FSRH consultation response - consultation on contracting arrangements for Integrated Care Providers by NHS England

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to respond to this consultation on contracting arrangements for Integrated Care Providers (ICPs) by NHS England (NHSE).

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

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 and general practice. Our goal is to ensure that SRH services are commissioned appropriately, guided by evidence-based standards of care, realising our Vision for individualised and holistic SRH care across the life course. Therefore, the scope of our response is limited to the implications that the draft ICP contract would have on funding arrangements, commissioning and delivery of SRH services in the community and general practice as well as the SRH workforce.

Summary of key points and recommendations

- FSRH welcomes the initiative by NHSE to introduce an ICP contract and wants to see new models of care developed and thriving. FSRH is conducting research into the synergies between community based SRH and emerging new models of care. Early results reveal clear opportunities and FSRH would be delighted to share the results with NHSE when ready in late autumn.

- FSRH experience is that contraception and SRH care need to be more broadly integrated into women’s healthcare pathways in the NHS to meet patient/public need. Sexual and reproductive health care does not just cover the prevention and treatment of sexually transmitted infections (STIs). Reproductive health includes the provision of contraception and the planning of families. It begins with education and ends with post-reproductive health, truly reflecting a woman’s life course. It is an inherent part of women’s health care.

- We echo the Health and Social Care Committee’s (HSC) consideration that legal barriers and fragmentation that arose out the Health and Social Care Act 2012 will need to be addressed. SRH care has born the brunt of the impact of the Act with the move of parts of SRH funding into Local Authority responsibility.

- FSRH is concerned that there is a risk that the population-based payment approach (WPAP), which would allow flexible redeployment of resources, might leave room for resources being moved away from financing public health interventions.

- Safeguards must be in place for the providers to be able to absorb rapid changes in demand that were initially unaccounted for when the WPAP was decided upon. It is also crucial to consider unmet need when calculating the WPAP; current spend on
services does not necessarily mean it is sufficient spending that meets the demand at present, which is the case of SRH services and public health funding generally.

- FSRH calls on NHSE to seize this opportunity of rethinking the delivery of integrated services and work with DHSC to introduce a single payment mechanism across SRH and GUM. We also urge NHSE to look into how the Integrated Sexual Health Tariff could fit with the WPAP.

- FSRH is concerned that the draft ICP contract might not strike the right balance between what should be nationally mandated and the degree of autonomy that local commissioners should have in determining providers obligations. FSRH believes that the national ICP contract must still outline certain types of essential services to be delivered, including complex contraception and other SRH related care so as not to risk patchy provision and reinforce inequalities.

- FSRH suggests the ICP contract needs to be more explicit as to what is nationally mandated for workforce development, and commissioners should be required to spell out in their service specifications a requirement for providers to offer training and Continuing Professional Development (CPD) for staff.

- We call for the Service Conditions in the ICP draft contract to specify that local service specifications for ICP providers are in line with the requirements of national service specifications such as PHE’s Integrated Sexual Health Service Specification1 and quality standards including from FSRH, BASHH and NICE.

- FSRH suggests that NHSE’s proposals to integrate local authority services within ICPs need to be clearer. For example how will the ICP contract be embedded in public health services including SRH to overcome silos that have resulted in fragmented care pathways for patients trying to navigate a very complex system.

- FSRH is supportive of the proposal that NHSE’s work with local authorities and LGA may result in further development of the Contract with public health and social care in mind and calls on NHSE to engage with the wider SRH sector and other public health and medical professional organisations including FSRH.

**Question 1: Should local commissioners and providers have the option of a contract that promotes the integration of the full range of health, and where appropriate, care services?**

**Yes/No/unsure; and please explain your response.**

FSRH welcomes the proposal by NHSE to introduce an ICP contract and supports the development of new models of care to improve patient care. The integration of contraception services and GUM based sexual health services was in itself a pioneering new model of care.

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introduced years ago from which lessons can be learned. The specialty of Community Sexual and Reproductive Healthcare (CSRH) is a medical specialty that provides medical leadership to a multi-disciplinary workforce, supporting community-based patient-centred care across a large geographical area. This model provides a useful example of how new models of care could work in the future.

