Written evidence from Brook

This inquiry submission will focus on aspects of sexual and reproductive health (SRH) funding and commissioning arrangements, with specific reference to the needs of young people.

Brook has been at the forefront of providing clinical sexual and reproductive health services to young people for over 50 years.

Brook has a unique insight into the way in which young people access and use sexual health services; and how to maximise the benefit to each young person we see, making every contact count through robust safeguarding processes, and by addressing young people’s broader emotional health and relationship issues. We welcome the opportunity to submit to this inquiry.

Executive summary and recommendations

Current commissioning arrangements, lack of prioritisation and underfunding are jeopardising the sexual and reproductive health of the population, exacerbating health inequality and putting the most vulnerable at risk.

We call for policies and funding with the ambition of creating a population of people with a high level of sexual, reproductive and psychosexual health and wellbeing.

1. Public health is prevention. Prioritise public health (including sexual health) in long term planning for the NHS.

2. Uplift and protect (through ring-fencing or other form of guarantee) future funding for sexual and reproductive health services.

3. Refine the definition and specificity of public health prescribed activities especially the definition of ‘open access’ to ensure services meet standards set by professional bodies such as FSRH, BASHH, and BHIVA.

4. Mandate commissioners to carry out robust equality impact assessments to inform commissioning decisions; and assess impact of service closures or changes on population health and health inequality.

5. Ensure commissioners consult and fund expert organisations with the skills, knowledge and networks to best reach, and provide support to, target communities to help tackle health inequality.

6. Address fragmented commissioning to eliminate counterproductive dis-integration of services, and encourage the co-production of SRH services that meet the needs of the
population and that ensure that the costs and benefits of investment in SRH are shared across local authority and NHS budgets.

7. Ensure that SRH services meet the needs of young people, recognising: their specific requirements in relation to safeguarding and support; and their potential to become a population who will be able to make informed decisions about and self-manage their sexual and reproductive health, and will understand how and when to seek help, throughout their adult lives.

8. Ensure that SRH services and RSE are LGBT inclusive

9. Ensure that the new Relationships and Sex Education guidance, funding for teacher workforce training, and inspection regimes will ensure that RSE meets its potential to elevate the sexual and reproductive health and wellbeing of people in this country: tackling stigma; increasing knowledge, understanding and skills; and preparing young people to be adults who can have healthy, enjoyable sexual relationships.

10. Capture at national level the scale of failed and undeliverable public health contracts to assess the size of the problem of underfunded contracts.

11. Support legislation to bring legal abortion to women in Northern Ireland

1. Why does our sexual and reproductive health matter?

1.1 Brook supports the World Health Organization (WHO) definition of sexual and reproductive health¹ Sexual health is ‘a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled….Reproductive health…implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice…’
1.2 The UK government is signatory to the UN Sustainable Development Goals\(^2\) and is committed to be ‘at the forefront of delivering the goals’. SDGs 3 Health and Wellbeing, and Goal 5 Gender Equality are not achievable unless we are able to deliver excellent sexual and reproductive health and rights to the UK population.

1.3 The UK Government is committed to tackling Health Inequality however, it is not possible to tackle health inequality without addressing inequality of access to sexual and reproductive health services.

1.4 For example, there is a disproportionate burden of STIs\(^3\), and unintended pregnancy leading to abortion\(^4\), on people from BAME communities, and an increase in unintended pregnancies leading to abortions in some of the most deprived local authority areas.

1.5 Public Health England’s Consensus Statement: Reproductive health is a public health issue\(^5\) sets out the importance of addressing reproductive health as a public health issue, looking not just at issues around contraception, but women’s health across the life course from menstruation to menopause and more. Good reproductive health is essential for women’s wellbeing.

1.6 SRH services contribute to key Public Health Outcomes including: reducing the rate of under 18 conceptions – and the additional public health outcomes impacted by reducing teenage pregnancy; 15-25 Chlamydia detection rate; late diagnosis of HIV

2 Funding for sexual and reproductive health represents good value for money and is vital for the health and wellbeing of the population

2.1 Investment in testing for HIV results in significant reductions in new HIV diagnoses. PHE figures show a 17 per cent fall in new HIV diagnose in 2017s, which it attributes to large increases in HIV testing.\(^6\)

2.2 Contraception represents excellent value for money, according to Contraception: economic analysis estimation of the return on investment (ROI) for publically funded contraception in England\(^7\) which finds savings of £9 across the NHS and local authority budgets for every £1 invested in contraception.

