National mapping of on-site sexual health services in education settings

Provision in schools and pupil referral units in England

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NCB promotes the voices, interests and well-being of all children and young people across every aspect of their lives.

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Introduction

This report presents findings from the first national mapping survey of on-site sexual health services in secondary and further education settings in England. The mapping survey was completed by teenage pregnancy coordinators between October and December 2007 and had a high response rate with coordinators from 70 per cent of local authority areas returning the survey.

The survey data gives a real picture of how widespread on-site sexual health services in education settings now are. Information provided in open questions on the survey form complement the numerical data by indicating both the commitment at local authority level to developing these services in the future and the barriers to development.

This report focuses on the mapping data relating to secondary education settings. A separate report will be published focusing on further education settings.
Why was the mapping survey carried out?

The Sex Education Forum has been at the forefront in sharing good practice about the provision of on-site sexual health services in schools. Following the publication of Secondary Schools and Sexual Health Services: forging the links (Thistle, 2003) the Sex Education Forum has hosted the ‘Schools and Sexual Health Services Network’ enabling professionals to share practice.

During the last three years interest in setting up on-site sexual health services in schools has grown. Professionals deciding whether or not to develop sexual health services in their area have often asked the Sex Education Forum, ‘How many schools have on-site sexual health services?’ The growing membership of the Schools and Sexual Health Services Network (currently over 300 individuals) suggested that on-site sexual health services in schools were increasingly common. However, in the absence of national data it was not possible to say just how common these services were. Furthermore, network members often reported a sense of isolation when developing services locally.

Journalists also contacted the Sex Education Forum with the same question; and in 2007, teenage pregnancy coordinators and local authorities were contacted by the press with requests under the Freedom of Information Act for detailed information about on-site sexual health services in schools. Press coverage followed which represented on-site sexual health services in schools as secretive, hidden from the view of parents and as promoting teenage sex.¹

The mapping survey was thus carried out with three objectives:

a) to gain information about regional and local distribution of on-site sexual health services in schools, enabling professionals (in the local authority and government offices) to compare the level of services in their area with other areas

b) to increase the confidence of professionals (including governors, headteachers, school nursing leads and commissioners) in deciding whether or not to develop services in their area

c) to demystify the provision of on-site sexual health services in schools.

¹ See particularly the press about Lutterworth Grammar School (Daily Mail, 30 April 2007) and the Tic Tac centre at Paignton Community College (The Sun, 11 December 2007).
The need for improved access to sexual health services for young people

Between a quarter and a third of young people have had sex by the time they are 16 (Wellings and others, 2001), indicating that a significant minority of young people need access to sexual health services at secondary school age.

Young people are the group least likely to access contraceptive and sexual health advice, putting them at high risk of unplanned pregnancy and/or contracting a sexually transmitted infection (STIs) (DfES, 2007b).

Over 50 per cent of conceptions to under-16s lead to an abortion and teenage mothers and their children experience far worse health and education outcomes than older mothers. This increases their likelihood of long-term social exclusion. STIs can cause fertility problems in later life and, in respect of HIV/AIDS, can be life-threatening (adapted from DfES, 2007b).

Teenage pregnancy rates have fallen steadily over the last seven years, to their lowest level for 20 years. The latest (2006) under-18 conception data shows that the rate has fallen by 13.3 per cent and the under-16 conception rate by 13 per cent (ONS, 2008) since the Teenage Pregnancy Strategy began. But the UK still has high rates of teenage pregnancy compared to its western European neighbours (adapted from DfES, 2007b).

Although the incidence of some STIs is declining, rates are highest among young people (DfES, 2007b). An estimated one in 10 young people are infected with Chlamydia (HPA, 2006).

Improving access to confidential advice and support on relationships, contraception and sexual health is a key factor in helping young people to make healthy and positive choices.

Young people often feel uncomfortable accessing services in community settings because of fear about being judged and confidentiality being broken. A typical comment from a young person is, 'We worry that the GP will phone our parents' (Thistle, 2003). That services are confidential is of critical importance to young people. Health professionals follow clear protocols to encourage young people to talk to their parents or a trusted adult about their relationships and any medical treatment they may need.

