

LESSONS FOR THE NEW ERA OF MANDATORY RSE

How Local Authorities are making the links
between schools and sexual health services



BACKGROUND

This research was carried out in order to support and inform planning for the new mandatory RSE topic. The evidence for high quality RSE is clear. According to UNESCO, 'Comprehensive Sexuality Education (CSE) leads to improved sexual and reproductive health, resulting in the reduction of sexually transmitted infections (STIs), HIV, and unintended pregnancy. It not only promotes gender equality and equitable social norms, but has a positive impact on safer sexual behaviours, delaying sexual debut and increasing condom use'.¹ The 2018 Teenage Pregnancy Prevention framework also cites RSE and young-people friendly local services within the ten key factors of effective local strategy for reducing unplanned pregnancy and improving sexual health outcomes.²

The statutory guidance for mandatory RSE³ asks schools not only to address all aspects of 'intimate and sexual relationships, including sexual health' but – crucially – 'how to get further advice, including how and where to access confidential sexual and reproductive health advice and treatment'. We were therefore particularly interested to examine the extent to which sexual and reproductive health information, including how to access services, is currently included in RSE; and to explore the role of local authorities in supporting schools in this task.

We aimed to find out more about local authorities' (LAs) current practice and plans. Between 2018 and 2019 Brook (in partnership with FPA until May 2019) and the Open University carried out a piece of research, looking into the ways that LAs support schools with providing RSE; how they support sexual and reproductive health (SRH) services; and how they support Links between schools and sexual health services.

¹ en.unesco.org/news/global-review-finds-comprehensive-sexuality-education-key-gender-equality-and-reproductive

² assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/836597/Teenage_Pregnancy_Prevention_Framework.pdf

³ www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education



**THE EVIDENCE FOR HIGH
QUALITY RSE IS CLEAR**



METHODOLOGY

The research was designed as an iterative piece of work in which findings at each stage informed the next stage of data collection. Between November 2018 and June 2019, we carried out the following activities:

1. Through a Freedom of Information request, we contacted every local authority (LA) in England to find out what they do to support RSE in schools; the extent of their sexual health service provision for young people; and what they do to promote links between schools and services in their areas. A high proportion (95% N=144) of LAs responded. A question was also added to the annual FOI request (2019, response rate 96% N=146) issued by the Advisory Group for Contraception to clarify LA commissioning of 'standalone' sexual health services for young people.
2. Identified areas that, according to our analysis of the FOI responses, were doing and/or investing the most to support schools in their area. We then interviewed local authority leads (N=8) with responsibility for commissioning sexual health services and/or RSE support services in these areas.
3. Identified schools as case studies in the eight selected areas. In the two schools that agreed to participate we:
 - a. Interviewed the RSE lead teacher to find out more about the support they receive and the challenges they face
 - b. Conducted two focus groups each, in two schools, to investigate the level of their knowledge of sexual health issues and where to go for services, acquired through RSE lessons.

The FOI data were compiled and analysed using Excel. The qualitative interviews and case studies were analysed thematically by research topics and by emerging themes. The analysis and findings have been sense-checked independently by four members of the research team.

FINDINGS

The research data were combined during the final level of analysis and are presented in three sections below. We first discuss local authority support for RSE; then local authority commissioning of young people's sexual health services. Finally, we examine the links between sexual health services and schools. The report ends with recommendations in all these areas.

