

Education & Children's Services Scrutiny Sub-Committee

Tuesday 4 October 2016

7.00 pm

Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1
2QH

Supplemental Agenda

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	A report from sexual health commissioners and a submission from Healthwatch on recent engagement work are enclosed.	

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Education & Children Services scrutiny committee - 4th Oct 2016

Report Title: Young people's sexual health services in Southwark

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1.0 Purpose of report:

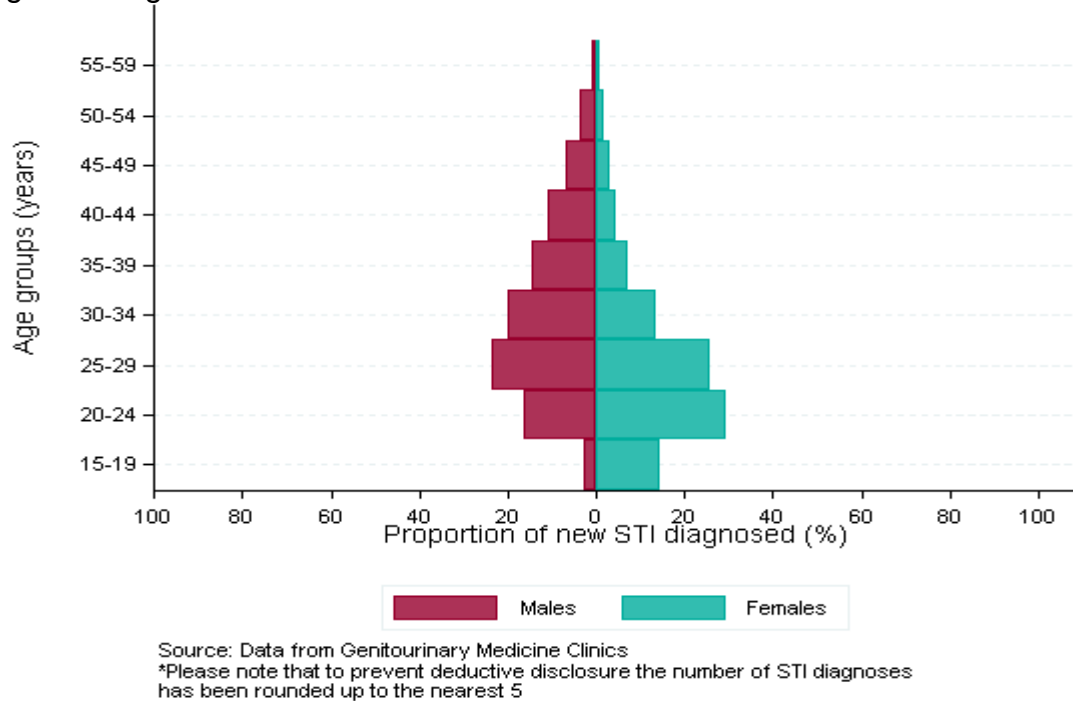
- To share with the committee information on the level of need and sexual health inequalities in young people in Southwark
- To inform the committee of the currently commissioned sexual health services for young people in Southwark
- To share with the committee public health recommendations for young people's sexual health services and seek feedback on those recommendations.

2.0 Inequalities and sexual health in young people in Southwark

2.1 Young People and rates of Sexually Transmitted Infections

Nationally, young people have a high burden of poor sexual health with diagnoses of sexually transmitted infections (STIs) highest in the 15-24 age group. Young people in deprived wards and from black African and black Caribbean groups are particularly at risk. In Southwark, 26% of diagnoses of new STIs made in GUM clinics were in young people aged 15-24 years.

Figure 1: Age and sex distribution of new STIs in Southwark.



The most common STI amongst young people is chlamydia. Chlamydia is usually asymptomatic and thus it is recommended that all sexually active 15-24 year olds are screened annually and on change of partner. A high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. Public Health England recommends that to decrease the prevalence of chlamydia infection, boroughs should aim to detect at least 2,300 infections per 100,000 resident 15-24 year olds. Southwark has consistently performed well with chlamydia screening.

Table 1: Chlamydia testing and performance

Chlamydia tests performed (Sexual health clinics and primary care)	Positive results	% of 15-24 year olds tested	Detection rate per 100,000 15-24 year olds	Rank within London for detection (1 best)
16673	1455	39.7%	3462.7	5

Young people are also more likely to become re-infected with STIs, because they lack the skills and confidence to negotiate safer sex. In Southwark, an estimated 13.4% of 15-19 year old women and 14.8% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 became re-infected with an STI within twelve months.

