Written evidence from Faculty of Sexual and Reproductive Healthcare

FSRH briefing oral evidence panel – Sexual Health inquiry HSC Committee

FSRH position

- Women, who make up half of the population, are being failed by a fragmented system. The UK’s population behaviour continues to change, with a widening of the gap between when people start having sex and the age when they have their first child.¹ Women are, therefore, spending a longer time preventing unplanned pregnancies and a lifetime of managing their reproductive and post-reproductive health.

- FSRH welcomes the commitment by NHSE and DHSC to look more closely at the role of NHS commissioning of sexual and reproductive healthcare (SRH) services as spelled out in the NHS long-term plan.

- However, regardless of where SRH is commissioned, the focus should be on ensuring sufficient levels of funding are in place. In the upcoming Spending Review 2019, we would like to see a reversal of cuts to the Public Health grant and additional funding for Public Health services.

- Regardless of where SRH is commissioned, the focus should be on achieving the best outcomes for patients. Patients should be at the centre of any review of SRH commissioning. This means taking stock of how shortage of funding and a fragmented commissioning system have impacted on patient care pathways as well as access and quality of care.

- The ‘review’ of SRH commissioning responsibility should also focus on women’s health. Women’s health has stood to suffer the most from the reorganisation of NHS services that ensued with the implementation of the Health & Social Care Act in 2013. Where once women could have all their reproductive health needs met in one place and one go, women are now subjected to disjointed, non-holistic, disintegrated care.

A good example is cervical screening and contraception for gynaecological purposes. Women used to be able to have their smear test done when having their coil fitted. Now doctors have to send women away without this life-saving test done because many services are not commissioned to do both.

Healthcare professionals are also being deterred from providing contraception as treatment for gynaecological conditions because, depending on local arrangements, the service is only commissioned to provide contraception for the purposes of avoiding unplanned pregnancies. Women are being referred to hospitals for simple gynaecological conditions which could be treated cheaply at community gynaecology clinics.

- This is not coherent with a focus on prevention championed by the SoS Matt Hancock and with a NHS service that aims to provide integrated care as envisioned in the NHS long term plan.

Evidence for oral session

Part 1: Worrying trends in SRH

Cuts to Public Health & SRH

- Between 2013/14 and 2017/18 the public health grant to local authorities decreased by 8% in real terms from £2.7 billion to £2.4 billion.\(^2\)
- Just before Parliament rose for the Christmas break, the Government confirmed a 2.6% cut (which has been announced previously) in the public health grant for 2019/20.
- Based on current spending plans, a reduction of almost a quarter in spending per person is expected between 2014/15 and 2019/20.\(^3\) There will have been a £700m real-terms reduction in the public health grant in that period.
- **SRH**: The Kings’ Fund estimates that between 2014/15 and 2018/19 there was an 18% real terms reduction in spending on sexual health services. Analysis of budget plans up to 2019/20 shows that cuts are set to deepen to a 25% real terms reduction in sexual health spend between 2014/15 and 2019/20.\(^4\)
- Services providing sexual health advice, prevention and promotion have been among the biggest losers from the decrease in public health spending\(^5\)
- **Demand**: LGA has reported that there is record demand for sexual health services, rising by 13% since 2013. The result of this extra demand, according to the LGA, is that services are at a “tipping point” and people are being turned away from services due to a lack of capacity\(^6\).

Cuts to contraceptive services

- According to the King’s Fund, during the period 2013/14–2016/17, 30% of local authorities reduced spend on contraceptive services by 20% or more; 31% increased spend by 20% or more.\(^7\) Picture is complex. Best approach is to focus on the cuts.
- **AGC FOI 2018**: the Advisory Group on Contraception (AGC) has released a new report based on Freedom of Information (FOI) requests issued to all 152 upper-tier LAs in England.\(^8\) The AGC found that two thirds of local councils have cut their SRH budget

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\(^2\) King’s Fund 2018 Sexual health services and the importance of prevention
https://www.kingsfund.org.uk/blog/2018/12/sexual-health-services-and-importance-prevention

\(^3\) Buck, D. 2018. Prevention is better than cure – except when it comes to paying for it

\(^4\) Written evidence from the King’s Fund

\(^5\) King’s Fund 2018 Sexual health services and the importance of prevention
https://www.kingsfund.org.uk/blog/2018/12/sexual-health-services-and-importance-prevention


\(^7\) Written evidence from the King’s Fund

since 2016/17. Since 2016/17, these cuts have meant that more than 8 million women of reproductive age live in an area where the council has reduced their SRH budgets.