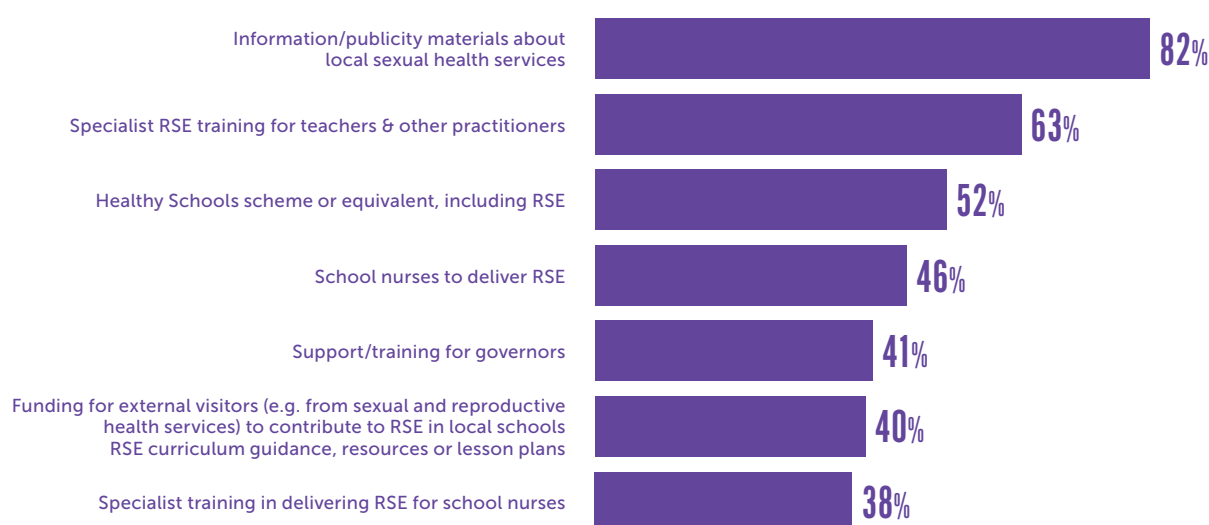
1. LOCAL AUTHORITY SUPPORT FOR RSE

Our data showed that local authority investment in this work varies widely, with some investing significantly in supporting their schools with RSE (see figure 1).

FINDINGS

1. As can be seen in Figure 1, most LAs provide schools with information on sexual health services (82%) and a substantial number provide training for teachers (63%). However, less than half of LAs offer support in the form of specialist training for nurses and school governors, or funding for external visitors. Half (52%) of the LAs maintain the Healthy Schools Schemes (or equivalent), which include elements of RSE, and – as indicated in FOI responses and discussed later – make links between schools (RSE) and local SRH.
2. The FOI data show that spending by LAs on supporting RSE varies significantly. Some LAs have a track record of providing sufficient funding and staffing to enable good support for RSE in schools. This was confirmed by seven out of the eight LA key informants who also said that they did not need or expect an increase in funding to prepare for mandatory RSE. However, 51% of LAs could not provide accurate estimates for spending on RSE support, 15% had no budget for RSE in 2018/19, and 12% had spent nothing for two years (FOI). In advance of mandatory RSE, 15% confirmed an increase in spending on RSE support while 65% indicated no increase. Some LA key informants, who reported no plans to increase funds, nevertheless said they would increase their RSE support activities. The research did not uncover how they would achieve this.

Figure 1: Percentage of local authorities offering different forms of support for RSE





3. In those LAs selected for good practice, it has been possible to make the case for funding for RSE support despite funding constraints. Key informants pointed to a high level of support from Directors of Public Health and local politicians who are influenced by findings from pupil surveys, national issues and the forthcoming mandatory RSE. Other important drivers for LA investment in RSE include: the LAs' public health remit, the legacy of the teenage pregnancy strategy; statutory duties around safeguarding; FGM; sexual exploitation and slavery; and sexual and reproductive health through the life course. In these LAs these statutory duties are underpinned by increasingly open attitudes on sexual and reproductive health and LGBT+ issues amongst politicians.
4. All eight selected LAs fund one or more staff member (in public health or school improvement) to support schools with RSE. These staff members provide advice, training, curriculum materials and other resources to schools, and can broker external SH providers. They may be RSE consultants or coordinators, health improvement or healthy schools' coordinators, or PSHE advisors. In our case studies, the teachers were aware of the LA's RSE lead and were supported to develop policies by the public health team. Some schools benefitted from a school nurse being provided free to the school.
5. Some LAs pay for young people's sexual health services to deliver local training to teachers and other professionals working with young people; and to provide one to one support. Others arrange this in-house. Some LAs commission external agencies and school nurses to deliver RSE to classes and targeted groups. In other areas schools have to fund external visitors themselves.
6. Diverse activities are commissioned and provided, including: campaigns, theatre productions, network meetings, an annual development day, multi-agency training days, parents RSE meetings, a policy review, LGBT guidance, topic-specific training on issues such as sexting and FGM, and a local annual RSE day.



