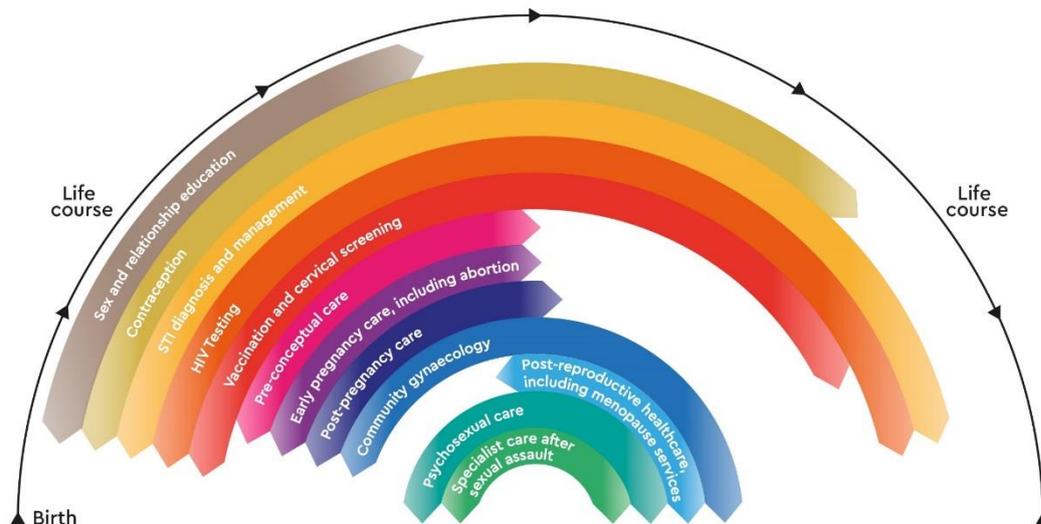


FSRH Submission – Developing the long term plan for the NHS – September 2018

The Faculty of Sexual and Reproductive Healthcare (FSRH) is very large cross-specialty UK professional membership organisation for health professionals delivering contraception and other forms of sexual and reproductive healthcare. We offer our 15,000 doctor and nurse members’ NICE-accredited evidence-based clinical guidance, including the UKMEC, the golden standard in contraceptive prescription, as well as clinical and service standards.

In addition, we have over 25 years experience of providing training and qualifications in sexual and reproductive health care, including overseeing the Community Sexual and Reproductive Healthcare (CSRH) Specialty Training Programme established in 2006. We promote learning through events, provide members with advisory services and publish the BMJ Sexual & Reproductive Health research journal jointly with the BMJ.

We are very much in touch with the experiences of sexual and reproductive healthcare professionals in the UK and it our member’s experience that accessible and effective sexual and reproductive health care is key to healthy communities. Our goal is to ensure that standards in sexual and reproductive delivery are promoted and enhanced, realising our vision of individualised and holistic sexual and reproductive healthcare across the life course. Below is our life course diagram, which illustrates the breadth of our field and our specialty. Our membership includes GPs, SRH consultants, SAS doctors, primary care nurses and nurses working in integrated sexual health services.



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FSRH welcomes the opportunity to respond to NHS England’s Consultation – Developing the Long Term Plan for the NHS. As an organisation focused on sexual and reproductive healthcare, we will respond to the overarching questions through the lens of sexual and reproductive healthcare, and women’s health more generally. We attach a copy of key evidence which has been specifically tailored for the various workstreams. The document provides substantial evidence to guide effective, high quality healthcare measures to deliver both immediate and long-term cost-effective results. In addition in question 2 and question 1.8, we provide an example of a community sexual and reproductive healthcare service which could be implemented more widely to deliver cost effective results at a local and national level.