2.3 The Teenage Pregnancy Prevention Framework published by the Local Government Association and Public Health England\(^8\) sets out long-term savings from investment in teenage pregnancy prevention: including provision of young people friendly sexual health services and quality Relationships and Sex Education.

3 Severe funding cuts are leading to a crisis in our sexual and reproductive health services, with negative impact on service-users and staff; exacerbating health inequality and leaving some populations underserved.

3.1 The Local Government Association reports that sexual health services in England are ‘at a tipping point’\(^9\) with symptomatic service-users being turned away, long waits for appointments and several services closing their doors entirely – a crisis resulting from an increase in demand for sexual health services at a time of significant and ongoing funding cuts.

3.2 The British Association of Sexual Health and HIV (BASHH), and The British HIV Association (BHIVA) published results of a surveys of their members\(^10\) which provide evidence
that sexual health services and HIV care are at ‘breaking point. Members of the Faculty of Sexual and Reproductive Health\textsuperscript{11} report on a range of adverse outcomes from cuts to contraceptive services.

3.1 A recent \textit{FOI of local authorities by the Advisory Group on Contraception}\textsuperscript{12}, finds that almost half of councils in England have closed sites providing contraceptive services since the public health budget cuts of 2015.

3.2 The same report finds 23 out of the 38 councils in the most deprived quartile (60\%) cut or froze their SRH budget between 2016/17 and 2017/18. Of these 23 councils, 15 saw an increase in abortions (65\%).

3.3 Nationally the abortion rate for over 30s has increased alongside concerns about limited contraceptive access. It is not known whether there is a causal link between the two. More research is needed on this, as anecdotal evidence from providers also suggests that austerity is having an impact on the choices people make once they become pregnant.

3.4 The \textit{RCGP report Time to Act}\textsuperscript{13} reports that reduced funding for GP training in contraceptive care and reduced payments for the cost of administration of contraception methods means it is becoming more difficult for women to access the full range of effective contraceptive methods recommended by NICE. At the same time only 74\% of GPs in England are able to access specialist care for their patients when they need it as a result of funding cuts to specialist services.

3.5 There is anecdotal evidence of contracts failing and providers ‘walking away’ from contracts that are underfunded and undeliverable.

4. In April this year the Government carried out a call for evidence on public health prescribed activities.

4.1 Brook responded \textit{here}. Our recommendations included:

4.2 Maintaining prescribed activities to ensure sexual health remains funded and commissioned and is protected from the risk that funding public health through business rates retention will lead to further and deeper cuts in some local authority areas; increase the variability, accessibility and quality of SRH services; and exacerbate health inequality.

4.3 Better defining of open access to ensure: service hours and locations make them accessible to the local population; they meet minimum service standards such as those defined by DHSC, PHE, BASHH, BHIVA, FSRH, NICE; that services are young people friendly and LGBT inclusive.

4.4 Increased accountability to PHE or DHSC for local authorities to demonstrate they are meeting the sexual and reproductive health needs of their population.

5 Commissioning issues in relation to young people’s sexual health

5.1 Young people experience the highest diagnosis rates of the most common STIs; and despite the success of the teenage pregnancy strategy and its legacy, the UK still has the highest teenage pregnancy rate in Western Europe.
5.2 There is wide recognition that young people today face a range of new and emerging challenges relating to developing safe, healthy relationships in a digital world; and in the context of cultures of sexual bullying, sexual exploitation and violence. Five select committees recognised the role that good quality Relationships and Sex Education can play in keeping young people safe\(^\text{14}\), the role for specialist young people’s sexual health services needs acknowledgement.

5.3 Specialist young people’s services and those that are committed to delivering in line with You’re Welcome standards are recognised as making a vital contribution to key public health outcomes including, but not limited to, reducing the under-18 conception rate\(^\text{15}\).

5.4 Specialist services teach young people to manage their sexual and reproductive health and to nurture good help-seeking practice.

5.5 The time and care Brook and other young people’s services take with service-users to build trust is the reason they are prepared to disclose abuse and sexual exploitation, and to seek support with unhealthy or unsafe relationships.

5.6 There is concern that this level of care may not always be delivered by all-age services that have a higher turnover of clients and fewer trained, experienced specialists, where safeguarding practices may be less robust and safeguarding issues may be missed.

5.7 Sexual health commissioners are responding to shortfalls in funding by commissioning services with reduced opening hours, reducing the age range of services they will fund, reducing staff capacity and defunding roles (for example ending funding of counsellors).