7. Some LA key informants explained that LAs' are hampered in their ability to support RSE because of limited financial resources within LAs to pay for activities and staff. They also reported that the impact of LA support for RSE can be limited by lack of participation by some schools in their initiatives and training offers. LA key informants spoke of resistance from schools due to competing curriculum demands, lack of prioritisation of RSE, and school budgets.
8. In the case studies, teachers spoke of the constraints they faced. They highlighted lack of resources, particularly time for teacher training and lesson time in the school day as the core curriculum crowds out PSHE. One of the schools had recently cut time spent on PSHE by 50%. The teacher interviews and focus group findings indicated that in the participating schools there is a shortage of teachers who are trained, knowledgeable and confident in RSE; and there also appears to be a failure by the schools to adopt and implement a consistent RSE curriculum so that all children receive the same lessons. The focus group and the teacher interview data also indicate a lack of ring-fenced and regular curriculum time for RSE.
9. Several LA key informants said that with academisation there were no mechanisms in place to support monitoring the quality of RSE delivery. With a diminishing number of maintained schools, LAs have a decreasing influence on and oversight of what happens in their local schools.
10. The focus group data indicate the possible consequences of this lack of monitoring. Even where LAs provide good support for RSE in schools, students do not automatically experience high-quality RSE. In the case studies, we found a disconnect between the high level of support reported by local authorities and school students' awareness of RSE topics and local services.
11. Young people in focus groups demonstrated very low levels of knowledge about SRH issues including different forms of contraception and STIs, their rights to confidentiality, and where to access SRH care. They articulated what they thought the problems are with RSE/PSHE in their schools such as wide variance in the confidence and knowledge of teachers; no set curriculum to ensure consistency across the school; and a lack of regular timetabled lessons. In the focus groups students claimed that some teachers did not want to talk about RSE and instead put them in front of films, and specifically compared the knowledge of a biology teacher favourably to that of other teachers. In one of the schools students noted that they had very different experiences depending on their teacher and that they didn't all do the same thing in RSE. In both schools, the focus groups made it clear that very little time was given to RSE over their school careers to date.

2. LOCAL AUTHORITY COMMISSIONING OF YOUNG PEOPLE'S SRH SERVICES

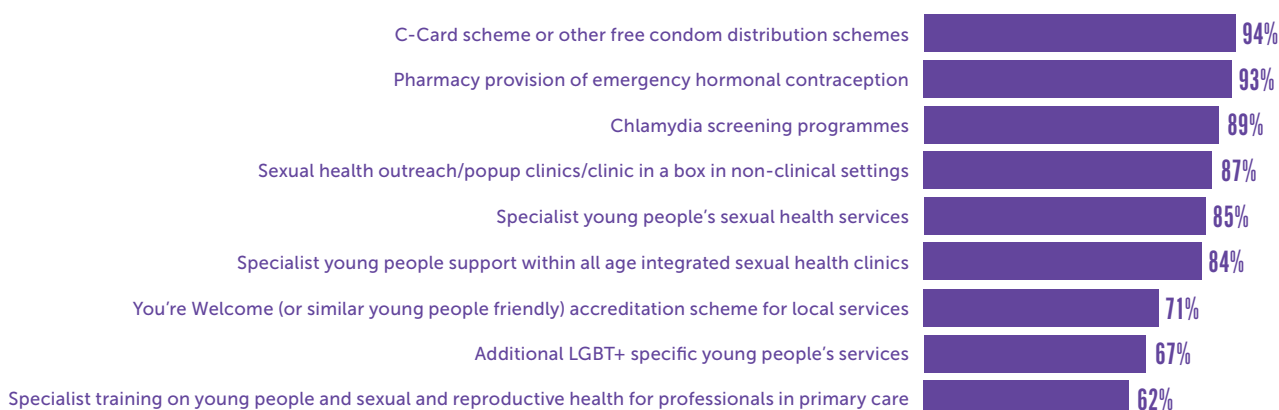
The importance of providing young people friendly clinical services alongside good quality RSE is widely acknowledged as key to improving sexual health outcomes for young people.