Service location and opening hours can also pose a barrier to access for young people, so young people need to be able to access services at a time, and in a place and style that they feel comfortable with. Early positive experiences in using health services are likely to give young people the confidence to access a wide range of services in the future.
Policy context

The development of on-site sexual health services in schools and other education settings is supported across government policy concerned with the health and well-being of children and young people. The Department of Health’s public health policy, *Choosing Health* (2004) explains the benefits of enhanced access to services in schools and identifies the Healthy Schools Programme and Extended Schools core offer as key drivers for service development. The Teenage Pregnancy Strategy recommends easier access to sexual health services as a key factor in reducing teenage conceptions.

The National Healthy Schools Programme is being rolled out to all schools with a target of all schools being Healthy Schools by 2010. To achieve healthy school status schools must meet criteria relating to Personal, Social and Health Education (PSHE). Effective PSHE is delivered as part of a whole school approach, including both classroom teaching and promotion of access to services. One of the criteria for healthy school status is that schools have ‘arrangements in place to refer pupils to specialist services who can give professional advice on matters such as contraception, sexual health and drugs’ (DH, 2005). These arrangements can include specialist services available on the school site as well as effective signposting to local services.

Clear information about sexual health services and how to access them is an important part of Sex and Relationships Education (SRE). The national *Sex and Relationship Education Guidance* states that ‘young people need access to, and precise information about, confidential contraceptive information, advice and services’ (DfEE, 2000).

The extended schools offer is based on the principle of co-locating services on the school site – extending the services already provided by a school. One of the four cornerstones of the extended schools core offer is ‘swift and easy access to targeted and specialised services’. This core offer should be available to all children in schools by 2010 (DfES, 2007a).

Locating services in places where children and young people go is central to the thinking of *The Children’s Plan* (DCSF, 2007), which sees that ‘by locating services under one roof in the places that people visit frequently, they are more likely to find the help they need’.

The Children’s Plan endorses the value and legitimacy of on-site sexual health services by committing to:

- increase young people’s knowledge of effective contraception and improve their access to advice through encouraging the provision of on-site sexual health services in schools, colleges and youth centres. (DCSF, 2007)

Schools now have a legal duty to promote the well-being of children and young people in their care. The Children’s Plan is committed to producing well-being guidance for schools to explain this duty in more detail. A set of school-level indicators is also being designed to measure a school’s contribution to pupil
well-being (DCSF, 2007). Indicators relating more or less directly to sexual health and teenage pregnancy are likely to form part of this measure. The provision of on-site sexual health services helps schools to fulfil their duty in promoting pupil well-being.

Schools and local authorities are already inspected against the five Every Child Matters outcomes for children. Helping young people access health services enables schools to support all children in achieving the ‘Being Healthy’ and ‘Staying Safe’ outcomes.

The Department for Children, Schools and Families and the Department of Health share a target to halve under-18 conception rates by 2010. At a local level, the primary care trust and local authority are jointly responsible for the Public Service Agreement to reduce teenage pregnancies. The provision of sexual health services in education settings will contribute to achieving this target.

Taken together, there is strong and consistent support within government policy to make sure that all young people have the information they need to make informed choices about their relationships and sexual health and that they can also access confidential sexual health services in the places that they go. As a place where the majority of young people go, schools are central to making this vision a reality.
The evidence base

The provision of PSHE (including SRE) and easy access to young-people-friendly contraceptive services have been identified as key factors in areas with declining teenage conception rates (DfES, 2006).

School-based services locate health advice closer to the point of need and ensure that young people can easily access services they may not be able (or want) to access in traditional clinical settings. They also allow closer links to be developed between one-to-one advice and the learning about sex and relationships within the PSHE curriculum (adapted from DfES, 2007b).

Early opportunities to talk to a health professional enable young people to make informed choices, reduce the likelihood that they are putting themselves at risk of STIs/unplanned pregnancies and provide opportunities to disclose concerns about abusive or coercive relationships (adapted from DfES, 2007b).

Evaluation of the Extended Schools Pathfinder Project found that access to a health professional on the school site supports young people with health-related problems and also improves school attendance by addressing some of the barriers to learning (Cummings and others, 2004).

Feedback from schools offering on-site health services shows a strong demand for sexual health advice, in particular. Many of these schools offer general health advice. This is partly to maintain the confidentiality of young people’s enquiries so that the particular reason why a young person is accessing the service is not obvious. It also widens the range of health concerns that can be addressed through one service, for example, smoking cessation, drug and alcohol problems, obesity, eating disorders and mental health (adapted from DfES, 2007b).