General questions for consideration:

1. What are the core values that should underpin a long term plan for the NHS?

Safe, accessible, non-judgemental, cost effective care should, in our experience, be the values that lie at the heart of NHS and social care. In addition we would add that prevention and health promotion should be the starting point of any effective long term health plan. Good sexual and reproductive healthcare should be based on the needs of the population and the principles of an open-access service. Patients need access to the full choice of contraceptive methods and be able see a trained healthcare professional to discuss the full range of options available to them. There are major benefits to be achieved through constructing an integrated sexual and reproductive healthcare system based on national standards delivered by a well-trained multi-disciplinary team that can draw on different medical specialties. People's bodies do not (usually) fit easily into one medical specialty. But a specialist can play a key role in overseeing and providing advice to a multi-disciplinary team including primary care professionals. FSRH considers that these principles are not fully recognised at present. Given that access and ease of access are core values in our view, we would like to see a women's health strand to the long term NHS plan as there is a great deal of evidence to suggest that women's access to healthcare is being skewed by fragmentation of commissioning and perverse financial incentives.

2. What examples of good services or ways of working that are taking place locally should be spread across the country?

Despite the difficulties created by cuts to public health funding and service fragmentation, there are examples of local good practice, which could be replicated elsewhere. For example a case study of the Greenwich integrated, community-based model for sexual and reproductive healthcare services, driven by Community Sexual and Reproductive Healthcare leadership (CSRH) has demonstrated significant savings as well as increased patient satisfaction and reduced appointments.

The overarching principle of this model of care is to increase capacity through cost efficiencies from the reorganisation of local services; and to reinvest these savings into community-based services to improve overall access to sexual and reproductive healthcare for the local population - an approach which chimes with several of the NHS Forward Plan's 'enablers of change'.

Benefits of this model include - A less fragmented, more convenient care pathway for women; efficiencies for the local health economy; care close to home; far fewer follow up appointments being required; a much more cost effective process. We give more detail on these benefits below.

The integrated pathway was sub-divided into 4 separately contracted services:

- Digital self-managed care via online access, highlighting an example of the role digital health can play in improving accessibility (www.greenwichsexualhealth.org);
- Contraception and Sexual Health, offering an integrated one-stop model of care, with access to specialist sexual and reproductive healthcare services on site, in order to minimise hospital admissions
- GSH clinics (community sexual health clinics based in primary care and a young people's clinic), with a strong emphasis on prevention;

- Hospital Genitourinary Medicine (GUM) department (specialist sexual health clinic, by referral only).

Benefits of this system include:

- Fostering collaboration with other healthcare professionals across community care settings to prevent unnecessary hospital admissions, increase overall capacity and access, and provide an effective interface with local GPs. A less fragmented, more convenient care pathway for women – e.g. if a woman has been referred to the service for heavy menstrual bleeding, the service can provide an ultrasound, consultation and insertion of an IUS, as opposed to secondary care where three appointments may be needed for the same presentation, resulting in undesirable expense on transport and time off work for the woman. Many women choose to see their GPs when they have a gynaecological issue, but Public Health England data shows that the number of prescriptions for LARCs has reduced by 8% across England between 2014 and 2016¹. 86% of GPs in England provide LARC in their practice, and 39% have reported experiencing cuts to the funding for this service ². An approach like that of Greenwich can help reverse these trends.
- Efficiencies for the local health economy and care close to home – the tariff for community gynaecology is 30% less than one undertaken in a hospital.
- Far fewer follow up appointments are required, a much more cost effective process - the current follow up rate ratio is 1:0.4 in community care compared to 1:1.8 in secondary care.

Since its implementation, Greenwich's model of care has had demonstrable impacts: Through providing effective and integrated sexual and reproductive healthcare in a community setting, and reserving GUM attendance – now exclusively at Level 3 - for those with referrals, it has reduced hospital based GUM activity by approximately 75%, increasing capacity in community settings for patients to access a wider range of sexual and reproductive healthcare. In terms of financial efficiencies, the Borough's sexual health service reconfiguration has facilitated a

£400,000 increase in the envelope for community services, whilst allowing the Local Authority to continue making savings against the Public Health budget.