2.2 Use of sexual health services

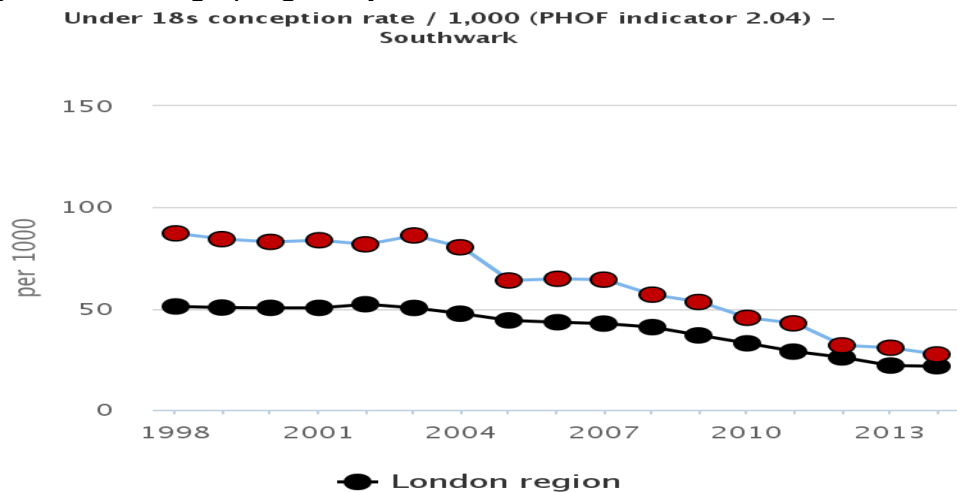
Table 2: Attendances at Southwark clinics by under 25s between 01/04/2015 to 31/03/2016

Age	1 st Attendances	STI screen
Under 15	50	21
15	173	93
16-19	3330	2138
20-24	11963	8427

Overall people aged 24 and under represented 29% of all attendances and 28.4% of STI screens.

2.3 Reproductive health

Figure 2: Teenage pregnancy



Southwark has had the third largest decline in London in teenage conceptions since 1998, although the rates of 27.4 conceptions per 15-17 year olds remains slightly higher than the London rate.

2.4 Abortions

National data shows that pregnancies among 16 to 19 year olds accounted for 7.5% of the total number of pregnancies, but 21.2% of the total number that were unplanned although the highest numbers of unplanned pregnancies overall occur in the 20 to 34 year age group.

Southwark has an overall high abortion and repeat abortion rate but a lower rate than London in repeat abortions amongst women under 25 – the third lowest in London. This reflects good access and contraceptive care pathways for women under 25 at first abortion. Southwark also performs well in the proportion of abortions carried out under 10 weeks, 85.8% compared to London rate of 83.6%.

3.0 Current commissioned services for young people in Southwark

- 3.1 Brook clinic – The Brook clinic on Amelia Street in Elephant and Castle sees young people up to age 25. The clinic is a level 2 sexual health clinic and offers advice and information, access to the Come Correct condom card scheme, contraception (including all methods of long acting reversible contraceptives), risk assessment (including for child sexual exploitation), STI testing and treatment of symptomatic but uncomplicated infections and referrals to other services.

WUSH (Wise up to sexual health) – The WUSH team is an outreach component of the Guy's and St Thomas's sexual and reproductive health (SRH) service. The WUSH Team undertakes outreach to individual vulnerable young people who are not engaging with open access SRH services and are at elevated risk of experiencing poor sexual health outcomes, e.g., looked after children.

Come Correct condom card scheme – The c-card scheme is delivered by Brook and is available for young people up to age 25. Young people register and receive an Oyster-style card which allows them to obtain free condoms from any youth or health outlet in London displaying the Come Correct logo. The c-card service also builds the capacity and capability for wider organisations to deliver and achieve improved outcomes for young people's sexual health and wellbeing by training c-card delivery staff, providing ongoing support to these staff and delivering an extensive wider youth workforce development programme.

Rise Partnership sexual health promotion – The Rise Partnership delivers a range of one to one and group-based sexual health promotion and HIV prevention interventions to groups that bear the greatest burden of sexual ill health: black African and Caribbean residents and men who have sex with men (MSM) with certain vulnerabilities, namely around chemsex. While the programme focuses on adults, they also engage with some young people in their early 20s, particularly young MSM, through peer-led groups for BME MSM. Regular groups for Southwark MSM include Portugays (for Portuguese-speaking MSM), Tongues (for black MSM) and Grupo Amigos (for Latin American MSM).

