual Health Services: Key Principles for Cross Charging](#)

51 Department of Health and Social Care, [Sexual Health Services: Key Principles for Cross Charging](#)

52 Annex 2

53 Annex 2

offer. Attendance for cervical screening is at a 20-year low, and it is clear that complex commissioning arrangements have contributed to this public health problem, particularly limiting opportunities for cervical screening in sexual health clinics.⁵⁴ It is unacceptable for women to have to undergo entirely unnecessary separate intimate examinations for smear tests that could have been carried out at the same time as an STI screen or contraceptive fitting at a single visit.

36. Long-acting reversible contraception (LARC)—injections, implants and intrauterine devices and systems—is another example of a service for which commissioning arrangements are leading to unacceptable outcomes. LARC is one of the most effective forms of contraception,⁵⁵ but use is relatively low at around 14% of women. This has been in part attributed to reduced provision in primary care due to commissioning issues. LARC is the commissioning responsibility of local authorities. Whilst local authorities pay for the contraceptive device itself, GPs feel that payment does not cover the full costs of providing the service as they are not always reimbursed for their time.⁵⁶

37. Councillor Hudspeth told us that the key to where commissioning is and is not working is collaborative relationships between commissioners:

It is about the relationship between local authorities, CCGs and the acute hospitals. If you all have the ability to work together to provide the right outcome, and focus on that, rather than people saying, “This is our domain and our silo,” that is where the benefits are. Everybody has to think about the funding they have, which will always be limiting, and make best use of it, by saying, “Actually, if it’s over there, it’s slightly better than if it is in this box.”⁵⁷

38. Professor Newton believed that concerning commissioner behaviour could be addressed within current structures but this requires concerted effort:

Where there is good collaboration, the problems can be solved, but collaboration is not easy, and it requires work and leadership.⁵⁸

Tendering and procurement

39. We heard mixed evidence around the tendering and procurement process. The process requires staff to divert significant amounts of time away from clinical care to deliver tender submissions, in an environment where many clinics are already under-resourced.⁵⁹ Dr Williams told us that it usually takes one consultant out of the service for two or three months.⁶⁰ This challenge is compounded by the frequency with which providers are required to carry out this exercise, due to short contracts—every three years in Plymouth.⁶¹ On our visit to Plymouth we heard that “the same things across the

54 DHSC ([SLH0044](#))

55 Bayer Plc ([SLH0025](#))

56 Faculty of Sexual and Reproductive Healthcare (FSRH) ([SLH0027](#)); Royal College of General Practitioners ([SLH0075](#))

57 [Q35](#)

58 [Q106](#)

59 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#)); Annex 2

60 [Q49](#)

61 Annex 2

country are being replicated over and over again,” which seems to be an unnecessary, time-consuming burden, with administrators having to be employed on both sides, solely to manage the contracting process.

40. There are also concerns about the outcomes of this process. We heard that whilst it is entirely reasonable to encourage services to be delivered in a cost-effective manner, competitive tendering has had a destabilising effect as competition has stifled the ability for providers to develop collaborative networks and relationships.⁶² We also heard that short-term contracts inhibit long-term service planning.

41. Conversely, we heard that tendering and procurement, if done well, drives up quality.⁶³ We also heard that, under current arrangements, longer-term contracts are possible. Professor McManus told us that the contract in his area is eight years, and there are a number of other places with contracts of a similar length. We were told that more sustainable funding would allow for longer contracts of this type.⁶⁴ Attendees at our focus groups in Plymouth were strongly in favour of longer contracts, up to eight or ten years, but many were still having to work within much shorter contracting arrangements.

42. What is clear is the unacceptable variation in experience of commissioning and tendering across the country. There is a need to build up good practice,⁶⁵ and more should be done to support commissioners nationally. There remain too many examples of service users being disadvantaged because of a failure of collaborative working across systems in their best interests. Some areas have shown that this joint working is possible but it should not have to be the time consuming and uphill struggle. National and local leaders should be assisting in identifying and clearing the barriers to good practice.

Structural changes

43. The NHS Long Term Plan stated that “the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services” due to close links between these services and NHS care.⁶⁶

44. We heard some calls to move responsibility for sexual health back to the NHS. These calls were largely based on the perception that sexual health services would be better funded under the NHS, as public health is an easy target for cuts.⁶⁷ Dr Williams also gave reasons why clinicians would want to move back to the NHS: “most doctors would say that they wanted to be back in the NHS” as “that is where they historically are comfortable”.⁶⁸

45. We are not convinced by these arguments. We reiterate the findings of our predecessors’ report, *Public health post-2013*, which welcomed the move of public health to local authorities in 2013. The report noted that local authorities are well placed to deliver public health objectives across their communities and in doing so can harness a far wider network of individuals who can help to improve public health. Our predecessors recognised the confusion and fragmentation of the public health system following the

62 Annex 2

63 [Q184](#)

64 [Q104](#)

65 [Q104](#)

66 NHS, [Long Term Plan](#)

67 Annex 2; Royal College of Nursing ([SLH0078](#))

68 [Q28](#)

2012 Act, but concluded that further large-scale restructuring is inadvisable.⁶⁹ Another structural change could lead to further instability, which would be counter-productive to service delivery.⁷⁰ Professor McManus highlighted that it took eighteen months for the system to settle down after the previous reorganisation.⁷¹

46. We have also heard broad agreement that the root of the problem is not where commissioning responsibilities sit, but the adequacy of funding. On that basis, moving sexual health back into the NHS would not address the key issue at hand. As Dr Williams argued:

we want adequately funded services, regardless of where they sit. Rearranging the deckchairs is not the issue; it is about fundamentally putting in the right package of money.⁷²

47. However, as our previous reports have shown, a system where services are commissioned locally inevitably leads to local variation. Some degree of local variation is appropriate, reflecting the different needs of different populations. However, the variation evident in the commissioning and provision of sexual health services—where people in one local area have access to the latest preventative treatment for HIV and those in the adjacent area do not; and where commissioners in some areas are able to work collaboratively to provide cervical screening within sexual health services, but others are not—clearly shows that acceptable standards are not being met in all areas, and that further support and direction for commissioners is needed.

48. We heard from the Association of Directors of Public Health that a single, agreed, national set of quality standards would be a useful tool to standardise practice and improve quality;

There is currently no single joined-up view of what good looks like... there is no single national set of quality standards, or minimum service specifications.⁷³

49. Agreed standards—spanning all types of sexual health provision—would also provide a clear basis for benchmarking and monitoring local areas' performance. In our reports on suicide prevention, we recommended a strong and clear quality assurance process to strengthen scrutiny of local authorities' performance on suicide prevention. This recommendation is now being implemented via a national quality assurance process of monitored self-assessment. This has resulted in a high level of local authority engagement with this issue, and an independent evaluation of the learning from this process is to be published shortly.⁷⁴

Conclusions and recommendations

50. Cuts to spending on sexual health have been severe. Local authority spending on sexual health services has decreased by 14% between 2013/14 and 2017/18. This has

69 Health and Social Care Committee, [Public health post-2013](#)

70 The King's Fund ([SLH0082](#))

71 [Q106](#)

72 [Q25](#)

73 [Q124](#)

74 [Suicide prevention follow up inquiry](#), Health and Social Care Committee, January 2019

happened in tandem with mounting demand. Attendances at sexual health clinics have increased by 13% over the same period. Inevitably, resources are stretched, and the sector has been described as “at breaking point.” This has inescapably affected the delivery of services and, ultimately, outcomes for service users.

51. There is a need to also address the unacceptable variation in joint collaborative working across commissioning. The reasons for this need to be addressed including by making sure all areas are supported to follow the best practice.

52. Sexual health must be sufficiently funded to deliver high quality sexual health services. Cuts to spending on sexual health, as with other areas of public health expenditure, are a false economy. Looking forward to the Spending Review, the Government must ensure sexual health funding is increased to levels which do not jeopardise people’s sexual health. Inadequate prevention and early intervention increase overall costs to the NHS.

53. As part of work to develop a new national sexual health strategy, we recommend that the national sexual health working group should set out the minimum levels of spending that will be required to ensure that all local areas are able to deliver high quality services.

54. Commissioning mechanisms fall short. Fragmented, seemingly unnavigable commissioning responsibilities have had a damaging impact on the delivery of sexual health services. This has had a harmful impact on outcomes for service users, a prime example of which is the nonsensical situation with cervical screening.

55. Nonetheless, we do not support calls for responsibility for sexual health services to be returned to the NHS. Efforts would be better directed at making the existing framework work, and supporting joined-up commissioning. Rather than either the NHS or local authorities taking sole responsibility, work should be done towards developing a joined-up system where nothing gets through the cracks. We have heard this conclusion before, and past actions have been insufficient to achieve the required change.⁷⁵

56. A wholesale reorganisation of commissioning responsibilities—moving responsibility for sexual health back to the NHS—is not the answer to the problems with commissioning which our witnesses have identified. As our predecessors concluded in their report on *Public health post-2013*, there is a need to address system boundary issues in the best interests of patients. Strengthened collaboration is key, and longer contracts should be introduced to enable better strategic planning and to lessen the burden that tendering currently imposes.

57. The difficulties in delivering effective, joined up sexual health commissioning are well known, and Public Health England and the Association of Directors of Public Health have taken steps to address them through the actions set out in their 2017 review. But despite these efforts, there is still marked variation in how well local areas are able to commission sexual health services, and to work collaboratively. **The national sexual health strategy, supported by a senior working group, must bring new impetus to work to drive forward change and improve services for patients.**

58. **Recognising the complexity of the provider and commissioner landscape in sexual health, the national sexual health working group should consist of senior representation from all relevant groups, including PHE, NHS England, local government, patient representatives, CCGs, and different provider groups.**
59. **Building on the recommendations set out by the ADPH and PHE 2017 review, the strategy should aim both to identify and to disseminate best practice, and to work supportively but robustly with areas which need to improve.**
60. **The strategy should set out one clear set of national quality standards for commissioners to adhere to, encompassing all aspects of sexual health. The standards should provide a holistic and unified overview of what good looks like, including setting out how all services should work together, and setting out standards for effective commissioner behaviour. Further recommendations for what these quality standards should include are set out in subsequent chapters.**
61. **The national sexual health strategy should also set out a clear framework through which local areas will be assessed against the quality standards, with the findings made public both to ensure best practice is widely shared, and to increase public accountability.**

2 Services

62. Sexual health services have been described by the Local Government Association as at ‘tipping point’.⁷⁶ This situation is ascribed to increased demand in the face of reduced funding and fragmented commissioning. There are issues around accessibility, especially for groups particularly vulnerable to poor sexual health outcomes. There are concerns about quality of care, and the provision of certain services is inadequate and inequitable.

