FSRH Response to Public Health England ‘Proposed changes to the Public Health Outcomes Framework from 2019/20’

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest UK multidisciplinary professional membership organisation. We represent the voices of more than 15,000 healthcare professionals working to deliver Sexual and Reproductive Healthcare (SRH) in a range of services funded by local authorities.

Our goal is to ensure that high standards in SRH care are achieved and maintained to ensure the population can access services which realise our vision for individualised and holistic SRH across the life-course.

As an organisation focused on Sexual and Reproductive Healthcare – recognised as a key component of public health - FSRH welcomes this review into the efficacy of existing public health indicators. We note with approval the Review’s attention to areas of sexual and reproductive healthcare where, as highlighted recently by the Public Health Minister, reporting and monitoring is limited. FSRH believes that the proposed changes would go some way to overcoming current limitations, improving the sexual and reproductive health of the population. Building on these changes, we wish to suggest further revisions.

Summary of Recommendations

- The PHOF should maintain indicators on conceptions in U18s.
- FSRH welcomes the following indicator proposed for inclusion: ‘total prescribed LARC rate per 1000 females 15-44’. We strongly support this measure and wish it to be prioritised – with an extension of the range of provision from 44 to 55, in recognition of women’s continuing fertility beyond their early forties.
- FSRH recommends that an indicator for unplanned pregnancy should be considered for inclusion.
- FSRH recommends a reduction in the time lag between datasets and their inclusion in PHE tools.

Existing indicators: under 18 conceptions

Indicators related to under 18 conceptions have contributed in directing attention to such conceptions, allowing for appropriate action and a significant decline in figures. The indicators should be maintained. Research has clearly demonstrated the negative social, economic and health impact which teenage conception can have on both society and the individual: by the age of 30 women who were teenage mothers are significantly more likely to live in poverty. However, whilst we advocate the retention of these indicators, we believe that they should be complemented by a broader SRH indicator or set of indicators which span the life-course. We therefore strongly support the proposal to include an indicator focused on LARC, which would be a significant step towards this more comprehensive objective.

1 Steve Brine, Genito-urinary Medicine Department of Health and Social Care written question – answered on 18th February 2019. [https://www.theyworkforyou.com/wrans/?id=2019-02-12.220226.h&s=%27STIs%27#g220226.r0](https://www.theyworkforyou.com/wrans/?id=2019-02-12.220226.h&s=%27STIs%27#g220226.r0)
2 Public Health England, A framework for supporting teenage mothers and young fathers, 2016. [https://dera.ioe.ac.uk/26423/1/PHE_LGA_Framework_for_supporting_teenage_mothers_and_young_fathers.pdf](https://dera.ioe.ac.uk/26423/1/PHE_LGA_Framework_for_supporting_teenage_mothers_and_young_fathers.pdf)
FSRH welcomes this proposed indicator and would like to see it be prioritised with an extension of the range of provision from 44 to 55, in recognition of women’s continuing fertility – in 2017 2357 births were to women over 45 – a small (<0.5%) but growing percentage.3

In terms of efficacy, cost-effectiveness and safety, LARC is a proven method of contraception, fully recognised by NICE.4 Yet despite this recognition at a national level, there has been a de-prioritisation of contraception – as shown by its removal from the Quality and Outcomes Framework (QOF) – in a context of increasing pressures on general practice. The increasing paucity of provision, exacerbated by the lack of training for device fitting/removal for long-acting methods, has created difficulties for women in gaining access to LARC, and in making informed choices about its use.

As FSRH evidenced in a response to the Health and Social Care Committee’s (HSC) Sexual Health Inquiry5, prescription of LARCs in general practice declined by 10% between 2014 and 2017. With successive annual cuts to public health budgets, increasing pressures on general practice, and concerns around the capacities of the future workforce to address SRH needs6, complex forms of contraception, like LARC, are under pressure.7 This makes little medical and financial sense, with Public Health England evidencing that every £1 spent on publicly-funded contraception saves £9 in averted direct public sector healthcare and non-healthcare cost.8

We strongly support the introduction of a relevant PHOF indicator as a move towards understanding and addressing these challenges and towards identifying issues of geographical variation and social inequalities of access. As pointed out by the Advisory Group on Concentration (AGC)9, there is currently a significant gap within the PHOF indicators in relation to access to contraception. The introduction of the proposed indicator would be one step towards ensuring that women’s access to the full range of contraceptive options is recognised as an essential function within wider public health services.

