

## **Call for evidence - local authority public health prescribed activity by the Department of Health and Social Care**

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to respond to this call for evidence on local authority public health prescribed activity by the Department of Health and Social Care (DHSC).

FSRH is the largest UK professional membership organisation that supports a diverse range of healthcare professionals in the delivery of high quality sexual and reproductive health (SRH) care. We offer our 15,000 doctor and nurse members evidence-based clinical guidance as well as clinical and service standards. FSRH also provides training and qualifications in SRH.

FSRH is responding to this consultation in its capacity as the UK organisation representing the voices of thousands of healthcare professionals working at the frontline of SRH delivery in the community. Our goal is to ensure that standards in SRH delivery are commissioned appropriately through high quality SRH services which realise [our Vision](#) for individualised and holistic SRH across the life course. Thus, the scope of our response is limited to SRH prescribed activity at local authority level and includes first-hand evidence from our members of the impacts of current prescribed activity.

### **Summary of evidence and recommendations**

- FSRH believes that the second principle could be more comprehensive if it specified that it is sexual **and reproductive** healthcare services that must be open access and available to all. FSRH would like to suggest rewording the second principle: *'Where certain aspects of the health service must be available and open access to all, for example sexual health and reproductive health (inclusive of contraception) services'*.
- FSRH believes the third principle could be rephrased: *'Where one of the SofS's functions is delegated to LAs in order to support their leading role in improving the population's health and addressing local needs'*.
- FSRH would like to encourage DHSC to take full stock of the evidence provided through this call for evidence in order to consider whether the SRH mandate should be brought back to the NHS. SRH services are quite unique in that, unlike other public health services, they are clinical services just like other NHS services, and therefore warrant further consideration as to whether the NHS is best placed to have this responsibility.
- FSRH believes that relying solely on business rates to fund public health will compound health inequalities in socio-economically deprived areas.
- Transitioning to a funding mechanism that will naturally deliver variance of yield between localities is not conducive to ensuring the stability of the healthcare system or the 'radical upgrade in prevention and public health' that is set out as a core pillar of the [NHS Five Year Forward View](#).
- FSRH believes much remains to be done to tackle regional inequalities and guarantee full access to contraception, including emergency contraception.

- The British Medical Association (BMA) has found that cuts to sexual health services are taking place in many areas with poor health outcomes, showing a mismatch between cuts and local population needs<sup>1</sup>.
- There is potential for LAs to develop tools to assess the impact of their prescribed activities on health inequalities. Resources such as PHE and the Local Government Association's (LGA) 'Teenage Pregnancy Prevention Framework'<sup>2</sup>, a framework for healthcare practitioners to assess the effectiveness of local teenage pregnancy prevention programmes, are invaluable to support LAs in maximising assets to strengthen the prevention pathway for all young people, thereby reducing inequalities.
- One of the principles of good SRH care in our 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 see a trained healthcare professional to discuss the full range of contraceptive options available to them*'<sup>3</sup>.
- 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.
- For FSRH's Vision to be realised, SRH services must be delivered by LAs in accordance with nationally recognised standards in SRH such as FSRH and BASHH standards, guaranteeing high-quality SRH care and patient safety. Strengthening LAs mandate on prescribed SRH activity requires mainstreaming standards of care at LA level, and FSRH would like to see DHSC and PHE collaborate on this matter. FSRH's Service Standards on Sexual and Reproductive Health have been developed specifically to support providers and commissioners in providing safe, high-quality SRH services. The standards are recommended for use by all providers commissioned or contracted by LAs who provide and manage all aspects of contraception and sexual health<sup>4</sup>.
- FSRH would like to stress that 'reasonable access' to a 'broad range' of contraceptive methods is unclear and ambiguous phrasing that does not lend itself to guaranteeing that LAs will fulfil their duty to provide and/or signpost women to all the contraceptive methods available in the UK.
- FSRH strongly advises DHSC to amend:
  - Regulation 6(3)(a) as follows: *Advice on, and confidential, open access to the full range of contraceptive methods available in the UK and access to specialist SRH services according to recommendations set out in nationally*