FSRH is conducting research into the synergies between effective community based SRH care and emerging new models of care. Early results reveal opportunities around the following areas: developing a clear vision in response to the local context; developing local relationships across silos, ensuring stable leadership and consistent collaboration; realising workforce opportunities through multidisciplinary and flexible working; harnessing the potential for technology in service delivery. FSRH would be delighted to share the results with NHSE when ready in late autumn. NHSE is very welcome to contact Camila Azevedo at externalaffairsofficer@fsrh.org to hear more about the findings.

**SRH and FSRH’s principles for integrated care**

FSRH believes there is a need for SRH care to be more broadly integrated into women’s healthcare pathways in the NHS. Sexual and reproductive health care does not just cover the prevention and treatment of sexually transmitted infections (STIs). Reproductive health includes the provision of contraception and the planning of families. It begins with education and ends with post-reproductive health, truly reflecting a woman’s life course. It is an inherent part of women’s health care and focused on prevention. Effective reproductive healthcare can often be overlooked in a system that focuses on sexual health and HIV.

*In our Vision*, holistic sexual and reproductive health (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*. FSRH believes that good SRH care should be underpinned by 10 principles, some of which refer to integration of services. SRH care should be:

- Fully integrated, with those involved in SRH care working together seamlessly across organisational and medical boundaries and settings in the patient’s best interest
- Designed and delivered to place patients at the heart of their care
- Delivered by collaborative multi-disciplinary teams with appropriate competency, training and experience
- Guided by and managed to clear, robust and consistent standards that are monitored and updated to reflect the best evidence and recommendations available
- Led by clinicians who are able to provide leadership to all aspects of care and who are committed to collaborative and cross-organisational working to improve care for the individual and the wider population

**Issues with the ICP contract**

In line with the conclusions reached by the Health and Social Care Committee (HSC) in its inquiry into integrated care, FSRH supports a move towards more integrated, collaborative

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and placed-based care as opposed to a competition-based environment, which has produced distortions in incentives with adverse outcomes for patients.

We are pleased to see that ICPs have a strong focus on prevention and long-term health and care outcomes. A healthier population is key to the long-term sustainability of all public services, including NHS, public health and social care services. There is strong evidence that prevention is cost-effective, reduce health inequalities and can deliver improvements in health and return on investment in the short, medium and long-term. Public Health England (PHE) has demonstrated how preventative healthcare can save money over time. For example, every £1 spent on publicly-funded contraceptive services saves £9 across the NHS. PHE states that prevention and early intervention are effective in improving or maintaining health and represent good value for money.

However, we agree with HSC’s conclusion about “critical questions remaining, particularly whether using an ACO contract to merge services into a single organisation accelerates integration and improves outcomes for patients”. HSC recommended that “ACOs [and therefore, ICPs] should be subject to careful evaluation”, a view that FSRH shares. Likewise, we also agree that the “legal barriers and fragmentation that arose out the Health and Social Care Act 2012 will need to be addressed”. SRH has been disproportionately impacted on by this Act with the medical aspects of contraception suffering much bigger cuts than cost pressures in the NHS as a whole.

FSRH is unsure about certain elements in the proposals that might prove challenging to the delivery of high-quality SRH care. These concerns, addressed in the subsequent questions, refer to how the ICP contract would change commissioning and service specifications, which would be less prescriptive, as well as the proposal for a population-based payment approach, the whole population annual payment (WPAP). These elements are addressed in questions 3 and 4.

FSRH also echoes the concern voiced by the British Medical Association (BMA), in its response to the previous consultation on the ACO contract, regarding the potential for non-NHS providers taking over the provision of care for entire health economies. Although at the moment it looks unlikely that non-NHS bodies would have the capacity to bid for and deliver on an ICP contract, the proposal by NHSE to “include additional provisions” […] to provide further assurance to commissioners and the population they serve in case non-statutory bodies are awarded an ICP contract in the future should be further developed. FSRH also

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7 Ibid. p06
agrees with the HSC’s conclusions that the Government needs to communicate more clearly and effectively concerning the scope of the ICP contract and private sector involvement\textsuperscript{10}.