Easy access to contraceptive services was found to be the single most important factor in reducing teenage conception rates in England (DfES, 2006). This finding is supported by research in the United States, which found that 86 per cent of the recent decline in United States teenage pregnancy rates is the result of improved contraceptive use (Santelli and others, 2007). Among school-aged adolescents (those aged 15 to 17 years) 77 per cent of the decline in pregnancy risk was attributable to improved contraceptive use.

Findings from the Teenage Pregnancy Strategy in England and the research led by Santelli in the United States provides strong evidence that having access to contraceptive services supports young people in taking control of their contraceptive choices, and preventing unwanted pregnancies.

Young people’s access to contraceptive services can be improved by changing the time, place, and style in which services are provided. These changes to make services young-people friendly are explained in the Department of Health’s You’re Welcome Quality Criteria: Making health services young people friendly (DH, 2007).
Locating services in schools improves access because the time and place fits in with young people’s everyday lives. There is currently a lack of research evidence comparing the effectiveness of different settings for providing sexual health services to young people. However, members of the Schools and Sexual Health Services Network have reported the success of services in schools.

School (and alternative provision) is the one place that the large majority of children and young people attend. Not all young people will need to use a sexual health service at school age, but providing a service in school is the best way of making sure that those young people who need the service can use it.

Research by the University of the West of England into the effectiveness of a pilot project by Brook sexual health outreach services in 16 schools in Bristol (Salmon and Ingram, 2008) provides evidence that services based in school can be effective in reaching vulnerable and ‘hard to reach’ groups of young people. Sixty-one per cent of young people using the Brook outreach service in school had attended because it was at school and easily accessible.

The Department of Health’s ‘Health Technology Assessment’ programme has commissioned Sheffield and Sheffield Hallam universities to synthesise national and international research about the effectiveness of ‘school-linked sexual health services’, and is due to report in 2009. In particular, the scope of this study includes cost–effectiveness modelling and a description of the range of models of on-site services.

This report provides new evidence of how widespread on-site sexual health services in schools now are. But it does not attempt to provide new evidence about the effectiveness of those services in schools, for example, in reducing teenage conception rates. As further research becomes available a more extensive evidence base will be built.
Mapping survey design

The survey was designed to be as simple as possible in order to maximise the response rate. Education settings were divided into three types:

- secondary schools (including schools with sixth-form provision)
- pupil referral units (PRUs)
- further education settings (including colleges and sixth-form colleges).

Teenage pregnancy coordinators were asked to list all secondary schools, PRUs and further education settings, and to classify them under one of four categories:

No sexual health services | Comprehensive sexual health services
---|---
**basic** sexual health services on site (includes free condoms and/or pregnancy testing) | **advanced** sexual health services on site (includes Chlamydia testing and/or emergency hormonal contraception (EHC))
**no sexual health services** on site (although advice, signposting and referral may be offered) | **specialised** sexual health services on site (includes prescription contraception in addition to EHC and/or wider range of STI testing in addition to Chlamydia testing)

Definition of a ‘sexual health service’

The entry level for categorisation as a 'sexual health service' involves the provision of something tangible, if the young person needs it, for example, condoms and pregnancy testing. This definition is important because all school nurses and student welfare advisors should be giving advice about sexual health, formally or informally, as part of their routine services. How proactive they are in this advice-giving role will vary; from responding to questions solicited individually by students, to giving advice as part of a clearly advertised drop-in session.

Offering the more clinical and physical services on the school site goes significantly further than giving advice. The barriers faced by young people in accessing sexual health advice are lower than the barriers they face in accessing contraception and testing. For example, advice can be accessed through telephone help-lines and the internet, but the issuing of contraception and testing services depends on professionals providing the service face to face at a particular time and place. Providing the physical and clinical services of contraception and testing on the school site tangibly improves young people’s
access to sexual health services by removing the barriers of timing and location – and in some cases, stigma – that hinder young people’s access to services in community settings.

The four categories of service level were designed to span a spectrum ranging from no sexual health services offered to comprehensive sexual health services offered. However, because it was found that Chlamydia testing was often provided in isolation,² it is recommended that ‘advanced’ services are interpreted as closer to ‘basic services’ than to ‘specialised services’ in the spectrum.

There is a range of models of service provision including ‘clinic in a box’, ‘mobile health buses’, outreach from local agencies and extension of the school nurse role. An ‘on-site’ sexual health service means that young people can access the service within the school grounds. Even if the service is run as a mobile outreach service it can provide on-site access during the visiting times.