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<sup>1</sup> BMA, 2018. *Feeling the squeeze. The local impact of cuts to public health budgets in England*. [pdf] London: BMA. Available at: <https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/public-health-budgets>

<sup>2</sup> PHE & LGA, 2018. *Teenage Pregnancy Prevention Framework. Supporting young people to prevent unplanned pregnancy and develop healthy relationships Teenage pregnancy prevention framework*. [pdf] London: PHE. Available at: <https://www.gov.uk/government/publications/teenage-pregnancy-prevention-framework>

<sup>3</sup> FSRH, 2015. *Better care, a better future: a new vision for sexual and reproductive health care in the UK*. [pdf] London: FSRH. Available at: <https://www.fsrh.org/about-us/our-vision/>

<sup>4</sup> FSRH, 2016. *Service Standards for Sexual and Reproductive Healthcare*. [pdf] London: FSRH. Available at: <https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-sexual-and-reproductive-healthcare/>

- recognised standards in sexual and reproductive healthcare such as FSRH and BASHH standards<sup>5</sup>.*
- Regulation 6(3)(b) as follows: *Advice on preventing unintended pregnancy, pregnancy risk assessments, pregnancy planning, pre-conception, conception and post-conception care according to recommendations set out in nationally recognised standards in sexual and reproductive healthcare such as FSRH and BASHH standards.*
  - Regulation 6(4) as follows: *The duty of the local authority under paragraph (1)(a) does not include a requirement to offer to any person services relating to a procedure for sterilisation or vasectomy, but does include a requirement for local authorities to ensure that services they commission offer thorough counselling on the suitability and availability of these procedures, providing direct referrals to patients according to recommendations set out in nationally recognised standards in sexual and reproductive healthcare such as FSRH and BASHH standards.*
  - Regulation 7 relates to LAs' requirement to provide or make arrangements to establish a public health advice service to any Clinical Commissioning Group (CCG) wholly or partly within the authority's area. FSRH would like to see this requirement strengthened.
- LAs and CCGs must work collaboratively to support positive health outcomes, and DHSC must ensure that this joint working happens in practice.
  - 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 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.
  - FSRH supports the Health Select Committee's recommendation that LA Directors of Public Health should be required, in their statutory annual reports to PHE, to publish clear and comparable information for the public on the actions they are taking to improve public health and to provide regular updates on progress<sup>6</sup>.
  - Both the [Department of Health's 'A Framework for Sexual Health Improvement in England'](#)<sup>7</sup> and PHE's '[Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV](#)'<sup>8</sup> respectively advocate a collaborative and whole-system approach to commissioning. PHE advocates principles for commissioners to adopt, which FSRH wholeheartedly supports.

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<sup>5</sup> All the FSRH Standards can be found here: <https://www.fsrh.org/standards-and-guidance/clinical-standards/>

<sup>6</sup> Health Select Committee, 2016. *Public health post-2013: Second report of the Session 2016-17* Available at: <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/140/140.pdf>

<sup>7</sup> DH, 2013. *A Framework for Sexual Health Improvement in England*. [pdf] London: DH. Available at: <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

<sup>8</sup> PHE, 2014. *Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV*. [pdf] London: PHE. Available at:

<https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services>

- FSRH would like to see existing accountability mechanisms enhanced and LAs directly accountable to the Secretary of State. Accountability lines will need to be further developed if the business rates retention (BRR) system is introduced in 2020.

**Question 1: What is your view on the principles of prescribed activity? Are they still the right ones? Is there evidence to support your view?**

FSRH supports the three principles of prescribed activity. Considering the current climate of uncertainty surrounding the replacement of the ring-fenced public health grant with local authorities' BRR funding from 2020, the principles must, if anything, be strengthened.