- From 2017/18 to 2018/19, 57% of councils reduced their budgets on sexual and reproductive health and 23% froze their budget.

**Part 2: Services – access and quality**

*Impacts on access to SRH services*

- **PHE and the Association of Directors of Public Health (ADPH)** in their 2016 survey of SRH service commissioning found that LAs cannot maintain the current levels of service provision due to cuts to the public health budget⁹.

- The British Medical Association (BMA) has found that cuts to sexual health services are taking place in many areas with existing poor health outcomes, suggesting a mismatch between cuts and local population needs¹⁰. The report’s main findings point out that “budget reductions are leading to unacceptable variation in the quality and quantity of services available to the public”¹¹. A useful case in point from the BMA findings is Dorset: ‘Dorset sexual health service was handed a three-year budget cut of 20% in 2016. Vacant posts are frozen. Clinics have cut opening times or stopped taking walk-in patients, extending waits and journey times. There are already long waits for routine contraception appointments.’

*Impacts on access to SRH services in GP practices*

- A report by the Royal College of General Practitioners, strongly endorsed by FSRH *(Time to Act)* indicates that years of progress in SRH care, including a halving of teenage pregnancy rates over the last decade and steadily increasing uptake of long-acting reversible contraceptives (LARCs), is at risk due to the mounting pressures facing GPs and practice teams.

- This increased difficulty in accessing provision is creating health inequalities between those who are able to navigate the system, and those who are not. Some of the most at-risk patients are the least able to reach the support they need. In some services, there is evidence of restriction of access to contraception and STI testing based on residency or age.

- GPs across the UK are finding it harder to access the training needed to be able to give the most effective forms of contraception.

- As an example of such impacts, one FSRH member has recently reported that self-referral to the local specialist service for LARCs has been stopped with patients being turned away and told to see their GP. However, this policy has not been communicated to local general practices, a reflection of poor communication across fragmented commissioning structures with no oversight over the entire system, and many practices are unable to pick up the demand.

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¹¹ Ibid. A useful case in point is Dorset: ‘Dorset sexual health service was handed a three-year budget cut of 20% in 2016. Vacant posts are frozen. Clinics have cut opening times or stopped taking walk-in patients, extending waits and journey times. There are already long waits for routine contraception appointments. [...] There are, however, certain areas with particularly high sexual and reproductive health needs that are likely to be disadvantaged as a result of these changes. In the district of Weymouth and Portland, for example, rates of under-18 conception are 24.5 (per 1000)” (BMA 2018).
Evidence from FSRH members survey

- Our members’ survey collects views and experiences of our 15,000 members, many of whom express concern about the ability to deliver safe, effective SRH to an increasing number of patients with reduced funding.
- 58% of respondents said that they had experienced cuts in funding to services over the last 12 months.
- 38% reported reduced provision of SRH services, saying that patients were unable to access particular services.
- 38% reported a reduction in the variety of available SRH services provided by their practice.
- 65% reported increased demand for services.
- 48% reported poorer patient experience as an impact of these changes.
- 58% predicted that in the future access to services would be further reduced. The reasons advanced for this included reduced funding - reported by 61% of respondents and reduced clinical capacity - reported by 46% of respondents.
- Many areas reported a reduction in the variety of contraceptive provision, particularly a reduction in LARC provision. The closure of specialist centres has squeezed the time available to GPs. Waiting times are increasing, with some patients having to wait more than 4 months for an appointment.
- Women over 25 are being adversely affected by a reduced variety of services. Sexual health service cuts for the over 25s, elimination of menopause services, elimination of fitting the intrauterine system (IUS) are all examples.
- Please see Annex A for testimonials by FSRH members.

Part 3: Funding and commissioning

- A recent systematic review of the effects of cuts to Public Health spending concluded that they were misconceived and that ‘local and national public health interventions are highly cost-saving’\(^\text{12}\).
- 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 paid for by different commissioners. So LA-driven reductions in specialist SRH services increases the workload on GPs and other core contraceptive providers, while the consequent reduced access increases the need for CCG-funded maternity and abortion services. Around 41% of GPs in England responding to an RCGP survey from 2017 agreed that appointments for contraceptive advice have increased over the past year\(^\text{13}\).