3. What do you think are the barriers to improving care and health outcomes for NHS patients?

There are many barriers – social, medical and organisational – but there are two very urgent barriers that could be addressed in any longer term plan:

a) lack of investment (cuts in fact) to public health funding, which are not only creating barriers to improvement, but which are actually contributing to decline, and costing the NHS.

A recent systematic review on the effects of cuts in public health spending, concluded that they were misconceived and that 'local and national public health interventions', far from being seen only in terms of their immediate costs, should be seen in a long-term perspective which would show that they are 'highly cost-saving' for the NHS. ³

¹ Public Health England Sexual and Reproductive Health Profiles, available at: <https://fingertips.phe.org.uk/profile/SEXUALHEALTH/data#page/4/qid/8000057/pat/6/par/E12000003/ati/102/are/E06000014/iid/92254/age/1/sex/2>

² 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>

³ Masters et al (2016) Return on investment of public health interventions: systematic review' <https://jech.bmj.com/content/early/2017/03/07/jech-2016-208141>

This conclusion applies strongly to sexual and reproductive healthcare. Cuts to the public health budget have forced councils to reduce spending on key public health services which are essential in ensuring preventative care, including access to contraception. Sexual and Reproductive Healthcare (SRH) services are the biggest loser when it comes to changes in spending compared to 2016/17, with a 5% cut equivalent to a £30 million cut in funding. Recent data highlight that almost half of councils in England have cut contraceptive services since 2015.⁴ Cuts are creating a situation in which innovation and service improvement are difficult.

Moreover, cuts to public health budgets represent a false economy, and are likely to generate millions of pounds of additional costs to health services and the wider economy. Conversely, PHE has demonstrated how preventative healthcare can save money over time: for example every £1 spent on contraceptive services saves £9 across the public sector.⁵

b) Issues of service design and fragmentation.

The impact of the 2012 Health and Social Care Act has been to further fragment service provision across NHS and LA/PHE commissioning and has been detrimental for women's health. For example, before the changes brought about by the 2012 Act, women were far more likely to be able to access different services at one appointment: e.g. smear test, coil fitting, response to heavy menstrual bleeding or amenorrhoea. This is no longer standard practice, and women may find themselves needing to book a number of separate appointments, at greater expense to healthcare services, or they will simply not attend.

Sexual health and contraception services have traditionally been a place where women were provided with or opportunistically offered to take part in cervical screening. This provides a strong example of the impact of system fracture and reduced funding on sexual and reproductive healthcare:

Cervical screening as a case study – system fracture

Cervical screening is commissioned by NHS England. An unintended consequence of the current commissioning structure design and reduction in public health funding has resulted in women no longer being able to access cervical screening in sexual health services.

Cervical screening is not a mandated requirement for local authority commissioning and is not usually included in new service specifications. Cuts to sexual and reproductive health services, the fragmentation of commissioning since 2013 and the absence of a national budget line for cervical screening have had a knock-on effect on the capacity of primary care, where most screening is provided, to deliver this life-saving test.

PHE (2017) stated: "*Health matters: making cervical screening more accessible*" that attendance at screening is falling, and has reached a 19-year low,⁶ in fact the number of screenings in sexual and reproductive healthcare services has halved in three years from 2014/15 – 2016/17. Their Survey highlights that the number of cervical cancer diagnoses has increased by 6% in the last decade. Less than 75% of women receive cervical screening in England yet cervical cancer is predicted to rise by 43% in the next decade. Further, this projection does not take account of the impact of the HPV vaccination programme. Sexual

⁴ Advisory Group on Contraception, Cuts to contraceptive care deepen as new data reveal half of councils closed sites providing contraception since 2015 <http://theagc.org.uk/wpcontent/uploads/2018/09/2018-FOI-audit-press-release-1.pdf>

