Written evidence from APPG on Sexual and Reproductive Health

About the APPG on Sexual and reproductive Health

The All Party Parliamentary Group on Sexual and Reproductive Health (APPGSHR) welcomes the opportunity to respond to this important and timely inquiry.

The APPGSRH aims to raise awareness of the importance of improving all aspects of the sexual health needs of men and women in the UK. It is co-chaired by Diana Johnson MP and Baroness Barker. It is supported by FPA (the Family Planning Association), who also provide the secretariat, as well as membership bodies the Faculty of Sexual and Reproductive Healthcare (FSRH), the British Association for Sexual Health and HIV (BASHH) and the Royal College of Obstetricians and Gynaecologist (RCOG), who together represent over 30,000 doctors and nurses working across sexual and reproductive health (SRH).

This submission aims to provide an overview of evidence outlining the current state of SRH services in England. It follows the APPGSRH’s *Breaking down the barriers* report in 2015.¹ The report, which considered many of the same issues as this inquiry, received written responses from across the sector, as well as oral evidence from the Public Health Minister, Shadow Public Health Minister, Public Health England (PHE), Health Education England (HEE) and NHS England. Many of the findings and recommendations are still relevant and the APPGSRH would be happy to provide members of the Health and Social Care Committee with copies.

Executive summary

- The 2012 Health and Social Care Act brought in radical changes to the public health framework, most notably the transfer of public health responsibilities from the NHS to local authorities (LA’s).

- Cuts, coupled with fragmented commissioning have had a severe impact on access to contraception and sexual health services. Many services have closed, relocated or reduced their opening. Others report high turn-away rates.

- This is compounded by significant increases in the number of visits to clinics and diagnosed cases of some Sexually Transmitted Infections (STIs).

- Changes have also had an impact on the workforce who report problems associated with training, recruitment and retention.

Background

1. Sexual and reproductive health services

1.1 SRH services offer a range of services including; information and advice on maintaining good sexual health; the provision of contraception; methods to prevent STIs; testing for HIV and STIs; and the treatment of infections when they occur.

1.2 Good SRH is crucial for education, work, families and society. It is an essential part of public health. It is about preventing disease, prolonging life and promoting good health.
1.3 SRH services are highly cost effective. In 2018 a PHE study reported that every £1 spent on contraception saves £9 in avoided costs across the public sector.²

2. Responsibility for sexual and reproductive health services

2.1 In April 2013 The Health and Social Care Act transferred much of the responsibility for Public Health, which encompasses sexual health, from the NHS to Local Government. LA’s are now responsible for commissioning the majority of services for STIs and contraception.

2.2 These services, collectively known as SRH services, are specifically mentioned in the local authority regulations which state that “each local authority shall provide, or shall make arrangements to secure the provision of, open access sexual health services in its area.”³

Recent trends

3. Local authority public health funding

3.1 LA’s receive an annual ring-fenced public health grant from the Department of Health and Social Care. They are required to use this grant to fund public health.

3.2 This budget has been significantly reduced in recent years. In 2015 a £200m in-year cut was made to the public health grant by Government.⁴ This was followed by a further cut of nearly 4% announced in the 2015 Spending Review. Kings Fund analysis shows that this totals a real term spending reduction of at least £600 million a year by 2020/21 (on top of the in-year cut from 2015).⁵

3.3 These cuts have had clear knock on effects as LA’s have been forced to reduce the money they spend on public health services.

- A quarter of LA’s cut spending on sexual health by 20% between 2013/14 and 2015/16 and LA’s spent £30m less on sexual health in 2017/18 compared to 2016/17.⁶
- Of 152 LA’s surveyed 72 reported plans to cut sexual health funding in 2018/19 compared with 2017/18.⁷
- Half of councils cut spending on contraception services in 2017/18.⁸
- Nearly half of councils reduced the number of sites commissioned to deliver contraceptive services in at least one year between 2015/2016 and 2018/19.⁹

3.4 The public health ring fence which has protected SRH services from the most severe cuts is due for removal. From 2020 public health will be funded through a proposed business rates retention (BRR) scheme. Although LA’s have an obligation to have regard to the need to reduce inequalities in their area, there is uncertainty about what it will mean in practise and the APPGSRH has serious concerns about what this will mean for health inequalities, particularly in deprived areas.