GUM and community SRH services – Under-25s also access local GUM and community SRH clinics for their sexual and reproductive healthcare. These include Burrell Street, Walworth Road Clinic, Artesian Health Centre and Lloyd Clinic (at Guy's Hospital).

SRE in Southwark schools – Schools are supported to achieve Healthy Schools London (HSL) status. To achieve this, Southwark has run three sex and relationships education (SRE) training sessions (over 40 teachers across 33 different schools), two Drugs, Alcohol and Tobacco training sessions (across 15 schools), three subject networks, SRE staff inset training to seven schools plus parental workshops, governor training and a

new personal, social, health and economic (PSHE) education & wellbeing curriculum framework as well as a school offer including CPD & commissioned services. Additionally, voluntary sector organisations contribute to SRE in Southwark schools. Esteem supports 14 secondary schools in delivering SRE. Bede Youth runs a programme in 3 secondary schools that promotes healthy relationships. The Metro Centre has supported LGBTQ Day at Walworth Academy.

3.2. Activity in Brook clinic, Come Correct c-card scheme and WUSH, 2014/15 and 2015/16

Brook Southwark clinic attendances and outcomes

Q1 2014/15	Q1 2015/16	% Change	LARC Treatment	Chlamydia Diagnoses
1105	981	-11.2%	109	61
Q2 2014/15	Q2 2015/16	% Change	LARC Treatment	Chlamydia Diagnoses
994	1042	5%	100	60
Q3 2014/15	Q3 2015/16	% Change	LARC Treatment	Chlamydia Diagnoses
1269	1215	-4%	92	72
Q4 2014/15	Q4 2015/16	% Change	LARC Treatment	Chlamydia Diagnoses
1346	1339	-1%	92	72

Come Correct condom card scheme*

(*Southwark did not commission the Come Correct scheme until Q3 2015/16)

Registrations			Repeat Visits			Condoms		
Q3 14/15	Q3 15/16	% Change	Q3 14/15	Q3 15/16	% Change	Q3 14/15	Q3 15/16	% Change
.	105	.	.	42	.	.	1635	.
Q4 14/15	Q4 15/16	% Change	Q4 14/15	Q4 15/16	% Change	Q4 14/15	Q4 15/16	% Change
.	188	.	.	59	.	.	2487	.

WUSH service to Southwark clients: Individual clients*

(*WUSH had major staffing issues in 2015/16 which impacted on the number of clients they could see. They were allowed to stop their SRE work to focus on particularly vulnerable young people.)

Q1 14/15	Q1 15/16	% chg	Q2 14/15	Q2 15/16	% chng	Q3 14/15	Q3 15/16	% chng	Q4 14/15	Q4/ 15/16	% chng
41	19	-54%	58	16	-72%	18	15	-16%	22	13	-41%

4.0 Young people and health: key principles when developing new services

4.1 Because young people represent a heterogeneous group, with different preferences on how they would like to engage with health services, several options should be developed to best serve their needs. These options should be complementary, providing choice for young people.

- Young people at the centre
 - Co-production
 - Assets of young people, including arts etc.
- Importance of relationships
 - Friends, family, trusted adult
- Young people friendly services
 - Locally developed
- Young people's pathway
 - 'No Wrong Door'
 - Co-ordinated services
 - Support transition(s)
- Workforce training
 - 'Use of Teen Health Check'
- Co-location of some services
 - Primary care, CAMHS
 - Proportionate universalism
- Health promotion/prevention/early intervention
 - E.g.. use of youth workers and peers
- Reducing health inequalities
- Communication/social media/health literacy
- Avoid duplication by different services

4.2 Building capacity with a potential new service model

The YP workforce should signpost and support access to a range of services already available in the community and work with partners to develop services including services communities can provide for themselves.

The following should be in all/most service contracts dealing with YP:

- Meeting 'You're Welcome' standards/young people friendly
- Undertaking a holistic teen health check (or variant)

- Staff trained in having ‘the difficult conversations’ about sex, drugs etc. to develop trusting relationships
- Development of young people’s health pathway with clear referral pathways between services – no wrong door
- Health information/advice to support above for YP and workforce
- Monitoring data
- Above should hopefully build capacity to deal with YP health
- CYPHP helping with some (not all) of the above over next 4 years

4.3 Outcomes for a potential new service model

- More local young people have access to youth-friendly services
- Vulnerable young people have access to a more holistic service, that meets their physical, mental health and social needs
- More health (eg. GPs) and non-health professionals (eg. youth workers) are trained to manage adolescent health concerns, including mental health problems
- More young people have a positive experience of care, including youth-friendly services and transition
- Reduction in unhealthy behaviours (e.g. unsafe sex, smoking, drug and alcohol consumption, violence, unhealthy diets and lack of physical exercise)
- Improved self-esteem, resilience and emotional wellbeing

Our engagement with young people around sexual health: Summary of findings

The full report, and a parallel report on mental health, will be launched at public “Young Voices Count!” [event](#) on 2nd November 2016, 4pm - 6.30pm, Cambridge House.