Local authorities are mandated to commission open access sexual and reproductive health services including contraceptive provision and STI prevention and treatment in their areas. However, they have the flexibility to commission the services needed by their particular local populations.

FINDINGS

1. Our FOI asked about LA provision of specialist young people's sexual and reproductive health services. 85% reported providing specialist young people's sexual health services (see Figure 2). However, 84% also reported commissioning specialist YP support within all-age services, which suggested they contained diverse interpretations of the term 'specialist services'. In 2019 the Advisory Group on Contraception included a question in its annual FOI⁴ about contraceptive services – specifically on whether local authorities commission 'standalone' sexual health services. This, more specific, question elicited a lower percentage of positive responses (51%). These may well include a broad definition of 'standalone', including, for example, discrete clinic times within an all-age service.
2. As can be seen in figure 2, the vast majority of LAs (94%) provide C-Card or Condom distribution schemes and 93% commission pharmacy provision of emergency hormonal contraception.
3. 71% reported using the You're Welcome framework or equivalent to assess the accessibility of their services for young people.
4. Lower numbers of LAs provide additional LGBT+ support for young people (67%) and specialist training for professionals about young people and sexual health (62%).
5. LAs were asked if they could provide data on how many contacts young people have had in SRH services, but a substantial number could not provide this data for either 2016-17 (51%) or 2017-18 (47%). Of those LAs that reported figures from community SRH services they were often incomplete (e.g. only covered specific activities such as LARC provision), or unreliable because the data covered more than one LA.
6. Over 90% of LAs reported that they couldn't provide any data about contraception provision in GP clinics.
7. 89% of LAs said that they could not identify their spend on young people's sexual health and contraceptive services. For 69% of respondents, this was because spending on young people's SRH provision could not be disaggregated from overall spend on integrated all-age services.

Figure 2: Percentage of local authorities investing in different sexual and reproductive health services for young people



⁴ theagc.org.uk/wp-content/uploads/2019/11/2019-AGC-FOI-audit-press-release-.pdf



3. LINKS BETWEEN LOCAL SEXUAL HEALTH SERVICES AND SCHOOLS

FINDINGS

1. The vast majority of FOI respondents (86%) confirmed that they provide updates about changes to local sexual health services to schools and 75% inform them of local sexual health priorities and concerns that need to be addressed in RSE.
2. They also confirmed that contracts with sexual and reproductive health services include a requirement to promote services for young people under 19 through schools (81%), and other routes such as public awareness campaigns (90%).
 - The majority of LAs reported using different mechanisms to communicate with schools asked about in the FOI: Information in pharmacies (89%), and on the local authority website (88%); online advertising including social media (85%); via youth services/clubs (84%); advertising via posters and leaflets (84%); information for RSE curricula (82%); and display publicity for schools (80%). Other routes used to communicate to schools included electronic messaging (texts, apps), training about specialist SH clinics, and a sexual health network.
3. In the two case studies, teachers spoke of school nurses being key to providing young people with information about local SRH services. This was primarily through drop in sessions and information leaflets, but also because – unlike most teachers – they not only worked but also lived in the locality and were aware of local services. The teachers acknowledged that they were not experts on local services. However, they both also emphasised that the nurses covered many schools and had very limited time in any one school.
4. For those LAs that identified barriers to developing links between RSE and young people's sexual health services, resistance from senior leadership in schools (41%) and budgetary issues (35%) were the most common. A fifth of LAs identified changes in school governance, e.g. academisation (22%) and fragmentation of service provision (21%). Additional barriers included religious and cultural resistance, including from parents; lack of clear guidance from government; and schools' prioritisation of academic subjects leading to RSE/PSHE having a low priority. A third of LAs (34%) did not identify any barriers.