4 Increased demand
4.1 Cuts to budgets have been compounded by increased demand on services. Between 2013 and 2017 the total number of new attendances at sexual health clinics increased by over 18.5% from approximately 2.2 million to 2.6 million per year.\textsuperscript{10} In September 2018 79% of respondents to a survey of BASHH members reported increased demand in the preceding 12 months.\textsuperscript{11}

4.2 Whilst the number of diagnosed cases of some STIs, such as genital warts, has decreased in recent years, others have increased significantly. Between 2016 and 2017, for example, the number of cases of gonorrhoea and syphilis increased by 22% and 20% respectively.\textsuperscript{8}

4.3 Demand for abortions among the 30-34 and 35 plus age group has also increased.\textsuperscript{12} Whilst there is no evidence of direct causation, there are concerns that these increases may indicate an unmet need for contraception.

**Commissioning of SRH services**

5 Commissioning arrangements

5.1 Whilst The Health and Social Care Act transferred much of the responsibility for Public Health, including sexual health, from the NHS to Local Government, overall responsibility for commissioning SRH services is split across LA’s, CCGs and NHS England.

<table>
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5.2 This has created a complex and patchwork commissioning landscape in which related services are commissioned by separate bodies.

5.3 This means that services are shaped by the source, availability and amount of funding, rather than by patient need. This inevitably disrupts a patient pathway:

- Whilst CCGs commission abortion services, LA’s commission contraceptive care. Patients who access abortion services are not automatically referred for contraceptive advice and treatment, this leave them at risk of further unintended pregnancy.\(^{13}\)

- Cervical screening is commissioned by NHS England and is not a requirement for LA commissioning. Women who attend a service for an STI screen or for contraception are not always offered a cervical screen. This is despite the fact that cervical cancer is the most common cancer for women under 35.

- Whilst NHS England commissions HIV treatment, LA’s commission STI testing. Patients attending hospital for HIV treatment will have to travel for routine STI testing if the services are no longer co-located.

5.4 Tendering arrangements, as the APPGSRH reported in 2015, can also create tension.\(^{1}\) Where procurement is done on a short-term basis, services often find it difficult to plan improvements and incentives to provide continued education and training and as a result staff development is reduced. This was highlighted at a recent meeting of the APPGSRH, Consultant Physician Dr Margaret Kingston, noted that training posts are being lost because of cost savings and that tendering has had a negative impact on staff, who are leaving as a result.\(^{14}\)

### Access to sexual and reproductive health services

#### Overview

6.1 Cuts to LA’s public health budgets have had significant impact on what can be delivered. The Kings Fund cites evidence of sexual health services being tendered with significantly lower budgets. In some cases, these reductions are up to 40% lower than under previous contracts.\(^{15}\)

6.2 There are reports of numerous clinics closing across England. In London alone, six sexual health clinics closed in the year leading up to January 2018,\(^{16}\) whilst a BBC FOI request found that three clinics closed in Suffolk in April 2018. Other clinics in Cambridgeshire, Nottingham, Brighton and Hove, Doncaster and Norfolk are either facing closure or reducing their opening hours.\(^{17}\)

6.3 A similar picture is apparent in relation to contraceptive services. As already highlighted the Advisory Group on Contraception (AGC) found that between 2015/16 and 2018/19, almost 50% of councils reduced the number of sites commissioned to deliver contraceptive services.

#### Access to contraceptive service
7.1 As well as services closing, some have been relocated, often to less convenient but cheaper locations. As a result, people struggle to access the contraceptive services they require.

7.2 A 2017 audit carried out by the AGC found that some areas only provide services to residents. Furthermore, age-based restrictions on access to emergency contraception, with some places restricting to under-19s or under-25s, were apparent. This is despite the mandate to commission confidential, open-access services for STIs and contraception.

7.3 Where cuts are made to the public health-funded elements of SRH provision, the impact and increased cost is often felt on other parts of the system, including on General Practice.