FSRH believes that the second principle could be more comprehensive if it specified that it is sexual **and reproductive** healthcare services that must be open access and available to all. A helpful definition to describe sexual and reproductive health, combining two World Health Organisation (WHO) definitions, can be found in FSRH's [Vision](#)<sup>9</sup>:

*'Sexual and reproductive health care supports all people in having a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of infection, coercion, discrimination and violence; enabling them to decide if, when and how often to have children by informing them of, and providing access to, safe, effective, affordable and acceptable methods of contraception of their choice. It also signposts women to the necessary support and care to go safely through pregnancy and childbirth, thus maximising the chance of having a healthy infant.'*

Good sexual **and reproductive** health enables individuals to pursue their ambitions in education, work and with their families. It supports strong and successful communities. SRH does not just cover the provision of contraception and the prevention and treatment of sexually transmitted infections (STIs). It includes supporting sexual well-being, no matter an individual's background or sexual orientation, and includes the planning of families. It begins with education and ends with encouraging post-reproductive health, truly reflecting a person's life course.

However, despite naturally overlapping, sexual health and reproductive health cover different areas of women's and men's health. Although the provision of integrated sexual health care attempts to address these overlapping areas, reproductive healthcare provision is, at times, diluted within broader efforts in sexual health and HIV, which leave women's unique reproductive health needs unmet. Solely specifying sexual health in the second principle mirrors the real-life lack of coherence and continuity in women's reproductive healthcare provision throughout women's life-course. FSRH would like to suggest rewording the second principle:

- *Where certain aspects of the health service must be available and open access to all, for example sexual health and reproductive health (inclusive of contraception) services*

The third principle which references contraception could also be improved. The current phrasing is reductionist because it implies that contraceptive services are being prescribed just because it is a delegated function. Not only must contraceptive services be prescribed

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<sup>9</sup> FSRH 2015. *Better care, a better future: a new vision for sexual and reproductive health care in the UK*. [pdf] London: FSRH. Available at: <https://www.fsrh.org/about-us/our-vision/>

because it is a delegated function, but also because reproductive health is the foundation of all good health and well-being across all populations.

Therefore, the third principle could be rephrased:

- *Where one of the SofS's functions is delegated to LAs in order to support their leading role in improving the population's health and addressing local needs*

FSRH is aware of the Government's clear commitment to maintaining the 2012 primary legislative framework for public health and the existing regulations, but the Faculty believes that it is important for DHSC to consider whether mandating LAs with these public health functions is the most effective approach to SRH provision, especially in the face of enormous funding uncertainty which the implementation of BRR systems will bring about.

FSRH would like to encourage DHSC to take full stock of the evidence provided through this call for evidence in order to consider whether the SRH mandate should be brought back to the NHS. SRH services are quite unique in that, unlike other public health services, they are clinical services just like other NHS services, and therefore warrant further consideration as to whether the NHS is best placed to have this responsibility. At a minimum, the evidence should inform DHSC's considerations of the impacts of cuts to SRH services, the risks of removing the public health grant ring-fence of introducing a system of 100% BRR.

**Question 2: What evidence are you aware of on the impact of the prescribing activity so far? Is there evidence to suggest the impact of the regulations varies between people or groups? This could relate, for example, to people of different gender, age, ethnicity or sexual orientation.**

### ***Health inequalities***

#### *Business rates retention*

DHSC should consider evidence of the impact of the prescribing activity at present in order to forecast future impacts of the introduction of the BRR system to fund LAs' public health functions. Although FSRH welcomes the Government's will to design a system that attempts to balance growth and address local needs, as seen in the initiative by the Department of Communities and Local Government to consult on 100% business rates retention systems last Spring<sup>10</sup>, FSRH believes that relying solely on business rates to fund public health will compound health inequalities in socio-economically deprived areas.

Transitioning to a funding mechanism that will naturally deliver variance of yield between localities is not conducive to ensuring the stability of the healthcare system or the 'radical upgrade in prevention and public health' that is set out as a core pillar of the [NHS Five Year Forward View](#). FSRH believes the Government has failed to sufficiently acknowledge that the public health grant should be prioritised as a cost-effective, fundamental healthcare spend that includes responsibility for clinical services.

