Written evidence from Camberwell Sexual Health Centre - Kings College Hospital NHS Foundation Trust, London

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We welcome the Health and Social Care Committee’s Sexual Health Enquiry and our department is pleased to have the opportunity to submit evidence on the recent trends seen at our sexual and reproductive health (SRH) service. We have chosen to focus on the demand for care by young people aged 17 and under, the majority of whom are part of our local black minority and ethnic (BME) populations.

Whilst funding reductions have affected all who access our service, we are particularly concerned about the impact on this diverse and vulnerable group; namely by reducing their access to care. ‘Care’ means many things, e.g. collecting condoms, being tested and/or treated for sexually transmitted infections (STIs) or obtaining contraception. But whatever the young person’s reason for attending a service, they are universally provided with the opportunity to speak with a non-judgemental professional about their concerns and we as service providers, are given the opportunity to assess a young person’s safeguarding risk.

Local Demographics

Camberwell Sexual Health Centre (CSHC) is part of King’s College Hospital NHS Foundation Trust, located in Camberwell, in the borough of Southwark. Southwark is a deprived, densely populated, ethnically diverse borough. It has a much younger population than the national average; 20% of the population are aged under 18 years. Of further note is that the population under 20 years is much more diverse than other age groups: 71% of children and young people in Southwark represent minority ethnic groups compared with 26% of children in the whole of the UK representing minority groups.

Southwark’s population is growing much faster than the national average, with this increase concentrated amongst young adults. Notably the number of people under 18 is projected to increase by 7,600 by 2030, as part of a 20% overall projected population increase.

Southwark is bordered by Lambeth. Lambeth and Southwark have the highest prevalence of diagnosed HIV in the UK. In 2017, Lambeth and Southwark had the highest and 3rd highest rates of new STIs and the 2nd and 3rd highest rates of chlamydia diagnoses in young people aged 15 - 24 years, respectively. In 2016, Southwark had the second highest rate of teenage pregnancies in London.

Southwark Council performed a ‘Joint Needs and Strategic Assessment’ in July 2018, which stated that ‘commissioners and policy makers should ensure services have sufficient capacity to accommodate our projected growth and the dynamic nature of our population.’ I.e. catering to the needs of a deprived, young and ethnically diverse community.

**Our Service**

CSHC is a fully integrated, specialist SRH service, offering both walk-in and appointment services. We also offer online testing for STIs for those aged over 16 as part of the London Sexual Health Transformation Programme’s e-services project.

Like so many services nationwide, we are keenly feeling the effects of the 2012 commissioning changes that moved responsibility for SRH funding to our local authority and the unprecedented cuts to the UK public health budget, planned to reach £600 million by 2021. In 2017/18 our Local Authority commissioners indicated their intention to move to funding our service through the integrated sexual health tariff (ISHT). This has equated to our income being reduced by 43% between 2016/17 and 2018/19.

Whilst we have made efficiencies in the way we work, as the single biggest expenditure in our budget is staffing, we have had to make similar percentage reductions in our workforce; mostly in our nursing establishment. We have had to reduce our opening hours by 30%, from 49.5 hours/week to 35 hours/week in order to staff the service as effectively and efficiently as possible and to ensure that we maximise the impact of our reduced capacity of staff. This is with the aim of providing care to as many patients as possible during our heavily reduced hours. Whilst this reduces access to our services for all, we are extremely concerned about the consequences of these service cuts on our young population in particular.

**Sexual Health and Child Safeguarding**

Young people are having sexual relationships and we have a duty to provide them with the information, knowledge, skills and clinical care to do so safely. As stated, Southwark is a deprived, at-risk borough, with some of the highest rates of STIs and teenage pregnancy in the UK and recognised significant rates of child sexual abuse (CSA) and gang activity amongst young people.

At CSHC, we aim to provide a high standard of care with regards to screening all under 18s for safeguarding risk and have worked hard to develop robust processes for those children deemed to be at risk. All under 18s are seen as part of our ‘Do Not Turn Away’ policy and all under 16s are ‘Fast Tracking’ to facilitate timely review. As per national guidelines, every young person using our service is opportunistically assessed using a standardised proforma to elicit concerns. If a risk is highlighted, the case is discussed with the relevant agencies, e.g. ‘Trust

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Safeguarding,’ Social Services or the Police. All young people of concern are discussed at our monthly ‘Safeguarding meeting,’ a multidisciplinary meeting chaired by our departmental consultant safeguarding lead and followed up to the best of our ability.

Child safeguarding is the action taken to protect children (aged 17 and under) from harm. As stated by the National Society for the Protection of Children (NSPCC)\(^6\) ‘all organisations that come into contact with children should have safeguarding policies and procedures to ensure that every child, regardless of race, religion or belief, sex, sexual orientation, age, disability or gender reassignment, has a right to equal protection from harm.’