LIMITATIONS

There are some limitations to this study that need to be pointed out. The quality of the FOI data is reliant on the request being directed to the best person within the LA to answer the particular questions asked. The accuracy/completeness of the answers is dependent on the knowledge of the respondent, whether they know where to source missing data, and their personal commitment to providing robust information. Missing data in an FOI response is not evidence that data doesn't exist, but instead may indicate a lack of institutional knowledge between LA teams about how to access and use available data. Where we asked for LAs to report on the support they deliver, FOI data do not provide us with any evidence of quality. For example, RSE training for teachers might vary widely, including from in-school lunchtime or twilight sessions and short contributions to INSET days, or whole day training for teachers across a local authority area. Moreover, many factors can affect the likelihood of a school taking up an offer of funded training, including the school's willingness to release a teacher from contact time and to fund teaching cover. Data derived from freedom of information requests can only ever be a 'snapshot' in time. Where we tried to address this limitation by asking for comparative figures from different years it didn't always enable a like with like comparison. This is because public

health commissioners, under pressure to meet increasing demand with shrinking budgets, often reduce the value or terms of contracts resulting in significant changes to services and the profile of service-users in a particular clinic. The picture is therefore far more complex than that presented in this report.

Data from the school student perspective are limited. We only ran four focus groups across two local authority areas, as opposed to our original plan to run groups in all of the eight local authority areas selected for best practice. However, the response from schools was low, with schools and local authority leads citing pressure on curriculum time, and time pressure on teachers as reasons that this kind of work is becoming increasingly difficult to arrange. We chose to run the groups with students at the end of year 10. It is possible that their knowledge levels will improve over the subsequent year, but teachers we consulted agreed with us that exam preparation in year 11 means that many students will have had the vast majority of their RSE by the end of year 10.

Despite these limitations, we are able to draw the following conclusions. They are primarily based on the FOI data but are supported by the discussions with LA staff, teachers, and students.

RSE MUST BE PROPERLY RESOURCED



CONCLUSION

RSE AND MAKING THE LINKS

This research found that the majority of Local Authorities do support RSE in schools, but that the extent and nature of that support varies significantly. This support is primarily driven by public health obligations. Although academisation means that many schools no longer come under local authority control, local authorities still have responsibility for specific public health outcomes which relate to sexual and reproductive health including reducing: late diagnosis of HIV, chlamydia amongst 18-25-year-olds, and under-18 and under-16 conceptions. Since 2019 the following outcomes were added: increasing the use of effective LARC methods of contraception; reducing STI rates; increasing STI testing rates for under-18s; and improving HIV testing coverage. Effective RSE is a key component of improving these outcomes.

INSUFFICIENT TIME IS DEDICATED TO RSE IN SCHOOLS

Areas that invest significantly in supporting schools with RSE also cited the legacy of the Teenage Pregnancy Strategy – including lessons learned and ongoing relationships between health and education developed during the lifetime of the strategy – as an important element in their ability to make the case for funding of RSE support and other young people's sexual health initiatives.

The research also found significant barriers to ensuring this investment is effective. These barriers were evident at the LA level, where there was often limited monitoring and evaluation of the support offered, but were most obvious within schools. The most significant barriers in schools concerned resources: time in the curriculum and money. These are issues that need to be resolved as mandatory RSE is implemented.

Most LA commissioners contractually oblige sexual health service providers to let schools and young people know about their services, but access to information for young people may be limited by the quality of RSE where RSE lessons are the main source/conduit for information. Overall, the most striking finding concerns the difficulty of ensuring that LA investment in RSE is effective in reaching the intended beneficiaries – young people. Although the findings are limited by being confined to two schools, these schools were selected from 'good practice' LAs. The young people in these groups demonstrated very low levels of knowledge about SRH issues. This finding requires that schools monitor and evaluate their RSE closely. It also suggests the need for further research in order to share best practice and ensure that investment in RSE will be effective. In these schools, implementation of RSE appears not to reflect characteristics of effective RSE as identified by the evidence-based UNESCO technical guidance and is not having the desired impact. Whilst LA support is very important, the Department for Education must take ultimate responsibility for providing clear guidance, the necessary resources and training, and effective monitoring of progress. Then schools will be better equipped to ensure effective deliver of RSE.

SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR YOUNG PEOPLE

LAs are required to commission clinical sexual health services that meet the needs of young people, but they are under severe funding constraints. According to annual FOI data from the Advisory Group on Contraception, this has led to a significant reduction in the number of sites providing contraception between 2015 and 2019.⁵ This includes specialist or standalone young people's clinics.

