Written evidence from METRO Charity

Sexual health Inquiry Response

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Executive Summary

1. METRO is a leading equalities charity that has been providing extensive sexual health services and support for over 30 years, across London and in the Southeast of England. We have an extensive understanding of, and insight to, multiple aspects of sexual health service provision, including education and training, prevention, community testing and treatment, clinical services, and behaviour change initiatives.

2. METRO have responded to the inquiry by exploring current trends, prevention considerations, commissioning, workforce issues, and local and national initiatives. In our response, we have highlighted a number of key points, including:

2.1. Statutory funding is becoming increasingly sparse and more restrictive, with a sense of movement back towards core services. METRO believes this will adversely affect the sexual health outcomes of society at large, and of those who are already at risk in particular.

2.2. The presence and quality of sex and relationships education is currently variable and insufficient. Mandating SRE as a part of PSHE from 2019 onwards is a positive step, but consideration needs to be given to content and quality management in addition to provision alone.

2.3. Sexual health services are still not adequately supporting individual who identify as LGBT+. Many services feel inappropriate and unwelcoming to individuals who are LGBT+, and there is a paucity of awareness and training amongst sexual healthcare providers around how to work with a more diverse population. Individuals who identify as trans feel particularly unsupported.

2.4. MSM, black Africans, and young people remain at higher risk of poor sexual health outcomes, but new and emerging communities need to be given consideration also. These include people over 45, women who have sex with women, children leaving care, new mums, and young women living in homes with strong traditional or religious values.

2.5. There is a growing preference amongst asymptomatic and non-complex service users for online testing, meaning that more people are able to know their sexual health status without needing to attend a clinic. This means that clinics can begin to focus more on those with complex sexual or reproductive health needs, making better use of limited sexual health resources. However, if site-based clinical services are deemed too costly and unnecessary as a consequence, there could be negative implications for those who do have complex needs.
2.6. METRO are seeing an increase in co-commissioning and integrated sexual health services, and in fact currently deliver services within such a model. Long term outcomes of such models are yet to be determined, though preliminary experience suggests benefits could be found in proactive collaboration between relevant departments, and weaknesses could be found in provider communication and expectations.

2.7. There is high demand for sexual health services that is not met consistently across the UK; cuts to funding will exacerbate the gap between demand and provision. Access to, and promotion of, services remains an issue.

2.8. There is increasing pressure on the sexual health workforce to provide more services with fewer resources. Inter-organisational collaboration and referrals suggest this is true across the whole health and social services landscape, with the impact of cuts to funding becoming increasingly apparent.

Context & Overview

3. METRO is a leading equalities charity that was founded in 1984 as a southeast London based LGBT community charity. We now operate across the whole of London and the Southeast and employ over 100 staff and have over 60 active volunteers who provide over 85,000 occasions of service to more than 20,000 people annually. We also operate nationally, both in partnership and in research projects, like the National Youth Chances survey, the largest of its kind, with over 7000 LGBTQ young people surveyed.

4. METRO operates five domains of service: HIV, Mental Health, Youth, Sexual and Reproductive Health and Community. To respond to this inquiry, the head of the sexual health domain was asked to gather information, reflections, and trends from her team and to draw on her own experience working in the sector. Our response offers reflections on as many of the points noted in the enquiry as possible, though no concrete questions or categories were offered as guidance.

5. We strongly welcome any government initiative aimed at supporting open access, relevant, and integrated sexual health services, which aim to provide cohesive sexual health education, to reduce harmful behaviours and beliefs, to offer accessible and non-judgemental testing and treatment, and to offer psychosexual support to those most at risk, as well as to society at large.

6. Sexual health outcomes are not impervious to standard social and economic interactions with health; those who experience one or more social and/or economic disadvantages are disproportionately at risk of experiencing poorer sexual health outcomes. Thus, the
following headings will attempt to respond to the enquiry in a strategic way, without losing sight of the broader systemic need to integrate meaningful sexual health elements to other core social and economic priorities: education, infrastructure, social services, probation services, prisons, and families.

Recent Trends

Sex & Relationships Education

7. The presence and quality of sex and relationships education (SRE) across the UK is varied, and local authorities differ in their expectations around coverage, content, and delivery. Currently there is no mandatory requirement for primary schools or any level independent schools to provide SRE, though it is encouraged. When SRE is provided, there are decided gaps in quality and outcomes. Ofsted reported that 58% of students assessed gained weak knowledge, and poor ability to apply knowledge to practice.