Quality of care

63. The service users we heard from broadly praised the care provided by staff, telling us that they had been kind, reassuring and non-judgemental. Service users also noticed that staff were under pressure, and that this affects services (case examples 2). Professor McManus highlighted that unmanageable pressures on staff can mean that they are unable to “go the extra mile” for service users:

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.⁷⁷

Case examples 2: service user views on quality of care

The quality of care I received following a sexual assault was incredible. I was looked after, everything was explained to me and they didn’t rush me. (bisexual woman aged 18–24)

As a man living with HIV for the past 6 years I have had almost uniformly excellent care, from health workers who are knowledgeable, considerate and highly professional. (homosexual man aged 36–45)

Quality of care: faultless – all clinical staff are friendly, professional, and non-judgemental. I think that many people who attend a sexual health clinic are scared or anxious, but the staff at [redacted] are amazing. (heterosexual woman aged 18–24)

The staff are always friendly but they clearly are stressed out with more patients to see. (homosexual man aged 46–60)

Source: Summary of survey responses received

Accessibility

64. Accessibility was the primary concern of the service users we heard from. They reported difficulties booking appointments, long waits at walk in sessions, impractical opening times, inconvenient locations and closures.

76 Local Government Association ([SLH0050](#))

77 [Q109](#)

Case examples 3: service user views on accessibility

At one clinic booking was almost impossible. You could only get an appointment in a two minute window twice a week before all were booked. Another clinic's system said they would phone back to book an appointment, and they never did.

It's hard to get an appointment with my GP surgery as you have to book three weeks in advance. (bisexual woman aged 18–24)

Even though I arrived as early as possible I still had to wait for a good 4 hours before getting an appointment, I was so happy with the service but the wait time was crazy for a midweek appointment. (bisexual woman aged 18–24)

Also most sexual health clinics are only open at specific times during the week, often a weekday during the day. This means that I would have to take time off work to attend. (heterosexual woman aged 25–35)

A few years ago I could get an appointment in several clinics quite easily, now I have to try and book appointments and a lot of the old clinics I visited have shut down. (homosexual man aged 46–60)

I would feel more confident to go to a clinic but they are far from where I live. (heterosexual woman aged 18–24)

Source: Summary of survey responses received

65. This patient perception is echoed in reports from those providing sexual health services. Written evidence from individual practitioners suggests that service closures are a problem in many parts of the country:

- i) In London seven services closed in the last year;⁷⁸
- ii) In Dorset one walk-in service closed, five outreach clinics closed, two evening clinics at the hospital closed and a LGBT service moved to smaller, less convenient premises;⁷⁹ and
- iii) In Surrey one service closed, resulting in patients having to travel additional distances to access remaining services.⁸⁰

66. Services that have remained open also report problems with access—in a recent membership survey carried out by BASHH, 54% of respondents reported that access to their service had decreased, and 63% of respondents reported that they have to turn away patients on a weekly basis.⁸¹ Dr Williams described how “some services across the UK are turning away more than 50 people a week; they cannot physically see them in the department, because there is no capacity.”⁸² Evidence from Public Health England agrees that there has been a reduction in access:

78 Dr Matthew Grundy-Bowers ([SLH0030](#))

79 Dr Alison Vaughan ([SLH0079](#))

80 Dr Amy Bennett ([SLH0073](#))

81 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#))

82 [Q15](#)

Evidence from a survey of lead GUM physicians suggests that, while the majority of clinics could still offer appointments within 48 hours, there has been a decline in access for symptomatic patients and even lower levels of access for asymptomatic women.⁸³

67. Reductions in access are also apparent in relation to contraceptive services. The Advisory Group on Contraception found that almost half of councils in England have closed sites providing contraceptive services since 2015. Public Health England states that one-third of women are not able to access contraception from their preferred provider.⁸⁴

68. According to the Royal College of GPs, services in one area can be vastly different to another, which has led to “disrupted, disconnected and ultimately disappointing experiences for patients.”⁸⁵ We have heard this from service users.⁸⁶

69. Good access to sexual health services is not only a matter of patient convenience. Sexual health services are essentially preventative services - diagnosing and treating an STI promptly helps prevent onward transmission, and good access to effective contraception services helps prevent unplanned pregnancies.

70. One area of provision that has expanded overall is online services such as self-testing and postal prescribing.⁸⁷ BASHH argued that

Where sexual health has been really innovative over the last year is in adopting modern technology. It has embraced and empowered the patient group to take self-testing on board and to get text results.⁸⁸

71. We heard in detail about the digital sexual health service being set up in Plymouth, and it was also described by service users in our online survey:

Case examples 4: service user views on online services

More online testing services as it is difficult to attend clinics when working full time and they're often full up. Some boroughs have online services, and this should be free to all across the country. People are probably more likely to check their sexual health if they can do it in the convenience of their home without having to find time to attend a packed clinic that doesn't offer appointments. (heterosexual woman aged 25–35)

Source: Summary of survey responses received

72. While there was broad support for increasing online services, we heard that they should not be driven by cost savings or commissioned in isolation or in lieu of existing services:

The shift to online testing has been reasonably successful, but it is not appropriate for everyone - those who are digitally excluded, for example. There are people who actually have multiple concerns about their sexual

83 Public Health England ([SLH0087](#))

84 Public Health England ([SLH0087](#))

85 Royal College of General Practitioners ([SLH0075](#))

86 [Experiences and perspectives of individuals using sexual health services](#), Health and Social Care Committee

87 London Councils ([SLH0049](#))

88 [Q50](#)

health, and going down a questionnaire and being sent an online test is not the most appropriate thing for them. There are people who have language barriers, and all sorts of things.⁸⁹

73. Clinicians and commissioners at our focus group agreed that it should not be seen as a “silver bullet”.⁹⁰

Vulnerable groups

74. Problems with accessibility disproportionately affect certain population groups, to the extent that some groups have inadequate access to sexual health services. Professor Newton told us that vulnerable groups—intravenous drug users, rough sleepers, recent migrants and victims of sexual violence—find it most difficult to access services.⁹¹ Witnesses also told us that groups who are disproportionately affected by poor sexual health outcomes—young people, MSM and BAME—struggle to access some services.⁹² We heard that the most vulnerable, chaotic or deprived are the ones that often cannot navigate the financial, social or cultural hurdles to access services. The changes in access described above, such as service closures, have particularly troublesome impacts on these groups.⁹³ The Royal College of GPs gave us this example:

I work in the centre of Bradford, where the cuts hit the most deprived most severely, because they cannot always negotiate the social, cultural or financial factors; they cannot navigate the hurdles put in their way when access is changed. We know that increased inequalities are occurring across the system, with reduced access ... women with busy lives, either working or with children, cannot go from one service to another because they just do not have the time. They neglect their own health.⁹⁴

75. This was echoed by the Faculty of Sexual and Reproductive Health:

What happens then is that the most vulnerable in our society suffer; the woman with the pram cannot navigate her way through the system and get access to her needs. As a consequence, the use of long-acting, reversible contraception—there is good NICE guidance suggesting that it is the best form—is decreasing.⁹⁵

76. Nearly half of respondents to a recent survey conducted by the British Association of Sexual Health and HIV reported a reduction in the provision of care to vulnerable populations.⁹⁶ In recent years sexual health service contracts have become larger, and may be predominately designed with the majority in mind, lacking incentives to seek out complex, hard-to-reach patients, who need longer and more frequent consultations.⁹⁷ Targeted service provision, including outreach and other forms of assertive provision, has reduced. Marion Wadibia, Chief Executive of the NAZ Project London, told us that

89 Dr Williams, [Q15](#)

90 Annex 2

91 [Q102](#)

92 [Qq61–65](#)

93 [Q4](#); [Q10](#)

94 Royal College of General Practitioners ([SLH0075](#))

95 [Q3](#)

96 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#))

97 SHRINE (Sexual and Reproductive Health Rights, Inclusion and Empowerment) ([SLH0021](#))

... the tailored and targeted approach that we know works with smaller groups and those who do not necessarily come forwards has been absolutely decimated.⁹⁸

77. We heard that although there is a place for a more universal approach, it should not be at the expense of targeted service provision.⁹⁹ Targeted provision is important for meeting the needs of specific population groups: the skills, knowledge and networks of targeted services mean they can better reach and support the specific groups they serve.¹⁰⁰ As Marion Wadibia said, “something needs to be relevant to you.”¹⁰¹ The NAZ Project London noted that their service’s grounding in BAME experiences of race, culture and sexuality—that they ‘spoke the language’ of their service user—was key to the service’s success.¹⁰² Brook told us that limiting provision specifically for young people leaves them to ‘fend for themselves’ in adult services. Adult services generally do not have the same kind of expertise, so safeguarding issues may be missed.¹⁰³ Regarding the LGBT experience, we heard from Stonewall that whilst LGBT people reported being discriminated against by health services in general, in fact their experience was more positive in sexual health services than in other types of health service.¹⁰⁴ However inequalities exist within the LGBT population, with gay and bi women and trans people less likely to access sexual health services than gay and bi men, and more likely to report poor experiences.¹⁰⁵

78. Witnesses told us that more needs to be done to ensure that services are designed in a way that meets the needs of all groups. We heard that a needs assessment that identifies the requirements of the local population, including the specific needs of certain groups, must be the base from which a service is built.¹⁰⁶ Services must be designed around meeting the needs identified, so that there is a pathway for every population.¹⁰⁷ We heard that the best commissioners currently do this, but that it must be done as standard.¹⁰⁸ Local accountability (for example to health and wellbeing boards) is currently not adequate to ensure that happens, pointing to a need to strengthen accountability at the national level.