The need for savings might be being confounded by a lack of evidence upon which to make commissioning decisions. Based on the FOI responses, LAs lack clear data on: how much they are spending specifically on SRH services for young people; where young people are accessing clinical SRH services; how much of young people's sexual and reproductive clinical care is provided via community/specialist sexual health services rather than primary care; and the relative cost of providing services in different settings.

⁵ theagc.org.uk/wp-content/uploads/2019/11/2019-AGC-FOI-audit-press-release-.pdf

**THE MOST SIGNIFICANT
BARRIERS ARE TIME
AND MONEY**



RECOMMENDATIONS

RSE

Local authorities, schools and service providers must all play their part if we want young people to get excellent RSE and experience positive sexual and reproductive health. Currently, lack of funding and lack of capacity are hampering these efforts. This report indicates the following recommendations:

- ❖ In order for statutory status for RSE to have the desired impact, RSE development and implementation needs to conform to all the UNESCO effectiveness characteristics (pp 90-93)⁶ particularly: assess the resources available for implementation; involve experts, young people and other stakeholders in curriculum development; focus on clear goals, outcomes and key learning to determine content; cover topics in a logical sequence; provide information about services that address young people's SRH needs.
- ✂ The Government guidance must be clearer (if necessary, more prescriptive) about what a quality RSE offer looks like, including ring-fenced, regular curriculum time
- There must be adequate funding (over and above existing school budgets) for staff training. This must cover costs to release teachers from teaching time to participate in training and to plan and implement support for staff to deliver RSE
- ☪ Ofsted (or equivalent) must have a topic focus on Relationship, Sex and Health Education (RSHE), offer scrutiny of and support for RSHE teaching in order to promote quality and consistency, and monitor the progress of RSHE nationally by:
 - a. including a subject-specific focus on RSE in inspections from September 2020 (with training for inspectors) that includes questions to pupils
 - b. publishing a specialist subject report of RSHE before the revision of guidance
- Initial teacher training must do more in support of good RSHE teaching, so that all teachers who might be expected to teach RSHE have basic training in key issues, appropriate pedagogy, and are introduced to high quality and reliable information resources
- ▶ The Government needs to give further thought to the mismatch between Local Authorities' responsibilities for public health and safeguarding – in which RSE plays a vital part – and their lack of financial capacity and authority to support and monitor the quality of RSE delivery in their local schools
- ❖ Further research is needed to understand the benefits of different forms of investment in RSE; and the most effective model for RSE delivery, including the role of school nurses, other specialist staff and external providers
- ✂ The COVID-19 situation has made the development of effective systems for online communication with young people about SRH information and services even more relevant and pressing.

⁶ unesdoc.unesco.org/ark:/48223/pf0000260770

COMMISSIONING SEXUAL HEALTH SERVICES FOR YOUNG PEOPLE

If they are not already doing so, local authorities should be collecting and interrogating data in order to understand more about:

- ◆ Their local population need, i.e the number of under 25s in the population. and the percentage who are sexually active and will need SRH services
- ✧ Where young people are accessing SRH services
- Which young people are falling through the gaps and what clinical offers, location and service times, are necessary to meet the needs of those at highest risk of poor SRH outcomes
- ☪ Whether young people have access to the same range of services at all locations. For example, can they access free condoms, STI testing, treatment and partner notification, and the full range of LARC contraceptive methods wherever they go – and if not, what are the signposting and referral routes into services which offer these services
- What difference it makes to where young people go for SRH services and whether/which groups of young people are falling through the gaps when a service is closed/moves/changes its age-range or hours
- ▶ What the relative costs are of different service models, for example, community specialist services versus GP provision

LINKS BETWEEN LOCAL SEXUAL HEALTH SERVICES AND SCHOOLS

- ◆ Local authorities should ensure that services' responsibility for communication with schools is explicit in all sexual health service contracts
- Local services should monitor the effectiveness of different forms of communication with young people
- ✧ Local services should be supported to visit schools in order to describe what their services can offer, provide a clear expectation of what it is like to visit the service, and reassure young people about their rights to confidential support

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