⁵ PHE Guidance, Contraceptive services: estimating the return on investment, 2 August 2018 https://www.gov.uk/government/publications/contraceptive-services-estimating-the-return-on-investment?utm_source=26490afe-f039-4007-ba27-6f9971c3ce5d&utm_medium=email&utm_campaign=govuknotifications&utm_content=immediate

⁶ PHE Health Matters: making cervical screening more accessible. <https://www.gov.uk/government/publications/health-matters-making-cervical-screening-more-accessible>

health and contraception services have traditionally been a place where women were signposted to or opportunistically offered to take part in cervical screening: 'when you fit a coil you should do a smear test.' An unintended consequence of the current commissioning structure design and reduction in public health funding is that women are no longer able to access cervical screening in sexual health services.

In addition, the absence of a national budget line for cervical screening in sexual and reproductive healthcare services compounds the challenge while primary care is not able to effectively meet the increased demand. Research funded by Jo's Cervical Cancer Trust found that 'Access to cervical screening is unequal, declining and risking lives'. (June 2018)⁷

In terms of problems of coverage, these are more significant for the age bracket 25-49, where there is a higher risk for cervical abnormalities. Evidence from our members also suggests that reducing open access even for a short period of time has resulted in women being deterred from accessing such services.⁸ These factors act as additional barriers on top of the existing ones, effectively preventing women from pro-actively or opportunistically attending screening.

Restoring cervical screening in both sexual health and family planning services would address these challenges and is urgently needed before the infrastructure and trained healthcare professionals to do this quickly and relatively cheaply is lost.

More broadly, women's healthcare needs to be recognised as a priority area for policy, with attention being given to ending problems of service fragmentation. Emerging research on the effects of service fragmentation⁹ is complemented by reports from our own membership, and the members of other organisations in the sector.¹⁰ Recent evidence from PHE, has shown that UK women's health is faring worse than their European counterparts, with UK women dying younger, ranked 18th, lowest out of 28 EU member states for premature death. PHE make clear when discussing this data, that prevention must be a centrepiece of the NHSE Long Term Plan.¹¹ It is vital that this principle is extended to women's healthcare, seen in holistic, life-course terms.

⁷<https://www.jostrust.org.uk/node/1074459>

⁸<https://www.rcog.org.uk/en/news/call-for-urgent-action-to-increase-cervical-screening-attendance-rates/>

⁹ 'Underfunded and fragmented — a storm is brewing for sexual and reproductive health services' Pathak and Tariq 2018. Nature Reviews Urology Volume 15, 472–473

¹⁰ As our members have told us, before the changes brought about by the 2012 Act, women were more able to access several interventions within the same time frame: e.g. smear test, coil fitting, response to heavy menstrual bleeding or amenorrhoea. This is no longer standard practice, and women may find themselves needing to book a number of separate appointments, at greater expense to the service. One FSRH member recently reported that self-referral to the local specialist service for long-acting reversible contraception (LARC), one of the most effective methods of contraception, has been stopped, with patients being turned away and told to see their GP. In most cases, however, general practices are unable to pick up the slack. Other FSRH members have commented 'women don't understand the system; they are running round in circles' trying to access dispersed services which are badly in need of re-grouping and co-ordination. See also Royal College of Nurses 'Sexual and Reproductive Health: RCN report on the impact of funding and service charges in England.' 2018.

¹¹ <https://www.gov.uk/government/news/current-and-future-state-of-nations-health-revealed>

Section 1 – Life stage programs: Staying healthy

1.5 What is the top prevention activity that should be prioritised for further support over the next five to ten years?

FSRH would like to see a woman's healthcare strand in the 10 year plan which would take a holistic, lifecourse approach. Enabling women and their partners to plan when and whether to have children through effective contraception provision – would not only enable direct savings for the NHS but it would clearly have benefits to individual families and relationships and to society.

PHE has demonstrated how prevention can save money over time: for example every £1 spent on contraceptive services saves £9 across the public sector.¹² PHE states ¹³ that prevention and early intervention are effective in improving or maintaining health and represent good value for money.' PHE's recent ROI tool for contraception (York's model)¹⁴ and the Bayer Cost Calculator¹⁵, looking at the impact of unplanned pregnancies are just two cost calculating tools which also evidence the cost savings which can be made through investment in contraception as a preventative method.