Conclusions and recommendations

79. There is no doubt that care is being delivered by committed professionals, and service users told us the quality of care they received was good. However, access to sexual health services is worsening and is a particular problem for vulnerable groups. To address this, national quality standards should be developed, setting out in detail a consistent basis for best practice across the country. These standards should be developed by the national sexual health working group in consultation with service providers and patients. As a minimum they must cover access, and the provision of services which meet the needs of vulnerable populations.

98 [Q66](#)

99 [Q62](#); [Q66](#)

100 Brook ([SLH0032](#))

101 [Q72](#)

102 Naz Project London ([SLH0090](#))

103 Brook ([SLH0032](#))

104 Laura Russell, [Q65](#)

105 Laura Russell, [Q65](#)

106 Brook ([SLH0032](#)); Stonewall ([SLH0056](#)); [Q104](#); [Qq73–75](#)

107 [Q106](#)

108 Annex 2; [Q104](#)

Testing and screening

80. Currently there are gaps in testing for certain emerging STIs. The integrated sexual health tariff has pathways to fund testing for chlamydia, gonorrhoea, HIV, syphilis and hepatitis A and B. However, funding is not directly there for trichomoniasis vaginitis (TV), an infection that increases the risk of HIV acquisition in women if untreated. This particularly affects BAME women and we have heard that it should be tested in a targeted way, including through online testing.¹⁰⁹

81. Funding is also not provided for testing for mycoplasma genitalium (MG). MG is a growing concern: the lack of testing for MG is causing it to be incorrectly diagnosed and treated as chlamydia, which is leading to anti-microbial resistance. Lack of funding for MG testing was particularly raised by attendees at our focus groups.¹¹⁰

82. We heard that although some sexual health services are testing for MG and TV without funding, the majority of sexual health services are not, given the increased costs associated with doing so.¹¹¹

83. A further concern is around testing the antimicrobial sensitivities of gonorrhoea, to ensure appropriate treatment and prevent the development of antimicrobial resistance, as Dr Williams described:

Quite a lot of clinics do not have access to culture for gonorrhoea, so they treat someone with gonorrhoea blindly, in a way, not knowing what their antimicrobial sensitivities are.¹¹²

84. PHE agreed that there was ‘variability’ in the availability of these tests.¹¹³

85. Funding is not currently provided for testing for mycoplasma genitalium (MG) and trichomoniasis vaginitis (TV) STIs. Although some sexual health services are testing for MG and TV without funding, the majority of sexual health services are not, given the increased costs associated with doing so. This is a significant concern. We are equally concerned by the fact that full testing for gonorrhoea is not available in all STI clinics, potentially fuelling the rise in multi-drug resistant, untreatable strains of this serious illness. All STI clinics should be funded to provide a full range of STI testing, including MG, TV and gonorrhoea, and this should be clearly set out in the national quality standards.

Cervical screening

86. As cervical screening rates have fallen to a 20-year low, it is clear that every opportunity to offer screening to women should be maximised. However, we were told about the absurd situation in some areas, where a patient having a coil fitted at a clinic cannot have a smear test done at the same time, even when they need a smear test and the clinician is trained to do it, because fragmented commissioning arrangements mean that many sexual health clinics are not funded to provide cervical screening:

109 Brook, [Q67](#)

110 Annex 2

111 Imperial College Healthcare NHS Trust ([SLH0076](#))

112 BASHH, [Q8](#)

113 [Q139](#)

In my clinic last week I saw a patient for a complex coil fitting. She was due her smear but I could not do it. I am able to do it, because I am a trained colposcopist, but the commissioning arrangements are such that the service is unable to provide the smear.¹¹⁴

87. This is not only a wasted opportunity for testing and an inefficient use of resource, but it is distressing for the patient to have multiple intimate examinations. Dr Connolly, Clinical Champion for Women’s Health of the Royal College of General Practitioners described it not only an “insult that a woman has to be examined so many times” but in fact an “assault”.¹¹⁵

88. Inequalities in access to cervical screening were raised as an issue by attendees at our focus groups, and Public Health England echoed these concerns. When we put these concerns to NHS England we were told that concerted action was now being taken to address this problem, and that they will be introduced as a standardised part of commissioned services by 2021.

89. Cervical screening is a life-saving intervention for a cancer which is largely preventable, yet still claims two lives a day. However, cervical screening rates have fallen to a 20-year low. We were shocked to hear how fragmented commissioning arrangements mean that in some parts of the country, women are not able to have cervical screening done at the same time as other sexual health provision.

90. Cervical screening must be clearly included as part of national quality standards for sexual health. But there is a need for more urgent action on this issue to save lives and prevent women having to undergo a second examination for a test that could and should be completed at a single visit. We call on PHE and NHS England to set out what immediate actions they are taking to address this in their response to this report.

Long Acting Reversible Contraception

91. Long Acting Reversible Contraception (LARC) is the most effective type of contraception available, and more widespread availability and promotion of LARC has been credited, at least in part, with reducing teenage pregnancy rates.

114 [Q11](#)

115 [Qq10-11](#)

Long Acting Reversible Contraception [LARC]

There are four long acting reversible contraception methods – intrauterine device/ system, contraceptive injection or implant. Once any of these are in place, you don't have to think about contraception each day or time you have sex.

- Contraceptive implant – a small flexible rod inserted under the skin of the upper arm. It slowly releases progestogen into the body, stopping the release of an egg from the ovary.
- Contraceptive injection – also releases progestogen into the body and last between eight and 13 weeks depending on which one you have.
- Intrauterine device/ system (IUD/ IUS) – a small T-shaped copper or plastic device that is inserted into the womb. It works by stopping the egg and sperm from surviving in the womb or the fallopian tubes.

Source: iCASH

92. However complexities in commissioning and funding have contributed to a reduced provision of LARC in primary care, which is where the majority of women access contraceptive services. The RCGP state that GPs are not financially incentivised to deliver an enhanced, or even core, provision of contraceptive services, and describe a reversal in the quality of clinical care: “we are going back quite a long way from the benefits we were seeing from good access to all contraception.”¹¹⁶

93. Service users told us about issues around contraceptive services delivered by primary care (case examples 5).

Case examples 5: service user views on contraception

I believe that most contraception should be available in GP's, like the injections, pills and possibly the implant as they are all fairly simple procedures and would save a lot of people a lot of time. (heterosexual woman aged 18–24)

GP services on contraception vary massively between the two areas I have lived. In [redacted] I was never invited to consider any other type of contraception except for the pill. On moving to [redacted] I was invited to consider a whole range of other contraception and decided to go for the IUS [intrauterine system] coil, which was then fitted within the GP surgery. (bisexual individual aged 18–24)

Source: Summary of survey responses received

94. At our focus group, we heard about good practice in extending access to GP-based provision of care in one part of the country, but reductions in many other areas.

95. Long Acting Reversible Contraception (LARC) is the most effective way of preventing unplanned pregnancy, and its more widespread availability has been credited with reducing teenage pregnancy rates. However, we are very concerned to hear that because of changed commissioning and funding arrangements, many women are no longer able to access some forms of this method of contraception, leading to a 13% drop in its use. Action must be taken to reverse this worrying trend. Access to LARC at all locations where sexual and reproductive health services are provided—including primary care—must form a key part of the national quality standards.

Pre-Exposure Prophylaxis for HIV

96. HIV pre-exposure prophylaxis (PrEP) is a medication taken to ensure individuals vulnerable to HIV acquisition remain HIV negative, and has been shown to be fully effective.¹¹⁷

97. In 2016, following the finding in the PROUD trial of an 86% reduction in new infections in MSM taking PrEP, NHS England announced a decision not to put it on the list of specialised commissioning treatments, arguing that it did not have the power to do so, and claiming that HIV prevention was the responsibility of local government. Several commentators disagreed at the time, and the National AIDS Trust, arguing that under the Health and Social Care Act 2012, NHSE could commission services directly, requested a judicial review by the High Court. This, and a subsequent appeal, determined that the NHS did have the power to provide PrEP.

98. NHS England is currently undertaking a PrEP Impact Trial to address outstanding questions around need, uptake and duration of use. NHS England and the Department told us that it will be important to examine the findings of the trial before national roll out, including around specific population groups, financial implications, any impact on STI rates and consequential system pressures, and any other unintended effects.

99. NHS England allocated £10 million for this trial, full results from which will be available in early 2020. NHS England and the Department argue that it will be important to examine the findings of the clinical trial before national roll out. Some interest groups have called for PrEP to be rolled out faster than proposed. The National AIDS Trust (NAT) call for a programme starting in April 2019.¹¹⁸ The Terrence Higgins Trust also calls for routine commissioning of PrEP as a matter of urgency, and in the meantime, scrapping the cap on trial places.¹¹⁹ Attendees at our focus groups laid bare the geographical inequities in access to PrEP,¹²⁰ and we also heard from service users about this:

Case examples 6: service user views on PrEP

PrEP needs to be available on the NHS in England. I asked for it but I was told that the trial was full up and that I would have to buy PrEP online at some cost. I am unable to afford this and so I feel let down by NHS England for not being able to provide a service which is otherwise available elsewhere on the UK. (homosexual man aged 25–35)

The NHS should provide more funding and places for the PrEP trial in England. This is a drug that while it has a cost now, in the long run will save the NHS significantly more by not having to pay for HIV management medication. (homosexual man aged 36–45)

Source: Summary of survey responses received

100. There is huge frustration amongst both patients and clinicians about the current inequitable access to PrEP, a new treatment which can prevent HIV. We note that NHS England has expanded its pilot sites to increase the number of people able to benefit from PrEP, but access remains a postcode lottery. We call on NHS England to review whether it is unreasonably restricting access to PrEP due to disputes about funding

117 Terrence Higgins Trust ([SLH0048](#))

118 NAT (National AIDS Trust) ([SLH0055](#))

119 Terrence Higgins Trust ([SLH0048](#))

120 Annex 2

pathways rather than questions about its effectiveness. PrEP should also be covered within the national quality standards—if it is deemed to be an effective and cost-effective treatment it should be universally available.

