Written evidence submitted by the Primary Care Women's Health Forum (PHP0019)

Introduction

The Primary Care Women’s Health Forum (PCWHF) is a network of over 5000 clinicians working in primary care and community health care settings, in the UK, who have an interest in women’s health. Our members are passionate about improving the healthcare for women and many of them provide enhanced services, including the insertion and removal of Long-acting Reversible Contraceptives (LARC), to their patients in addition to core contraceptive care.

Providing contraception is an important aspect of the work of primary care, with over 80% of women opting to access this from their General Practice. Our members believe that women should have the right to be provided with sufficient information to make the choice of a method of contraception that is right for them, and then be able to access the method of their choice without having to negotiate unnecessary hurdles.

In 2002 the government of the time acknowledged the importance of reducing teen pregnancies because of the adverse health and social implications these cause. Financial support was made available for training and improved access to contraceptive care, and wherever this was provided and improving LARC access was identified as a priority.

LARC methods include intrauterine devices, intrauterine systems and the contraceptive implant and injection. NICE guidelines have recommended the increased uptake of LARC methods as being more effective at preventing unintended pregnancies. This is largely because unlike user-dependent methods such as condoms or the oral pill, the effectiveness of LARC methods does not depend on daily concordance (NICE Guideline CG30). (1)

Since this time there has been a significant reduction to teenage pregnancy rates and, more recently, to abortion numbers. There is good evidence to demonstrate the increased uptake of LARC methods has produced a significant association with the reduction of teen pregnancy. (2) (3)

Since the passage of the 2012 Health and Social Care Act the commissioning responsibilities for contraception care has been fragmented:

- Core contraception provided by primary care is commissioned from NHSE Enhanced services
- Specialist services and enhanced services delivered from primary care are the commissioning responsibility of Public Health from Local Authorities
- The consequences of reduction in access to provision; complicated maternity and abortion, are the responsibility of the Clinical Commissioning Groups.
• Enhanced services for intra-uterine system insertion for contraceptive purposes is commissioned and funded by Public Health, whereas the insertions for gynaecological purposes are reimbursed from the CCGs.

This has made planning and delivery of joined-up contraceptive care much more complicated. It has also reduced accountability and made it more difficult to monitor the contraceptive services that women can access in an area. The situation is compounded by the cuts to public health budgets (£200m in-year cuts in 2015, followed by further ongoing reductions announced in the Spending Review).

The recently published FPA ‘Unprotected Nation 2015’ report (4) clearly outlines the financial and economic impacts of restrictions to contraception and sexual health services which will inevitably result from cuts to the public health budget.

The PCWHF response to the Health Select Committee’s Inquiry covers:

• The impact of the fragmentation of commissioning and funding for contraceptive services
• Concerns about Public Health grant funding cuts
• PCWHF survey results and case studies from PCWHF members
• The need to hold a case study hearing on contraception provision (wherever this is provided).
• Recommendations to the Committee

The impact of the fragmentation of commissioning and funding for contraceptive services

Members of the PCWHF have expressed concern about the care they are able to offer their patients and the problems women are experiencing in accessing care from the community sexual and reproductive health clinics.

Our members are concerned that this is becoming increasingly problematic since the fragmentation and confusion for responsibility of commissioning resulting following the 2012 Health and Social Care Act. They are concerned that this is producing unnecessary barriers to patient care as changes are being made for financial and contractual reasons without ensuring that the needs of the woman are central to any commissioning decisions.

The priorities for primary care work are currently dictated by managing increasing demand for appointments, reducing emergency admissions and providing care of patients with long-term conditions. There is minimal incentive to improve or provide contraceptive care for our women. Payment for contraception provision from primary care is complicated, coming from different funding streams:

• Core contraception (pills and injections) payments changed following the 2003/4 contract are now part of the global sum and have lost identity
• There are few QoF points to focus GP attention or encourage greater
The funding for enhanced LARC services is from the Public Health budget. Current payments were set many years ago and in many areas are not sufficient to cover clinician time and costs for equipment.

There is also no current quality or quantity auditing of contraceptive care provided by primary care services and no benchmarking data to compare current provision or standard.

**Concerns about public health funding cuts**

Local Authority funding cuts are resulting in difficult decisions being made. This has an inevitable effect on the funding for sexual and reproductive health (SRH) service provision and the payment for primary care LARC services. A recent snap-shot survey of our members, which produced over 600 responses, has raised significant concerns:

- Reductions in the numbers of SRH clinics and reduced appointments mean that more women are accessing their primary care service for contraception. This additional demand for appointments from primary care is unfunded and will mean that there will be a reduction in LARC provision in those services who do not have a trained clinician or commissioned enhanced service.

