

FSRH and RCOG response to the Cross-Party Group on SRH Inquiry into Access to Contraception

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The [Faculty of Sexual and Reproductive Healthcare \(FSRH\)](#) and the [Royal College of Obstetricians and Gynaecologists \(RCOG\)](#) welcome the opportunity to respond to the *Inquiry into Access to Contraception by the Cross-Party Group on Sexual and Reproductive Health (SRH)*. FSRH is the largest UK multidisciplinary professional membership organisation, representing more than 15,000 doctors and nurses working at the frontline of Sexual and Reproductive Health (SRH) care delivery. FSRH works to ensure that the population can access high-quality and holistic SRH services across the life course, and that essential SRH services remain available to the population during and after the COVID-19 pandemic. RCOG is a professional membership organisation made up of over 16,000 members worldwide. RCOG works to improve health care for women¹, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's health care.

Introduction

Access to contraception in England has been challenged in recent years by funding cuts to public health services, and the fragmented commissioning of SRH services. The outbreak of COVID-19 has compounded these issues, and caused further disruption to contraceptive services. The post-pandemic landscape offers significant opportunities to tackle these challenges. However, to enable positive change to last, we will need to go further than restoration. We propose the following recommendations, which will be explored in this document:

- Include a Long acting reversible contraceptive (LARC) indicator within the Primary Care Quality Outcomes Framework (QOF).
- Reclassify the progestogen-only pill (POP) from 'prescription-only' to 'pharmacy product'
- Increase investment into current Public Health and SRH services
- Develop a national digital service platform for SRH in England
- Develop integrated holistic commissioning of SRH, with one body maintaining oversight and holding accountability for all commissioning decisions
- Ensure that any review of SRH commissioning responsibility should focus on women's health
- More broadly integrate SRH into women's healthcare pathways in the NHS

¹ We acknowledge that not only individuals who identify as women require access to sexual and reproductive healthcare services, and that services must be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth. The terms 'woman' and 'women's health' are used for brevity, on the understanding trans men and non-binary individuals assigned female at birth also require access to women's health services.

- Ensure the availability of all modalities of consultation, including remote and face to face consultations
- Enhance the local authority mandate in relation to contraceptive services to adhere to FSRH Standards.

Impact of Changes to Contraceptive Services during the COVID-19 Pandemic

The outbreak of COVID-19 has resulted in a significant disruption to contraceptive services in the UK. To ensure patient safety as well as protect healthcare professionals, service providers have limited face-to-face consultations and increased remote consultations. As a result of reductions in staff numbers due to redeployment and illness, clinics have made difficult service provision decisions, including temporarily suspending many 'usual' functions of their service, or closing entirely. According to the [FSRH COVID-19 members survey](#):

- 54% of SRH service providers have ended or limited the provision of emergency long-acting reversible contraception (LARC)
- 39% have ended or limited provision for LARC complications
- 12% have ended or limited the provision of emergency oral contraception
- 23% have ended or limited the provision of routine oral contraception
- Over half (55%) of those who have ended the provision of SRH services are not confident their patients can access this care elsewhere.

Services for LARC have been most detrimentally impacted by the pandemic. This is particularly worrying as LARC provision has declined in many areas of the country in recent years.² The closure of specialist centres has put pressure on GPs to provide LARC services. However, a combination of system fracture, reduced funding, and a lack of financial incentives for GPs to provide LARC has also led to a reduction in the availability of LARCs in general practice. As a result, women reported waiting up to four months for LARC fittings prior to the pandemic. To ensure that LARC services resume and can improve after the pandemic, changes are needed to ease pressure on services, as well as to promote the provision of LARC through primary care.

Recommendation: Include a LARC indicator within the Primary Care Quality Outcomes Framework (QOF). This would act as a significant step in counteracting the challenges threatening the training of primary care clinicians to deliver LARC.

Recommendation: Endorse the work of the Medicines and Healthcare Products Regulatory Agency (MHRA) to reclassify the progestogen-only pill (POP) from 'prescription-only' to 'pharmacy product', thereby making it easily accessible in pharmacies, while reducing unnecessary pressures on GPs. POP is a reliable bridging method if it is not possible for women to access their preferred method while the requirement for social distancing remains, making reclassification of POP even more urgent.

² Advisory Group on Contraception, 2018. [At tipping point: An audit of cuts to contraceptive services and their consequences for women.](#)

Recommendation: Support the adoption of the national Patient Group Directives (PGDs) templates, developed by FSRH together with the Specialist Pharmacy Service (SPS). These templates provide a consistent presentation that has been reviewed by specialists within reproductive health. They enable healthcare professionals to provide medicines to a pre-defined group of patients, such that patients do not first need to consult a prescriber. This enables pharmacists to provide up to a 12-month supply of the combined pill and POP. The PGD templates can be adapted to reflect local policies and commissioning arrangements.

Recommendation: Ensure that all individuals have access to free emergency contraception at time and place of need. Though consultations with pharmacists are recommended and best practice, a consultation should not be a barrier to receiving emergency contraception.

Recommendation: Public Health England should monitor and publish real time trends of conception, abortion, and birth rate, so the extent of the impact of COVID-19 on these trends is monitored and can be responded to accordingly.

Impact on Vulnerable Populations

Vulnerable populations are particularly at risk during the COVID-19 pandemic. According to the FSRH COVID-19 members survey, just 31% of respondents were confident that vulnerable patients could access contraception and other SRH care during the COVID-19 pandemic. Of the 21% of respondents who provided outreach services for vulnerable groups prior to the COVID-19 outbreak, 37.5% were no longer providing outreach services. Several respondents were no longer providing routine LARC to vulnerable populations, while others stated that their satellite sites had closed, or that they could not reach vulnerable patients. The impact of these changes is explored in the [FSRH response to the Women and Equalities Select Committee Inquiry into the effects of COVID-19 on people with protected characteristics](#).