3 Prevention

101. Prevention is central to achieving good sexual health outcomes. Prevention covers both activities that encourage healthy behaviours and changes that reduce the risk of poor sexual health outcomes, for example countering the influence of pornography on what young people see as normal, which witnesses to this inquiry told us is increasing risk. Government's rhetoric around prioritising prevention must translate into action in this area. Education is a key aspect of prevention, and Government's plans for new Relationships and Sex Education (RSE) are an opportunity to correct a long-running inadequacy, and properly equip young people with the knowledge base they need to look after their sexual health.

Behavioural trends

102. Concerning trends in sexual health are driven not only by poor access to services, but by behavioural change. Significant increases in syphilis and gonorrhoea in particular have largely been attributed to behavioural factors.¹²¹ There has been a drop in condom use, with some 47% of people not using a condom for their first sexual experience with a new partner.¹²² These are complex social trends, differing by age, sexual orientation and perceived gender.¹²³

103. On our visit to The Zone, a young people's community-based clinic in Plymouth, we heard that many young people are getting their education through pornography. This is informing their expectations of sex and influencing what they perceive as acceptable. Condomless sex, different types of sex, such as anal sex, and rougher sex have become increasingly normalised. These behaviours, without the use of appropriate protection, increase the risk of poor sexual health.¹²⁴

104. We also heard about changes in how people are meeting sexual partners. We were told that apps have led to more casual sexual encounters, which can mean there is less communication and less negotiation of safe sex, which increases STI transmission.¹²⁵ The geo-spatial nature of these apps also means that STIs are increasingly passed between what would have otherwise been disconnected sexual networks.¹²⁶ Dr Williams pointed out that apps can also make it difficult for an individual, if they find they have an STI, to inform their partner:

Part of the growth is how people access their sexual partners. I won't blame the internet or apps, but it is often due to the fact that a profile disappears; someone meets up with someone, hooks up, and then the profile disappeared. It is impossible for that person then to inform the person that have had sex with about their condition, which means that they can go on unwittingly to transmit.¹²⁷

121 [Q85](#)

122 [Q2](#)

123 [Q89](#)

124 Annex 1

125 Annex 1

126 [Q89](#)

127 [Q5](#)

Prioritisation and funding

105. In the face of concerning behavioural trends, instead of gearing up to address them, Government and local authorities have deprioritised prevention. Professor Newton told us that:

The longer we neglect this aspect of the agenda, the more we will have behaviourally driven issues sideswipe us, such as chemsex.¹²⁸

106. As shown previously (figure 1), prevention has taken the brunt of cuts to the sexual health budget. There has been a 35% real terms reduction in local authority spending on sexual health advice, prevention and promotion between 2013/14 and 2017/18, compared to a 14% decrease in local authority spending on sexual health overall.¹²⁹ Advice, prevention and promotion is inherently susceptible to disinvestment as, unlike STI testing and treatment and contraception services, they are not mandated services which local authorities are required by law to provide.¹³⁰ At our roundtable in Plymouth providers and commissioners told us that it has been hard not to prioritise treatment services in the face of increasing demand and reduced funding. Treatment services were described as an “at-the-door pressure”—service users turn up and need to be treated. Prevention, meanwhile, was described as easier to lose sight of—these activities are less noticeable in the immediate term.¹³¹ Therefore it is particularly important to ensure that there is robust accountability for the provision of preventative services.

107. Disinvestment in prevention is short-sighted because pays for itself in a whole-system, total cost sense, but not necessarily for individual commissioners. Financial incentives for prevention are not lined up: one part of the system can do an excellent job preventing a poor sexual health outcome, but the savings made averting this negative outcome are gained in a different part of the system. For example, if a local authority prevents someone from acquiring HIV, the NHS reaps the benefit as it does not have to fund HIV treatment for this person. Conversely, if someone is not given good prevention advice and PrEP if applicable, and then acquires HIV, the NHS will pay the significant lifetime cost of treatment. Dr Menon-Johansson, Clinical Director of Brook, highlighted the need to address this, and stated that money saved through prevention should be put back into prevention:

Because the funding streams are not linked, people do not think about how prevention really does pay for itself. It is the best investment we have, and we need to make sure that the money comes back. Every time we stop another [case of] HIV, that money should be coming back into prevention services. We are talking millions of pounds over the country.¹³²

108. The lack of emphasis on prevention in sexual health runs directly against the Government’s ambition to prioritise prevention. This imbalance must be redressed, and Government’s stated position must translate into action. As we heard at our focus group in Plymouth, the Government must “put its money where its mouth is.”¹³³ The service

128 [Q94](#)

129 The King’s Fund, [Sexual health services and the importance of prevention](#)

130 The King’s Fund ([SLH0082](#))

131 Annex 2

132 [Q70](#)

133 Annex 2

users we heard from reiterated this point (case examples 7). **We welcome the Minister’s indication that prevention in sexual health will be a central part of the prevention Green Paper, and we expect the Government to set out in the response to this report how that commitment will be followed through into action, including the funding required to put it into practice.**¹³⁴

Case examples 7: service user views on prevention

Government talks about prioritising prevention in its new NHS long term plan yet cut the public health budget weeks before – sexual and reproductive health care appears not to be a priority for the Government and therefore doesn’t receive the necessary funding to empower people to exercise informed choice and make responsible decisions regarding their own sexual and reproductive health. (heterosexual woman aged 25–35)

Source: Summary of survey responses received

Education and information

109. Good education is a vital part of the sexual health prevention agenda. People must have the information they need to look after their sexual health. For example, they need to know that they should think about getting tested if they have condomless sex.¹³⁵ We have heard examples of successful programmes. Professor Newton told us about Rise Above, a programme done with PSHE teachers which moves beyond the traditional approach and aims to equip young people with skills to face challenges around new technology and pornography.¹³⁶ However, programmes such as these are not consistently available in all parts of the country.¹³⁷ This was highlighted by the service users we heard from (case examples 8).

Case examples 8: service user views on education and information

I received lots of sex and contraception information at school and university which I rely on, and the fact that not everyone received the same as me shocks and terrifies me. (bisexual woman aged 18–24)

Where I live in London, I often come across public information adverts (especially regarding testing for HIV and other STDs), which I believe are helpful for informing about services available and reducing the stigma around these things. However, I don’t think I have ever come across such a campaign in the rural area where my family home is and where I live when I am not studying. Growing up in the countryside, I felt that sexual health information and services were much less accessible. (bisexual woman aged 18–24)

Source: Summary of survey responses received

110. We heard that the “glaring omission”¹³⁸ in the current system is that young people are not being educated in a way that helps them make intelligent choices. As stated previously, young people are getting their education through pornography, which has troubling effects on sexual behaviours and health.¹³⁹ The current lack of good relationships and

134 [Q129](#)

135 [Q5](#)

136 [Q91](#)

137 [Q94](#)

138 [Q94](#)

139 Annex 1

sex education (RSE) at school means people are at risk from an early age, as they are not building a strong knowledge base from which to make informed decisions throughout their life. As Ian Green, Chief Executive of the Terrence Higgins Trust, told us:

It is absolutely vital. If we want a society where good sexual health is a right for all, it starts with good-quality relationship and sex education.¹⁴⁰

111. We are pleased that the Government has brought forward plans for RSE. This is a welcome initiative that has been a very long time coming¹⁴¹ and presents an opportunity to ensure young people are given the knowledge, skills and values they need to look after their sexual health. It will be important to ensure the substance of this is up-to-scratch: we have heard “the devil is in the detail”.¹⁴² Evidence to our inquiry argues that this education must be age-appropriate, culturally competent, strong on diversity and inclusion, and up-to-date with medical advances.¹⁴³ It also indicates that RSE should link up with local authorities and local providers to enable teaching to be informed by local health priorities and point to local services.

112. RSE must be delivered by people who are adequately trained to do so. On our visit to Plymouth we heard that “you wouldn’t want just anyone to teach maths, so why would you have just anyone teach RSE?” Schools are already stretched, and will need support to deliver RSE effectively. Dr Menon-Johansson stressed that schools should bring in outside, third sector support where needed to “ensure that the quality is there across the board for all young people.”¹⁴⁴

113. We heard persuasive arguments supporting a strong stance on participation. Speaking about calls to allow parents to withdraw children Professor Newton stated:

My tendency would be to resist [calls to allow patents to withdraw children], unless there are very good cultural or religious grounds ... I urge whoever is making those decisions to allow as many children as possible to benefit from it.

... 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.

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.¹⁴⁵

114. We were pleased to hear that the Minister said he is confident that parents will not be able to deprive their children of the sort of education they would need later in life to help them avoid STIs. The Minister gave a personal view regarding teaching trans and LGBT issues:

140 [Q77](#)

141 [Q77](#)

142 [Q77](#)

143 [Qq77-80](#)

144 [Q77](#)

145 [Qq98-99](#)

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 opinions around that or anything else, political or otherwise. I think that young people should be taught exactly what 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.¹⁴⁶

115. The Local Government Association raised concern about what happens when young people leave school. The number of STI diagnoses in young people increase significantly after school leaving age, in the 20–24 age group: in 2015 there were 78,066 new STI diagnoses in 15 to 19-year olds, compared to 141,060 in 20 to 24-year olds.¹⁴⁷ Witnesses told us that there should be a consistency of approach when you leave school, and that young people need to know where to go next, and what that will look like.¹⁴⁸ Ian Green argued:

Everybody, regardless of age, needs good, up-to-date sexual health information. It is the responsibility of all of us to provide that.¹⁴⁹

Conclusions and recommendations

116. Prevention is a vital aspect of the sexual health agenda, particularly in the face of concerning behavioural trends that are leading to poor sexual health outcomes. Lamentably, investment and practice does not reflect the importance of prevention.