- Many Local Authorities are decommissioning or cutting funding to the primary care LARC enhanced service. As funding for primary care is dependent on payments for service provided (and the costs for clinical and administrative time and equipment for LARC provision were set many years ago), difficult but understandable business decisions are being made resulting in reduced service provision by some primary care providers.

- PCWHF members are also reporting reduction in training opportunities as the SRH services are prioritizing training of their own clinicians, medical students and training doctors. In addition many of our members have no communication with the public health commissioners and no commitment to fund their services over future years, which further reduces any incentive to cover the costs and time away from practice to undertake training.

**PCWHF survey results and case studies from PCWHF members**

The PCWHF have surveyed our members in 2013, 2014 and November 2015 to collect snapshot evidence about their local services. Between 500 and 1000 members have responded to each survey.
On each occasion the results have identified similar concerns that include:

- Reduced access to LARC and funding restrictions in some areas where services have been retendered.

- Lack of communication between Public Health Commissioners and providers of primary care LARC services, which threatens future provision and development of these services. Additional services, such as enhanced contraceptive services cannot be planned at a time when we are under pressure for appointments, especially for management of patients with long-term health conditions.

- A reduction in training opportunities because of the time and costs required to attend training when there is uncertainty of future service provision.

- 37% of our respondents confirmed a recent increase in women seeking primary care appointments for contraception as women are finding access to and appointments at the community SRH clinics harder to obtain.

- Many examples of individual cases where services have been reduced meaning women have to travel long distances and at times which are inconvenient to obtain their LARC if the local GP service has been decommissioned.

- Examples where intra-uterine device insertion for contraceptive purposes have been decommissioned by public health, so the skills of the clinician are not maintained to insert these for gynaecological (heavy menstrual bleeding) reasons. This makes no financial sense and provides additional hurdles for women to navigate.

To further illustrate what is happening to contraceptive services across the country, we have included a number of comments from PCWHF member who responded to our 2015 survey.

1. I have worked in Huntingdon and Godmanchester for 23 years providing everyday general practice and contraception to our population. We have three partners including myself who are approved in Intrauterine devices and two who are skilled in Nexplanon [contraceptive implant].

   We have a 25% cut in our basic funding as Personal Medical Services (PMS) contracts will cease to exist and we have to revert to General Medical Services (GMS). We therefore are looking at every activity and its funding. Fitting intrauterine devices is underfunded. The fees paid do not cover the time necessary for counselling to choose the right method of contraception, then a doctor or nurse assistant and a treatment room with instruments for the fitting, the 6 week check and the subsequent removal let alone any complications. In addition the doctor has to pay an annual subscription for the DFSRH.
We are considering if we can afford to subsidise the LARC service with already a catastrophic decline in our income.

2. I am a GP in York and provide LARC contraception. You may be interested to know York City Council have just given notice to GPs in York that they are going to stop the Local Enhanced Service for payment to GPs for LARCs in March 2016.

3. One of my partners only has a local letter of competence in Nexplanon. His local letter will not be recognised in a few months. We will then have only one nexplanon doctor for our 13,500 patients of two separate site practices. This is not enough to continue a nexplanon service.

In short LARC is underfunded and provision is reducing.

4. From April 2015 funding for LARCS has come from the East Riding Council (Hull). This has resulted in 2 main issues
   - The funding for insertions and removals has significantly reduced which makes it a loss making exercise for GP Practices
   - The admin and paper work have increased with the Council requiring data on the procedures to be submitted back
   - Claiming for the individual procedures has become more complicated thus using up more Practice Manager time

As a result of these changes our Practice has taken the reluctant step to reduce the number of appointments that we offer to women seeking LARCs. Instead we direct them to the local (overstretched) community services.

As the Practice is continuing to make a loss on each procedure performed it is very likely that we will stop offering the service when the time comes to renew the contract. I am aware of several GP Practices locally who have already stopped offering the service.

This results in
- Patients having to travel further to obtain services
- Services being provided by an anonymous service rather than by clinicians/nurses who patients are already familiar and comfortable with
- GPs becoming deskill
- Inadequate training opportunities for newly qualified GP’s and GP Registrars

If the focus is to reduce teenage pregnancies and the unwanted pregnancy termination rate, then this is counterproductive.

5. I’m a GP partner in Rushden, in South Northamptonshire. I trained in both
Implant and coil provision and have offered a full LARC service to my patients (practice population 12000) since 2010. Prior to 2012 the town, population of around 40 to 50 thousand, had a centrally located family planning clinic offering full LARC services.

In 2012 the provision of service was taken over by genitourinary medicine services, as a local GP I was not sent any formal information but discovered some time later. Initially none of their clinicians were trained in LARC and patients were told to travel to other sexual health clinics in our locality, the nearest being 12 miles away.