As set out in the 2013 regulations, all LAs have a duty to maximise the wellbeing of the people living in their locality, and the public health grant has expenditure conditionalities which enables LAs to achieve positive long-term health outcomes. One such condition is LAs' obligation to have regard to the need to reduce inequalities in their area and to only use

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<sup>10</sup> FSRH's response to Department of Communities and Local Government's consultation on the design of the 100% business rates retention system can be found here:  
<https://www.fsrh.org/news/fsrh-responds-to-consultation-on-the-design-of-new-business/>

the grant for expenses related to the purposes of their public health functions. Funding LA prescribed activity with business rates does not seem to support LAs in exercising their duty to take steps to improve public health and reduce inequalities, and it might negatively impact on the success of well-established public health strategies.

*Teenage pregnancy rates – successful intervention still affected by post-code lottery*

[Data published by the Office for National Statistics \(ONS\) statistics on conceptions for women aged under 18 in England and Wales for the year 2016](#) shows a reduction of 60% in under-18 conception rates since 1998, the baseline year of the Teenage Pregnancy Strategy, the lowest level since records began<sup>11</sup>. However, young people are still at highest risk of unplanned pregnancies and teenage births remain higher than comparable Western European countries. Stark inequalities persist among regions – Northwest, Northeast and East of England are the regions which have shown a pace of reduction below the national average. Whilst the continuing decline in teenage pregnancy rates is very welcome, progress should not lead to complacency.

Access to SRH services is directly related to their availability in the individual's area of residence and levels of deprivation. [NHS Digital reports](#) that 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 3 per 1000 in the least deprived areas to 8 per 1000 in the most deprived areas<sup>12</sup>.

FSRH believes much remains to be done to tackle regional inequalities and guarantee full access to contraception, including emergency contraception. There is potential for LAs to develop tools to assess the impact of their prescribed activities on health inequalities. Resources such as PHE and the Local Government Association's (LGA) 'Teenage Pregnancy Prevention Framework'<sup>13</sup>, a framework for healthcare practitioners to assess the effectiveness of local teenage pregnancy prevention programmes, are invaluable to support LAs in maximising assets to strengthen the prevention pathway for all young people, thereby reducing inequalities.

### **Cuts to SRH services**

A factor which has largely influenced the impact of prescribing activity are the cuts to the public health grant and SRH services. Councils' public health grant has been reduced by £331 million from 2016/17 to 2020/21. This followed a £200 million in-year reduction in 2015/16<sup>14</sup>. Findings from [an analysis carried out last year by the King's Fund](#) on councils' forecast expenditure in 2017/18 shows that cuts to the public health budget have forced

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<sup>11</sup> ONS, 2018. *Conception statistics, England and Wales*. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/datasets/conceptionstatisticsenglandandwalesreferencetables>

<sup>12</sup> NHS Digital, 2017. *Sexual and Reproductive Health Services, England - 2016-17*. Available at: <https://digital.nhs.uk/catalogue/PUB30094>

<sup>13</sup> PHE & LGA, 2018. *Teenage Pregnancy Prevention Framework. Supporting young people to prevent unplanned pregnancy and develop healthy relationships Teenage pregnancy prevention framework*. [pdf] London: PHE. Available at: <https://www.gov.uk/government/publications/teenage-pregnancy-prevention-framework>

<sup>14</sup> LGA, 2017. *Sexual health services at tipping point warn councils*. *Local Government Association*. [online]. Available at: <https://www.local.gov.uk/about/news/sexual-health-services-tipping-point-warn-councils>

councils to reduce spending on key public health services. Sexual health services suffered the biggest loss with a 5% cut that amounts to £30 million<sup>15</sup>.

The LGA has warned that SRH services are at a “tipping point”<sup>16</sup>, a similar conclusion reached by [PHE and the Association of Directors of Public Health \(ADPH\)](#) in their 2016 survey of SRH service commissioning, which found that LAs cannot maintain the current levels of service provision due to cuts to the public health budget<sup>17</sup>.

