Written evidence from the Royal College of General Practitioners (RCGP)

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Introduction

The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to The Health and Social Care Committee Inquiry into Sexual Health.

The RCGP is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 52,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. RCGP is an independent professional body with expertise in patient-centred generalist clinical care.

Executive summary

In August 2017 the RCGP published the Time to Act report. This publication highlighted concerns reported by members of the Royal College of General Practitioners that are reversing previous positive advances made in promoting sexual and reproductive health. Including:

- GPs across the UK are finding it harder to access the training needed to be able to provide the most effective Long-Acting Reversible Contraceptives (LARC) methods of contraception.
- In England payments to GPs for providing the service to deliver LARC often no longer cover the cost of administering them.
- Fragmented commissioning pathways are meaning patients are not able to access the best care for their needs.
- Cuts to public health funding have resulted in reduced access to specialist Sexual and Reproductive Health (SRH) services in England.

The ability to be provided with sufficient information to choose a method of contraception that is right for them and then to be able to access the method of their choice without having to negotiate unnecessary hurdles is a fundamental right for patients. The government guidelines in England say that ‘all services, and interventions commissioned by local authorities and other service commissioners should be patient-centred and aimed at improving the health of individuals and the wider population’. Because of split commissioning responsibilities, no oversight of the system as a whole and reduced funding, SRH provision no longer meets this requirement.

The RCGP is concerned that the increased difficulty in accessing provision of sexual and reproductive care is creating health inequalities between those who are able to navigate the increasingly complex system and those who are not. Some of the most at-risk patients are the least able to reach the support they need due to cultural, language, financial or geographical difficulties and some services are restricting access to contraception and sexual health services based on residency or age thereby further reducing access for patients. As access to essential SRH care reduces, the impact of poor sexual and
reproductive healthcare increases with patients experiencing the harmful psychological and social burden of unplanned pregnancy and increased costs to the NHS overall with higher demand for the maternity and abortion services, commissioned by the CCGs.

‘It is essential that appropriate sexual and reproductive health provision is available to patients when they need it, wherever they seek support. Some patients want to visit their local GP, while others prefer the anonymity of a specialist SRH service. The current issues with fragmented commissioning in England and training across the whole of the UK are causing problems with patient choice, creating health inequalities, generating unnecessary costs for the NHS, and risking patients experiencing the psychological burden of unplanned pregnancy’.

RCGP Patient and Carers’ Participation Group1. (Time to Act)

The RCGP has written to Steve Brine, Parliamentary Under Secretary for Health and Social Care about this issue with the support of Faculty for Sexual and Reproductive Health and the Royal College of Obstetricians and Gynaecologists expressing our concern about the ongoing problems of with the provision of sexual and reproductive healthcare. We said:

“The issues outlined in our report are still pressing. Funding has been cut in many areas and the commissioning of sexual and reproductive healthcare in England is complicated and fragmented. Services across the country are provided inconsistently and provision of care in one area can be vastly different to another. This has led to disrupted, disconnected and ultimately disappointing experiences for patients.”

This is an issue that is still pressing that professionals across the healthcare sector are concerned about.

Introduction

1. The 2012 Health and Social Care Act led to the fragmentation of commissioning responsibilities for sexual and reproductive health provision in England; including but not complete:

NHS England:

- Core contraception provided by primary care as an ‘additional service’ under the GP contract.
- STI testing and treatment in general practice when clinically indicated or requested by individual patients
- Cervical screening in a range of settings

CCGs:

- Abortion services
- Male and female sterilization
- Contraception for non-contraceptive purposes

Local Authorities:

- Contraception in specialist SRH service and LARC provision in primary care.
- STI testing and treatment in specialist SRH services.
2. Reimbursement for primary care contraception provision is complicated because of the fragmented commissioning and responsibility for provision outlined above:

- Core contraception (oral and injectable methods) payments included in the global sum following the changes to the 2003/4 contract.
- Enhanced Long-Acting Reversible Contraception services (intra-uterine contraceptives and sub-dermal implants) from public health budgets.
- And whether the method is provided for a contraceptive (public health commissioned) or a non-contraceptive (CCG commissioned) benefit funded from different sources.

3. This fragmented commissioning and unprecedented cut to local authority funding is already reducing the capacity and capability of primary care sexual and reproductive health care provision with payment for work not covering the costs of delivery and the supply of trained clinicians reducing.

**Demand**

4. Primary care is the main provider of contraceptive services with an estimated 80% of women of reproductive age accessing their contraception from their GP practice. Long acting reversible contraceptive (LARC) methods are the most effective and recommended by NICE. Although these superior methods are one of the factors in achieving the reduction in teen pregnancy there has been a reduction in prescribing of 11% of LARC methods between 2014 and 2016 in primary care.

5. This reduction in provision of the more effective methods of contraception in primary care is limiting the choice for women and increasing numbers of unplanned and unwanted pregnancies with the associated personal and social costs. The financial benefit to the health and social care economy is estimated to produce savings of £9 for every £1 spent on contraception.

6. General Practice is already experiencing unprecedented pressure, with a reducing whole-time equivalent workforce and increasing demand for appointments from an aging population with complex health and social care needs. There is limited funding and incentives for general practice to deliver core sexual and reproductive health care and no requirement to deliver enhanced service provision.

7. Primary Care Women’s Health Forum 2017 SRH survey has demonstrated that of those surveyed: 35% said they were seeing more women attending their practice for non-LARC contraception as access to the SRH service had reduced.

**Access**

8. It is the woman who wants to access a choice of where and which method of contraception to choose who is most compromised by reductions in access and funding for quality SRH provision. Reducing access to skilled clinicians particularly compromises those with limited health literacy who find hard to navigate the
complexities of the health and social care system. This can result in increasing inequalities.