117. Prevention—activities that encourage healthy behaviours and changes that reduce the risk of poor sexual health outcomes—must be prioritised and adequately funded. Prevention is—or should be—an integral part of all sexual health provision, and the new national quality standards should therefore include preventative interventions within all aspects of sexual health.

118. Good sexual health starts with good Relationships and Sex Education (RSE). The Government’s new plans for RSE present an opportunity to correct a longstanding inadequacy, and to lay the foundations for young people to make intelligent, informed sexual health decisions throughout their lives.

119. The Government must take a strong line on participation in Relationships and Sex Education (RSE). Public health arguments are overwhelmingly in favour of ensuring that all children have appropriate RSE.

120. Furthermore, relationships and sex education should be

- **high quality—in particular, age-appropriate, culturally competent, strong on diversity and inclusion, and up-to-date with medical advances;**
- **delivered by appropriately qualified people; and**
- **linked appropriately and usefully to local health priorities and local services.**

In its response to this report, the Government should indicate what steps it is taking to ensure that each of these recommendations is being implemented.

146 [Q192](#)

147 Local Government Association ([SLH0050](#))

148 [Q77](#)

149 [Q80](#)

4 Workforce

121. Securing a safe, well trained, supply of staff is imperative to the delivery of good sexual health services. The sexual health workforce is varied and includes a broad range of medical and non-medical, specialist and non-specialist staff providing services from hospital, primary care and community settings:

- Specialist clinicians are trained in either Community Sexual and Reproductive Health (CSRH) or Genitourinary Medicine (GUM).
- Non-medical staff working in these services are mainly nurses, midwives, allied health professionals, sexual health advisers, administrative and clerical staff and healthcare scientists, with some physician assistant roles also emerging.
- Many other health professionals, such as GPs, practice nurses, school nurses, health visitors and pharmacists, provide sexual health services as part of their wider roles.

122. Over the course of our inquiry we have heard first-hand from staff about the pressures they face around system change and rising demand, and concerns about the impact of pressures on morale, retention and recruitment.

Morale

123. Morale amongst the sexual health workforce is low.¹⁵⁰ The British Association of Sexual Health and HIV describe staff morale as at “breaking point”. Of respondents to their 2018 members survey, 81% reported that staff morale had decreased within their service in the past year with 49% reporting that staff morale had greatly decreased.¹⁵¹

124. This situation is attributed to the pressures the workforce faces: organisational change, funding cuts, heavy demand and service closures have put pressure on staff. Practitioners at our focus group in Plymouth told us that working in sexual health was seen as insecure, and staff feel uncertain about the future of sexual health services. We heard that the sexual health workforce feel a lack of parity with NHS staff.¹⁵² The British Association of Sexual Health and HIV told us the experience of their members:

Demand for the service continues to increase, we have high levels of sickness and staff are exhausted

All staff have experienced adverse reactions and our complaints and incidents have risen significantly.¹⁵³

Retention and recruitment

125. Low morale has contributed to challenges in retention and recruitment: uncertainties and pressures in the sector have made working in sexual health less attractive to both

150 [Q51](#); Royal College of Nursing ([SLH0078](#))

151 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#))

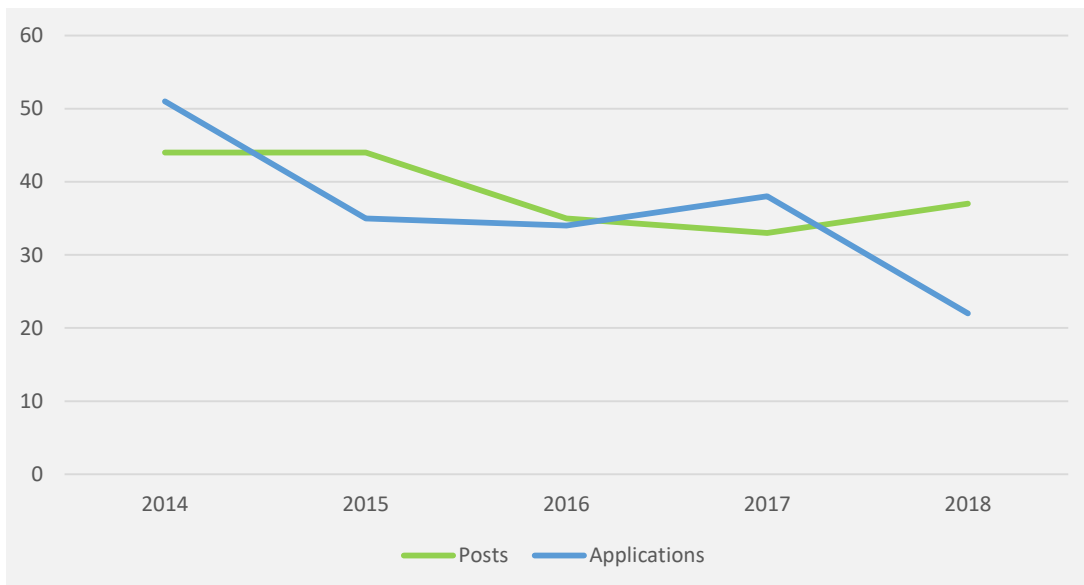
152 Annex 2

153 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#))

new and existing staff.¹⁵⁴ The current workforce is ageing and leaving.¹⁵⁵ A diminishing pipeline of staff makes this situation particularly challenging. 65% of respondents to the British Association of Sexual Health and HIV’s 2018 survey reported that it had become more difficult to recruit appropriate staff in the past year.¹⁵⁶ People are not being trained to replace the skills lost when people retire. CSRH and GUM consultants play a key leadership role in supporting the nursing and general practice workforce to deliver all aspects of sexual health. The Faculty of Sexual and Reproductive Health argue that the sexual health consultant workforce is in a “succession crisis” and estimate that one-third of this workforce could retire in the next 5 years.¹⁵⁷

126. As a specialty GUM used to be very competitive, but there has been a crash in demand for GUM specialisation, and now it is the least popular. The Specialist Advisory Committee for Genitourinary Medicine told us that recruitment to GUM training programmes is in “crisis” and “doctors no longer wish to train as Genitourinary Medicine Specialists due to the career instability.” The output of training falls short of replacing vacancies that will arise due to retirement. Applications to training posts have declined, and in 2018 less than 40% of posts advertised were filled (figure 5).¹⁵⁸

Figure 5: applications to GUM training posts have decreased



Source: Specialist Advisory Committee for Genitourinary Medicine

127. In contrast, CSRH speciality training programmes are competitive, yet also still fall short of replacing vacancies, let alone address the fact that current numbers are

154 Royal College of Nursing ([SLH0078](#)); Annex 2

155 [Q51](#); Annex 2

156 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#))

157 Faculty of Sexual and Reproductive Healthcare (FSRH) ([SLH0027](#))

158 Annex 1; Specialist Advisory Committee for Genitourinary Medicine, Joint Royal College of Physicians Training Board ([SLH0029](#))

inadequate.¹⁵⁹ The Royal College of Nursing states that the recruitment of nurses is also a key area of concern, with members reporting that sexual health is not regarded as attractive to new staff.¹⁶⁰

Training

128. Retention and recruitment difficulties are exacerbated by diminished training opportunities: limited learning and development opportunities feed into the decreasing attractiveness of working in sexual health.¹⁶¹ Training across multi-disciplinary teams is vital, but training is falling through the gaps.¹⁶² We heard that although services would like to build capacity and develop the clinical and wider workforce, they are not incentivised to invest in training. At our roundtable in Plymouth clinicians told us that taking time out, and finding the money, to do specialist training in the context of an overstretched service is challenging.¹⁶³

129. The Royal College of GPs raised significant concerns around training to develop and maintain competency in LARC fittings. As discussed previously, LARC is one of the most effective forms of contraception but use is relatively low. This has been in part attributed to reduced provision in primary care due to problems with commissioning and funding. We have also heard that access to training in the provision of LARC is a factor. The Primary Care Women's Health Forum found in 2017 that almost one-third of respondents had seen reduced access to training to provide LARC. The Royal College provided anecdotal evidence from a GP in England:

With GP recruitment so difficult now, gone are the days when a new GP had to have SH qualifications. Our last 2 appointments do not have SRH experience. I am the sole LARC fitter to a practice population of 11,500 and aim to retire in a few years' time.¹⁶⁴

130. We have heard that the move to local authority commissioning and competitive tendering has exacerbated issues around training—the NHS prioritise training to a greater extent.¹⁶⁵ Training is not included in service specifications, and an organisation may win a contract to provide a service and not take part in training programmes.¹⁶⁶ We were told that providers should not be able to 'opt out' of training in this way.¹⁶⁷

131. The Minister recognised that training the future sexual health workforce is an issue that is falling through the gaps. The Minister assured us that the Harding review—the development of the workforce plan to go alongside the NHS Long Term Plan—would take a joined-up approach to the future workforce. The Minister stated that this review would look at sexual health, including the issue of providers being able to 'opt-out' of training.¹⁶⁸

159 Faculty of Sexual and Reproductive Healthcare (FSRH) ([SLH0027](#))

160 Royal College of Nursing ([SLH0078](#))

161 Royal College of Nursing ([SLH0078](#))

162 [Q51](#)

163 Royal College of General Practitioners ([SLH0075](#))

164 Royal College of General Practitioners ([SLH0075](#))

165 Annex 2

166 [Q41](#)

167 Annex 2

168 [Qq201–205](#)

Conclusions and recommendations

132. Development of the sexual health workforce, including training, has been given insufficient priority. Training across multi-disciplinary teams is vital, but is falling through the gaps in the face of other pressures providers face.

133. It is clear that fragmented arrangements for the commissioning and provision of services have meant that workforce planning, development and training have suffered. The Harding review should set out a deliverable plan for the workforce needed to deliver sexual health services across England in the next 10 years. Meanwhile, the national sexual health strategy should include a clear programme of further action to re-establish training and development for both the current and future sexual health workforce at the heart of commissioning and provision arrangements.