In some cases sexual health services have been set up near the school site rather than on the school site itself. This has sometimes been necessary in order to reach a compromise where the school is concerned about having an on-site service, but recognises that young people do need to access such services. Services provided near the school site have not been included as ‘on-site sexual health services’ in this survey.

There is variation in the opening hours of on-site services and also in how services are run – either as drop-in or by appointment only. Whether a service is actively promoted and or not will also affect the uptake and effectiveness of the service. The survey was designed to be straightforward in order to attract a high response rate, so variations in opening hours and promotion, etc., have not been captured.

In summary, respondents were asked to include all services currently being delivered in schools and PRUs and any planned to open by January 2008, and to identify the level of service provided in each of the four categories.

Characteristics of the survey sample

All local authority areas were asked to take part in the survey (via their teenage pregnancy coordinator) and 70 per cent of local authority areas responded – creating a sample that covers a large proportion of the country. Information was provided about PRUs in 55 per cent of local authorities creating a smaller sample for data about PRU provision.

² When the survey was designed it was assumed that setting up Chlamydia testing and EHC would require considerably more training and clinical input than setting up a service offering condoms and/or pregnancy testing only. However, in practice it was found that, particularly in the case of further education settings, several institutions were offering Chlamydia testing only. In these cases the Chlamydia testing was delivered in college typically by outside agencies commissioned by the local Chlamydia Screening Programme, who had usually approached the college requesting to screen their students. The need to meet screening targets has provided a powerful incentive for proactive engagement with further education settings.
It is likely that areas were more likely to complete the survey where information about services in education settings had already been collated and was easy to access. In some cases areas delayed in responding because of the time needed to gather the necessary information – sometimes by contacting schools individually to find out what services they offered.

It is also possible that the areas that responded have a higher level of on-site sexual health services than areas that did not respond. If this is the case, the prevalence of services nationally can be estimated to be lower than the prevalence of services in the sample covering 70 per cent of England.

Another reason for not responding to the survey may have been to do with worry about making local data public – and the possibility of data being misinterpreted. This may have been of equal concern in areas with both higher and lower levels of on-site sexual health services.
Findings

Summary of findings

- Between a quarter and a third of secondary schools in the sample have on-site sexual health services (627 schools within the sample area are reported as having services).
- More than a third of PRUs in the sample have on-site sexual health services (84 PRUs within the sample area are reported as having services).
- On-site sexual health services have successfully been set up in a wide range of institutions including faith-based schools, special schools, independent schools, PRUs and young parents’ units.
- There are wide local and regional variations in the distribution of on-site services in education settings.
- There is a high level of commitment to developing on-site sexual health services in the future.
- There are institutional barriers to setting up on-site sexual health services in some areas.

Prevalence in schools

Between a quarter and a third of secondary schools in the sample have on-site sexual health services (28.7 per cent). The sample included 2185 secondary schools in England of which 627 reported having on-site sexual health services. Owing to the characteristics of the sample it is probable that the prevalence of on-site services in schools is lower nationally than it is in the sample.

There is considerable variation in the percentage of schools with on-site sexual health services between government regions. Table 1 below shows that the level of services within the sample is highest in the North East and South West and lowest in the North West and London.

Table 1: Prevalence of on-site sexual health services in schools and PRUs by government region

<table>
<thead>
<tr>
<th>Government region</th>
<th>Percentage of schools with on-site sexual health services</th>
<th>Percentage of PRUs with on-site sexual health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>15.2%</td>
<td>40%</td>
</tr>
<tr>
<td>North East</td>
<td>40.6%</td>
<td>50%</td>
</tr>
</tbody>
</table>
It should be noted that the proportion of local authority areas responding to the survey varied by region (see maps in Appendix for further details).

The services in schools range from ‘basic’ to ‘specialised’ sexual health services. Overall, around 1 in 6 (16 per cent) of the services in schools are specialised and the majority of services are ‘advanced’ (see Chart 1 below).

Chart 1: Level of service provided in schools with on-site sexual health services

Prevalence of on-site sexual health services varies widely from one local authority area to another: for example, between neighbouring authorities York (which has services in more than 75 per cent of schools) and North Yorkshire (which has services in less than 25 per cent of schools).