See also our public forum [report](#), “Parents and Families Event!” where we spoke with adults about their knowledge and experience of supporting young people around wellbeing, mental health and sexual health.

Background

Over the summer of 2016, Healthwatch Southwark has engaged with young people aged 13-25 to find out about their experiences of sex education and information, access to services, and where they prefer to go for support. We conducted six focus groups reaching 38 young people who were members of local youth organisations, ran an online survey with 13 responses, and were kindly enabled by Walworth Academy to distribute a paper survey to their pupils aged 13-15 (mostly 14), to which we received 47 responses (note that not everyone answered every question, as reflected in counts below, and that there was also a ‘don’t know’ or ‘half and half’ option). Responses from the groups and online survey have been counted separately to the Walworth Academy responses, in recognition of the fact that many respondents attending the same school might well skew results.

Including Walworth Academy, we received responses from pupils from 5 Southwark schools/colleges, plus 15 other South East London schools and 6 north of the river, as well as responses from young people who had been educated abroad. At least 50% of respondents were Southwark residents. 57% were female and 35% male (others were non-binary or did not specify). We reached a wide range of ethnic and religious groups, particularly many Black and Latin American young people, and 31% were born abroad, including 4 refugees/asylum seekers. 11 respondents out of 98 had been ‘looked after’ (in care), and we also spoke to a number of young carers. 5 respondents were transgender or did not know. However, only 3 of our 98 respondents said they had a disability and only 1 said they were gay/lesbian (7 were bisexual), highlighting some gaps in our engagement to be addressed in the future.

Key findings

49/57 workshop/online participants and 22/43 Walworth Academy respondents agreed that they knew how to protect themselves from STIs or unwanted pregnancy.

Interestingly, the 2 group participants who actively disagreed were both Trans and educated abroad, though 7 at Walworth also disagreed. Most of the groups were able to list a variety of contraceptive methods between them, and nearly all survey respondents listed condoms. However, some young people felt that they did not have detailed knowledge of a range of

methods. Some felt that there was a *'difference between knowing and doing'*, and some appeared to emphasise careful choice of who they slept with.

38/47 workshop/online participants and 24/46 Walworth Academy respondents agreed that social media and new technology influence how young people behave sexually.

Some felt that younger or more vulnerable teens are the most likely to be influenced. Many noted how easy it is to find sexual content on social media. Most of the described impacts were negative, for example people having a false idea from pornography about what sex ought to be like, or seeing things but not knowing how to do them safely. There were mentions of dangerous aspects such as revenge porn, live streaming, and ease of connection with older young people. Many noted the false and overtly sexualised images presented online, especially by celebrities, and how people might feel they needed to emulate this.

Other influences on sexual behaviour discussed were cultural norms (with many feeling sex was largely accepted, even expected), drugs and alcohol, peer groups, media and celebrities. In the light of all these influences, we discussed at what age young people should be educated about sex and met with a range of responses from age 7 to age 14. Some felt early sex education was important due to some people becoming sexually active young, whereas others had been uncomfortable when taught too much too young. People in all groups felt that sex education should be taught progressively and some wanted refreshers as they got older. Many people felt that the emotional elements of healthy relationships should be taught much earlier - even before the physical elements of sex.

38/58 workshop/online participants and 24/45 Walworth Academy respondents agreed that it is easy for young people to get information about sexual health. 3 and 10, respectively, actively disagreed.

Some felt that they had not even had basic information, *'All I want to know is how to be safe, I don't think I have been taught.'* Several felt that information was available only to those who actively sought it. However, there were mixed opinions on all the sources of information we discussed, including schools, leaflets, family and friends, the internet, and sexual health services. Many people were aware that much on the internet is inaccurate, but several trusted the NHS website.

27/54 workshop/online participants and 26/47 Walworth Academy respondents agreed that their school/college provide(d) good information and education about sexual health, with 22 and 12 respectively disagreeing.

