Rebuilding a Public NHS: Health and Social Care Policy Commission

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to respond to Labour's consultation on Rebuilding a Public NHS as part of its Health and Social Care Policy Commission for 2019.

FSRH is the largest UK multidisciplinary professional membership organisation representing the voices of more than 15,000 healthcare professionals working to deliver Sexual and Reproductive Healthcare (SRH). Our members work primarily to ensure contraceptive, cervical/ gynaecological, and pregnancy choices are best enabled.

Our goal is to ensure high quality SRH services which realise our **Vision** for individualised and holistic SRH across the life-course. We believe that access to high-quality SRH care for all is a human right. Thus, in relation to this consultation, our response is focused on SRH services.

Key Recommendations:

Commissioning

FSRH, along with RCOG, RCGP and the over-arching body representing all medical royal colleges – the AoMRC, have produced a detailed position statement outlining the following recommendations:

- We are calling for integrated holistic commissioning of SRH, with one body maintaining oversight and holding accountability for all commissioning decisions.
- We strongly recommend that any review or reorganisation of SRH commissioning responsibility should focus on women's health.
- We believe there is a need for SRH care to be more broadly integrated into women's healthcare pathways.
- In a mixed economy of providers, particularly young person specialist providers such as Brook, should be able to compete under any new arrangement.

Funding

- FSRH calls for a fully funded SRH services based on the needs of the population and the principles of open-access services. All SRH services should be delivered to FSRH clinical standards.
- There should be an immediate reversal of the cuts to public health budgets since 2015 to ensure public health services are put on sustainable footing for the future. This funding must be afforded the same protections and share of investment as the NHS.
- The inclusion of a LARC indicator within the Primary Care Quality Outcomes Framework (QOF) would act as a significant step in counteracting the challenges threatening the provision and training of primary care clinicians to deliver LARC.
- When considering what it needs to do in its first term in Government to ensure NHS funding reaches the area's most in need, we recommend Labour takes account of regional inequalities. The integrated holistic commissioning of sexual and reproductive healthcare services and the funding of services based on the needs of the population must be central to this.

Workforce

- The Labour Party must ensure that whichever body is responsible for commissioning sexual and reproductive healthcare going forward is mandated to re include training requirements in service specifications in order to optimise the contraceptive services that the current SRH workforce can offer.

- FSRH recommends an expansion of funded CSRH training and consultant posts to ensure the system is effectively training, educating and investing in adequate SRH leadership. FSRH recommends an increase in the number of training posts by one third to meet the supply gap.

Brexit

- We strongly recommend Labour think hard about how any form of Brexit will impact on their plans for the NHS. The Labour Party must also address the challenges a no deal Brexit poses to the SRH sector.

Introduction

Sexual and Reproductive Healthcare (SRH) services are highly fragmented, and there is huge unwarranted variation in both quality and availability of services. Access to SRH care is often very limited, and public awareness of both SRH and what services are available is often scant.

This impacts disproportionately both on women, for whom access to contraception and abortion services in particular is important, and on minority groups, leading to high levels of health inequality. Much of this is preventable, through a holistic, person-centred approach to SRH which does not seek only to treat or prevent illness but which seeks to empower people to make informed choices about their SRH.

Clearly a multi-faceted strategy is needed to enable such an approach. With this in mind our response focuses on the challenges caused by current commissioning and funding arrangements, as well as the need to ensure a sustainable and well-trained workforce.

A publicly delivered NHS

Should public health services continue to be provided by local government or should they return to the NHS?

FSRH supports any move towards establishing a more collaborative, co-ordinated and joined-up health and care system.

The NHS Ten Year Plan indicates that the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and what best future commissioning arrangements might therefore be[1].

In light of this pledge, FSRH, RCOG and the RCGP have produced the following position statement, which has been endorsed by the overarching body representing all medical royal colleges – the AoMRC. Together, we have made **three key recommendations** which we strongly recommend the Labour Party adopt**:**

- **We are calling for integrated holistic commissioning of SRH, with one body maintaining oversight and holding accountability for all commissioning decisions**. Notably, 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.

[1] NHS England Long Term Plan, 2019. Available here.