\(^{12}\) Masters, R., et. al., 2017. Return on investment of public health interventions: a systematic review. *Epidemiol Community Health* 2017 (71), pp. 827–834 [https://jech.bmj.com/content/early/2017/03/07/jech-2016-208141](https://jech.bmj.com/content/early/2017/03/07/jech-2016-208141)

\(^{13}\) Time to Act [https://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx](https://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx)
Impacts on access to women’s health

- The apportioning of SRH commissioning responsibilities between CCGs, LAs and NHSE disrupts patient pathways in SRH because services are shaped by the source, availability and amount of funding rather than by patient need. In addition to finding that LAs cannot maintain the current levels of service provision due to cuts, the review of commissioning by PHE and ADPH mentioned previously has also confirmed the experience of FSRH members that fragmented commissioning of services is threatening access to contraception and other sexual health services. PHE and ADPH specifically indicate that “LARC and cervical cytology might suffer.”

- **Contraception:** at the same time as funding for contraception is being cut, prescriptions for LARCs are declining. PHE data shows that the number of prescriptions for these LARC has reduced by 8% across England between 2014 and 2016. More than a quarter (27%) of GPs in England responding to a RCGP survey disagreed that patients who need LARC are always able to access it. Out of 86% of GPs in England who provide LARC in their practice, 39% said they have experienced cuts to the funding for this service. This is despite NICE recommending increasing uptake of LARC methods.

- **Emergency contraception:** the likelihood of young women aged 13 to 15 accessing SRH services for emergency contraception, a vital method to avoid unplanned pregnancies, varies according to the level of deprivation in their area of residence. This ranged from 2 per 1000 in the least deprived areas to 8 per 1000 in the most deprived areas. The likelihood of females aged 13 to 15 using SRH services for emergency contraception, was highest in Blackpool and St. Helens. LAs recorded a rate of less than 1 per 1,000 population.

- **Cervical screening:** despite being provided by some SRH services, cervical screening is not a mandated requirement for LA commissioning and is not included in most SRH service specifications. Cuts to services, fragmentation of commissioning and the absence of a national budget line for cervical screening have had a knock-on effect on the capacity of primary care, where most screening is provided, to deliver this life-saving test. Cervical screening rates have dropped for the fourth year in a row and are now at their lowest in two decades. Coverage for women aged 25 to 64 is now at 71.4%, significantly below the 80% national target. Even lower are rates in the younger age bracket (25-49), when there is higher risk for cervical abnormalities, with coverage at only 69.1%. FSRH members have been consistently reporting that women are being turned away from SRH services, too stretched to manage to deliver what is currently in their service specifications, which many times do not include cervical screening.

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17 Time to Act
• **Contraception for gynaecological purposes**: many women choose to see their GPs when they have a gynaecological issue, but 39% of GPs in England surveyed by RCGP have reported experiencing cuts to the funding for LARCs\(^{20}\). Women used to be treated cheaply and effectively in the community and are now being sent to gynaecologists in hospitals despite the much higher cost of this and inconvenience to the patient.

• **Abortion**: abortions among the 30-34 age group increased from 15.1 per 1,000 women in 2007 to 18.2 in 2017, while rates for women aged 35 and over increased from 6.9 per 1,000 women in 2007 to 8.5 per 1,000 women in 2017 resident in England and Wales\(^{21}\). Whilst there is no evidence of direct causation, FSRH is concerned that the increase in terminations of pregnancies for those aged 30 and over may indicate an unmet need for contraception. Additionally, CCGs commission abortion services, while LAs commission contraceptive care. This creates a break in the care pathway which means that the patients who access abortion services are not automatically referred to contraceptive advice and treatment through the same care pathway, leaving them at risk of further unintended pregnancy\(^{22}\).

**How much investment in Public Health is needed?**

• The Health Foundation argues that an extra £3.2bn of funding per year is needed if the impact of cuts to public health funding is to be reversed, and investment is available to those areas who face highest levels of demand and need. Even this additional funding will not go far enough with The Health Foundation stating that *“this increase will bring a more equitable distribution of funding for public health but is far short of the update called for in the NHS Five Year Forward View”*\(^{23}\).