8. SRE will become a mandatory part of PSHE from 2019 onwards, although the statutory requirements do not apply to sixth forms colleges, 16-19 academies, or Further Education Colleges. This is a positive step forward, but concerns about variable quality remain, with no current indication as to how schools will be required to deliver good SRE, and whether expert advice will be sought regarding curriculum content and methodology. METRO would advocate for broader consultation around what mandatory SRE must include in order to impact meaningfully on current outcomes.

9. METRO have experienced an increasing demand for expert sessions not only on more biological topics such as pregnancy and STI prevention, but also on broader issues such as sex and the law, consent, healthy relationships, sexting, pornography, pleasure, and online safety. This suggests that the more traditional understanding of SRE is not reflective of, or responsive to, the needs of young people today. Policies around SRE this need to reflect the changed sexual health landscape that young people exist within.

10. METRO are currently developing and delivering an array of sexual health training modules, which include greater emphasis on the topics noted above. When delivering this training, METRO continue to be surprised at the degree to which young people remain misinformed or uninformed, even by college age, particularly amongst those most at risk. Myths about pregnancy and STI transmission abound, and very few mechanisms for challenging these.

Sexual Health Services & LGBT communities

11. Findings show that sexual health services in general are not meeting the needs of their LGBT+ service users. For example:

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11.1. Young people who identify as LGBTQ do not feel that sex and relationships education (SRE) is appropriate or relevant to them, as most training is couched in heteronormative language and does not explore what health and safe sexual relationships might look like for them.

11.2. Many people who identify as LGBTQ feel judged by sexual health services, or invalidated by healthcare practitioners who assume they are straight. This is less true in specific sexual health clinics, where clinicians are trained to do a full sexual health risk assessment, yet exacerbated in maternal/maternity care, contraception, and GP practices where healthcare providers can be more traditional in their approach.

11.3. Service provision also varies widely between primary care providers, some of whom are either unable or unwilling to provide welcoming and appropriate services to those who are LGBTQ and others who are more informed/aware/skilled up/prepared

11.4. Trans people in particular feel excluded from sexual health services

11.5. Many LGBT specific sexual health services are explicitly geared towards MSM and overlook trans and WSW.

12. Sexual health services need to be open, welcoming, and relevant to all communities, particularly those who identify with different sexual orientation or gender norms.

Clinical Services

13. METRO currently offer an array of online sexual health services, including free condom schemes and Chlamydia screening for young people, an online health promotion and testing service for MSM, and a variety of at-home kits for Over 18s to test for HIV, Syphilis, Chlamydia, Gonorrhoea, and Hepatitis. We currently provide either one or all of these services to Kent, Medway, the Royal Borough of Greenwich, and the London Boroughs of Bexley, Merton, Wandsworth, and Richmond.

14. Without exception, online services are increasing in popularity quarter on quarter, and METRO has found online sexual health services are increasingly preferred over site-based clinical services for asymptomatic and non-complex service users.

15. The preference for online testing amongst the general population means that more people are able to know their sexual health status, without clinics being overrun with “the worried well”. This means that clinics can begin to focus more on those with
complex sexual or reproductive health needs, making better use of limited sexual health resources. METRO are starting to look into online treatment as well, to increase options, as well as to explore the idea of virtual / ad-hoc clinics.

Emerging Risk Groups
16. An emerging group of those at risk of sexual ill health seems to be appearing, as those aged 45+ are exiting longer term relationships / marriages. Preliminary explorations suggest that awareness of STIs / STI transmission is poor amongst this age group, as sexual health education delivered to them during their youth was focused predominantly on pregnancy prevention. More initiatives are needed to address the sexual health needs of this population, and to engage them in education and awareness around STI prevention in particular.

17. Young women living in homes where strong traditional or religious values are upheld are also emerging as a risk group, as their sexual activity outside of the home does not correlate to the support for, and expectations of, them inside the home. Strong beliefs about virginity mean that some young women are choosing to have anal sex so as to keep their hymens intact, but are not receiving the education and resources to do so safely. Equally, many young women in such homes are closely monitored by parents or male relatives, meaning that it is difficult for them to access sexual health and contraception services outside school hours. Services in areas where many young women live in such homes could consider linking sexual health services to schools more closely so that support can be given without exposing actual or perceived sexual activity. Culturally appropriate education for parents could also be beneficial.