- **We recommend that any review of SRH commissioning responsibility should focus on women's health**. Women's health has stood to suffer the most from the reorganisation of NHS services that ensued with the implementation of the Health & Social Care Act in 2013. Where once women could have all their reproductive health needs met in one place and one go, women are now subjected to disjointed, non-holistic, disintegrated care.
- **We believe there is a need for SRH care to be more broadly integrated into women's healthcare pathways.** Since the 2012 Health & Social Care Act came into force, there has been inherent system fracture, which has meant that holistic care for many women has been effectively blocked.

In the following section we describe the effects of this situation, in which fragmented patterns of commissioning work against women's access to SRH. There must be a significant change in SRH culture towards holistic integrated SRH care. This 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.

The below table demonstrates quite clearly why by-design the current system has inherent faults across SRH, whereby there is not a single body vested in ensuring the holistic needs of the women are being met[2]. To underline how this fractured system does not meet the needs of women, we have highlighted the split in women's reproductive health commissioning responsibilities with a ✓.

Local Authorities	Clinical Commissioning Groups (CCGs)	NHS England
✓ Contraception and advice on unplanned pregnancies in SRH services	✓ Abortion services, incl. contraception, STI & HIV testing in abortion pathway	✓ Contraception under GP contract
✓ LARCs in primary care	✓ Contraception for gynaecological purposes	✓ Cervical screening
▫ STI testing and treatment in SRH services and primary care; partner notification	✓ Female sterilisation	✓ Specialist foetal medicine services, incl. late termination of pregnancy for foetal anomaly between 13 and 24 gestational weeks
▫ HIV testing and partner notification	▫ Male sterilisation	▫ HIV treatment
▫ Sexual health specialist services incl. young people's services, outreach and promotion	▫ Non-sexual health aspects of psychosexual health services	▫ STI & HIV testing and STI treatment in general practice when clinically indicated / requested by patient
✓ Support for teenage parents	▫ HIV testing when clinically indicated in CCG-commissioned services	▫ HIV testing when clinically indicated in NHSE-commissioned services
✓ Chlamydia Screening		✓ HPV immunisation
▫ Sexual health aspects of psychosexual counselling		✓ Sexual assault referral centres (SARCs)
		▫ Sexual health in secure and detained settings
		✓ NHS Infectious Diseases in Pregnancy Screening

Although so many of the downstream benefits of preventing unplanned pregnancy are felt in the NHS (costs to maternity services, abortion pathways etc.), it has been particularly difficult to engage Local Authorities to prioritise commissioning for benefits which are realised under NHS auspices, not least at a time where the public health budgets of Local Authorities are being severely cut.

[2] RCGP, 2017. *Sexual and Reproductive Health Time to Act*. [pdf] London: RCGP, available here.

Conversely, there are policy decisions being undertaken through the NHS, which demonstrate a lack of holistic planning, not least the example of contraception having no clear workstream pathway under the NHS's Maternity Transformation Programme.

This makes little economic sense – access to SRH care can be highly cost-saving. PHE has recently commended that for every £1 spent on publicly-funded contraceptive services, £9 is saved, most of which is realised in the NHS.[3]

Building on our 2017 manifesto promises, what more can Labour do to ensure the NHS is fully funded and able to deliver universal health services?

Context of cuts

The narrative of disjointed care described above has been compounded by cuts to funding, notably cuts to SRH services which local authorities have been mandated to provide. In fact, there will have been a £700m real-terms reduction in the public health grant between 2014/15 and 2019/20[4]. Further, the Kings Fund estimates that between 2014/15 and 2018/19 there was an 18 per cent real-terms reduction in spending on sexual health services.

Cuts are set to deepen to a 25 per cent real-terms reduction in sexual health spend between 2014/15 and 2019/20.[5] Services providing sexual health advice, prevention and promotion have been among the biggest losers from the decrease in public health spending[6]. At the same time, the Local Government Association has reported that there is a record demand for sexual health services, a demand which has risen by 13 per cent since 2013. As a result, services are at tipping point, and a lack of capacity is leading to people being turned away.[7]

Where cuts are made to the public health-funded elements of SRH provision, the impact and increased cost is often felt in other parts of the system paid for by different commissioners. So LA-driven reductions in specialist SRH services increases the workload on GPs and other core contraceptive providers, while the consequent reduced access increases the need for CCG-funded maternity and abortion services. Around 41% of GPs in England responding to an RCGP survey from 2017 agreed that appointments for contraceptive advice have increased over the past year[8].