Finally, the Five Year Forward View envisioned new models of care as a solution to the NHS funding crisis. Whilst vital to reform the system, FSRH believes new models of care, including ICPs, should not be considered the only solution to the funding crisis; extra funding is essential to guarantee a sustainable future for NHS and Public Health services. HSC does stress that countries which have implemented integrated care models took a long-term approach “with dedicated upfront investment”\textsuperscript{11}. We support the Committee’s call for a “national transformation strategy backed by secure long-term funding to support local areas to accelerate progress towards more collaborative, place-based and integrated care”\textsuperscript{12} in tandem or prior to the introduction of the ICP contract.

The issues with the ICP contract mentioned previously are given added relevance in a context of continued cuts to the Public Health grant by central Government. We expand on this on questions 3 and 4.

\textbf{Question 3:}

\textit{The draft ICP Contract is designed to be used as a national framework, incorporating core requirements and processes. It is for local commissioners to determine matters such as:}

- The services within scope for the ICP
- The funding they choose to make available through the contract, within their overall budgets
- Local health and care priorities which they wish to incentivise, either through the locally determined elements of the financial incentive scheme or through additional reporting requirements set out in the contract

\textit{Have we struck the right balance in the draft ICP Contract between the national content setting out requirements for providers, and the content about providers’ obligations to be determined by local commissioners? Yes/no/unsure; and please explain your response.}

FSRH is unsure whether the ICP contract strikes the right balance between national requirements for providers and the freedom of local commissioners to determine providers’ obligations. Likewise, FSRH is concerned that the draft ICP contract does not strike the right balance concerning the level of prescriptiveness as to the types of services to be delivered and how they are to be delivered.

Local commissioners aim to achieve the best outcomes possible for the population they serve, but demand for achieving more efficiencies in the face of increasing demand for

\begin{itemize}
  \item \textsuperscript{12} Ibid.
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services leaves local commissioners with an impossible task at hand, and SRH care, like other Public Health areas, suffer as a result.

To support this position, it is useful looking into the three key areas in question: the services within scope for the ICP; the local health and care priorities which local commissioners wish to incentivise; and funding

**SRH services**

In principle, if ICPs are to be empowered to deliver on their long-term objectives of providing population-based care that focuses on prevention and meeting local population’s needs instead of the prevalent model of activity-based care, local commissioners will certainly need some autonomy to determine providers’ obligations themselves. Local commissioners are the ones best placed to understand the local populations’ health needs.

FSRH is concerned that the draft ICP contract might not strike the right balance between what should be nationally mandated and the degree of autonomy that local commissioners should have in determining providers obligations, and that this might have a significant impact on SRH services. FSRH produce national guidelines and standards to try to ensure that all healthcare professional’s work is informed by the latest research findings and best practice. It is important that these sort of indicators are used in every area.

SRH services are commissioned by different parts of the system (CCGs, local authorities and NHSE) and are delivered in a variety of settings including GP practices and in the community. SRH services form part of the basis of general health and well-being and are essential for society’s well-being. Every individual, male or female, will need SRH services throughout their whole lives whether or not they are planning a family. FSRH believes that the national ICP contract must still outline certain types of essential services to be delivered, such as SRH services, and how they should be delivered, so as not to risk piecemeal, patchy provision of these crucial services that are highly cost effective.

**Determining local health and care priorities**

A 2017 survey of SRH commissioning by PHE and the Association of Directors of Public Health (ADPH) showed that more than half of CCG respondents did not know when their most recent needs assessment had been undertaken. Around 60% stated that either a needs assessment had not been carried out for specific population groups such as young people or LGBT or that they were unsure.13 This could be in part because LAs might instead have conducted these assessments. However, if CCGs themselves are, for some reason, not always able to fulfil their duties, it is easy to see how an activity such as conducting a needs assessment – as crucial as it is for informing the development of the service specification – can slip under competing priorities, especially if ICP providers are to be paid a whole population annual payment (WPAP) similar to a block payment and are left to decide on how to best allocate this budget. Many women using reproductive and sexual health systems – particularly more vulnerable women – may not come forward to express their need for services such as safe abortion care or treatments for Heavy Menstrual Bleeding.