Prevention
18. METRO delivers a number of prevention methodologies for the most at risk client groups, manifesting our profound belief that prevention is key to reversing poor sexual health trends and outcomes. These include:

18.1.1. Opportunistic Chlamydia Screening for young people, though the National Chlamydia Screening Programme (NCSP)
18.1.2. Free condom schemes, available both in person and online, for young people
18.1.3. Sexual health outreach geared towards young people
18.1.4. Online sexual health services for MSM
18.1.5. Peer mentoring for migrant and emerging communities at risk of STI or HIV infection, such as Latino, Polish, and Romanian communities
18.1.6. 1:1 assessments, key working, and health and wellbeing coaching that support clients to identify risk-taking behaviours, to enhance sexual health knowledge, develop tools, and to engage in safer sex.
18.1.7. PrEP interventions with ‘at risk’ communities via innovation fund targeting MSM, BME, Trans and Women
18.1.8. Online sexual health advice, information, signposting, and home sampling services for MSM
18.1.9. Provide support to MSM and Black African communities around HIV prevention through 1:1 interventions and group work

19. METRO also deliver services to young people to prevent sexual harassment, sexual exploitation, sexual assault, and rape. METRO are responding to requests for training on consent by developing and delivering bespoke workshops to schools who have requested support. Further, METRO provide a service for boys and young men (B YM) who have been identified as displaying harmful sexual behaviours, offering 1:1 and group sessions with the aim to challenge and reshape their ideologies.

20. Through this work, METRO have noted that the narrative around consent is still very heteronormative, focusing on how women need to give consent and how men need to gain it. This narrative is significantly lacking in complexity and is not embedded in the daily reality of many of our service users, particularly those who identify as LGBT. Thus, METRO identify that further initiatives are needed not only around consent itself, but on healthy relationships and how they interact with traditional gender stereotypes.

21. It is important to note that funding for preventative work is decreasingly available and harder to secure, and that preventative work is absent for certain demographics, such as women who have sex with women (WSW) ²,³, those who are aged 45+⁴, those who do not speak English as a first language, care leavers⁵, and new mothers⁶.

Commissioning of Services
Demand

22. METRO deliver six Greenwich Sexual Health Clinics and two Greenwich-based Pitstop Clinics for MSM each week. These clinics are regularly over-subscribed and attended by non-Greenwich residents who have been unable to find suitable services in their home boroughs, clearly evidencing unmet demand. Through these clinics, METRO have in the last 12 months:

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² Varney, J. and Newton, E. (2018) Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women, PHE
³ Varney, J. The Health and Wellbeing of Lesbian, Gay, Bisexual and Trans Londoners
https://www.london.gov.uk/sites/default/files/The%20Health%20and%20Wellbeing%20of%20LGBT%20London%20FINAL.pdf
⁵ JSNA (2017) The health and wellbeing needs of young adults age 18-25,
https://www.lbhf.gov.uk/sites/default/files/young_adults_jsna_lbhf.pdf
22.1.1. Seen 400 MSM in our Pitstop Clinics
22.1.2. Supported 500 Under 18s in our Greenwich Sexual Health Clinics
22.1.3. Supported a 17% Black African service user base
22.1.4. Dispensed 146 instances of EHC, of which 52 were to Under 18s
22.1.5. Seen 3300 service users at our Greenwich Sexual Health Clinics, 17% of whom were black African
22.1.6. Had a 14% positivity rate of Chlamydia at our young person’s clinic (higher than the national average)
22.1.7. Delivered 50 pregnancy test to Under 18s

23. METRO also run a sexual health helpline for residents of the Royal Borough of Greenwich and the London Borough of Bexley. Daily phone calls are received by the helpline from service users living all over the UK, who are unable to find or who do not have access to sexual health services closer to home. Again, the disparity between services offered to residents of some local authorities, and not others, shows that a postcode lottery is still very much in effect. This could become worse if cuts to funding for sexual health services continue.

Decommissioning of non-core services

24. With over 50% of local authorities indicating they are going to cut funding for sexual health services in the next financial year\(^7\) (BBC 2018), METRO are concerned that sexual health services will become increasingly unable to meet the demand of society at large, and particularly of those who are most vulnerable. Non-core services, such as those for prevention outlined above, are most at risk.