7.4 However, evidence shows that access to contraception is also restricted in primary care settings. A 2016 survey conducted by FPA found that only 2% of GPs in England offer the full range of contraceptive methods available on the NHS, with 20% of practices unable to provide long-acting reversible contraception (LARC). Furthermore, in 2018/19 over 10% of councils reduced the number of contracts they hold with GP surgeries to fit very-LARC in 2018/19.

7.5 These findings are supported by testimonial from the FSRH rolling survey of members:

- An East of England GP pointed to a ‘lack of capacity at local FP clinic for the IUCD, so increased requests in general practice’,

- An associate GP in South West England reported that ‘A lot of GPs have stopped doing LARCs. As a result the wait to have a coil inserted may be 8 weeks.’

8 Access to STI services

8.1 BASHH research suggests that, at present, the number of people who are being seen within the longstanding target of 48 hours is declining. Research carried out in 2014 found that, when contacted by telephone, 95.5% of clinics offered patients, who presented with symptoms suggestive of an acute STI an appointment within 48 hours whilst in 2015 90.8% of clinics offered symptomatic ‘patients’ an appointment within 48 hours in 2015.

8.2 There are also reports of patients being turned away from sexual health services.

- Between April and September 2017 Guy’s and St Thomas’ Trust reported turning away up to 600 people a week from open-access services.

- In January 2018 Dean Street Express reported that 1,500 people were trying to book 300 spots on a daily basis.

- More than 6 in 10 respondents to BASHH’s 2018 survey reported turning away patients on a weekly basis and 19% said they were having to turn away more than 50 patients every week.

8.3 Having said this, there are examples of innovations which may help manage demand. Almost half of respondents to the same survey reported increases in the access of online testing.
9 Access to HIV prevention services

9.1 A 2017 survey conducted by the National Aids Trust (NAT) found an 11% cut in HIV prevention and testing expenditure between 2015/16 and 2016/17 and that a quarter of local authorities in England did not commission any primary HIV prevention or testing.\(^{24}\)

9.2 This is supported by clinicians. In a survey of members of the British HIV Association (BHIVA), 63% or respondents reported access to HIV prevention services and condoms had reduced.\(^{25}\)

10 Other non-mandated services

10.1 Whilst STI and contraception services are to a degree, protected by the 2013 regulations, certain non-mandated areas are subject to even greater threats.

10.2 Despite being provided by some SRH services, LA’s are not mandated to commission cervical screening. Cuts to SRH services and the fragmentation of the commissioning landscape has affected the capacity of primary care to deliver cervical screening and at 72%, the uptake of screening is now at its lowest rate in 20 years and well below the 80% target.\(^{26}\)

10.3 As we well as significant reductions in the delivery of HIV prevention activity, 42% of respondents to the 2018 BASHH survey reported reduced provision of psychosexual health services and 47% reported reductions in the provision of cervical cytology functions in the last year.\(^{11}\)

11 Growing inequalities

11.1 Closures and relocations can increase inequalities as patients have to travel further and to less convenient locations. This disproportionately affects groups without the means or finances to travel further. For example:

- The movement of clinics away from bus routes inhibits people who rely on public transport, for example young people, disabled people or those without private transportation.

- The movement of clinics into new areas inhibits people who are unable to travel to for cultural reasons. At a recent meeting of the APPGSRH, Dr Anne Connolly reported the reduction in uptake of cervical screening by South Asian women in some areas where clinics have moved.

- Cuts to text messaging services and the movement of condom distribution services from pharmacies which also, for example, provide methadone, to a cheaper location, disproportionately affects sex workers.

- Reduced open hours and weekend closures, affects young people unable to visit during school or college hours.

11.2 There is evidence of regional variance in access to contraception. Cheshire and Merseyside has the lowest provision of LARC methods within GP Practices. Just over half offer the contraceptive implant and 56% and 58% offer the IUD and IUS, respectively. The comparative figures for practices in the South-Central area are over 90%.\(^{27}\) It also stands in conjunction with rising teen pregnancies in the North West of England – the only region in England experiencing this trend.\(^{28}\)
11.3 Respondents to BASHH’s survey were also five times more likely to report reduced care for vulnerable populations compared to those reporting increased care in the area.9

12 Workforce and training

12.1 The sexual health workforce encompasses a number of different professions and specialities. Evidence shows that many of these professions are experiencing problems associated with training, recruitment and retention. In some cases, not only have numbers of staff reduced, but also clinics are being run with less consultant input, presenting a safety concern.