Of the 79% of FSRH survey respondents who did not provide outreach services to vulnerable groups prior to the pandemic, many commented that they used to provide outreach, but could no longer do so due to funding cuts to their service. Furthermore, respondents noted that there is a walk-in culture in many disadvantaged areas, and that a shift towards remote consultations could create barriers to access for vulnerable groups. To ensure that vulnerable women and girls can access contraception, it is imperative that SRH services are adequately funded.

Recommendation: Increase investment into current Public Health and SRH services to ensure their continued operation, and increase long-term investment in SRH services to ensure that service provision can be restored and improved in the years ahead. Sustainable, long term funding for public health services is one of our key priorities for a national SRH strategy that provides comprehensive SRH care for vulnerable women and girls.

Effectiveness of Remote Consultations

According to the FSRH COVID-19 members survey, remote consultations for SRH care have risen from 18% before the pandemic to 89% currently. Remote consultations have advantages for women in rural areas or those who struggle to travel to a central clinic due to childcare

responsibilities, disability, or financial constraints. Remote consultations can also save time for healthcare providers, and reduce waiting times for patients. However, face-to-face consultations are crucial to guarantee comprehensive SRH care. The lack of face-to-face consultations has detrimentally impacted SRH care for vulnerable groups in particular. Without face-to-face consultations, picking up on safeguarding issues, domestic abuse and teenage pregnancy is more difficult. Remote consultations can also be a barrier to access in areas where there is a walk-in culture.

Temporary changes to abortion legislation to enable remote provision of abortion care have had a positive impact. [Most women are opting for medical abortion during lockdown in England](#). Remote telemedical abortions now account for 78% of total early medical abortions (EMAs) and around two thirds of total abortion procedures. The average waiting time for patients has dropped from 9.6 days to 7.3 days since the beginning of social distancing measures, and the average gestation at the time of procedure has dropped by almost a week, from 8.0 weeks to 7.1 weeks in England.

To ensure the sustainable continuation of telemedicine for contraception, abortion, and other SRH services, it is imperative that the correct information is available to patients, and that it is easily accessible. The availability of different modalities of consultation - face-to-face, remote and online - is vital to provide comprehensive SRH care for all women and girls, and to deal with the increased demand for SRH care after services normalise. Remote and online services are a complement, not a substitute, to face-to-face consultations and, irrespective of consultation modality, [best practice and guidelines](#) must be observed to ensure safety and quality of care.

Recommendation: Develop a national digital service platform for SRH in England, which will serve as a one-stop point of access for the general public and will support the maintenance of access to essential care – including contraception, STI and HIV testing and treatment, and abortion care. This service should operate seamlessly with regional face-to-face services – providing effective triage and a streamlined care pathway for those patients referred for face-to-face treatment.

Recommendation: Ensure that all modalities of consultation, including face-to-face, are available in a manner that is safe for both patients and healthcare professionals when moving beyond the pandemic. This is particularly important to ensure that vulnerable groups have access to care, via opportunities for face-to-face meetings.

Impact of Commissioning Structures on SRH Care

SRH services in England have suffered from the re-organisation of NHS services that followed the implementation of the Health and Social Care Act in 2013. Commissioning of SRH services is currently split between Clinical Commissioning Groups (CCGs), NHS England and local authorities. This fragmentation of governance and commissioning responsibilities has created confusion and barriers for women when trying to access healthcare, as well as around who holds accountability for SRH services across the healthcare system.

During this time, some leading clinicians and service leads have worked for SRH care to be more broadly integrated into women's healthcare pathways in the NHS. For example, maternity services can be well-placed to provide effective contraception after birth, reducing the need for women to seek further care once they have left the maternity unit. There is [consensus across professions that postpartum contraception programmes should be better rolled out in maternity services](#).

However, maternity services are often not commissioned to provide contraception, and in many cases it has taken a pandemic to bring leads from across the NHS, CCGs and local authorities together to make this concept work on local bases. This example demonstrates the way in which commissioning can create a barrier to patient centred care. If SRH were more broadly integrated into women's healthcare, healthcare providers would not need to circumnavigate commissioning structures in order to provide holistic care.

Holistic SRH care means integrating care around the needs of the individual, not institutional silos, where people can access integrated/holistic advice and support across the breadth of SRH, particularly in relation to contraception. FSRH and RCOG, alongside the Royal College of General Practitioners, have produced a [Joint Statement on Holistic Integrated Commissioning endorsed by the Academy of Medical Royal Colleges \(AoMRC\)](#), which we strongly recommend is taken into consideration in addition to this response. FSRH also examines the need for integrated commissioning in its [submission to the APPG for SRH](#).

Recommendation: Develop integrated holistic commissioning of SRH, with one body maintaining oversight and holding accountability for all commissioning decisions.

Recommendation: Ensure that any review of SRH commissioning responsibility should focus on women's health.

Recommendation: Urge the Department of Health and Social Care to work together with NHSE, local authorities and other commissioners to ensure that essential SRH services as outlined by [FSRH guidance](#) remain accessible during the COVID-19 pandemic, with SRH clinics being adequately staffed, and PPE provided to all staff.

Recommendation: Enhance the local authority mandate in relation to contraceptive services to adhere to FSRH Standards.

Recommendation: More broadly integrate SRH into women's healthcare pathways in the NHS. For example, introduce contraceptive care throughout the maternity pathway, including in maternity services consistently across the UK.

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