Despite this, a 2018 FOI request¹⁶ conducted by the Advisory Group on Contraception (AGC) provides strong evidence on the extent of the cuts to the public health budget which have forced councils to reduced spending on key public health services which are essential in ensuring preventative care and access to contraception.

In order to prioritise a prevention focused approach to SRH and contraception, workforce challenges must be addressed.

Workforce

One example of using resources effectively, would be to give preconception advice to women in family planning' services/appointments. This is not currently happening because of a lack of time, training and joined up thinking which has been stimulated by system fracture and commissioning responsibilities being split between NHSE, CCGs and local authorities Cervical screening is another example. (See below).

There are problems of training and retention at all levels of sexual and reproductive healthcare provision.¹⁷ The Community Sexual and Reproductive Healthcare (CSRH) consultant workforce is too small to support the growing need for medical leadership of these services. HEE's Small Specialty Report on community sexual and reproductive healthcare estimated that one third of the current medical workforce could retire in the next 5 years. There are still very few community sexual and reproductive healthcare consultants and the

¹² PHE Guidance, Contraceptive services: estimating the return on investment, 2 August 2018 https://www.gov.uk/government/publications/contraceptive-services-estimating-the-return-on-investment?utm_source=26490afe-f039-4007-ba27-6f9971c3ce5d&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate

¹³ <https://www.gov.uk/government/publications/health-matters-health-economics-making-the-most-of-your-budget/health-matters-health-economics-making-the-most-of-your-budget>

¹⁴ <https://www.fsrh.org/news/phe-tool-return-investment-contraceptive-services-public-health/>

¹⁵ <http://theagc.org.uk/useful-resources/>

¹⁶ <http://theagc.org.uk/wp-content/uploads/2018/09/2018-FOI-audit-press-release-1.pdf>

¹⁷ Royal College of Nurses 'Sexual and Reproductive Health: RCN report on the impact of funding and service charges in England.' 2018.

number of funded training places has not been increased significantly despite recommendations from HEE and unfilled vacancies. Without this leadership, there will not be sustainability for new care models. The community sexual and reproductive healthcare specialty has been recognised by the GMC and HEE as a highly fit-for-purpose curriculum that supports community-based patient-centred care. HEE's report rightly points out that training numbers are small and unlikely to provide the service required for the future, specifically when looking at potential retirements and the increasing feminisation of the workforce.¹⁸

Consultants in CSRH play a crucial role in supporting the wider multidisciplinary workforce to support safe and effective care and patient choice. PHE found in a recent survey¹⁹ that there are critical medical vacancy gaps in sexual and reproductive healthcare.

LARC

In the same survey PHE highlights an absence of investment in training, including training in the most effective forms of contraceptive provision (LARCs). Investment in training GP's to deliver LARC is increasingly being overlooked by Local Authorities and yet NICE estimated that fully implementing its guidance on long-acting reversible methods of contraception would save NHS England approximately £102 million per year. Perhaps these savings should be shared with Local Authorities to give them an incentive to invest in training?

1.8 Are there examples of innovative/excellent practice that you think could be scaled up nationally to improve outcomes, experience or mortality?

As previously outlined, the case study of Greenwich integrated, community-based model for sexual and reproductive healthcare services, driven by Community SRH leadership (CSRH) could be scaled up nationally and greatly improve outcomes. This represents value for money at a local level.

The overarching principle of this one stop model of care is to increase capacity through cost-efficiencies from the reorganisation of local services; and to reinvest these savings into community-based services to improve overall access to sexual and reproductive healthcare for the local population - an approach which chimes with several of the NHS Forward Plan's 'enablers of change'.

Benefits of this model include - A less fragmented, more convenient care pathway for women; efficiencies for the local health economy; care close to home; far fewer follow up appointment being required; a much more cost effective process. We give more detail on these benefits below.