The LARC indicator is the only indicator in this proposed outcome set that acknowledges the importance of women’s access to contraception across much of their life-course, in contrast to the current indicators which focus on under 18 conceptions alone. The rate of LARC prescribing is a useful measure of the availability of all contraceptive methods in an area for all women; providing an indication on the extent to which high quality advice is available that can enable women to make an informed choice about their best method of contraception regardless of their stage in life. Though not allowing a comprehensive understanding of access to different forms of contraception, the proposed indicator would provide local authorities with a valuable instrument to benchmark their progress in improving access to contraception for women, irrespective of a their age.10

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7 BMA (2018) Feeling the Squeeze: the local impact of cuts to public health budgets

9 Advisory Group on Contraception, response to PHOF consultation, 2019
In addition, mandating the reporting of data at local level through a national LARC indicator would help draw the attention of local policy actors to a situation which FSRH members have commented on for some time – absences of LARC provision, at both GP and SRH services, where challenges are significant and national data is currently lacking. As acknowledged by the Public Health Minister, data collected on contraception is limited. Data by age for example, is not collected when contraception is supplied by general practice under the GP Contract. This gives rise to a significant gap in knowledge which should be filled.

The frequency of data collection and reporting

We would add a further point concerning data collection and reporting. Currently there is a time lag of 14-15 months between some datasets and their inclusion in PHE tools – e.g. U18 conceptions and LARC statistics. There is a case for considering whether a reduction of this time lag is at all possible, so that the data does more to enable a real-time understanding of key trends.

An indicator for Unplanned Pregnancy - such as the London Measure of Unplanned Pregnancy (LMUP)

Alongside the proposed LARC indicator and the retention of indicators related to under 18 conceptions, we believe there would also be significant added value in including an indicator to measure unplanned pregnancy. This would allow for more accurate evidence, and better enable action to address access to contraception, thereby reducing significant costs to the healthcare system associated with unplanned pregnancy.

The lack of emphasis on indicators directly relating to adult unplanned pregnancy represents a significant gap in the existing PHOF. The Department of Health and Social Care’s A Framework for Sexual Health Improvement in England (2013) and PHE’s Making it Work (2015) shared the objective of “[reducing] unintended pregnancy amongst all women of fertile age.” Yet there is no nationally established metric to support this ambition. This is especially problematic given that there is a clear link between unplanned pregnancy and three of the four PHOF domains: improving the wider determinants of health; health improvement, and; health protection. The absence of such an indicator overlooks a policy intention which is at the forefront of Government policy.

Several datasets demonstrate the importance of developing an indicator for unplanned pregnancy beyond 18. Abortion statistics for England and Wales show an abortion rate in the 30-34 age group that is more than double that for under-18s. The most recent National Survey of Sexual Attitudes and Lifestyles, which interviewed over 15,000 men and women between September 2010 and August 2012, found that most pregnancies occurred between women aged 20-34, whilst 51% of all unplanned pregnancies occurred in women aged 25-44.

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11 FSRH Members Survey 2019
12 Steve Brine, Genito-urinary Medicine Department of Health and Social Care written question – answered on 18th February 2019. https://www.theyworkforyou.com/wrans/?id=2019-02-12.220226.h&s=%27STIs%27#g220226.r0
13 Baroness Tonge, Contraceptives, House of Lords written answer, 11 February 2019 https://www.parliament.uk/business/publications/written-questions-answers-statements/written-questions-answers/?page=1&max=50&questiontype=AllQuestions&house=lords&member=200
The survey also established that over the past 60 years, the gap between the age people start having sex and the age when they have their first child has significantly widened.\(^{19}\) In this context, the absence of an indicator for adult unintended pregnancy means that the Department of Health and Social Care’s aim to champion SRH ‘across the life course’ is not being fully realised.\(^{20}\)

Unintended pregnancy is a very real concern for women aged over 25 and has a financial and social consequence for both the individual and society. The FPA’s *Unprotected Nation predicted £298.6 million in additional NHS health costs between 2013 and 2020*, resulting from an increasing number of unintended pregnancies – including the provision of 22,036 more NHS abortions a year by 2020.\(^ {21}\) These financial ramifications could be significantly reduced by increasing the access to contraception for all women of fertile age.

The long-established and internationally-recognised London Measure of Unplanned Pregnancy (LMUP) provides the basis for an indicator.\(^ {22}\) (To be put into practice, the LMUP would have to be introduced into routine maternity data collection and included in the minimum maternity dataset).

**Conclusion**

FSRH welcomes the maintenance and strengthening of indicators relating to sexual and reproductive healthcare, specifically the U18 conceptions and LARC indicators. These measures would be enhanced if balanced with broader SRH indicators that act as a metric for unintended pregnancy across the life-course (such as the London Measure of Unplanned Pregnancy). We would also recommend a reduction in the time lag between some datasets.

\(^{19}\) Ibid.


\(^{22}\) London Measure of Unplanned Pregnancy http://measure.ascody.co.uk/index.htm