‘Harm’ is a wide spectrum and covers many types of abuse, e.g. neglect, emotional abuse, physical abuse, online abuse, CSA (including rape) and female genital mutilation (FGM). An increasingly recognised form of CSA is child sexual exploitation (CSE), which occurs where an individual or groups/gangs takes advantage of an imbalance of power to coerce, manipulate or deceive a young person into sexual activity. Young people in these sexually exploitative situations and relationships are persuaded or forced to perform sexual activities or have sexual activities performed on them in return for affection, gifts, money, drugs or all of the above. The young person has often been groomed into trusting their abuser and may not understand they are being harmed.

Approximately 10% of CSA is first disclosed to professionals, including sexual health professionals\(^7\). However, studies demonstrate that supporting young people to disclose a safeguarding concern is a complex area and that they often choose not disclose, thus preventing access to help and allowing perpetrators to continue undetected\(^8\). Studies also show that understanding of consent amongst young people is worryingly variable\(^9\), a factor that directly influences a young person’s likelihood to disclose concerns.

**Our Data**

Over an 8-month period (March - October 2017), there were 892 attendances by young people aged 17 and under. Despite ‘Do Not Turn Away’ and ‘Fast Track’ policy, 62 of these patients did not wait to be seen and were marked as ‘Did Not Attend’ (DNA). A ‘DNA’ is declared once the patient has been called from the waiting room three times. Reasons for DNA are not clear, but departmental data analysis that for 82% of DNAs, transit time (i.e. time from patient registering to being marked as ‘DNA’) was in excess of 2 hours. Of the 830 attendances that were completed, the average transit time for a patient was just under 2 hours (1 hour 54 minutes), ranging from 17 minutes for a young male requesting condoms to 5 hours and 30 minutes for a young female requesting a symptomatic screen. This data is taken prior to our clinic opening hours being reduced and we are currently analysing the DNA/waiting time rates over the 6 month period since the opening hour changes. Discussion amongst the healthcare team indicates that young people waiting times and DNAs remains a significant issue.

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Of further concern is that over the same time period (March – October 2017), 88 young people aged 27 and under were deemed of significant concern to be discussed in our monthly safeguarding meeting. Reasons for concern were diverse, but patients universally required a high level of input: considerable time spent with the patient, high clinical expertise and time spent liaising with third parties such as Trust Safeguarding, Social Services and other agencies. All patients are routinely offered follow up with our Sexual health Intervention and Prevention (SHIP) team, where significant time is spent building a relationship with the young person and appropriate interventions offered. Notable time is then spent discussing the patient going forward to ensure ongoing support is in place until an acceptable outcome is achieved. Of note is that the majority of this safeguarding activity is currently not specifically funded and thus the service receives no financial remuneration for this extensive, time consuming and expert clinical activity.

**Impact**

We are very concerned about the effect of our reduced opening hours and lack of financial resource on this group of vulnerable young people. The combination of young people not always wanting or knowing to disclose and the complexity of safeguarding situations means that maintaining sufficient access to specialist sexual health services is of the highest importance. As a service we have a clinical duty to offer young people the acceptable and accessible services and reducing their ability to access such care cuts off a potential lifeline for this extremely vulnerable population.

The high volume of patients we are seeing during our compressed hours means that undesirable waiting times for young people are unavoidable. For a young person accessing sexual health services, we feel these waiting times are unacceptable. Most young people are time limited, fitting sexual health care around school/college commitments and the need to be ‘home’ at certain times as expected by parents or other responsible adults. We feel that by not providing young people with timely, accessible care we are doing them a disservice at their time of need and missing opportunities for health intervention and promotion and screening for safeguarding risks.

Online testing intends to remove the pressure from clinics by providing STI testing and for certain non-complex populations is an excellent solution. However, the efficacy of online safeguarding screening and the translation of online to clinical care for those who disclose a safeguarding risk online is poorly understood. Additionally, under 16s are not able to access the e-service at all.

Of further concern is that every contact with a young person requires time and clinical expertise. Once a safeguarding concern is raised, considerable time and specialist input from clinical staff are required to ensure the best outcome for the patient. Reduced clinic hours and staffing, alongside lack of funding and subsequent payment for this work means that these efforts will eventually be impossible to maintain. This leaves NHS workers unable to fulfil the clinical duties they have been highly trained to perform and potentially puts young people at risk.

**Case Studies**

To put this information into context, we have summarised two recent safeguarding cases from our department.
Case One

X is a 16 year old mixed race female patient who attended the walk in clinic at CSHC for a sexual health screen due to a 3 week history of vaginal discharge and discomfort when passing urine.

She underwent a full sexual health screen including tests for chlamydia, gonorrhoea, HIV and syphilis in addition to microscopy assessing for trichomonas and non-STI conditions such as thrush and bacterial vaginosis.

As is the case with all young female patients seen in clinic, her contraceptive needs were also assessed and she was found to be at high risk of pregnancy. A full contraceptive consultation was undertaken and after discussion around the different options available, X was quick started on a contraceptive pill with both verbal and written information given about how to reliably use it and was provided with condoms.