Conclusions and recommendations

Overview – a new national strategy

1. We recommend that Public Health England, in collaboration with a broad-based working group of representatives drawn from all sectors involved in commissioning and providing sexual health services, should develop a new sexual health strategy, to provide clear national leadership in this area. The rest of this report—covering funding, commissioning, services, prevention, and the sexual health workforce—sets out the key areas that this strategy should focus on. (Paragraph 15)

Funding and commissioning

2. Sexual health must be sufficiently funded to deliver high quality sexual health services. Cuts to spending on sexual health, as with other areas of public health expenditure, are a false economy. Looking forward to the Spending Review, the Government must ensure sexual health funding is increased to levels which do not jeopardise people's sexual health. Inadequate prevention and early intervention increase overall costs to the NHS. (Paragraph 52)
3. As part of work to develop a new national sexual health strategy, we recommend that the national sexual health working group should set out the minimum levels of spending that will be required to ensure that all local areas are able to deliver high quality services. (Paragraph 53)
4. A wholesale reorganisation of commissioning responsibilities—moving responsibility for sexual health back to the NHS—is not the answer to the problems with commissioning which our witnesses have identified. As our predecessors concluded in their report on *Public health post-2013*, there is a need to address system boundary issues in the best interests of patients. Strengthened collaboration is key, and longer contracts should be introduced to enable better strategic planning and to lessen the burden that tendering currently imposes. (Paragraph 56)
5. The national sexual health strategy, supported by a senior working group, must bring new impetus to work to drive forward change and improve services for patients. (Paragraph 57)
6. Recognising the complexity of the provider and commissioner landscape in sexual health, the national sexual health working group should consist of senior representation from all relevant groups, including PHE, NHS England, local government, patient representatives, CCGs, and different provider groups. (Paragraph 58)
7. Building on the recommendations set out by the ADPH and PHE 2017 review, the strategy should aim both to identify and to disseminate best practice, and to work supportively but robustly with areas which need to improve. (Paragraph 59)
8. The strategy should set out one clear set of national quality standards for commissioners to adhere to, encompassing all aspects of sexual health. The standards should provide a holistic and unified overview of what good looks like, including

setting out how all services should work together, and setting out standards for effective commissioner behaviour. Further recommendations for what these quality standards should include are set out in subsequent chapters. (Paragraph 60)

9. The national sexual health strategy should also set out a clear framework through which local areas will be assessed against the quality standards, with the findings made public both to ensure best practice is widely shared, and to increase public accountability. (Paragraph 61)

Services

10. There is no doubt that care is being delivered by committed professionals, and service users told us the quality of care they received was good. However, access to sexual health services is worsening and is a particular problem for vulnerable groups. To address this, national quality standards should be developed, setting out in detail a consistent basis for best practice across the country. These standards should be developed by the national sexual health working group in consultation with service providers and patients. As a minimum they must cover access, and the provision of services which meet the needs of vulnerable populations. (Paragraph 79)
11. Funding is not currently provided for testing for mycoplasma genitalium (MG) and trichomoniasis vaginitis (TV) STIs. Although some sexual health services are testing for MG and TV without funding, the majority of sexual health services are not, given the increased costs associated with doing so. This is a significant concern. We are equally concerned by the fact that full testing for gonorrhoea is not available in all STI clinics, potentially fuelling the rise in multi-drug resistant, untreatable strains of this serious illness. All STI clinics should be funded to provide a full range of STI testing, including MG, TV and gonorrhoea, and this should be clearly set out in the national quality standards. (Paragraph 85)
12. Cervical screening is a life-saving intervention for a cancer which is largely preventable, yet still claims two lives a day. However, cervical screening rates have fallen to a 20-year low. We were shocked to hear how fragmented commissioning arrangements mean that in some parts of the country, women are not able to have cervical screening done at the same time as other sexual health provision. (Paragraph 89)
13. Cervical screening must be clearly included as part of national quality standards for sexual health. But there is a need for more urgent action on this issue to save lives and prevent women having to undergo a second examination for a test that could and should be completed at a single visit. We call on PHE and NHS England to set out what immediate actions they are taking to address this in their response to this report. (Paragraph 90)
14. Long Acting Reversible Contraception (LARC) is the most effective way of preventing unplanned pregnancy, and its more widespread availability has been credited with reducing teenage pregnancy rates. However, we are very concerned to hear that because of changed commissioning and funding arrangements, many women are no longer able to access some forms of this method of contraception, leading to a 13% drop in its use. Action must be taken to reverse this worrying trend. Access to

LARC at all locations where sexual and reproductive health services are provided—including primary care—must form a key part of the national quality standards. (Paragraph 95)

15. There is huge frustration amongst both patients and clinicians about the current inequitable access to PrEP, a new treatment which can prevent HIV. We note that NHS England has expanded its pilot sites to increase the number of people able to benefit from PrEP, but access remains a postcode lottery. We call on NHS England to review whether it is unreasonably restricting access to PrEP due to disputes about funding pathways rather than questions about its effectiveness. PrEP should also be covered within the national quality standards—if it is deemed to be an effective and cost-effective treatment it should be universally available. (Paragraph 100)

Prevention

16. We welcome the Minister's indication that prevention in sexual health will be a central part of the prevention Green Paper, and we expect the Government to set out in the response to this report how that commitment will be followed through into action, including the funding required to put it into practice. (Paragraph 108)
17. Prevention—activities that encourage healthy behaviours and changes that reduce the risk of poor sexual health outcomes—must be prioritised and adequately funded. Prevention is—or should be—an integral part of all sexual health provision, and the new national quality standards should therefore include preventative interventions within all aspects of sexual health. (Paragraph 117)
18. The Government must take a strong line on participation in Relationships and Sex Education (RSE). Public health arguments are overwhelmingly in favour of ensuring that all children have appropriate RSE. (Paragraph 119)
19. Furthermore, relationships and sex education should be
 - high quality—in particular, age-appropriate, culturally competent, strong on diversity and inclusion, and up-to-date with medical advances;
 - delivered by appropriately qualified people; and
 - linked appropriately and usefully to local health priorities and local services.

In its response to this report, the Government should indicate what steps it is taking to ensure that each of these recommendations is being implemented. (Paragraph 120)

Workforce

20. It is clear that fragmented arrangements for the commissioning and provision of services have meant that workforce planning, development and training have suffered. The Harding review should set out a deliverable plan for the workforce needed to deliver sexual health services across England in the next 10 years. Meanwhile, the national sexual health strategy should include a clear programme

of further action to re-establish training and development for both the current and future sexual health workforce at the heart of commissioning and provision arrangements. (Paragraph 133)

Annex 1: Visit to Plymouth

On Monday 11 February 2019 the Health and Social Care Committee visited Plymouth in connection with their inquiry into sexual health. The following Members and staff attended:

Committee members

Dr Sarah Wollaston (Chair); Rt Hon Ben Bradshaw; Diana Johnson; Johnny Mercer; Dr Paul Williams.

Staff

Laura Daniels, Senior Committee Specialist; Dr Joe Freer, Clinical Fellow; Victoria Pope, Inquiry Manager.

Introduction

The visit programme was arranged by Laura Juett, Public Health Specialist at Plymouth City Council. The Committee are extremely grateful for the time and effort put into hosting the visit by Laura and by the wide range of others who contributed, and for the generous welcomed that was extended to them by Cllr Ian Tuffin, portfolio holder for health and social care at Plymouth City Council; by the Council's public health specialists; by managers and clinicians at University Hospitals Plymouth NHS Trust; and by the staff of the Zone.

Why Plymouth?

The Committee places a high value on meeting those directly involved in the planning and provision of services in their own local areas to hear first hand about the challenges being faced and the innovations being adopted in delivering health and social care. The Committee is also committed to meeting service providers from as wide a range of areas as possible, and following recent visits to services in Lancashire, Yorkshire and Essex, was keen to hold a visit in the South West of England.

Recorded rates of sexually transmitted infections in Plymouth are high when compared to similar areas. In 2017, the rate of all new STI diagnoses was the 28th highest out of 326 local authorities in England. Overall, 2,860 new STIs were diagnosed in residents of Plymouth, a rate of 1,090.1 per 100,000 residents (compared to 743 per 100,000 in England).

In response to the challenges of increasing demand for health and social care services, complexity of need and severe financial pressures Plymouth formed an integrated commissioning function in April 2015. This whole system approach is characterised by joint strategic leadership, an integrated fund (including the Public Health Grant), shared financial framework and risk share arrangements and a series of joint commissioning strategies.

It is within this context that the council re-commissioned sexual health services in 2017. Following detailed discussions with legal and procurement experts the council used a negotiated procedure to work with existing providers of sexual health services to design

a new integrated model of provision and ensure continuous improvement and cost efficiencies. More detail about the Plymouth experience can be found in their written submission.

Who the Committee met and what they heard about

SHiP

The Committee began their visit at the SHiP sexual health centre based at Derriford Hospital, part of University Hospitals Plymouth NHS Trust. The visit was hosted by Dr Derval Harte (Consultant in Sexual Health and HIV Medicine) and Keith Chapman (Care Group General Manager, Women and Children's), and provided Members with an opportunity to see a working clinic; to discuss demand/capacity, innovation and integration, and to see a demonstration of the online service.

Other attendees included Anne James, Chief Executive, University Hospitals Plymouth (UHP) NHS Trust; Megan Griffiths, Consultant Sexual and Reproductive Health; Dr David Pao, Consultant in Sexual Health and HIV; Emma Collins, Sexual Health Nurse Consultant; Debbie George, Admin Lead; and Kath Williams, Matron.

The Zone

The Committee then visited the Zone, a charity which provides free and confidential information and support to young people in the centre of Plymouth. Its drop in service offers young people emotional support and information around housing, sexual health and mental health and the options available to them.