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The ICP contract also places responsibility for managing any increases in demand on the ICP provider, who would be responsible for delivering the extra services required within the same budget granted when the contract is awarded. Although there is merit in incentivising providers to plan and manage the budget appropriately through the duration of the contract\(^\text{14}\), this might still pressurise ICP providers to do too more for less, impacting on quality and availability of SRH services. The King’s Fund is optimistic about commissioners making use of longer-term, outcome-based contracts, but believes the commissioners “will have a key role in holding providers to account for delivering outcomes agreed in contracts”\(^\text{15}\). We revisit this issue in our answer to question 4 on integrated funding.

**Funding and commissioning**

Local commissioners surely aim to achieve the best outcomes possible for the population they serve, but demand for achieving more efficiencies in the face of increasing demand for services leaves local commissioners with an impossible task at times and less visible services can suffer in these scenarios including those that may be stigmatised such as abortion care.

SRH services should not be completely subject to discretionary decisions by local commissioners. There must still be strong requirements at national level setting out providers obligations regarding essential healthcare services. This is given added relevance in a climate of uncertainty regarding the continuity of service provision due to cuts to the Public Health grant and the possible removal of the ring-fence in 2020.

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\(^\text{16}\). 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 councils to reduce spending on key services. Sexual health services suffered the biggest loss with cuts that amounts to £30 million\(^\text{17}\). The Health Foundation estimates that sexual health services have been cut by 18% since 2014/15\(^\text{18}\). The Local Government Association (LGA) has warned that SRH services are at a “tipping point”\(^\text{19}\).

Fragmented commissioning leading to less-than-optimal fragmented care for patients is also part of the equation. The review of SRH service commissioning by PHE and ADPH has confirmed the experience of our members that fragmented commissioning of services is

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\(^{16}\) 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


\(^{19}\) 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
threatening access to contraception and other sexual health services. Around two thirds of local councils have cut their SRH budget since 2016/17. More than 8 million women of reproductive age are now living in an area where the council has reduced funding for SRH services.

Additionally, reduced capacity in general practice is leading to a reduction in the provision of complex contraception, with fewer GPs training or retaining essential skills in this area. PHE and ADPH in their survey of SRH commissioners indicate that “decrease in capacity was, in their view, due to a complex interaction between funding, commissioning and workforce” and that “LARC [long-acting reversible contraception, the most effective methods of contraception] and cervical cytology might suffer.” RCGP's 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. Indeed, PHE data shows that the number of prescriptions for LARCs in general practice has reduced by 8% across England between 2014 and 2016.

Cuts to LAs’ budgets and fragmented commissioning have unintended effects on clinical services that fall outside of the LA mandate but are, nevertheless, essential to the delivery of holistic SRH care. This is the case with cervical screening and contraception for the purposes of managing gynaecological issues. Please refer to Annex 1 for more detail.

The national content setting out requirements for providers needs to be robust enough to overcome a recent history of cuts and fragmented commissioning in SRH services.

National frameworks can be helpful in this regard - and Schedule 3 of the Service Conditions of the ICP Contract does require providers to develop and use principles and tools contained in Making Every Contact Count (MECC) Guidance, something we strongly support. Other national frameworks such as Department of Health’s ‘A Framework for Sexual Health Improvement in England’ and Public Health England’s (PHE) ’Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV’ would be helpful for local commissioners in taking a collaborative and whole-system approach to


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commissioning essential SRH services, and these kinds of frameworks could be referred to in the ICP contract.

**Service specifications and quality standards**

FSRH does not see prescriptiveness on the part of local commissioners as a barrier to affording providers the flexibility for ongoing service redesign, responsiveness to the needs of the population and developing best practice. We see it as a necessary means to ensure that the population will have access to basic healthcare such as SRH care that is high-quality, safe and guided by evidence-based standards of care.