The British Medical Association (BMA) has also found that cuts to sexual health services are taking place in many areas with poor health outcomes, showing a mismatch between cuts and local population needs<sup>18</sup>. The report’s main findings are striking, pointing out that “*budget reductions are leading to unacceptable variation in the quality and quantity of services available to the public*”<sup>19</sup>. 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)’<sup>20</sup>*

Further evidence seems to indicate that cuts coupled with fragmented commissioning have had a severe impact in access to contraception. The Advisory Group on Contraception (AGC) released [a new report in late 2017](#)<sup>21</sup> corroborating much of what FSRH’s members have been reporting through our members survey (see sub-section ‘*Evidence from the frontlines of SRH delivery - FSRH members’ survey*’ below). The AGC found that contraceptive care services have closed or are under threat in more than one third of English local councils since 2015. Around 32 councils closed services in the financial year 2016/17, compared with 12 councils in 2015/16. In addition, of the 51 councils who provided year on year data, half have cut their allocated budget for contraception for the financial year 2017/18<sup>22</sup>.

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<sup>15</sup> Buck, D., 2017. Chickens coming home to roost: local government public health budgets for 2017/18. *The King’s Fund*. [online] Available at: <https://www.kingsfund.org.uk/blog/2017/07/local-government-public-health-budgets-2017-18>

<sup>16</sup> LGA, 2017. Sexual health services at tipping point warn councils. *Local Government Association*. [online]. Available at: <https://www.local.gov.uk/about/news/sexual-health-services-tipping-point-warn-councils>

<sup>17</sup> PHE, 2017. *Sexual Health, Reproductive Health and HIV. A Review of Commissioning*. [pdf] London: PHE. Available at: <https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-commissioning-review>

<sup>18</sup> BMA, 2018. *Feeling the squeeze. The local impact of cuts to public health budgets in England*. [pdf] London: BMA. Available at: <https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/public-health-budgets>

<sup>19</sup> *Ibid.*

<sup>20</sup> *Ibid.*

<sup>21</sup> AGC, 2017. *Cuts, Closures and Contraception. An audit of local contraceptive services in England*. [pdf] London: AGC. Available at: <http://theagc.org.uk/our-work/>

<sup>22</sup> *Ibid.*

The AGC findings are in line with [data published by NHS Digital in October 2017 for the year 2016-17](#)<sup>23</sup>, which shows a 7% decrease in contacts with SRH services<sup>24</sup> when compared with the previous year and a decrease of 6% over the last three years in prescriptions for long-acting reversible contraceptives (LARCs), the most effective methods of contraception recommended by the National Institute for Health and Care Excellence (NICE) and PHE.

At a time when cuts to budgets are creating a climate of uncertainty surrounding service provision, [FSRH's Vision](#)<sup>25</sup> defines the fundamental principles that should underpin SRH provision for all to ensure that providers and commissioners are held to account and service users can access high quality SRH. One of the principles of good SRH care in our 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 see a trained healthcare professional to discuss the full range of contraceptive options available to them*'<sup>26</sup>.

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.

### ***Fragmented commissioning***

Besides finding that LAs cannot maintain the current levels of service provision due to cuts, the previously mentioned PHE and ADPH's survey has also confirmed the experience of our members that fragmented commissioning of services is threatening access to contraception and other sexual health services<sup>27</sup>. The survey echoes FSRH's concern that reduced capacity in general practice is leading to a reduction in the provision of complex contraception in primary care, with fewer GPs training or retaining essential skills in this area.

PHE and ADPH's data also supports the findings of the Royal College of General Practitioners (RCGP), whose survey carried out in 2017 indicates that the fragmentation of SRH service commissioning across England is leading to a decrease in services in the community. The findings reveal that vulnerable patients are being excluded from accessing the full range of contraceptive methods, and that health inequalities are being widened as a result<sup>28</sup>.