25. Some local authorities suggest that they are offering cheaper online services to replace more costly site-based services. This puts complex clients and those who are symptomatic at risk of not getting the support they need, and could fail to support service users with issues that are high-stake and time-sensitive, such those needing emergency contraception, termination of pregnancy, or post-exposure prophylaxis for HIV risk.

26. With the de-commissioning of non-core services, and the reduced commissioning of core services, sexual health services are very unlikely to meet the ever-expanding sexual health needs of society, particularly those already at risk.

Co-Commissioned Services

27. Many commissioning teams are putting forward Integrated Sexual Health (ISH) service specifications, which typically have a larger clinical body as a lead provider and smaller aligned service providers as subcontractors. There are opportunities with co-commissioning when strong partnerships are formed that benefit the entire health system. However, the integrated sexual health model has put NHS Trusts back into the

\(^7\) BBC 2018: Cuts to Sexual Health Services [https://www.bbc.co.uk/news/health-44353615](https://www.bbc.co.uk/news/health-44353615)
position of lead contractor/commissioner, of the smaller parts of these programmes. These include outsources Chlamydia screening, condom programmes, HIV prevention, and community outreach.

28. METRO are involved in a number of ISH contracts, with varying roles to play in each. Preliminary experience suggests that potential risks of ISH contracts are: the ability of the lead provider to effectively manage the contract, lack of ability of the lead provider to oversee non-clinical service delivery, poor communication mechanisms between partners, overlapping priorities leading to relationship breakdown, and service users experiencing a lack of continuity of care.

29. However, the idea of co-commissioned services does raise the concept of co-commissioning across public health departments, for example by linking up contraceptive services to overall reproductive health (cervical screening, breast health, testicular cancer), or by joining up service provision between services that address some of the factors influencing risk taking (eg, mental health, substance misuse, housing and homelessness).

Access

30. METRO are committed to providing and advocating for services which are easy to access, non-judgemental, and relevant to all potential service users. All METRO services which target young people are built upon the You’re Welcome Quality Criteria for Young People Friendly Services (Department of Health 2011), ensuring that even the most vulnerable young people can access us for support. Further, all services at METRO are promoted and delivered in such a way that all feel welcome, and METRO attempt to deliver services which reach out to where service users live, work, learn and play rather than expecting them to travel to us.

31. The same cannot be said in good faith about many other services available. Young people and adults alike report not knowing where to go for sexual health support, even for time-sensitive issues such as emergency contraception. Services that are available are often difficult to get to, particularly when financial restrictions are an issue, or offered at times that suit clinicians but not service users. This forces individuals to seek information and support from alternative sources, often with no clinical governance or quality control.

32. When services are found and accessed, young people and adults alike often report difficult experiences, with rude reception teams, judgemental practitioners, and services couched in ways that do not reflect their lived experiences. This reduces the likelihood of engagement with services, again forcing individuals to seek information and support elsewhere.
Workforce issues

33. METRO are witnessing a workforce which is increasingly tasked to do more, in less time and with less funding available. This is a direct result of commissioning bodies expecting providers to increase their performance and decrease their costs. There is also tension between different service providers when changes to commissioning structures result in diminished services (or, the perception of diminished services), meaning that service users could be impacted by communication breakdowns and limited understanding of the available local offer.

34. Similarly, with cuts being made to other social and healthcare services, METRO are noticing that it is increasingly difficult to refer vulnerable service users into alternative support services. The threshold for young people to receive CAMHS support is high and increasing, and early start and social services seem overburdened and under-resourced. Many youth services are closing down or decreasing their capacity, and anecdotally, schools report feeling increasingly stretched in terms of their ability to identify and support their most vulnerable students.

Action at national and local level to improve SH services

35. In order to meet the expanding needs of society’s sexual health, particularly with regards to new and emerging at risk populations, further research to identify needs and goals is required. For example:
   35.1.1. To identify the needs of over 50s living with HIV
   35.1.2. To discern the risk behaviours, and potential opportunities for education, amongst the over 45 population
   35.1.3. To explore gaps in training amongst healthcare providers regarding LGBT+

36. Additional policies to direct and set quality standards for mandatory SRE would also be a useful step towards providing good SRE in all schools, and reduce the impact of the postcode lottery.

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