There is a high concentration of on-site sexual health services in several rural areas, for example, in Northumberland, Rutland and Staffordshire, where services are available in more than 75 per cent of schools. However, there are some more rural areas where on-site provision is very low, for example, Lancashire, East Sussex and Bedfordshire, which have services in less than 25 per cent of their schools.

While several of the large urban areas have low levels of on-site sexual health services in schools, for example, Liverpool and Birmingham, which have services in less than 25 per cent of their schools, other cities have high levels of
services, for example Bristol, York and Portsmouth, which all have services in 75 per cent or more of their schools.

**Prevalence in Pupil Referral Units**

Nationally, more than a third (34.4 per cent) of pupil referral units in the sample have on-site sexual health services. This makes on-site sexual health services more common in PRUs than in schools. The prevalence in PRUs is 5.7 per cent higher than the prevalence in schools. However, this difference should be treated with caution because fewer local authority areas provided information about PRUs than schools, creating a smaller sample for data about PRUs.

Amongst PRUs providing services there are roughly equal numbers of basic, advanced and specialised sexual health services. The proportion of specialised level services in PRUs (27 per cent) is higher than in schools (16 per cent) (see Chart 2 below).

![Chart 2: Level of service provided in PRUs with on-site sexual health services](chart)

Regional variation in the distribution of services in PRUs shows a high level of services in Yorkshire and Humber (63.3 per cent) and a low level of services in the East Midlands (11.1 per cent) (see Table 1 above).

There is no obvious pattern to explain local and regional variations in the distribution of services in PRUs. Further research would be needed to find out how resources are allocated locally when a choice has to be made between prioritising either PRUs or school settings for service development. Respondents’ comments on the survey suggested that the following factors are important:

- level of support from school or PRU for an on-site service
- how accessible other local services are
- level of vulnerability to poor sexual health outcomes of young people attending the institution
- number of young people likely to access a service on-site
- distance and time required for staff to travel to site.
A low level of educational achievement is a factor strongly linked with a high likelihood of teenage pregnancy (DfES, 2006). Young people attending pupil referral units are likely to have a lower level of educational achievement than their peers in mainstream schools. Thus, on-site sexual health services in PRUs can enable professionals to access young people with a high level of vulnerability to poor sexual health outcomes.

Some of the PRUs listed are exclusively young mums’ or young parents’ units. Respondents were not asked to identify young parents’ units separately. However, information from five local authorities identified on-site sexual health services in young parents’ units. One of these authorities has no on-site services in schools or other PRUs – but only has a service in their young mums’ unit.

**Prevalence and school profile**

Nine in 10 of the schools in the sample are coeducational secondary schools. Among single-sex schools a slightly higher percentage of all girls’ schools (14 per cent) than all boys’ schools have on-site sexual health services (10 per cent). Both percentages are lower than the average across all schools (28.7 per cent). Further investigation would be needed to explain why there are fewer on-site sexual health services in single-sex schools in the sample.

At least 17 faith-based schools have on-site sexual health services. This includes Church of England, Catholic and Roman Catholic schools. The level of service offered varies and some of these schools may provide pregnancy testing and/or Chlamydia testing but not access to contraceptives. The 17 faith schools identified that have on-site sexual health services are distributed across seven of the nine government office regions.

Most areas did not provide information about independent schools. However, there is evidence from the data provided that some independent schools do have on-site sexual health services. Although not all areas included special schools in the data provided there is evidence in the survey that there are special schools with on-site sexual health services.

**Access to services**

Where schools have post-16 provision, respondents were asked to indicate if the service in the school was only available for young people aged 16 years and over. This was true of nine schools in the sample. This represents less than 2 per cent of all the on-site services available.
Discussion

The data shows that on-site sexual health services in schools and pupil referral units are now widespread. This evidence can now dispel the impression that such services are a rare peculiarity.

The fact that between a quarter and a third of secondary schools in the sample have on-site sexual health services shows that progress is being made in implementing the Extended Schools core offer and objectives of the National Healthy Schools programme.

The higher level of on-site sexual health services in PRUs compared to schools suggests that resources are being targeted to reach young people who are more vulnerable to poor sexual health outcomes.

The number of faith-based schools with on-site sexual health services shows that services can be successfully set up in faith-based schools and complement the school ethos. Individuals have been in contact with the Sex Education Forum asking if any faith-based schools have on-site sexual health services. In one case, a decision to set up a new service in a faith-based school rested on the need for evidence that this school would not be the only one. Schools in a similar position can draw confidence from these findings.