We are pleased that the draft ICP contract allows for “some security about the nature of what the ICP must provide” and that “this might involve specifying types of services rather than their detail”. Crucially, it is positive that the ICP contract allows local commissioners to act if they “wish to specify certain services which must always be available to particular patient groups, or to specify particular premises or locations from which services must be provided, or impose quality standards (in addition to those imposed by the mandatory elements of the Contract) which must always be maintained”. It is also positive that Schedule 5.1.4 of the Service Conditions asks providers to have “regard to other Guidance issued by NICE from time to time”; however, the same is not asked of providers in Schedule 6 “Service Standards”.

FSRH, therefore, calls on NHSE to ask providers in the draft ICP contract Service Conditions to have regard for NICE guidance and NICE quality standards to guide the provision of high-quality care in priority areas. FSRH also calls on NHSE to work further on the ICP contract so that it allows for local commissioners to be more prescriptive concerning types of SRH services, how they should be delivered as well as requirements for workforce development. We call for the Service Conditions in the ICP draft contract to specify that local commissioners should develop service specifications for ICP providers that are in line with the requirements of national service specifications such as PHE’s Integrated Sexual Health Service Specification and quality standards including those produced by FSRH and BASHH.

**FSRH quality and service standards**

There is considerable variation in how SRH services are provided within the country. These vary from distinctly separate general practice and community-based contraceptive provision with hospital-based abortion and genitourinary medicine (GUM) services, to fully integrated SRH services in the community. FSRH acknowledges the great differences that exist between services, and the FSRH’s Service Standards on Sexual and Reproductive Health provides a framework of standards which can be applied to all SRH services to enable equitable service provision. These include services within general practice, hospital- and

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30 Ibid. pp. 08-9


community-based clinics and pharmacies, as well as voluntary and independent-sector organisations.

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 the NHS, CCGs or LAs who provide and manage all aspects of contraception and sexual health. It also covers services providing pregnancy planning, pregnancy choices, abortion, community gynaecology, sexual wellbeing and health promotion33.

Using nationally-recognised evidence-based standards to develop their service specifications not only guarantees that a high-quality service is commissioned placing patient safety at the heart of care, but it also allows for the delivery of SRH care that is not compromised by cuts and the politicisation of the SRH mandate at local level.

**Question 4: Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers? Yes/No/unsure; and please explain your response**

The whole population annual payment (WPAP), as described in this consultation, is an integrated budget payed as a package rather than on a service-by-service basis. This is to be arrived at by local commissioners based on the size of the ICP’s population and *current spend on services in scope for the ICP*. The ICP contract places responsibility for managing any increases in demand to the ICP provider, who would be responsible for delivering the extra services required within the same budget granted when the contract is awarded.

Although there is merit in incentivising providers to plan and manage the budget appropriately through the duration of the contract34, and there is proposed scope for the budget to be adjusted from time to time as “required where an ICP budget is no longer sufficient to provide the full range of in-scope services to its population”35, this might still pressurise ICP providers to do too much for less, impacting on quality and availability of SRH services. Safeguards must be in place for the providers to be able to absorb rapid changes in demand that were initially unaccounted for when the WPAP was arrived at. It is also crucial to consider unmet need when calculating the WPAP; *current spend on services* does not necessarily mean it is *sufficient* spending that meets the demand at present, which is the case of SRH services and public health funding generally.

FSRH is also concerned that there is a risk that the population-based payment approach which allows “flexible redeployment of resources”36 by providers might leave room for resources being syphoned out of financing crucial public health interventions. Non-mandated sexual health services have been cut by more than 30% since 2015/1637; “flexible

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Redeployment of resources” might prove to be detrimental to SRH services when providers are looking to accrue efficiencies and manage demand. This is given added relevance in a context of possible removal of the public health grant’s ring-fence and introduction of a BRR system to fully fund LA prescribed activity from 2020.

**Financial incentives**

Misaligned financial incentives have been defined as persistent barriers to integrated care. Different payment mechanisms have certainly created distortions in SRH service delivery. At present, genitourinary medicine (GUM) services and SRH services often work on different funding mechanisms. Tariff contracts allow service providers to be paid for activity, whilst block contracts pay a fixed sum of money to provide a service set out in a specification. In many areas GUM activity is on the national Payment by Results tariff whilst SRH activity (contraception) is on block contract. This means that providers are more incentivised to provide STI care than contraception, which distorts service provision and access to SRH in a way that is unrelated to need. In certain areas this happens within the same SRH specialist service. At GP practices, GPs are paid based on their practice population, and increasing demand exacerbated by cuts to community services often means that practices are left short-changed when providing complex contraceptive care.