The apportioning of SRH commissioning responsibilities between CCGs, LAs and NHSE also disrupts patient pathways in SRH because services are shaped by the source, availability and amount of funding rather than by patient need[9]. In addition to finding that LAs cannot maintain the current levels of service provision due to cuts, the review of commissioning by PHE and ADPH has also confirmed the experience of FSRH, RCOG and RCGP members that fragmented commissioning of services is threatening access to contraception and other sexual health services[10]. PHE and ADPH specifically indicate that "LARC and cervical cytology might suffer"[11].

[3] PHE 2018. Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England. [pdf] London: PHE: available here.
[4] Buck, D. 2018. Prevention is better than cure – except when it comes to paying for it, available here.
[5] Written parliamentary evidence by the King's Fund, available here.
[6] King's Fund 92018) Sexual health services and the Importance of prevention, available here.
[7] LGA, 2017. Sexual health services at tipping point warn councils. *Local Government Association*, available here.
[8] RCGP, 2017, Time to Act, available here.
[9] RCGP, 2017, Time to Act, available here.
[10] PHE, 2017. *Sexual Health, Reproductive Health and HIV. A Review of Commissioning*. [pdf] London: PHE, available here.
[11] PHE, 2017. *Sexual Health, Reproductive Health and HIV. A Review of Commissioning*. [pdf] London: PHE, available here.

Impacts on access to women's health

- **Contraception**: at the same time as funding for contraception is being cut, prescriptions for Long Acting Reversible Contraception (LARC) are declining. PHE data shows that the number of prescriptions for LARC has reduced by 8% across England between 2014 and 2016. More than a quarter (27%) of GPs in England responding to a RCGP survey disagreed that patients who need LARC are always able to access it. Out of 86% of GPs in England who provide LARC in their practice, 39% said they have experienced cuts to the funding for this service[12]. This is despite the Government and NICE recommending increasing uptake of LARC methods.
- **Contraception for gynaecological purposes**: A combination of system fracture, reduced funding, and a lack of financial incentives for GPs to provide LARC has led to a reduction in the availability of LARCs in general practice. This has raised concerns regarding the deskilling of SRH clinicians across primary care. As most women choose to access contraception in primary care, it is paramount that women are able to access LARCs and that clinicians working in primary care have adequate opportunity to gain competencies in delivering LARCs. 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.
- **Abortion**: abortion rates to women over 30 have been increasing over the last 10 years[13]. Whilst there is no evidence of direct causation, FSRH, RCOG and RCGP are concerned that the increase in terminations of pregnancies for those aged 30 and over may indicate an unmet need for contraception. Additionally, CCGs commission abortion services, while LAs commission contraceptive care. This creates a break in the care pathway which means that the patients who access abortion services are not automatically referred to contraceptive advice and treatment through the same care pathway, leaving them at risk of further unintended pregnancy[14].

Recommendation: There should be an immediate reversal of the cuts to public health budgets since 2015 to ensure public health services are put on sustainable footing for the future. This funding must be afforded the same protections and share of investment as the NHS.

Recommendation: FSRH calls for a fully funded SRH services based on the needs of the population and the principles of open-access services. All SRH services should be delivered to FSRH clinical standards.

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

[12] RCGP, 2017, Time to Act, available here.
[13] Department of Health and Social Care, 2018, Abortion Statistics 2018, available here.
[14] RCGP, 2017, Time to Act, available here

What does Labour need to do in its first term in Government to ensure NHS funding reaches the area's most in need?

Poverty exacerbates this narrative of reduced provision, increased demand and inefficient care:

- Recent Abortion statistics published by DHSC this month indicate that women living in more deprived areas are much less able to access contraception, presenting a worrying trend of abortion rates rising as levels of deprivation increase. The rate in the most deprived decile is 25.2 per 1000. This is over twice the rate in the least deprived decile - 11.6[15].