Prevalence of services varies widely between government regions and individual local authorities, with stark contrasts in levels of service between neighbouring authorities.

There is some evidence that services in schools are more highly concentrated in rural, than in urban, areas. However, some urban areas have invested in intensive development of services in schools.

A range of factors are likely to influence the development of on-site services locally. Key issues that presented barriers to service development were captured in the open questions in the survey. An example from each of the government regions describing barriers to service development perceived by teenage pregnancy coordinators is included in Table 2 below.

Table 2: Examples of difficulties faced in developing on-site sexual health services

<table>
<thead>
<tr>
<th>Region of local authority</th>
<th>Example of areas facing difficulties in developing on-site sexual health services in response to question: ‘Are you planning to develop more on-site sexual health services in the future?’</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>Struggled to get schools engaged; and their confidentiality restrictions make most sites inappropriate for young people. However, most schools recognise the importance of service provision and facilitate access to school health practitioners and other health staff.</td>
</tr>
<tr>
<td>North East</td>
<td>Yes – however, due to capacity issues, due to PCT restructure, we are experiencing capacity</td>
</tr>
</tbody>
</table>

June 2008
<table>
<thead>
<tr>
<th>Region</th>
<th>Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yorks and Humber</td>
<td>Yes – subject to staffing and support from schools.</td>
</tr>
<tr>
<td>East Midlands</td>
<td>We are currently having discussions with interested individual schools about a menu of options. We do not anticipate many schools will choose on-site services. Concerns are parental objection, moral issues, diversity, and confidentiality.</td>
</tr>
<tr>
<td>West Midlands</td>
<td>There are a number of family planning trained nurses within the school health team. However, they face difficulties getting into some schools, especially if wanting to provide condoms, pregnancy testing, etc.</td>
</tr>
<tr>
<td>East of England</td>
<td>Yes. I am actively contacting schools and governors to try and set up more sites but heads are not keen to go ahead. Some schools show interest in setting up a school-based health service (SBHS) but have issues re: maintaining young person’s confidentiality.</td>
</tr>
<tr>
<td>London</td>
<td>Low recruitment to school nurse and other outreach posts, so not enough specialist staff to deliver this service at present.</td>
</tr>
<tr>
<td>South East</td>
<td>The school nurses are family planning trained so are able to offer basic contraception advice to young people and signpost them to appropriate services. The barrier to setting them up is the school, so we are working with the school nurses and youth workers to highlight sexual health with the school. I am also working with the PSHE leads.</td>
</tr>
<tr>
<td>South West</td>
<td>Yes, subject to further funding. Current services funded through Neighbourhood Renewal funding.</td>
</tr>
</tbody>
</table>

The key recurring issues highlighted in Table 2 above are:
- school confidentiality requirements not being compatible with health service requirements
- lack of staff capacity and difficulties in recruiting specialised staff
- concerns about parental objection
- funding needed to extend pilot projects
- resistance from schools.

There is a wide variety in the level of services that are offered in schools and PRUs ranging from pregnancy testing only to a wide range of prescription contraception (including long-acting and reversible contraception, or 'LARCs') and STI testing and treatment.

The level of service offered depends on several factors, including, perhaps, an assessment of how far away other specialised services are. However, in some cases the level of service has been limited by the wishes of the school. For example, a school might feel comfortable providing a more basic level of service such as pregnancy testing and condoms, but might not want to provide...
prescription contraception. A survey respondent reported that in one area school nurses with family planning training are only able to provide advice about contraception but are not able to prescribe it because of the wishes of schools.

This survey does not look at how well used services are. It is hoped that further research will provide more information about the numbers of young people accessing on-site services in schools and the characteristics of the young people who access those services. For example, it will be important to know if young people accessing on-site sexual health services in schools have made use of any other services locally.

A number of the services listed in the survey were being set up at the time the data was collected. Sixteen of the school-based services and five of the PRU-based services were being set up during the period September 2007–January 2008. This shows a trend towards increasing numbers of on-site sexual health services in education settings.

Respondents were asked in an optional open question if there were plans locally to develop on-site sexual health services in education settings in the future. Forty local authority areas indicated that they are planning to develop on-site sexual health services further. This high level of commitment is shown by the selection of comments below.