In order to make integrated budgets work at a local level to ensure fully integrated SRH care, integrated SRH services should be placed on the Integrated Sexual Health Tariff to avoid distortions in service provision. FSRH calls on NHSE to seize this opportunity of rethinking the delivery of integrated services and work with DHSC to introduce a single payment mechanism across SRH and GUM. We also urge NHSE to look into how the Integrated Sexual Health Tariff could fit with the WPAP. This would ensure integration of care and avoid unintended variations in access to contraception and STI care.

**Question 7:**

a) Do you think that the draft ICP Contract adequately provides for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services? Yes/No/Unsure; and please explain your response.

b) If not, what specifically do you propose? Please explain your response.

The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (SI 2013/351) regulations makes provision for the prescribed functions to be taken by LAs in exercising their public health functions. When it comes to SRH services, LAs are mandated to deliver open access services that cover:

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40 Ibid.

prevention and treatment sexually transmitted infections (STIs); partner notification; advice on and access to contraception as well as advice on how to prevent unplanned pregnancies.

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 the grant for expenses related to the purposes of their public health functions.

We welcome Service Condition 1.8 of the draft ICP Contract which prohibits an ICP provider from doing anything that would put the commissioner in breach of its statutory duties or amount to an unlawful delegation as well as Service Conditions 1.4 and 1.5 which impose obligations on the ICP and the commissioner to perform all their obligations under the contract in accordance with the law. LA public health prescribed activity are key mandated functions that LAs carry out on behalf of the Secretary of State and this mandate must be protected and strengthened.

FSRH also welcomes the NHSE’s collaboration with the Local Government Association (LGA) and LAs to gather feedback and tailor the contract to meet the needs of public health service commissioning. We support the proposal for the ICP contract to allow for the population to be served by the ICP to be defined in a way which can accommodate the different statutory responsibilities of CCGs and LAs, especially when SRH services are commissioned by both CCGs and LAs. For high-quality SRH services to be delivered both within and outside an ICP contract, LAs and CCGs must work collaboratively to support positive health outcomes.

However, FSRH believes that NHSE’s proposals to integrate LA services within ICPs are somewhat vague. More clarity is needed on how the ICP contract will embed public health services including SRH so as not to deepen or maintain artificial silos that have resulted in fragmented care pathways for patients trying to navigate a very complex system, failing to achieve the goal of truly integrating care.

Whilst NHSE acknowledges, in this consultation, that inclusion of local authority services “would likely need to be supported by a ‘section 75 agreement’ between NHS and local authority commissioners”42, there are no concrete suggestions on the scope of a section 75 agreement in the context of ICPs, just an acknowledgment that this agreement would be needed. Likewise, acknowledging that there are several models of integration already pursued, but leaving it for “local health and council partners to decide the approach best suited to local circumstances” is equally vague and not helpful on guiding commissioners and providers in this herculean task of joining up LA services with other NHS services.

Therefore, more consideration needs to be given to how LA services are to be truly integrated in ICPs. FSRH is supportive of the proposal that NHSE’s work with LAs and LGA “may result in further development of the Contract with public health and social care in mind”43, but calls on NHSE to engage with the wider SRH sector and other public health and medical professional organisations such as FSRH.

FSRH is also concerned about the fact that the contract makes it explicit that some provisions apply only to healthcare services, some only to public health and/or social care services, and some to all services. Whilst this division is likely useful for LAs as we assume this has been part of their feedback to NHSE, it conceals the fact that some services such as SRH services are both public health services and “healthcare services” (clinical services) at the same time. SRH is both a medical specialty with healthcare professionals that deliver complex clinical care to patients and a domain of public health which aims to achieve long-term positive health outcomes at the population level.