As X was under the age of 18 further questions were asked to assess safeguarding risk. She disclosed at this time having over 20 previous sexual partners in the last 12 months with partners sometimes giving her gifts or money which may have been in return for sex. She described a situation where she was pressured by her ‘boyfriend’ to have sex with his friends at a party he brought her to. This episode had led to subsequent social services, school and police involvement.

X was identified as being extremely vulnerable, at high risk of STIs, pregnancy and CSE. Although she had previously been known to social services it was unclear if they were still actively involved and her parents were unaware of her ongoing sexual activity.

X was referred to our SHIP team and reviewed in clinic 1 week later. At this appointment X was treated with antibiotics as her STI screen was positive for chlamydia. Assessment revealed she was struggling to remember to take the pill so a contraceptive implant was fitted. In addition to these interventions, risk reduction strategies were discussed and further information regarding safeguarding and CSE concerns was gathered. X was reviewed a further 3 weeks later in clinic for a pregnancy test to ensure an early pregnancy had not been missed as a result of unreliable contraception prior to contraceptive implant insertion and to ensure she had completed her chlamydia treatment and partner notification had been completed. Multiple subsequent attempts were made to contact X to arrange a chlamydia test of cure but were unsuccessful.

Due to the high level of risk identified, X’s case was discussed with both the departmental and trust safeguarding teams. Enquiries were made to Croydon social services who confirmed that the previous safeguarding case had been closed. A further referral was made to the Multi-Agency Safeguarding team (MASH) and subsequently a key worker visited X and her family to discuss concerns. Partner agencies were involved at this stage to further support X and her family.

X’s case was carefully followed over a 3 month period with regular discussion at departmental safeguarding MDTs, liaison with trust safeguarding and contact with social services. X will be reassessed at any future presentations to CSHC to ensure there are no new safeguarding concerns.

Case Two
Patient G was a seventeen-year-old, first time user of our service, who attended as she thought she might have an STI. As she was under 18 and thus considered as being part of a high-risk group, alongside taking a full medical, sexual and contraceptive history, we also screened for safeguarding risk.

Assessment revealed Patient G had been living independently for the last 6 months, spending time between different hostels, was known to social services from an early age and had support in the community. She was in a stable relationship and raised no concerns about her partner. She smoked 10 cigarettes/day.

Patient G said her reasons for attendance were pain during sex, sores around her genitals and new onset of vaginal discharge. On examination she had lesions consistent with herpes simplex and based on her investigations at CSHC that day she was treated for bacterial vaginosis and herpes infections.

She was given information about both conditions. Our health professional ascertained that patient G currently had a contraceptive implant in situ, but discussed the importance of barrier methods for the protection of STIs, which patient G did not think she was at risk of. We also advised around smoking cessation.

Patient G was discussed in our safeguarding MDT. She was happy for us to contact her social worker which allowed us to correlate that she indeed had adequate support in the community. Following on from her initial visit at CSCH her results confirmed the sores were indeed herpes simplex type 2 and she additionally tested positive for chlamydia and gonorrhoea.

She was re-called for treatment of both infections and for review of her herpes management. Her herpes had resolved and she was given treatment for chlamydia and gonorrhoea. She was seen by our SHIP team to talk her through safer sexual practices to prevent further STIs. Her partner was also contacted, screened, and treated for chlamydia and gonorrhoea.

We follow-up our patients to make sure we have successfully treated STIs to prevent onward transmission and disease complications. Patient G was booked for an STI “test of cure” appointment, but unfortunately did not attend. The SHIP team attempted to contact her on many occasions and due to their perseverance we eventually managed to speak to her and make a further “test of cure” appointment. Patient G also did not attend the second appointment. However due to the continued hard work of the SHIP team we eventually got in contact again and patient G has since attended and her results are awaited.

Conclusions/Recommendations

Our service is based in a young, deprived area with some of the highest rates of STIs and teenage pregnancy in the UK. As reflected by both local data and our own clinical data and experience, significant rates of safeguarding risk are seen amongst our local young population, some of which is first disclosed to sexual health professionals.
Despite this, our service has suffered a 43% cut in budget, forcing a 30% reduction in clinic opening hours. It additionally does not received any specific funding for the time-consuming, complex and expert work required when assisting a young person at risk.

This restricts access to sexual health services for young people, who then cannot access STI care or contraception; further perpetuating the already high rates of STIs and teenage pregnancy seen in our borough. What is deeply worrying is the number of young people who are being denied access to safeguarding screening and education around consent, leaving children vulnerable to abuse in all its forms.

We find this unprecedented reduction in access to some of the UK’s most vulnerable young people both unacceptable and concerning and hope that our evidence submitted here will assist policy makers in deciding to reinvest in specialist sexual health services thereby ensuring that clinical and safeguarding expertise and access for vulnerable young people is maintained.

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