Now they offer Implant fitting and removal, but not coils, I am told because they don’t have the appropriate facilities available, ie resuscitation equipment. Prior to 2010 my practice did not fit implants. In 2014 I fitted 67 implants to my practice population, and the family planning clinic did 10.

Prior to 2010 my practice fitted around 20 coils a year, and the town family planning clinic around another 10. In 2014 I fitted 60 coils and the family planning service based 12 miles away as no local service provision fitted 4.

From April this year the contract for my LARC service provision came from Northamptonshire county council. The main difference is that I am now contracted to provide IUS for contraceptive purposes only, and it specifies that I am not contracted to fit for non contraceptive indications. I estimate this will lead my practice to refer around 20 women a year to gynaecology outpatients for fitting of IUS for non contraceptive purposes, when it is a service I am trained and able to provide but am no longer funded to do so.

I feel the change in service provision has led to a reduction in access to my practice population, in particular disadvantaging those who can’t travel or prefer to access the anonymity and convenience the family planning clinic provides.

6. I am a GP in a Practice of 9,300 patients in the very north of Somerset and have been fitting coils for 28 years and implants for 7 years. Since the other female partner who fitted coils and implants retired in August 2014, I am the only doctor who can remove implants and fit coils without supervision and I am completely overwhelmed with demand, particularly for coils. Local Family Planning services are almost non existent, services in Bath are not funded by Somerset although it is where most of our secondary care takes place and I have given up using any specialist services eg with difficult coil fits or implant removals as our patients will not travel to Bridgewater or other distant venues in Somerset. The few we have with eg lost threads, end up in gynae OPD resulting in higher costs and CCG funded care.

The biggest problem however is training. I will have fully retired within 18 months and I am committed to ensuring that both of these salaried doctors are competent in both coils and implants before I leave but its an uphill struggle as
there is no local trainer available. Even for my own implant training I had to travel to Taunton to be assessed which is the other end of the county.

7. In Hampshire all our LARC contracts have gone to Hampshire County Council and we have been told they are out to tender and we can apply for them. We are now in the middle of this process but every practice has had to apply separately and we have no idea when we will hear and what the outcome will be.

We do know that there is a cap on the budget and in the past when we ran short of funding we could make an application to the PCT and then CCG & they would top up the funds for that year. We know that this will not be the case in the future so with an increasing list and no uplift on money we will not be able to do as much as we have done as the costs to practice of consumables remains (and increases inexorably).

Conclusions

The shift in commissioning arrangements from mainly clinical commissioning groups to mainly public health is having a significant and detrimental impact on:

- Patients’ seamless access to women's health services
- General practice provision

This needs urgently redressing for all the reasons stated above. We would therefore urge the Health Select Committee to use contraceptive services as one of your inquiry’s detailed case studies. The changes to commissioning since 2013 cross the boundaries between local authority public health responsibilities and the ability of GP practices to provide the care and support that we know women want and need.

Recommendations to the Health Select Committee’s inquiry into public health post-2013 from the Primary Care Women's Health Forum

- The PCWHF urge the Health Select Committee to consider how contraception is being commissioned since the 2012 Health and Social Care Act. The concern of our members is that Local Authority are responsible for SRH service and enhanced service provision and any cuts made to the Public Health budget will inevitably increase costs to the Clinical Commissioning Groups who hold responsibility for managing the consequences of reduced service provision.

- The PCWHF urge the committee to consider the impact that financial cuts to contraception are already having on the health and well being of our women and the inevitable reversal to the excellent results of reducing teen pregnancy made since 2002.
The PCWHF urge the committee to request that the different commissioning streams work together to ensure that changes to provision of contraception provision are commissioned using a holistic approach by Department of Health, Public Health England and NHS England working together, rather than in silos.

The PCWHF urge the committee to recommend that spending on contraceptive provision is prioritised and further cuts are not made.

The PCWHF urge the committee to consider the journey of a woman when attempting to access contraception if she does not have the financial, social or language skills to negotiate the unnecessary hurdles that have been put in place since the commissioning changes resultant from the 2012 Health and Social Care Act.

The PCWHF urge the committee to recommend that sufficient funding is made available to primary care to prioritise and manage the extra demand for contraception appointments.

The PCWHF urge the committee to recommend that training of clinicians providing contraception in primary care should be supported, prioritised and standardized to ensure that quality care is provided to all women, wherever it is delivered.

References

(2) Contraceptive CHOICE study http://www.choiceproject.wustl.edu
(3) Association between long-acting contraception use, teen pregnancy and abortion rates in the UK. Connolly A et al. International Journal of Women's Health. 2014. 6; 961

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