The same rationale seems to apply for integration of NHS and LA services “through separate arrangements” between LAs/LA providers and the ICP. It also applies to the contract Particulars which allows for separate specifications for healthcare services, public health services and social care services if required, meaning it provides for certain obligations to apply only in relation to healthcare services, or only in relation to public health and/or social care services despite the stated aim that this is “not intended to detract from the need to deliver services on an integrated basis.”

**Question 11: In addition to the areas covered above, do you have any other suggestions for specific changes to the draft ICP Contract, or for avoiding, reducing or compensating for any impacts that introducing this Contract may have?**

Yes/No/unsure; and please explain your response.

The establishment of a single ICP organisation that potentially will bring acute, community, primary care, public health services and the voluntary sector together to deliver integrated care for a given area will likely spur significant changes for the workforce, demanding a culture of openness to change and new ways of working across professional silos. Thus, the proposed staff transition and development programme (Schedule 9.1) is welcome in principle, but NHSE must make more information available on this proposed programme and work with medical Royal Colleges and Faculties and others to develop the programme.

As we stated in our answer to question 3, FSRH is concerned that the draft ICP contract might not strike the right balance between what should be nationally mandated and the degree of autonomy that local commissioners should have in determining providers obligations. Likewise, the draft ICP contract leaves it to commissioners to decide how detailed they make their service specifications, and we believe that the draft ICP contract does not strike the right balance concerning the level of prescriptiveness by commissioners as to the types of services to be delivered and how they are to be delivered – and adding to that, requirements for workforce development.

Therefore, FSRH believes the ICP contract needs to be more explicit as to what is nationally mandated with regard to workforce development, and commissioners should be required to specify in their service specifications a requirement for providers to provide training and Continuing Professional Development (CPD) for staff. We reiterate our position that we do not see a degree of prescriptiveness on the part of local commissioners as a barrier to affording providers the flexibility for ongoing service redesign and responsiveness to the needs of the population. We see it as a necessary means to ensure that the population will

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45 Ibid.

have access to SRH care that is high-quality, safe and guided by evidence-based standards of care, and this can only be achieved by a workforce that is appropriately trained and supported to deliver the best care possible.

Finally, it is essential to highlight that around 80% of SRH care is undertaken in general practice. One of the major problems faced in the delivery of SRH services in GP practices is that fragmentation of commissioning of SRH services between the NHS and local authorities means that budgets for training are often lost or unspecified. It is vital budgets for training are specified in service specifications and that a specialist SRH workforce is available to train and support primary care healthcare professionals.

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Annex 1

Cuts to LAs’ budgets and fragmented commissioning have unintended effects on clinical services that fall outside of the LA mandate but are, nevertheless, essential to the delivery of holistic SRH care. This is the case with cervical screening and contraception for the purposes of managing gynaecological issues.

Cervical screening is commissioned by NHS England. Despite being provided by some SRH services, cervical screening is not a mandated requirement for LA commissioning and is not included in most sexual health service specifications. Cervical screening rates have been consistently falling and are now at their lowest in two decades. Coverage for women aged 25 to 64 is now at 72%, significantly below the 80% national target\footnote{NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-programme/cervical-screening-programme-england-2016-17}. Cuts to services, the fragmentation of the commissioning landscape and the absence of a national budget line for cervical screening have had an impact on the capacity of primary care, where most screening is provided, to deliver this life-saving test.

Similarly, contraception for gynaecological purposes, such as the intrauterine system (IUS), which is a long-acting reversible contraceptive (LARC) method used for the management of menstrual heavy bleeding, is commissioned by CCGs. Currently, CCGs are also responsible for commissioning other important SRH services such as abortion care, contraception as part of the abortion pathway, female sterilisation and vasectomy. Many women choose to see their GPs when they have a gynaecological issue, but as PHE data has shown, the number of prescriptions for LARCs has fallen between 2014 and 2016\footnote{Public Health England Sexual and Reproductive Health Profiles, available at: https://fingertips.phe.org.uk/profile/SEXUALHEALTH/data#page/4/gid/8000057/pat/6/par/E12000003/ati/102/are/E06000014/iid/92254/age/1/sex/2}. 86% of GPs in England provide LARC in their practice, and 39% have reported experiencing cuts to the funding for this service\footnote{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}. These 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.