The visit, where the Committee met Mike Jarman, Chief Executive, Jodie Frost, Emotional Health and Wellbeing in Schools Lead; and Lucy Green, Sexual Health Project Lead - gave Members the opportunity to see a young people's service being delivered in a different setting, and to discuss the importance of whole systems approach, prevention, community based approaches and to hear first hand about the challenges and issues facing young people in Plymouth.

Roundtable discussion

Finally, the Committee attended a roundtable discussion with a wide range of people involved in commissioning and providing sexual health services in Plymouth.

Attendees included:

Cllr Ian Tuffin, Portfolio Holder for Health and Social Care, Plymouth City Council; Dr Ruth Harrell, Director of Public Health, Plymouth City Council; Laura Juett, Public Health Specialist, Plymouth City Council; Dave Schwartz, Public Health Specialist, Plymouth City Council; Dr. Shelagh McCormick, Chair, Western Locality, NEW Devon Clinical Commissioning Group; Dr. Derval Harte, Consultant in Sexual Health and HIV Medicine SHiP-UHP NHS Trust; Keith Chapman, Care Group General Manager, Women and Children's, UHP NHS Trust; Dr. Megan Griffiths, Consultant Sexual and Reproductive Health SHiP-UHP NHS Trust; Zoe Warwick (title); Mike Jarman, Chief Executive, SHiP - The Zone; Jodie Frost, Progeny Lead-Emotional Health and Wellbeing in Schools, SHiP-

The Zone; Lucy Green, Project Lead—Sexual Health, SHiP–The Zone; Emma Collins Sexual Health Nurse Consultant; Shelley Shaw, Development Support Officer, NSPCC, Together for Childhood; Matilda Fraser, Vice President Welfare and Diversity, University of Plymouth Student Union; and Nick Cook, Strategic Children’s Services Manager/Care Journey Services Barnardos.

The session gave the Committee the opportunity to hear views on a wide range of issues including the public health grant and financial challenges; commissioning of sexual health services; innovations and whole systems approaches; accountability; prioritising prevention; workforce; primary care; and Relationships and Sex Education and the impact of pornography.

Annex 2: Sexual health focus groups– frontline experiences of commissioning and providing services

On Monday 11 February 2019 the Health and Social Care Committee visited Plymouth in connection with their inquiry into sexual health. During the morning the Committee visited sexual health services in Plymouth and heard specifically about the Plymouth experience.

In the afternoon, the Committee invited a wide range of people involved in delivering and commissioning frontline sexual health services. Patient representatives were also invited. The attendees came from a variety of professional backgrounds, and travelled from eleven different areas of the country.

The Committee is extremely grateful to all those who attended for their frank, positive and expert contributions. In particular the Committee would like to express sincere thanks to the many attendees who travelled long distances to attend the event. We are also indebted to Plymouth City Council for providing the venue and giving assistance with the practical arrangements.

Participants

Attendees with experience of commissioning and providing sexual health services

Kate Horne, Senior Programme Manager, Calderdale Council

Dr Emily Hosfield, General Practitioner, Birmingham

Sarah Aston, Advanced Public Health Practitioner, Torbay Council

Dr Michael Brady, London Sexual Health Providers Group

Dr Lisa Haddon, consultant in sexual health, Royal Cornwall Hospital

Paul Jamieson, Lead Officer Public Health, Wigan Council

Yasmin Dunkley Prevention and Testing Manager, Positive East, London

Natalie Slayman-Broom, Business Manager, Umbrella Integrated Sexual Health Services, Birmingham

Mike Passfield, Head of Integrated Contraception & Sexual Health (iCaSH), Cambridgeshire

Mary Hague, Public Health Lead, Sexual and Reproductive Health, Derbyshire County Council

Dr Amy Evans, Lead Clinician and Consultant in Genitourinary Medicine and HIV, Leeds Teaching Hospitals Trust

Rebecca Spencer: General Manager, Integrated Sexual Health Services, Derbyshire Community Health Services NHS Foundation Trust

Dr Gillian Holdsworth, Director, SH:24

Liz Sawyer, patient representative, Healthwatch Surrey

Derval Harte, Consultant in Sexual Health and HIV Medicine, Plymouth University Hospitals NHS Trust

Laura Juett, Senior Public Health Specialist, Plymouth City Council

Committee members

Dr Sarah Wollaston (Chair); Rt Hon Ben Bradshaw; Diana Johnson; Johnny Mercer; Dr Paul Williams.

Staff

Laura Daniels, Senior Committee Specialist; Dr Joe Freer, Clinical Fellow; Victoria Pope, Inquiry Manager.

Discussion

Services

Services were described by some as being in ‘**crisis**’ and at ‘**breaking point**’. It was felt that there were no areas left in which further efficiencies could be made—services identified as ‘low hanging fruit’ had already been cut.

The emergence of **AMR in gonorrhoea** and **increases in syphilis**—with some areas reporting that rates of syphilis had tripled—were described.

Inequities were described in the provision and availability of many aspects of sexual health services, meaning that these were available in some areas but not in others. These included:

- Psychosexual services
- MG testing
- Cervical screening
- Emergency contraception
- Full range of contraceptive methods (including LARC)
- PrEP

On **PrEP**, attendees described “huge issues with the IMPACT trial—geographical inequities in access, north/ south divide, depending on what kind of contract you have, depending

on all sorts of commissioning and provider arrangements”—this was described as “a microcosmic representation” of the fragmentation and variability that besets all aspects of sexual health provision.

On access to different methods of **contraception**, including **LARC**, attendees reported a number of issues relating to primary care provision. It was seen to be hard for smaller practices to get enough experience; lots of GPs with fitting experience were retiring; and this was not seen as a priority by many practices. Economic analysis by one local authority suggested that not enough funding was attached to provision of LARC. One area reported that while some 2/3 of GP practices offered LARC fitting, patient experience was often poor. An innovative networked service model was reported in one area whereby patients can access services at any participating practice.

Attendees reported the success of **pharmacy** provision of emergency hormonal contraception; this has been extended in one area to including chlamydia testing and treatment, hep B vaccination, starting oral contraception.

Online sexual health services were discussed by many attendees, with a digital offer promoting self-care and self-management. This was seen to be positive in freeing up clinical services, but only for a specific cohort, mainly people already in contact with sexual health services. There were many people for whom such services would not be suitable, and there was general agreement that it should not be viewed as a ‘silver bullet’. More generally, there was also a view that sexual health services could do more to increase their digital profile and online visibility.

Major concerns were reported by many attendees about the fact **that outreach services** for vulnerable populations has been ‘stripped back’. This includes work with asylum seekers, work done in conjunction with food banks, and efforts to target children in foster care and care leavers, although some areas reported ongoing outreach work targeting public sex environments. On the whole there was felt to be “lots of unmet need in communities who are at risk, because they are not part of the clinic population, and are therefore slipping through the net.

On a similar note, attendees were supportive of attempts to improve **RSE** but felt that unless these were properly financed they wouldn’t work—busy services can’t spare clinicians to contribute.

Workforce

Working in sexual health was seen as insecure, and staff reported feeling uncertain about the future of sexual health services

Training was raised as a concern—both of GPs and sexual health specialists. Queries were raised about how training was funded and funding levels, as well as uncertainty about roles and responsibilities, in particular role of HEE.

Attendees argued strongly that “the clinical workforce needs to feel parity with the NHS workforce, it is no longer competitive and seen as insecure”.

Funding cuts

Attendees described a strong “sense of injustice that, unlike the NHS budget, local government public health spending was ‘an easy target’ for cuts.” One attendee reported cuts of up to 18% of their local sexual health budget.

Cuts were seen to be “affecting the ability to focus on anything beyond the bare minimum.” In particular, as detailed above, attendees described how funding for prevention, wider supportive services, and outreach for vulnerable groups, has been ‘stripped back’.

This was widely seen to be a false economy - reduced HIV prevention will lead to increased HIV cases which will incur a high cost which will be borne by NHS.

Attendees described the difficulty sexual health has competing for funding against other council provisions, like bin collections and libraries. Some local authority representatives felt that their Cabinet did not understand the importance of health promotion and education; and also that it could be hard to gain support for focusing on marginalised groups with high levels of sexual health need like MSM and sex workers.

Commissioning

Attendees told us it was possible to successfully design and implement **integrated and collaborative approaches** to commissioning, including lead provider consortium models. Further details on these approaches can be found in the written evidence submitted by attendees.

However this was not always possible. Some attendees argued that collaborative working was ‘easier said than done’ and that **behavioural change and culture change are challenging** to deliver. A particularly difficult issue was the funding of **cervical screening** as ‘funding pots are split so resolutely’.

Cross charging was identified by many attendees as a significant difficulty. Guidance was described as ‘completely inadequate’; some local authorities refuse to be cross charged, leaving cost pressures of up to £250,000; in London 31 boroughs worked collaboratively on this, but can’t recoup funds from residents who are out of London, who often travel to London from areas which have had their services cut. There is a significant administrative burden, with ‘people employed on both sides solely to manage this issue’. When asked if ICS might help, the response was that ‘possibly’ they would, but there are issues around lack of coterminosity.

There were many **criticisms of the tendering process**, particularly the repetitive, short term nature of the process, which has to be repeated frequently in many areas. Attendees were strongly in favour of longer contracts, up to eight or ten years, but many were having to work within much shorter contracting arrangements. Short term contracts also inhibit long term service planning and in the words of one attendee, ‘bind our hands’.

While attendees felt it was reasonable to expect services to be delivered cost effectively, some argued that competitive tendering can have a **destabilising** effect as competition has stifled the ability for providers to develop collaborative networks and relationships. The negative impact of competition on **innovation** was also raised: “sexual health services are not a group who are afraid to innovate, but difficult to innovate when competing”.

In terms of what type of organisation provides care, some attendees reported poor experiences with private providers and felt services should be NHS provided, but others thought it did not matter, or that it depended on the service that was being provided.