- Research conducted by the AGC has found that the effect of cuts is significant among disadvantaged social groups. The women who are most affected by cuts are also those who have the greatest need for services. 61% of councils in the quartiles with the highest social deprivation cut or froze their SRH budgets between 2016/17.[16] and 2017/18 and of these 89% are planning to freeze or cut budgets in the next financial year.

Recommendation: Thus, when considering what it needs to do in its first term in Government to ensure NHS funding reaches the area's most in need, we recommend Labour takes account of these inequalities. The integrated holistic commissioning of sexual and reproductive healthcare services and the funding of services based on the needs of the population must be central to this.

The NHS workforce

What further steps can the Labour Party take to ensure the NHS has a sustainable health and social care workforce fit to deliver a truly publicly provided NHS and National Care Service?

Current commissioning structures and funding pressures also have an adverse impact on those delivering healthcare.

SRH consultants

The SRH consultant workforce is in a succession crisis. It is estimated that one third of the current consultant workforce could retire in the next 5 years.[17] This will be a central issue for a new Government to address.

A single SRH consultant can provide leadership in service provision to a population of at least 125,000[18] and will support the restructuring of services to ensure they are patient-centred, efficient and based on public health principles. Around 80 per cent of SRH care is undertaken in general practice, and it is vital that a specialist SRH workforce is available to train and support healthcare professionals working in Primary Care. They play a pivotal role in supporting the nursing and general practice workforce to deliver all aspects of contraceptive care, especially complex contraception.

Recommendation: FSRH recommends an expansion of funded CSRH training and consultant posts to ensure the system is effectively training, educating and investing in adequate SRH leadership. FSRH recommends an increase in the number of training posts by one third of current numbers to meet the supply gap.

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[15] Department of Health and Social Care, 2018, Abortion Statistics 2018, available here.
[16] AGC, 2018 At tipping point: An audit of cuts to contraceptive services and their consequences for women. available here.
[17] HEE, 2015. Small Specialty Community Sexual and Reproductive Health.
[18] The one SRH Consultant per 125,000 population figure is a widely cited and ratified figure. The figure was most recently recognised in HEE Small Speciality Community & Reproductive Health report (2015) and prior to that was cited by the Centre for Workforce Intelligence (2013). The figure was originally determined and published in the joint Department of Health, Royal College of Obstetricians & Gynaecologists & FSRH report, Developing Specialties in Medicine – The case for recognition of Sexual and Reproductive Healthcare as a new CCT specialty (2008)

How can the Labour Party address issues such as morale, staff retention, and professional development in the health and social care workforces? How do we ensure this in the workforce outside the NHS?

Continued Professional Development and Specialty training

It is deeply concerning that Local Authorities do not have to fund continued professional development (CPD) or Specialty training for healthcare professionals in service specifications for SRH services. FSRH believes that all LAs should ensure that service specifications for SRH services are designed to include training requirements in their contracts and optimise the contraceptive services that the current SRH workforce can offer including access to a clinical lead in SRH.

Recommendation: The Labour Party must ensure that whichever body is responsible for commissioning sexual and reproductive healthcare going forward is mandated to include training requirements in service specifications in order to optimise the contraceptive services that the current SRH workforce can offer.

The wider international picture – Brexit

It is difficult to address workforce issues, as well as the challenges evidenced throughout this response, without addressing the current international environment. Healthcare experts have highlighted time-and-time again,[19,20] that any form of Brexit will be detrimental, potentially severely on just about every aspect of healthcare preventing a better staffed, better funded and more joined-up, person centered healthcare system.

In an open letter to the prime minister, FSRH, along with other organisations in the sector, has pointed out the imminent danger to health provision presented by a "No Deal" Brexit, which would have serious implications for the availability of staff in care and research settings, the arrangements governing reciprocal healthcare, the regulation of medicines and devices, the UK's involvement in pan-European research and innovation, and in public health and prevention initiatives.[21]

Recommendation: We strongly recommend Labour think hard about how any form of Brexit will impact on their plans for the NHS. The Labour Party must also address the challenges a no deal Brexit poses to the SRH sector.

[19] BMJ, last accessed June 2019, Brexit is bad for our health, accessible here
[20] Kingsfund, February 2019, Brexit: the implications for health and social care, accessible here.
[21] National Voices, and multiple organisations, February 2019, "No deal Brexit and Health, accessible here.