The integrated pathway was sub-divided into 4 separately contracted services:

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- GSH clinics (community sexual health clinics based in primary care and a young people's clinic), with a strong emphasis on prevention;

¹⁸ HEE, 2015. Small Specialty Community Sexual and Reproductive Health, see also FSRH (2018) FSRH consultation response: Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027 by HEE. <https://www.fsrh.org/news/fsrh-hee-workforce-strategy-consultation-challenges-solutions/>

¹⁹ Sexual Health, Reproductive Health and HIV: a review of commissioning August 2017

- Hospital Genitourinary Medicine (GUM) department (specialist sexual health clinic, by referral only).

Benefits of this system include:

- Fostering collaboration with other healthcare professionals across community care settings to prevent unnecessary hospital admissions, increase overall capacity and access, and provide an effective interface with local GPs. A less fragmented, more convenient care pathway for women – e.g. if a woman has been referred to the service for heavy menstrual bleeding, the service can provide an ultrasound, consultation and insertion of an IUS, as opposed to secondary care where three appointments may be needed for the same presentation, resulting in undesirable expense on transport and time off work for the woman. Many women choose to see their GPs when they have a gynaecological issue, but Public Health England data shows that the number of prescriptions for LARCs has reduced by 8% across England between 2014 and 2016²⁰. 86% of GPs in England provide LARC in their practice, and 39% have reported experiencing cuts to the funding for this service²¹. An approach like that of Greenwich can help reverse these trends.
- Efficiencies for the local health economy and care close to home – the tariff for community gynaecology is 30% less than one undertaken in a hospital.
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²⁰ 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>

²¹ 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>

Section 2 – Clinical Priorities – Cancer

2.1 What should the top priority for improving cancer outcomes and care over the five and ten years be?

To restore cervical screening in sexual health and family planning services would see fast and immediate results in access. FSRH strongly advises this method of prevention is prioritised within the 10 Year Plan. This is urgently needed before the infrastructure to do this quickly and relatively cheaply is lost.

Due to the current commissioning structure design, a reduction in public health funding and the absence of a national budget line for cervical screening in sexual and reproductive healthcare services, women are often unable to access cervical screening in sexual health clinics. Primary care is not able to meet the increased demand.

This is resulting in a decline in screening as well as reducing the skillset of the next generation of healthcare professionals. Research funded by Jo's Cervical Cancer Trust found that 'Access to cervical screening is unequal, declining and risking lives'. (June 2018).²² The RCOG pointed out in January 2018, that the minimum 80% national target is far from being achieved currently, with all regions reporting a fall in coverage. Particularly over 25's fair worse in coverage.

Building on this, PHE (2017) evidence in their Guidance: "*Health matters: making cervical screening more accessible*" that attendance at screening is falling, and has reached a 19-year low,²³ in fact the number of screenings in sexual and reproductive healthcare services has halved in three years from 2014/15 – 2016/17. Their Survey highlights that the number of cervical cancer diagnoses has increased by 6% in the last decade. Less than 75% of women receive cervical screening in England yet cervical cancer is predicted to rise by 43% in the next decade.

²² <https://www.jostrust.org.uk/node/1074459>

²³ PHE Health Matters: making cervical screening more accessible.
<https://www.gov.uk/government/publications/health-matters-making-cervical-screening-more-accessible>

Section 3 – Enablers of improvement: Workforce

3.1 What is the size and shape of the workforce that we need over the next ten years to help deliver the improvements in services that we would like to see?

Holistic, safe and effective SRH care can be delivered in a cost effective way by ensuring that training and support is available to doctors and nurses working in primary care supported by more specialist services based in the community and overseen by a consultant in community SRH.