5.8 Age restrictions set by commissioners, for example by restricting a previously under-25s service to under 19s, may be arbitrary and do not always relate to the social and sexual networks or the additional needs or vulnerability of some service users.

5.9 As commissioners limit young people’s services, the proportion of more vulnerable service users in the service increases. This leads to an increase in the average time taken with each young person’s consultation; a greater percentage of consultations resulting in safeguarding concerns; and an increase in the average cost of each consultation. This makes the services look more expensive than that offered by all-age providers and increases the likelihood that commissioners will not recommission specialist young people’s services.

5.9.1 When commissioners try to reduce costs by limiting or closing young people’s services it can leave young service users to ‘fend for themselves’ in adult services increasing demand on GPs and on all-age services that are already overstretched and are already turning people away.

5.9.2 If service users who are turned away are delayed in accessing contraceptive support, and sexual health services, this will begin to impact on unintended pregnancy rates and STI rates.

6 Sexual Health contracting arrangements exclude VCS and local expert organisations

6.1 The trend towards commissioners creating large all-age contracts creates significant barriers to entry for specialist organisations, smaller providers and the voluntary sector; who are expert at working with vulnerable groups.
6.2 Contracts are often structured around ‘prime’ and ‘sub’ contracts where a prime provider is expected to sub-contract to a specialist provider like Brook to demonstrate their ability to meet the needs of younger or more vulnerable service-users.

6.3 In practice the sub-contract often diminishes in value over time, leading to specialist service reduction and closures, leaving vulnerable young people faced with trying to access generic often hospital-based provision.

6.4 Sub-contractors are sometimes gagged by prime contractors from providing feedback and using their experience to inform future commissioning decisions.

6.5 Sub-contractors often have concerns about service standards, but also innovative ideas, or challenges to the status quo, that could inform improvements but are rarely given an opportunity to voice these.

7 The new mandatory Relationships and Sex Education subject provides a great opportunity to ensure that all young people are given the tools – the knowledge, skills and values – to lead positive, sexually healthy lives.

7.1 The draft guidance from the Department for Education, currently out for consultation, will not help to achieve these ends without significant revision. Although it has been written to update the 2000 guidance, in many topic areas it is less fit for purpose than the old guidance.

7.2 There is widespread consensus amongst educational and medical organisations that the draft guidance fails in a range of ways and should mandate all schools to:

7.3 deliver RSE that is inclusive of and relevant to all students including LGBT students, disabled students and those with SEN

7.4 teach medically accurate terms for body parts, including external genitalia from the beginning of primary school in order to familiarise children with their own bodies; to remove stigma and embarrassment about talking about bodies which inhibits help-seeking behaviour and prevents accurate reporting of abuse.

7.5 teach about human fertility and human reproduction in primary school to create a foundation of knowledge for all children on which to base more complex conversations about human sexuality that need to take place in secondary schools.

7.6 teach all topics in a ‘timely’ way with a view to ensuring children learn what they need to know in advance of changes they will experience in their bodies e.g. puberty and menstruation. The current formulation of ‘age-appropriate’ encourages schools to take a protective, cautious approach and results in information that is ‘too little, too late’.

7.7 address human reproduction and sexuality as something positive, not simply a source of fear, risk and harm, by addressing sexual pleasure, and ensuring that enjoyable relationships and sex are seen as an equal entitlement and expectation for all young people regardless of gender or sexuality.

7.8 work with local authorities to ensure that the curriculum is informed by local public health priorities (e.g. teenage pregnancy prevention, chlamydia prevention); assures students of their right to confidential advice and support; and familiarises young people with local sexual health services.

7.9 teach about abortion as a part of reproductive life and in the context of pregnancy prevention and parenting choices as in the 2000 guidance and not simply about the legal framework.
7.9.1 Without a commitment to fund teacher training the promise of quality RSE in all our schools cannot be realised.

7.9.2 Brook will be submitting more comprehensive input to the DfE draft guidance consultation. However, these issues are key in relation specifically to sexual and reproductive health.

8 Abortion law and policy

8.1 CCG and public health commissioners must work together to ensure that those accessing abortion are able to have their chosen method of contraception provided at the time of abortion (in line with current evidence-based practice) or as soon as possible within primary care or SRH services.

8.2 Northern Irish abortion law is incompatible with human rights. Westminster must legislate to enable women in Northern Ireland equal rights to access safe, legal abortion without having to travel to the UK mainland or risk criminal prosecution by taking abortion medication at home.

October 2018
accessed 25/09/2018