Written evidence from The Royal College of Obstetricians and Gynaecologists (RCOG)

The Royal College of Obstetricians and Gynaecologists (RCOG) works to improve health care for women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women’s health care worldwide. Founded in 1929, the RCOG now has over 16,000 members worldwide and works with a range of partners both in the UK and globally to improve the standard of care delivered to women, encourage the study of obstetrics and gynaecology (O&G), and advance the science and practice of O&G.

We welcome the opportunity to submit our views to the Health and Social Care Select Committee’s Inquiry into Sexual Health. In submitting, the RCOG also supports the responses from the Faculty of Sexual and Reproductive Health (FSRH) and the APPG on Sexual and Reproductive Health - we are one of four organisations that provide secretariat support.

This response focuses on key three themes within sexual health care, cervical screening, contraception and abortion care.

Cervical Screening

1. Cancer is a common cause of death amongst women, but gynaecological cancers are silent killers. Whilst 12% of all cases of cancer are gynaecological, they comprise 10% of all cancer related deaths. Womb cancer is on the rise, linked to a rise in obesity and reduced number of hysterectomies. Cervical cancer has also increased by 6% in the last decade. 1 and 10 year survival rates for ovarian cancer are poor (compared to uterine cancers), 64% and 35% respectively (compared to 90% and 78%). Cancer Research UK found significant barriers preventing women presenting early for diagnoses; 45% of women reported difficulty in securing an appointment with the GP, as well as not talking to the receptionists and about symptoms due to embarrassment, and 46% of women being unaware of the symptoms.

2. The RCOG would to see a gendered approach to preventing cancer, to ensure that improvements in cancer are addressing inequalities. Access to and quality of care for women with cancer needs to be dramatically improved. There also needs to be more awareness raised about the symptoms of gynaecological cancers, and work needs to be done to reduce stigma and raise awareness.

3. Cervical screenings rates in the UK haven’t reached their target of 80% since 2009, with access to the screening programme decreasing over the past decade. Sexual health and contraception services have traditionally been a place where women were provided with or opportunistically offered to take part in cervical screening. However the Director of Programmes for the UK National Screening Committee for PHE has recently stated that new service specifications for SRH services are not including cervical screening. Cuts to SRH services by Local Authorities under severe budgetary pressure compound the problem, with fewer settings to attend screening and longer waiting times.

4. On the other hand, overburdened GP practices are unable to effectively take on the extra demand in the face of mounting financial and capacity pressures, and find it challenging/difficult to retain the necessary skills and miss the chance to offer opportunistic
appointments, an effective way of increasing attendance. The RCOG believes that a swift intervention is required to ensure cervical cancer is prevented where possible, and diagnosed earlier and quicker to improve survival rates. To achieve swift action and encourage more women to attend, the RCOG would also like to see the target for cervical screening be set at 88%. The National Screening Inequalities strategy should incorporate gynaecological cancers, HPV vaccination and cervical screening, to focus on women’s cancers, not just breast. Reduction of stigma and increased awareness in symptoms should also be part of this.

Contraception

5. Public Health England (PHE) has demonstrated the value of preventative sexual healthcare, highlighting that every £1 spent on publicly funded contraception services saves £9 across the public sector. PHE also state that prevention and early intervention are effective in improving or maintaining health and represent good value for money.

6. Yet, despite this, councils’ public health grants have been reduced by £331million from 2017/17 to 2020/21. Findings from an analysis carried out in 2017 by the King’s Fund on councils’ forecast expenditure in 2017/18, shows that cuts to the Public Health budget have forced councils to reduce spending on key services. Sexual health services suffered the biggest loss with a 5% cut that amounts to £30million.

7. Further evidence indicates that cuts coupled with fragmented commissioning have had a severe impact in access to contraception. The Advisory Group on Contraception (AGC) has just released a new report based on Freedom of Information (FOI) that found that two thirds of councils have cut their SRH budget since 2016/17. Meaning that more than 8 million women are now living in an areas where the council has reduced funding for SRH services.

8. The RCOG supports the FSRH’s visions that there is a need for SRH care to be more broadly integrated into women’s healthcare pathways in the NHS. This includes though patient-centered commissioning with care pathways designed around the needs of the individual.

9. The RCOG would like to see an expansion in the roles that pharmacies play in maintaining women’s health. Women often struggle to get contraception from their preferred source, usually GPs, due to the strain on primary care, waiting times for appointments and because one third of contraceptive appointments are to maintain existing contraception.

10. Pharmacies such as Lloyds and Superdrug privately offer the option for women to purchase their contraception online, approved by a doctor, with the required health check conducted by a pharmacist. The RCOG would like to see a similar model rolled out on the NHS, whereby women can access repeat prescriptions through their local pharmacy without the need for a GP appointment. This has the opportunity to significantly relieve pressure on primary care services whilst making it easier for women to access vital services.

Emergency contraception

11. Over the last couple of years, due to public and political pressure, the cost of emergency contraception purchased at pharmacies has decreased. Nevertheless, the cost is still prohibitive and creates an inequity in access. The RCOG strongly believes that emergency contraception should be provided free at the point of care for all women, as is the case in Scotland and Wales.
12. Although it is well recognised that long acting reversible contraceptive methods (LARCs) are more reliable than other methods, they are not always the method of choice for an individual. Women might opt for other contraceptive methods, such as the pill or condoms. Emergency contraception is not only required when no contraception is used, but also when these established methods fail, e.g. a burst condom, forgotten pills, or an interacting medicine is taken which might reduce efficacy.

13. Women should never have to pay for such an important method of contraception and have to live with the consequences of an unplanned pregnancy.