However the current model is not working for a number of reasons:

- The lack of CSRH consultants to oversee/support services.
- The number of vacancies in primary care.
- The lack of incentives for nurses and doctors in primary care to fit LARC.
- The expectation that doctors and nurses will pay for their own training to do SRH-related work.
- The lack of a workforce strategy to support training of HCPs in this area of healthcare.
- The reliance on doctors and nurses giving their time for free to train the next generation of healthcare professionals – this is not sustainable.

A PHE survey (Sexual Health, Reproductive Health and HIV: a review of commissioning August 2017) found that there are critical medical vacancy gaps in sexual and reproductive healthcare. This highlights an absence of investment in training, including training in the most effective forms of contraceptive provision (LARCs). The Ten Year Plan must speak to HEE's Workforce Plan to ensure such investment. Training is cost-effective: for instance, the integrated model of care discussed above is based on a cost-effective model of consultant leadership and nurse/GP delivery: consultants have a role but the system is not consultant heavy – we recommend a ratio one consultant to a population of 125,000 people.

With this in mind, training for local GPs, medical students and nurses must be a mandatory part of specialist Sexual and Reproductive Healthcare services' contracts. Currently, clinicians work free of charge through Medical Colleges/Faculties, often also having to pay for their own training and a College membership fee. A model based on a volunteer culture is becoming harder to sustain, not least because many commissioners do not acknowledge this is an integral part of the way the workforce is trained in the UK.

The long-term plan should acknowledge this, recognising that support of these roles is needed if this model is to be sustainable in the future.

Section 3 – Enablers of improvement: Digital Innovation and Technology

3.8 How can digital technology help the NHS to: a) Improve patient care and experience? b) Enable people and patients to manage their own health and care? c) Improve the efficiency of delivering care?

The development of the Digital technology has the potential to play a strong role in improving outcomes, efficiency, and overall service improvement, e.g. improving accessibility through online contraception care.

A high-quality digital agenda if implemented correctly could allow for improved accessibility within sexual and reproductive healthcare services as well as improved workforce planning. For this to be effective however the NHSE Ten Year Plan must:

- Embrace the most effective model to deliver care - i.e. for sexual and reproductive healthcare services, an integrated, and community-based model, driven by CSRH leadership. Digital technology cannot substitute for poor service design.

- Adhere to high quality Standards²⁴.

- Hold accurate and high-quality data. A digital agenda is only as good as the quality of data which it holds. Building on the need for effective data capture across the NHS, the digital agenda should extend beyond immediate issues of patient care. At the moment the NHS lacks data which is vital for effective planning. For instance, a workforce census to illuminate issues of training, qualification and capability is lacking. Reliable data must be available from across all sectors to inform workforce planning.

3.11 How do we ensure we don't widen inequalities through digital services and technology?

To ensure inequalities are not widened through digital services and technology, the Ten Year Plan should address issues of access at a more fundamental level. Social inequalities will result in variations in patient access to digital resources, and this may in some circumstances widen inequalities in health outcomes. A digital agenda must enhance patient access for all (e.g. in terms of access to health records and the level of online transactions). In part this could be achieved by reinvesting any savings made by digital access of services in providing services in the poorer parts of our communities. Data must also be available to measure patient access. Key measures could focus on patient capability, usage and awareness. We have provided links to our Service Standards for Online and Remote Providers of sexual and reproductive healthcare services²⁵. There may be a need for a more joined up approach to service standards dealing with online access across the Medical Royal Colleges and Faculties.

FSRH September 2018

For more information contact:

Harry Walker,

Head of External Affairs and Standards, Email: externalaffairshead@fsrh.org

²⁴ FSRH BASHH Service Standards for Online and Remote Providers of SRH services, Currently out for consultation, final to be published Autumn 2018 <https://www.fsrh.org/news/bashhfsrh-standards-for-online-and-remote-providers-of-sexual/>

²⁵ FSRH BASHH Service Standards for Online and Remote Providers of SRH services, Currently out for consultation, final to be published Autumn 2018 <https://www.fsrh.org/news/bashhfsrh-standards-for-online-and-remote-providers-of-sexual/>