12.2 The integration of SRH has brought together GUM and contraceptive care. Only a service led by a GUM consultant can be defined as being a specialist GUM service (Level 3) for the management of STIs. Likewise a consultant in Community Sexual and Reproductive Health (CSRH) should provide clinical leadership for complex contraceptive care.29

12.3 However, increasing financial pressures, as the AGC highlights, mean some LA’s struggle to commission these services with joint clinical leadership encompassing at least one consultant CSRH.6 Furthermore, concerns have been raised by the FSRH about the current CSRH workforce as an estimated third could retire within the next five years and the output of the training program falls short of filling vacancies.30

12.4 GUM training posts have also become increasingly difficult to fill. HEE data provided to the British Medical Association, for example, shows that only 61% of GUM positions were filled in 2016.31

12.5 In 2018 the Royal College of Nurses published a survey of members in the SRH sector which highlighted significant staffing pressures. 57% of respondents reported a reduction in the number of registered nurses, members also reported concerns about education and training.32

12.6 As FSRH pointed out in a recent submission to HEE, 80% of SRH care takes place within General Practice. Given this, it is concerning that a 2017 survey conducted by the Royal College of GPs noted training concerns which are exacerbated by fragmentation. For example, where IUD insertion for contraceptive purposes has been decommissioned, the skills of the clinician are not maintained to insert these for gynaecological reasons. The report also found that some staff providing contraceptive advice have not had specialist training and noted that whilst specialist SRH services contracts used to specify a requirement to train local GPs, medical students and nurses, in many cases this is no longer the case.33

13. Recommendations

13.1. Future funding

- SRH services must be fully funded to meet local need.

- Before changes to public health funding, the impact of the removal of the ring-fence and the adoption of a BRR model should be scrutinised. Furthermore, accountability lines must be developed with further consultation.
13.2 High quality services

- To guarantee high-quality care, SRH services must be delivered by LA’s in accordance with nationally recognised standards in SRH, such as FSRH, BASHH and BHIVA standards. To protect the quality of services, these standards should be referred to in the mandate. We also recommend DHSC and PHE collaborate to strengthen the SRH mandate at a local level.

- Tools should be developed to support LA’s to assess the impact of their activities on health inequalities.

- LA’s and CCGS should be supported with their SRH commissioning responsibilities in line with the whole-system approach outlined in PHE’s "Making it work" guide.

13.3 Workforce and training requirements

- It is vital that enough staff are sufficiently trained to meet the rising demand for sexual health services. This will require increased government investment.

- HEE should conduct a review of workforce needs in sexual and reproductive health. They should require Local Education and Training Boards (LETBs) to assess local need for training in SRH and the best way to meet it.

- Training for local GPs, medical students and nurses should be a mandatory part of specialist SRH services’ contracts.

13.4 Accountability

- Given the APPSRH’s 2015 findings that there is a lack of clarity with regards to accountability, we recommend existing accountability mechanisms are enhanced, enabling the Secretary of State to hold LA’s to account in the delivery of public health responsibilities.

October 2018

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4 HM Treasury, *Chancellor announces £4.5 billion of measures to bring down debt*, 2015
5 Kings Fund, *Chickens coming home to roost: local government public health budgets for 2017/18*, 2017
6 Kings Fund, *Big cuts planned to public health budgets*, 2017
7 BBC News, *Cuts to sexual-health services imminent*, 2018
8 AGC, *Cuts, Closures and Contraception: An audit of local contraceptive services in England*, 2017
9 AGC, FOI audit of local authorities, achieved a 97% response rates, conducted in 2018
10 PHE, *Sexually transmitted infections (STIs): annual data tables*, 2018
13 RCGP, *A time to act*, 2017
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