Table 3: Examples of commitment to develop on-site sexual health services in education settings

<table>
<thead>
<tr>
<th>Region of local authority</th>
<th>Example of commitment to develop services further in response to question ‘Are you planning to develop on-site sexual health services in education settings in the future?’</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>Yes, we are – using the extended schools route. We have all the protocols etc. in place to commence a pilot scheme in the near future.</td>
</tr>
<tr>
<td>North East</td>
<td>Yes, looking to roll out pilot drop-in sessions in remaining schools.</td>
</tr>
<tr>
<td>Yorks and Humber</td>
<td>We aim to have all schools offering advanced services including PRUs and colleges but Catholic and private school unlikely to engage.</td>
</tr>
<tr>
<td>East Midlands</td>
<td>We have recently taken a paper to PCT Board and Cabinet (LA) to get strategic support for developing extended schools-based sexual health services so that schools knew there was strategic support. Both boards support this development. Secondary school heads were involved in this process and, although lengthy, this was a positive and worthwhile process.</td>
</tr>
<tr>
<td>West Midlands</td>
<td>Liaison occurring between Young People’s Health Advisors and directors of learning/senior management in local schools. We have developed a Service Level Agreement and interested schools will sign up to this commitment.</td>
</tr>
<tr>
<td>Region of local authority</td>
<td>Example of areas with preference for off-site approach</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>North West</td>
<td>There are a significant number of community-based sexual health services which young people can access across the local authority. The current local policy is to focus resources on raising awareness of these services, and encouraging and enabling young people to access them. Investment in sexual health services in alternative venues will only be considered if consultation with young people demonstrates this to be what young people want/need.</td>
</tr>
<tr>
<td>East Midlands</td>
<td>We are not planning to set up full sexual health and contraception services in all secondary schools, as the targeted work of the local strategy is to reach young people not in schools. We have, therefore, invested in a large number of young people’s community-based contraceptive and sexual health (CaSH) outreach clinics.</td>
</tr>
<tr>
<td>West Midlands</td>
<td>Our strategic approach to commissioning contraceptive services for young people has previously been to adopt a town-based approach to provision of contraceptive services for young people. With a dedicated young person’s contraceptive clinic in five of the six towns in the authority. Plus services are commissioned to target the most vulnerable young people.</td>
</tr>
<tr>
<td>London</td>
<td>When new services are developed, they tend to be outside the school environment (e.g. our full service extended school is a primary school, so the school nurse is offering a sexual health service for young people in the local community centre rather than within the school itself).</td>
</tr>
</tbody>
</table>
This survey does not aim to link prevalence of on-site sexual health services and teenage conception rates. Because conception data becomes available two years behind it will not be possible to look for a link between prevalence of services found in this survey and conception data until 2010. Some of the on-site services are newly established and there is no data to show how many years each service has been running and whether it would, therefore, be expected to have impacted on teenage conception data. Some local authority areas with high and increasing rates of teenage conception have high levels of on-site sexual health services – and others have very low levels. This does not mean that on-site sexual health services do not work because it may be simply that the services have been newly set up.

Furthermore, evidence shows that a combination of factors are necessary for teenage conception rates to drop, including access to young-people friendly confidential sexual health services as well as good PSHE (including SRE). The delivery of on-site sexual health services in schools is, therefore, one of many factors that will contribute in reducing teenage conceptions.
Conclusions and recommendations

The Sex Education Forum welcomes the findings from this survey, which shows that good progress has been made in making sexual health services more accessible to young people. The Sex Education Forum recommends that all schools, together with their local authorities and primary care trusts, consider setting up on-site sexual health services. The following points summarise the current situation identified by the survey and makes recommendations for action.

1. Local authorities to take a strategic and coordinated approach to service development in schools

There is a wealth of experience within many local authorities of setting up on-site sexual health services in schools and PRUs, including special schools, independent schools, faith-based schools and single-sex schools. This expertise and learning can be harnessed to help carry out the commitment in *The Children’s Plan* (DCSF, 2007) to ‘increase young people’s knowledge of effective contraception and improve their access to advice through encouraging the provision of on-site sexual health services in schools, colleges and youth centres’.

In particular, local authorities that have taken a coordinated and strategic approach to supporting the development of on-site sexual health services in schools have been successful in getting buy-in from a broad range of stakeholders, and this has resulted in the majority of schools engaging in on-site service development. Learning from these examples needs to be shared, and local authorities who are struggling to set up services will need support from other local authorities and from government offices.