### ***Overcoming impacts of fragmented commissioning***

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<sup>23</sup> NHS Digital, 2017. *Sexual and Reproductive Health Services, England - 2016-17*. Available at: <https://digital.nhs.uk/catalogue/PUB30094>

<sup>24</sup> SRH services include family planning services, community contraception clinics, integrated GUM and SRH services and young people's services e.g. Brook advisory centres. A contact may be a clinic attendance or a contact with the service at a non-clinic venue such as home visits/outreach, or a non-face to face contact such as by telephone or e-mail.

<sup>25</sup> FSRH 2015. *Better care, a better future: a new vision for sexual and reproductive health care in the UK*. [pdf] London: FSRH. Available at: <https://www.fsrh.org/about-us/our-vision/>

<sup>26</sup> *Ibid*.

<sup>27</sup> PHE, 2017. *Sexual Health, Reproductive Health and HIV. A Review of Commissioning*. [pdf] London: PHE. Available at: <https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-commissioning-review>

<sup>28</sup> RCGP, 2017. *Sexual and Reproductive Health Time to Act*. [pdf] London: RCGP. Available at: <http://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx>

FSRH believes there is a need for SRH care to be more broadly integrated into women's healthcare pathways in the NHS. [In our Vision](#), holistic SRH care means *'integrating care around the needs of the individual, not institutional silos, with people able to get integrated/holistic advice and support across the breadth of SRH including contraception and STI testing and treatment'*<sup>29</sup>. Another key principle in our Vision is the importance of integration – *'establishing clear referral pathways between services so that care can be integrated around the needs of the individual'*<sup>30</sup>.

Both the [Department of Health's 'A Framework for Sexual Health Improvement in England'](#)<sup>31</sup> and PHE's ['Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV'](#)<sup>32</sup> respectively advocate a collaborative and whole-system approach to commissioning. PHE advocates principles for commissioners to adopt, which FSRH wholeheartedly supports, including patient-centred commissioning with care pathways designed around the needs of the individual; collaboration among commissioners across boundaries as required by the care pathway and ensuring contractual arrangements for the commissioned services support the delivery of seamless pathways in the most effective and efficient manner<sup>33</sup>.

### ***Evidence from the frontlines of SRH delivery - FSRH members' survey***

Our members' survey is designed to collect views and experiences of our 15,000 members, covering issues related to changes in funding and provision. We welcome the views and experiences from FSRH members working in the community, general practice and other care settings.

The data<sup>34</sup> indicates that access to services depends on a postcode lottery. FSRH members express concern about the ability to deliver safe, effective SRH to an increasing number of patients with reduced funding. Of particular note is reporting that sites commissioned to deliver contraceptive services have been closed, in significant numbers, with adverse consequences for patients.

The main patterns the data reveals include:

- While some areas reported that resourcing of SRH services remained stable, in others there was clear and extensive evidence of cuts in funding and reductions in access
- 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

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<sup>29</sup> FSRH 2015. *Better care, a better future: a new vision for sexual and reproductive health care in the UK*. [pdf] London: FSRH. Available at: <https://www.fsrh.org/about-us/our-vision/>

<sup>30</sup> *Ibid.*

<sup>31</sup> DH, 2013. *A Framework for Sexual Health Improvement in England*. [pdf] London: DH. Available at: <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

<sup>32</sup> PHE, 2014. *Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV*. [pdf] London: PHE. Available at: <https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services>

<sup>33</sup> *Ibid.*

<sup>34</sup> More than 100 respondents have answered FSRH's rolling members survey to date. The data refers to the previous 12 months. The survey can be accessed here: <https://www.fsrh.org/policy-and-media/members-survey/>

- 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
- 49% reported poorer staff morale
- 47% reported reduced staffing levels
- 58% predicted that in the future access to services would be further reduced. The second highest prediction was that there would be increased restrictions on services. The reasons advanced for this included reduced funding - reported by 61% of respondents and reduced clinical capacity - reported by 46% of respondents.
- GP surgeries are faced with a double burden: not only is demand for services increasing, but at the same time the effect of cuts is such that services previously able to cater for patients are no longer able to do so.
- Many areas reported a reduction in the variety of contraceptive provision, particularly a reduction in IUS and 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 IUS are all examples.