• Gauging return of investment for contraceptive services is challenging because the cost of providing contraceptive services is borne by councils, but the associated savings from use of contraception mostly benefit NHS budgets. Public Health England (PHE) estimates that every £1 spent on publicly-funded contraceptive services saves £9 across the public sector\(^{24}\). This estimate does not consider the wider societal impacts of unplanned pregnancy and so the actual savings are likely to be much greater.

• NICE estimates that fully implementing its LARC guidance would save NHSE approximately £102 million per year\(^{25}\).

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\(^{22}\) Time to Act https://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx


Part 4: Workforce Challenges

- King’s Fund research suggests that cuts are already having an impact in some parts of the country: staffing levels are lower and services are reduced and in some cases closed altogether. Although there is evidence of services innovating to maintain or improve quality, the extent of cuts goes beyond what can be addressed through productivity improvements alone.\(^{26}\)
- FSRH members survey has revealed that 49% reported poorer staff morale and 47% reported reduced staffing levels.
- **Consultants**: a SRH consultant can provide leadership to a population of at least 125,000.\(^{27}\) The SRH consultant workforce is in a succession crisis. HEE estimates that one third of the current medical workforce could retire in the next 5 years.
- **CSRH Programme**: the Community Sexual and Reproductive Healthcare (CSRH) Specialty training programme is one of the most competitive specialist training programmes in the UK. Yet the current predicted output of the programme falls well-short of replacing the vacancies that will arise due to consultant retirement, let alone address the fact that current consultant numbers relative to population numbers are inadequate. Health Education England (HEE) indicate that training numbers are small and unlikely to provide the service required for the future.\(^{28}\)
- **CPD**: it is deeply concerning that LAs do not have to stipulate or fund continued professional development (CPD) for healthcare professionals in service specifications for SRH services. FSRH believes that all LAs should ensure that service specifications for SRH services are designed to include training requirements in their contracts.
- **Deskilling in primary care**: the decommissioning of LARCs in general practice is raising concerns regarding the deskilling of SRH clinicians across primary care.\(^{29}\) In England, where specialist SRH services contracts used to specify that they were required to train local GPs, medical students and nurses, a lack of funds from public health to pay for these courses means that in many cases this clause has now disappeared.\(^{30}\) As most women choose to access contraception in primary care, it is paramount that women are able to access LARCs and that clinicians working in primary care have adequate opportunity to gain competencies in delivering LARCs.

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\(^{26}\) Written evidence from the King’s Fund

\(^{27}\) The one SRH Consultant per 125,000 population figure is a widely cited and ratified figure. The figure was most recently recognised in HEE Small Specialty Community & Reproductive Health report (2015) and prior to that was cited by the Centre for Workforce Intelligence (2013). The figure was originally determined and published in the joint Department of Health, Royal College of Obstetricians & Gynaecologists & FSRH report, Developing Specialties in Medicine – The case for recognition of Sexual and Reproductive Healthcare as a new CCT specialty (2008).

\(^{28}\) HEE, 2015. Small Specialty Community Sexual and Reproductive Health


\(^{30}\) Time to Act
Part 5: National Action

- Although there is data from those visiting SRH services, this is not linked with data held by GP services, meaning that pressures on GP services are not being recorded.
- DH’s ‘A Framework for Sexual Health Improvement in England’ identified four priority areas for sexual health improvement: HIV incidence, STIs incidence, unplanned pregnancies and teenage pregnancies. The goal related to unplanned pregnancies is clear: to increase access to all methods of contraception, including LARCs and emergency contraception. However, there is a mismatch between ambition and reality: out of the four priority areas, unplanned pregnancies is the only one with no associated indicators monitored by the Public Health Outcomes Framework (PHOF). The lack of such a basic metric in women’s reproductive health is unacceptable.