2. Support school governors and heads to understand the benefits of on-site service provision

In some cases health professionals working in schools are unable to fully use their skills because of objections from schools and other stakeholders. Ironically, this contrasts with other cases where lack of skilled staff/capacity is the only factor preventing further development of services in schools.

Governors, heads and senior management need access to training and support to understand the benefits for young people, in their achievement and attainment, of providing a wide range of contraception within an on-site service. New guidance on governor training has been promised in the Children’s Plan and this should be used as an opportunity to inform and educate governors about the value and legitimacy of on-site sexual health services.

Additional work is needed to address other institutional barriers including schools’ worries about confidentiality and parental concerns (either real or imagined). Schools that have set up on-site sexual health services have generally had very positive feedback when consulting parents.
3. Enable professionals to share practice
The Schools and Sexual Health Services Network run by the Sex Education Forum has proved invaluable in enabling professionals to share practical know-how about service development (see page 27 for more information). Further networking and practice sharing will help build a body of knowledge about what works and how to develop the best quality services.

4. Develop tools to maximise service effectiveness
It is important that clear information is available about how to develop a good quality on-site sexual health service – which also makes efficient use of resources. By maximising the skills of both clinical and non-clinical staff, for example, nurses and youth workers, resources can go further. On-site sexual health services must also be advertised clearly and effectively, with young people’s involvement, to make sure that services are fully utilised. Tools need to be developed to monitor the use of on-site sexual health services consistently and help to make sure that services are equally accessible to all young people. Evaluation also needs to capture how effective the service is in supporting young people to access services beyond the school.

5. Build on the evidence base
By 2010 it will be possible to look for links between areas that currently have a high prevalence of on-site sexual health services and trends in conception data. Responding to evidence from the Teenage Pregnancy Strategy it is necessary to ensure that good quality PSHE (including SRE) is developed alongside better access to services. Without learning about what services offer, and where and how to access them, on-site services are unlikely to be effective.

6. Track progress
This survey is the first national mapping survey of on-site sexual health services in schools and provides a baseline against which future developments can be measured. Progress can be tracked by repeating the survey at intervals. Future surveys should consider mapping the full range of health services that are provided in education settings alongside sexual health services. Similarly, it is recommended that regular mapping at local authority level be carried out to ensure that adequate knowledge is available to inform service development. Mapping needs to be combined with ongoing consultation with young people to ensure that services meet their needs.

7. Celebrate success
Schools and commissioners should be congratulated on the rate of progress in developing on-site sexual health services in schools. In some cases local champions of on-site sexual health services have worked tirelessly to gain the backing of other stakeholders. Careful and proactive work with local media helps to share this success.
Experiences in developing services vary between areas but more local authorities now have schools with on-site sexual health services than those who do not. Given the reported success of on-site sexual health services and the strong support in government policy, this is a trend that is sure to continue, helping to provide young people with the access to the services that they need.
References


Acknowledgements

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Further information

Sex Education Forum

The Sex Education Forum is the national authority on Sex and Relationships Education (SRE). The Forum's 50 member organisations believe that good quality SRE is an entitlement for all children and young people and are working to achieve this.

The Sex Education Forum runs the Schools and Sexual Health Services Network, enabling practice-sharing between professionals developing on-site sexual health services.

A range of case-studies and frequently asked questions can be accessed from the Sex Education Forum web site: www.ncb.org.uk/sexualhealthservices

Contact Lucy Emmerson for more information: lemmerson@ncb.org.uk
Appendix 1

Prevalence of on-site sexual health services in secondary schools and pupil referral units in England by local authority
Prevalence of on-site sexual health services in Secondary Schools in England by Local Authority

Percentage of secondary schools in the Local Authority with on-site sexual health services:
- 0%
- <25%
- 25% to <50%
- 50% to <75%
- 75% to 100%
- n/a or no data

Map prepared by DSG: Data Warehouse and Local Statistics Unit

Schools1.mxd

Percentage of secondary schools in the Local Authority with on-site sexual health services:
- 0%
- <25%
- 25% to <50%
- 50% to <75%
- 75% to 100%
- n/a or no data

Map prepared by DSG: Data Warehouse and Local Statistics Unit

Schools1.mxd

GORs

Map prepared by DSG: Data Warehouse and Local Statistics Unit

Schools1.mxd

department for children, schools and families

Map prepared by DSG: Data Warehouse and Local Statistics Unit

Schools1.mxd