Abortion care

14. The RCOG supports the rights of girls and women across the world to access safe, high-quality family planning, contraception, abortion and post-abortion services, always working within the local legal framework and respecting the diversity of personal opinion among our members and society. Abortion care is an essential aspect of women’s health. We believe that the Committee needs to consider abortion care alongside other sexual health services as they are intrinsically linked, and access and commissioning issues have knock on effects on each other.

The healthcare provider workforce in the UK

Workforce factors:

15. Before the 1967 Abortion Act, unsafe abortion was a leading cause of maternal mortality, responsible for 14% of maternal deaths. The RCOG has identified as a key priority the need to ensure today’s abortion services are sustainable into the future. Changes to the commissioning and delivery of abortion services have had a significant impact in recent years. The shift towards provision of abortion services by the independent sector has directly led to a reduction in the training opportunities and placements available to doctors working within the NHS. This has resulted in a smaller number of doctors with the requisite skills to deliver abortion care to women across the UK. The low prestige and stigma that can be associated with abortion care are also affecting morale within the profession.

16. In England and Wales in 2017, 28% of abortions were performed in NHS hospitals and 68% in approved independent sector places under NHS contract. With over two-thirds of NHS-funded abortions being delivered by the independent sector, junior doctors are finding it increasingly difficult to access training and experience of abortion care as there are now fewer NHS based consultants working in abortion care and therefore fewer opportunities available.
17. The future of sexual healthcare services requires careful workforce planning in order for abortion services to be available to the women who need it most. In the RCOG’s 2016 workforce survey of UK consultants and equivalent, only 5.2% of the 1736 consultants who responded (roughly 60% of the obstetrics and gynaecology workforce) stated that sexual health and abortion care formed part of their work. In the specialty training programme, abortion care is covered in two modules of the core curriculum in obstetrics and gynaecology, and there is an Advanced Training Skills Module (ATSM) in abortion care. The ATSM covers everything from the legal and ethical aspects of abortion, the medical and surgical procedures, as well as aftercare. Since 2007, only 33 junior doctors have completed the abortion care ATSM, with an additional 13 currently registered. This is out of a total of 5284 doctors who have registered for one of the 20 ATSMs since their introduction in 2007, with 3614 successfully completing an ATSM. With the current generation of doctors providing this service nearing retirement, there is a risk that the future workforce will not be trained to provide this essential care.

18. Anecdotally it appears the lack of role models and career pathways within abortion care partly explains the low take-up of ATSM training in this area. There is also an overall feeling that abortion care has low prestige in the NHS and as a result staff working in this field report feeling undervalued and isolated, rather than feeling as though their work is regarded as an essential part of delivering improvements to women’s health.

19. This sense of low prestige for the workforce is also exacerbated by negative press coverage around abortion and the intimidating tactics of anti-abortion groups outside of clinics. Furthermore, consistent political activity, such as Private Members’ Bills in the Houses of Commons and Lords looking to further restrict abortion services and regular Parliamentary questions on abortion, means that the feeling of low prestige for abortion care services is continuous.

20. There is a similar picture within the Faculty of Sexual and Reproductive Healthcare (FSRH) training programme, with only 20 people having successfully completed the FSRH Special Skills Module in abortion care.

System factors:

21. There are also particular concerns around services for women with complex co-morbidities or who are seeking abortions at later gestations. In the UK, there are dwindling numbers of consultants providing this service, with few doctors in training who will be in position to carry out these procedures in the future. Due to commissioning patterns in England and Wales, independent sector providers now provide the majority of abortion procedures. However, they do not have the necessary facilities or licenses to carry out more complex procedures or late stage abortions.
22. Clinical Commissioning Groups (CCGs) often lack the specialist knowledge needed to commission abortion services appropriately. The tariff used by CCGs is similar for medical, surgical and complex cases. However, costs are greater for abortions taking place at a later gestation and/or where there are additional complexities. Commissioning must not be based on a single tariff, but instead based on the complexity of the procedure, which is determined by each woman’s individual needs. In addition, CCGs should commission the training of doctors in abortion services.

23. To help overcome the challenges with the healthcare provider workforce, the RCOG has established an Abortion Task Force, led by the College President, Professor Lesley Regan. The Taskforce works collaboratively with the main independent-sector providers to develop system-wide solutions to ensure that women have access to safe, sustainable, high-quality care. The Abortion Taskforce is exploring models for obstetrics and gynaecology trainees to gain training and experience in the independent sector, following successful models already established in some parts of the country. Furthermore, the Abortion Taskforce is working closely with NHS England, which has provided welcome support to develop models for specialist abortion services for complex and late stage abortion services for women.

24. The National Guideline Alliance (NGA), hosted by the RCOG, has been commissioned by the National Institute for Health and Care Excellence (NICE) to update the current clinical guideline on the care of women seeking abortion, which was published in 2011. The guideline will be co-badged by NICE and the RCOG – the first time NICE has published a co-branded guideline. As abortion services are now varying based on local commissioning, and with services increasingly shifting from the NHS to the independent sector, the guidance will look at the best available evidence to ensure that services provide safe and appropriate access to women who require an abortion. The draft scope highlights that the guideline will examine inequalities relating to: living in remote areas, complex pre-existing medical conditions, coexisting mental health problems, learning disabilities, vulnerable women (including sex workers and women who are homeless), girls and younger women and women who have communication difficulties. The guideline is expected to be published in September 2019.

25. The RCOG respects that individual views on abortion amongst its members, and indeed across wider society, will differ on the topic of abortion. However, as an organisation whose core purpose is to improve women’s health, the College supports the rights of women and girls across the world to access safe, high-quality family planning, contraception, abortion and post-abortion services, working within the local legal framework.