### Testimonials by themes

#### *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'*

**Question 3: How, if at all, does the evidence suggest that we could change the regulations prescribing activities to support better public health outcomes -for example, as expressed through the objectives of PHOF to increase healthy life expectancy and reduce differences in life expectancy?**

FSRH believes it is a fundamental right for men and women living in the UK to have confidential access to the full range of contraceptive methods across settings. Men and women living in the UK should always have the right to choose in which setting they would prefer to access contraception. We believe that all specialist services should provide open-

access care with the full range of contraceptive services available, including emergency contraception, with extended opening hours to ensure access for all.

For this vision to be realised, SRH services must be delivered by LAs in accordance with nationally recognised standards in SRH, guaranteeing high-quality SRH care and patient safety. Strengthening LAs mandate on prescribed SRH activity requires mainstreaming standards of care at LA level, and FSRH would like to see DHSC and PHE collaborate on this matter.

FSRH's Service Standards on Sexual and Reproductive Health have been developed specifically to support providers and commissioners in providing safe, high-quality SRH services. The Standards are recommended for use by all providers commissioned or contracted by LAs who provide and manage all aspects of contraception and sexual health<sup>35</sup>. FSRH would also welcome DHSC and PHE supporting LAs in using the forthcoming Integrated Sexual Health Service Specification developed by PHE.

Likewise, if the SRH mandate is to be strengthened and enhanced, an urgent task for DHSC is to improve the three prescribing principles, as outlined in our answer to question 1, and amend the prescribing regulations.

### ***The 2013 Regulations***

Regulation 6(3)(a) establishes that in 'exercising the functions in relation to the provision of contraceptive services under paragraph (1)(a), each local authority shall ensure that' [...] 'a) advice on, and reasonable access to, a broad range of contraceptive substances and appliances'.

FSRH would like to stress that 'reasonable access' to a 'broad range' of contraceptive methods is unclear and ambiguous phrasing that does not lend itself to guaranteeing that LAs will fulfil their duty to provide and/or signpost women to all the contraceptive methods available in the UK. FSRH strongly advises DHSC to amend regulation 6(3)(a) so that it includes the following:

- *Advice on, and confidential, open access to the full range of contraceptive methods available in the UK and access to specialist SRH services according to recommendations set out in nationally recognised standards in sexual and reproductive healthcare such as FSRH and BASHH standards<sup>36</sup>.*

Regulation 6(3)(b) establishes that 'advice on preventing unintended pregnancy' is provided. For women to be able to plan whether and if they want to conceive, FSRH advises DHSC to amend regulation 6(3)(b) so that it includes the following:

- *Advice on preventing unintended pregnancy, pregnancy risk assessments, pregnancy planning, pre-conception, conception and post-conception care according to recommendations set out in nationally recognised standards in sexual and reproductive healthcare such as FSRH and BASHH standards*

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<sup>35</sup> FSRH, 2016. *Service Standards for Sexual and Reproductive Healthcare*. [pdf] London: FSRH. Available at: <https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-sexual-and-reproductive-healthcare/>

<sup>36</sup> All the FSRH Standards can be found here: <https://www.fsrh.org/standards-and-guidance/clinical-standards/>

Regulation 6(4) establishes that the ‘duty of the local authority under paragraph (1)(a) does not include a requirement to offer [...] services relating to a procedure for sterilisation or vasectomy, other than the giving of preliminary advice on the availability of those procedures as an appropriate method of contraception’.