The groups also discussed the **location of sexual health within local authorities' public health function, and whether it should move back to the NHS**. A few attendees thought it should as might be better funded. Public health was seen to be an easier target for cuts than standard NHS services. However some attendees felt that there had been lots of learning through the relocation of public health to local authorities, especially around VFM, and that the prevention agenda has been strengthened since PCT days.

Attendees also felt that there were **real benefits** of commissioning sitting with local authorities—for example integration with education. A recent example was given of vaccinating foreign sex workers against measles. However some felt these advantages were not being properly utilised. Some reported local authorities spending money badged for public health on other things as they have so many competing priorities. Conversely, other attendees gave examples of local authorities shifting resources towards prevention, but consequently leaving gaps in service provision.

One attendee suggested that local authorities should retain the benefits of the savings they are making e.g. £450m saved by HIV prevention.

Many attendees felt that it did not matter where money and commissioning were located, as long as the money was there.

Engagement

**Sexual Health Report:
Committee Engagement**

2 oral evidence sessions

96 written submissions

385 responses to online survey of sexual health service users

Leeds
Calderdale
Wigan
Matlock
Birmingham
Cambridge
London
Kingston
Truro
Plymouth
Torbay

Plymouth: visit and focus groups
16 participants from all across England

Formal minutes

Tuesday 21 May 2019

Members present:

Dr Sarah Wollaston, in the Chair

Mr Ben Bradshaw	Johnny Mercer
Angela Crawley	Andrew Selous
Diana Johnson	Dr Paul Williams

Draft Report (*Sexual health*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 133 read and agreed to.

Annexes agreed to.

Summary agreed to.

Resolved, That the Report be the Fourteenth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 4 June at 5 pm.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 5 February 2019

Councillor Ian Hudspeth, Chairman of the Community Wellbeing Board, Local Government Association, **Dr Olwen Williams**, President, British Association for Sexual Health and HIV (BASHH), **Dr Anne Connolly**, Clinical Champion for Women's Health, Royal College of General Practitioners, **Dr Asha Kasliwal**, President, Faculty of Sexual and Reproductive Healthcare [Q1–59](#)

Ian Green, Chief Executive, Terrence Higgins Trust, **Marion Wadibia**, Chief Executive, NAZ Project London, **Laura Russell**, Head of Policy, Stonewall, **Dr Anatole Menon-Johansson**, Clinical Director, Brook [Q60–82](#)

Tuesday 26 February 2019

Professor John Newton, Director of Health Improvement, Public Health England, **Professor Jim McManus**, Vice President, Association of Directors of Public Health [Q83–124](#)

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, **Dominic Hardy**, Director of Primary Care Delivery, NHS England [Q125–212](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

SLH numbers are generated by the evidence processing system and so may not be complete.

- 1 The Advisory Group on Contraception (AGC) ([SLH0043](#))
- 2 All-Party Parliamentary Group on Women's Health ([SLH0033](#))
- 3 APPG on Sexual and Reproductive Care ([SLH0041](#))
- 4 Association of Directors of Public Health ([SLH0047](#))
- 5 BASHH Sexual dysfunction special interest group ([SLH0016](#))
- 6 BASHH Sexual Dysfunction Special Interest group ([SLH0018](#))
- 7 Bayer Plc ([SLH0025](#))
- 8 BD ([SLH0085](#))
- 9 Bennett, Dr Amy ([SLH0073](#))
- 10 British Association for Sexual Health and HIV (BASHH) ([SLH0094](#))
- 11 British Association for Sexual Health and HIV / British HIV Association ([SLH0042](#))
- 12 British Medical Association ([SLH0005](#))
- 13 British Pregnancy Advisory Service ([SLH0036](#))
- 14 Brixham College, pupils at ([SLH0097](#))
- 15 Brook ([SLH0032](#))
- 16 Camberwell Sexual Health Centre, Kings College Hospital NHS Foundation Trust ([SLH0035](#))
- 17 Cash, Mr Patrick ([SLH0006](#))
- 18 Derbyshire Community Health Services NHS Foundation Trust ([SLH0060](#))
- 19 Derbyshire County Council ([SLH0020](#))
- 20 DHSC ([SLH0044](#))
- 21 Dr Peter J White and Ms Lilith K Whittles ([SLH0057](#))
- 22 Eccleston, Dr Kathryn ([SLH0088](#))
- 23 The Eddystone Trust ([SLH0081](#))
- 24 Evans, Professor David ([SLH0059](#))
- 25 Faculty of Sexual and Reproductive Healthcare (FSRH) ([SLH0027](#))
- 26 Faculty of Sexual and Reproductive Healthcare (FSRH) ([SLH0091](#))
- 27 Fash, Mr Stephen ([SLH0070](#))
- 28 Gilead Sciences ([SLH0012](#))
- 29 Grundy-Bowers, Dr Matthew ([SLH0030](#))
- 30 Health Protection Research Unit in Blood Borne and Sexually Transmitted Infections – 'Understanding Risk & Risk Reduction in STIs' theme ([SLH0026](#))
- 31 Healthwatch Suffolk ([SLH0086](#))
- 32 The Hepatitis C Trust ([SLH0001](#))

- 33 Herpes Viruses Association ([SLH0065](#))
- 34 Hildebrandt, Dr Timothy ([SLH0093](#))
- 35 Homerton Sexual Health Services ([SLH0083](#))
- 36 Hore, Mr Mike ([SLH0074](#))
- 37 Imperial College Healthcare NHS Trust ([SLH0076](#))
- 38 Jo's Cervical Cancer Trust ([SLH0015](#))
- 39 Keane, Dr Frances ([SLH0004](#))
- 40 The King's Fund ([SLH0082](#))
- 41 Kunelaki, Remziye Kunelaki Remziye ([SLH0014](#))
- 42 Lambeth, Southwark and Lewisham local authority public health departments ([SLH0045](#))
- 43 Local Government Association ([SLH0050](#))
- 44 London Councils ([SLH0049](#))
- 45 London Sexual Health Providers Group ([SLH0058](#))
- 46 majewska, Ms wendy ([SLH0069](#))
- 47 Mermaids ([SLH0066](#))
- 48 METRO Charity ([SLH0068](#))
- 49 NAT (National AIDS Trust) ([SLH0055](#))
- 50 Natsal ([SLH0084](#))
- 51 Naz Project London ([SLH0090](#))
- 52 Orr-Ewing, Mr Jonathan ([SLH0019](#))
- 53 Palmer, Dr Bret ([SLH0089](#))
- 54 Pao, Dr David ([SLH0095](#))
- 55 Passfield, Mr Mike ([SLH0008](#))
- 56 Pegasus, Miss Camille ([SLH0031](#))
- 57 Phillips, Dr Matthew ([SLH0077](#))
- 58 Plymouth City Council ([SLH0023](#))
- 59 Positive East ([SLH0009](#))
- 60 Public Health England ([SLH0087](#))
- 61 Public Health, CMBC ([SLH0053](#))
- 62 Royal College of General Practitioners ([SLH0075](#))
- 63 The Royal College of Midwives ([SLH0039](#))
- 64 Royal College of Nursing ([SLH0078](#))
- 65 Royal College of Obstetricians and Gynaecologists ([SLH0062](#))
- 66 Royal College of Physicians ([SLH0024](#))
- 67 Sawyer, Liz ([SLH0096](#))
- 68 Sawyer, Ms Liz ([SLH0011](#))
- 69 Sex Education Forum ([SLH0071](#))

- 70 Sexual Health Improvement Programme (Bristol Health Partners Health Integration Team) ([SLH0034](#))
- 71 SH:24 Community Interest Company ([SLH0013](#))
- 72 SHRINE SHRINE (Sexual and Reproductive Health Rights, Inclusion and Empowerment) ([SLH0021](#))
- 73 Somerset County Council ([SLH0040](#))
- 74 South Gloucestershire Council ([SLH0054](#))
- 75 Specialist Advisory Committee for Genitourinary Medicine, Joint Royal College of Physicians Training Board ([SLH0029](#))
- 76 Staffordshire County Council ([SLH0080](#))
- 77 Stonewall ([SLH0056](#))
- 78 Stuart, Mr David ([SLH0007](#))
- 79 Studholme ([SLH0002](#))
- 80 Terrence Higgins Trust ([SLH0048](#))
- 81 Terrence Higgins Trust ([SLH0092](#))
- 82 Time for Action – UK Families Affected by HPV Vaccinations ([SLH0028](#))
- 83 UCL ([SLH0037](#))
- 84 University Hospital Plymouth NHS Trust ([SLH0063](#))
- 85 University Hospitals Birmingham - Umbrella Sexual Health Service ([SLH0017](#))
- 86 University Hospitals Bristol NHS Foundation Trust ([SLH0038](#))
- 87 Vaughan, Dr Alison ([SLH0079](#))
- 88 Wandsworth Sexual Health Action Group (WSHAG) ([SLH0064](#))
- 89 Wigan Council ([SLH0022](#))
- 90 Wilson, Dr Janet ([SLH0067](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Appointment of the Chair of NHS Improvement	HC 479
Second Report	The nursing workforce	HC 353 (Cm 9669)
Third Report	Improving air quality	HC 433 (HC 1149)
Fourth Report	Brexit: medicines, medical devices and substances of human origin	HC 392 (Cm 9620)
Fifth Report	Memorandum of understanding on data-sharing between NHS Digital and the Home Office	HC 677
Sixth Report	The Government's Green Paper on mental health: failing a generation: First Joint Report of the Education and Health and Social Care Committees of Session 2017–19	HC 642 (Cm 9627)
Seventh Report	Integrated care: organisations, partnerships and systems	HC 650 (Cm 9695)
Eighth Report	Childhood obesity: Time for action	HC 882 (CP23)
Ninth Report	Long-term funding of adult social care	HC 768
Tenth Report	Appointment of the Chair of NHS England	HC 1351
Eleventh Report	Antimicrobial resistance	HC 962
Twelfth Report	Prison health	HC 963 (CP 4)
Thirteenth Report	First 1000 days of life	HC 1496
First Joint Special Report	Children and young people's mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17	HC 451