Some schools focused on puberty or pregnancy prevention and gave little else. Others went into more detail and provided information in a variety of ways. Participants in at least three groups attributed their schools' reluctance to provide good sex education to religion or culture. Other elements affecting the quality of sex education included teachers' discomfort, having a teacher of the opposite sex, and limited and repetitive information. One group had had very poor experiences and were therefore adamant that sex education should be provided by parents, not schools - though some later conceded that certain models could be effective.

People from four different schools said they had had some information on healthy relationships, although this was often limited or too late. Many people wanted more education about abuse, rape, consent, gender roles/responsibilities, and healthy relationships in general.

Many young people in Southwark start and even finish their education abroad, where again the quality of sex education is variable. Some come from countries where sex, and particularly non-heteronormative sex, is taboo, and where cultural/religious influences play a very important role.

34/54 workshop/online participants and 23/46 Walworth Academy respondents would feel comfortable talking to friends if they needed support around their sexual health, with 11 and 16 respectively disagreeing.

Some felt that sex ought to be private or were concerned that their friends would *'joke about'* or be judgemental, or not have helpful information. Others were very open with their friends about sex, and saw this as part of modern culture.

18/55 workshop/online participants and 20/45 Walworth Academy respondents would feel comfortable talking to parents/carers if they needed support around sexual health, but 22 and 17 respectively disagreed.

Reasons for not talking to parents included feeling uncomfortable, parents feeling uncomfortable, and parents being opposed to young people being sexually active - again often because of strict cultural backgrounds (which sometimes also led to contradictory expectations for girls versus boys). While some parents were seen as prying too much, other young people appreciated their concern. Some were close to their families and did feel able to talk to their parents and get support from them.

34/54 workshop/online participants and 24/46 Walworth Academy respondents would feel comfortable talking to health professionals if they needed support around sexual health - though it should be noted that in one workshop of 5 people, everyone said the service would have to be anonymous. 6 and 16 respectively disagreed.

While some felt embarrassed, many recognised that professionals *'are more experienced'*, *'have the knowledge'*, and *'know what advice to give.'*

Some groups discussed their personal interactions with different professionals. One person had had poor experiences at the sexual health clinic, feeling judged even when they had gone for a check-up to be responsible. Others however had found professionals mostly respectful. Generally young people were positive about using the service in sexual health clinics. Reasons for this included not having to wait for an appointment, and anonymity - though others felt awkward because people would know why they were at the clinic, and some mentioned queues. Brook Sexual Health Clinic was praised due to its discrete entrance whereas Walworth Road Clinic was seen as less discrete in its location. A couple of people mentioned confidentiality concerns if talking to the GP or a school nurse.

15/42 workshop/online participants would feel embarrassed if someone knew they had sought support around their sexual health, and 16 not. Among Walworth Academy respondents 20/38 would feel embarrassed but 6 disagreed.

While some felt their sexual health was private and did not want others to know they had sought help, even if they would not actually be embarrassed, others were adamant that seeking help for sexual health was a sign of responsibility and set a good example to others. Some young people who were Trans felt a strong sense of shame partly due to their cultural backgrounds, and struggled to talk to anyone.

Early indications of recommendations

We have not yet finalised our recommendations arising from this engagement work. However, we asked the young people themselves what could be improved in terms of education in schools, health professionals' support to young people, preventing people from being embarrassed to seek help, and sexual health services in general. Key themes were:

- Colleges and schools should bring in external sex educators who can deliver sex education in a detailed, relevant and much more engaging way - a discussion rather than a lesson. However, better training for teachers is also needed.
- More education on healthy relationships is needed.
- Beliefs and culture should not be allowed to influence the sex education given. However, schools should work in partnership with parents, take backgrounds into account and be sensitive.
- Sex education should be progressive as students get older, and repeated.
- Students should be given the perspective of an educator of their own sex.
- Schools should normalise asexual/homosexual relationships.
- Sexual health services should publicise themselves better, including in the community and schools and on social media, and encourage people to get tested.
- One person suggested 'shock tactics' about STIs, such as bus adverts. Adverts could also be used to reduce stigma around sexual health.
- Many people wanted an anonymous sexual health service.
- Reducing queues at clinics was mentioned.
- Some preferred younger staff and some older.
- Empathy and a non-judgmental attitude towards young people were seen as key - staff should recognise that the people attending services are the people who are trying to be responsible.

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**EDUCATION & CHILDREN'S SERVICES
MUNICIPAL YEAR 2016-17**

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