Recommendations

- One of the principles of good SRH care in FSRH’s Vision is that SRH must be ‘fully-funded based on the needs of the population and the principles of an open-access service’ and ‘patients must have access to the full choice of contraceptive methods and be able to see a trained healthcare professional to discuss the full range of contraceptive options available to them’. FSRH encourages DHSC to take into account the principles of FSRH’s Vision as guidelines for the delivery of high-quality SRH care that is not compromised by cuts and the politicisation of the SRH mandate at LA level.
- SRH services must be delivered in accordance with nationally recognised standards in SRH such as FSRH and BASHH standards, guaranteeing high-quality SRH care and patient safety.
- FSRH would also welcome support to LAs, by the Government, in using the Integrated Sexual Health Service Specification developed by PHE.
- FSRH believes PHE should have stronger enforcement powers to enable the agency to act on the findings and analyses it produces and to hold LAs and commissioners to account for their performance, developing more stringent accountability structures with LAs. This is a point also endorsed by the APPG SRH’s Breaking down the Barriers report.
- FSRH would like to see an indicator on unplanned pregnancies associated with PHOF’s Outcome 2 “Health improvement”. A useful indicator could mirror the London Measure of Unplanned Pregnancy (LMUP).
- FSRH would welcome fully funded CSRH training and consultant posts to help ensure the system is effectively training, educating and investing in the new workforce.
- FSRH believes that all LAs should ensure that service specifications for SRH services are designed to include training requirements in their contracts and optimise the contraceptive services that the current SRH workforce can offer including access to a clinical lead in SRH.

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32 Ibid.
• Training for local GPs, medical students and nurses must be a mandatory part of specialist SRH services’ contracts.
• SRH is and will be increasingly delivered by nurses and other healthcare professionals in multidisciplinary teams. In order to further the development of nurse competencies and strengthen their leadership role, FSRH believes that service providers should commit to actively supporting nurses to undertake further professional training. FSRH believes that there should be a structured career pathway for nurses working in SRH.

Annex A: Testimonials by themes – FSRH members’ survey

Reduced opening hours, availability of venues and geographic location

• A GP in East of England writes:

‘Our local sexual health service has reduced to nurse led clinic with reduced clinic times and reduced experience and loss of experienced health [workers] and problem with recruiting from cuts made in training over 5 years ago. Universal access to essential services is becoming more problematic and arbitrary depending on location, not need’

• A GP in West Midlands writes:

‘Reduction in opening hours and venues available. Reduced from 13 sites to 4 for provision of service’

• A GP nurse in Suffolk writes:

‘Closure of facilities increases travel time for patients, a particular problem in low-income areas, and areas without good public transport. Thus to access CASH services in Suffolk involves for some rural clients two bus changes and £5 or more in bus fares.’

Long waiting times

• An SRH doctor in South East England writes:

‘Very few walk-in services available for women or men. Long wait times’

Poorer patient experience and decreased capacity

• A nurse in South West England, writing from within an NHS integrated sexual health service provider, writes:

‘There have been 25% funding cuts, and due to staffing cuts as a direct response to funding cuts, we are focusing on complex, vulnerable and high risk needs and diverting others back to GPs.’

• An East of England GP noted:

“Lack of capacity at local FP clinic for IUCD fits, so increased requests in general practice.”

Reduction in range of contraception offer

• An associate GP in South West England, specialist in sexual and reproductive health, writes:

“A lot of GPs have stopped doing LARCs. As a result the wait to have a coil inserted may be 8 weeks”
A GP nurse in East of England reports:

'Less access for LARC services … Currently the wait for a LARC is six weeks at some local CASH clinics! Also women who require an IUS for HMB [heavy menstrual bleeding] and HRT [hormonal replacement therapy] have to wait more than 18 weeks as the CASH service are no longer providing this service.'

A nurse in Yorkshire and Humber reports:

'Patients inform they are unable to access and get an appointment from their GP service or for LARC. No nurse or doctor is trained within their service. Some comments suggest that GPs are no longer providing the LARC service as part of their practice.'

**Impacts on women over 25**

A GP in South West England reports:

'Very few sexual health clinics locally except the local Brook - over 25s must travel to nearby town (5 miles) or further to central Hub (13 miles) - this from a deprived area containing 3 of the top 20 most deprived areas in Britain, where travelling is not always feasible.'

**Fragmentation of commissioning**

A consultant in Northwest London writes:

'No agreement to pay for cross border flow for CaSH patients and 2 bordering boroughs saying will not pay - 15% of activity therefore not paid for currently by local commissioners'