‘The new provider of the local contraception and sexual health service seems to be struggling with a long waiting list, they have cut back on outlying clinics, so they are hard to access for our rural population. We want to be able to provide a better service in Primary Care, however due to pressure on our core services, SRH is seen as much lower priority and there is not sufficient financial incentive. The disconnect between the public health contract for LARC and CCGs commissioning of termination of pregnancy is frustrating’.

GP in England. (Time to Act)

9. Primary Care Women’s Health Forum 2017 SRH survey has demonstrated that of those surveyed:
   • 60% stated that there was insufficient access to the full range of SRH in their local area and this had reduced over the past year.
   • 35% of those who had been subcontracted to deliver their service by a single commissioned SRH service had seen reduced access to services.

Funding

10. Any enhanced service delivery of LARC in general practice requires funding directly from public health or subcontracted from the public health commissioned SRH service.

11. In many areas funding for this enhanced work has been cut or remains inadequate meaning that many practices have ceased or reduced the work they were delivering.

   ‘GPs are fitting IUDs for insufficient money in our area at the moment. This is unsustainable as other members of the practice team point out what other activities the contraceptors should rather be contributing to’.

   GP in England (Time to Act)

12. Additional concerns include the lack of communication from public health commissioners and uncertainty about future funding arrangements. This uncertainty reduces incentives to fund training costs or backfill to attend training if there is no guarantee that the skills acquired will be useful in the future. Many currently trained primary care clinicians are also concerned they are not able to maintain their skills and many of those already skilled, plan to retire within the next 5 years.

13. Primary Care Women's Health Forum 2017 SRH survey has demonstrated that of those surveyed:
   • 30% had seen a reduction in funding for their work in 2017,
   • 50% did not have an information about whether their service would continue to be funded after the following April,
Implications for workforce and training

14. In a Local Authority area where funding of LARC for contraceptive purposes has stopped, primary care clinicians are discontinuing their work in providing intrauterine system insertion for non-contraceptive gynaecological purposes (heavy menstrual bleeding or menopause management). The consequent lack of local provision of care adds the cost of a gynaecology referral to the health economy and increases inconvenience to the woman who will require further time away from her family or workplace.

15. Surveyed GPs have also confirmed a reduction in access to training with many SRH services not commissioned or funded to provide training for primary care clinicians. In services that are still able and willing to train, GPs access is harder with long delays and extended travel times.

‘Local SRH services are very much geared to under 25 year olds so general practice is the preferred place for older women. With this demand and GP recruitment at crisis point there is a perfect storm for SRH provision to decrease. SRH takes up a lot of my time clinically and with the decrease in reimbursement my partners can be forgiven for questioning whether it is a service we can afford to continue.’

GP in England (Time to Act)

‘With GP recruitment so difficult now, gone are the days when a new GP had to have SH qualifications. Our last 2 appointments do not have SRH experience. I am the sole LARC fitter to a practice population of 11,500 and aim to retire in a few years’ time.’

GP in England. (Time to Act)

16. Primary Care Women’s Health Forum 2017 SRH survey has demonstrated that of those surveyed:
- 30% had seen reduced access to training of primary care clinicians to provide LARC

Summary

The RCGP believes that GPs are an essential provider of contraception and sexual health care at a time of rising demand for such provision. Patients have a fundamental right to receive the best contraception for them, and with the reduced access to specialist SRH services – particularly in rural areas – the accelerating reduction in LARC services delivered through GP practices risks negatively impacting on previous positive trends in unplanned pregnancy.

Recent reports produced by Public Health England5 identify the need to refocus reproductive health as a life course person-centred approach to include fertility, cervical screening, menstrual problems and menopause management. To deliver this patient-focused, holistic and preventative healthcare, as recommended by the NHS Five Year Forward View, changes to the funding and oversight of the currently
fragmented commissioning is essential. Otherwise, the advances of recent years in this area are likely to be reversed.

RCGP Recommendations\(^1\)

**England**

1. Commissioners from Clinical Commissioning Groups (CCGs), local authorities and NHS England should agree joint plans for SRH, with the aim of maximizing choice and creating the best outcomes for patients, according to assessed local need;

2. The contracts and payment systems used for commissioning SRH and Genitourinary medicine services need to be reviewed to ensure they focus on integration, incentivizing prevention and early intervention;

3. Public Health England needs to monitor and standards of service provision and make recommendations for action when outcomes decline;

4. The introduction of guidance on the number, type, and specifications of SRH services which local authorities must provide would be welcome;

5. The introduction of public health indicators which cover the whole care pathway for SRH and include people aged over 25 would be helpful;

6. The Department of Health should review the framework for Sexual Health Improvement in England and establish an indicator set to monitor progress against it.

**UK**

7. Specialist SRH should meet the requirements of the Service Standards for Sexual and Reproductive Healthcare, outlined by the Faculty for Sexual and Reproductive Healthcare and equivalent standards should be developed for GUM services, drawing on sources such as the British Association for Sexual Health and HIV clinical guidelines;

8. Health Education England, The Northern Ireland Medical and Dental Training Agency, NHS Education for Scotland and Wales Deanery need to work with Local Education and Training Boards or deaneries to assess the local SRH training needs and the best way to meet these.

**References:**

1. RCGP Time to Act Report

2. Commissioning Sexual Health Services and Interventions; Best practice for Local Authorities (Department of Health, 2013)
3 Breaking down the barriers: The need for accountability and integration in sexual health, reproductive health and HIV services in England, All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015 pg. 23