FSRH would like to stress that LAs must have a duty to ensure that services they commission offer thorough counselling on the suitability and availability of these procedures as highly effective methods of contraception in accordance with our vision of full access to the whole range of contraceptive methods available in the UK. FSRH advises DHSC to amend regulation 6(4) so that it includes the following:

- *The duty of the local authority under paragraph (1)(a) does not include a requirement to offer to any person services relating to a procedure for sterilisation or vasectomy, but does include a requirement for local authorities to ensure that services they commission offer thorough counselling on the suitability and availability of these procedures, providing direct referrals to patients according to recommendations set out in nationally recognised standards in sexual and reproductive healthcare such as FSRH and BASHH standards*

Regulation 7 relates to LAs’ requirement to provide or make arrangements to establish a public health advice service to any Clinical Commissioning Group (CCG) wholly or partly within the authority’s area. FSRH would like to see this requirement strengthened. LAs and CCGs must work collaboratively to support positive health outcomes, and DHSC must ensure that this joint working happens in practice.

FSRH strongly supports the requirement that, as set out in regulation 7(5)(a), the range of matters to be covered by the advice service should be reviewed regularly and take into account the needs of the local population, including the ‘creation of a summary of the overall health of the people in the local authority’s area’ [regulation 7(6)(a)]; the ‘provision of assessments of the health needs of groups of individuals [...] with particular conditions or diseases’ [regulation 7(6)(b)] and ‘advice on the development of plans for the anticipated care needs of persons for whom a clinical commissioning group is responsible’ [regulation 7(6)(c)].

### **Supporting better public health outcomes**

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<sup>37</sup>. The goal related to unplanned pregnancies is clear: to increase access to all methods of contraception, including LARCs and emergency contraception<sup>38</sup>. 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 and FSRH would like to see an indicator on unplanned pregnancies associated with PHOF’s Outcome

<sup>37</sup> DH, 2013. *A Framework for Sexual Health Improvement in England*. [pdf] London: DH. Available at: <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

<sup>38</sup> *Ibid.*

“Health improvement”<sup>39</sup>. Whilst a focus on young people’s access to contraception is vital, and PHOF does include an indicator on teenage pregnancies, it is crucial to understand unplanned pregnancies at all ages, especially considering the continuing trend of increasing abortion rates in women over 25<sup>40</sup>.

A useful indicator could mirror the London Measure of Unplanned Pregnancy (LMUP). To put this measure into practice, the LMUP would have to be introduced into routine maternity data collection and included in the minimum maternity dataset. Another indicator that would be incredibly useful to measure health outcomes is access to emergency intrauterine devices (IUDs).

Finally, given that the majority of women access their desired method of contraception in primary care, it is paramount that health system leaders work to develop a well-functioning indicator to ensure a better understanding of access, delivery and outcomes.

### ***Accountability for impacts***

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. FSRH supports the Health Select Committee’s recommendation that LA Directors of Public Health should be required, in their statutory annual reports to PHE, to publish clear and comparable information for the public on the actions they are taking to improve public health and to provide regular updates on progress<sup>41</sup>.

FSRH would also like to propose that LAs should be *directly* accountable to the Secretary of State for Health and Social Care. As evidenced in this consultation’s document, the 2013 regulations set requirements against which a LA could be challenged in court, and the Secretary of State can hold LAs to account through the commissioning of an independent audit. However, FSRH would like to see the existing accountability mechanisms enhanced and LAs directly accountable to the Secretary of State. Importantly, accountability lines will need to be further developed if the BRR system is introduced in 2020.

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<sup>39</sup> DH, 2016. *Improving outcomes and supporting transparency Part 2: Summary technical specifications of public health indicators. Updated August 2016.* [pdf] London: DH. Available at: <https://www.gov.uk/government/publications/public-health-outcomes-framework-2016-to-2019>

<sup>40</sup> DH, 2017. *Abortion Statistics, England and Wales: 2016. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales.* [pdf] London: DH. Available at: <https://www.gov.uk/government/statistics/report-on-abortion-statistics-in-england-and-wales-for-2016>

<sup>41</sup> Health Select Committee (2016) *Public health post-2013: Second report of the Session 2016-17* Available at: <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/140/140.pdf>