

## FSRH Response - APPG on Sexual and Reproductive Healthcare's Inquiry into Access to Contraception

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to respond to the APPG's Inquiry into Access to Contraception in England. 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 for the benefit of women, ensuring contraceptive, cervical/ gynaecological, and pregnancy choices are best enabled.

FSRH believes there is a need for SRH care to be more broadly integrated into women's healthcare pathways in the NHS. Holistic SRH care means integrating care around the needs of the individual, not institutional silos, with people able to get integrated/holistic advice and support across the breadth of SRH, particularly in relation to contraception.

In particular, FSRH supports any move towards establishing a more collaborative, co-ordinated and joined-up health and care system. It welcomes the pledge by NHS England in its Long-term Plan that:

*"the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services"*

FSRH, alongside RCOG and RCGP has produced a [Joint Statement on Holistic Integrated Commissioning](#) in light of this pledge, which we strongly recommend the APPG has regard to in the context of this Inquiry.

### Key recommendations:

#### Commissioning and funding

- FSRH recommends holistic integrated commissioning of Sexual and Reproductive Healthcare (SRH) with one body maintaining oversight and holding accountability for all commissioning decisions. (See [Annex 1](#) for a case study of best practice in integrated care).
- SRH services must be delivered in accordance with nationally recognised standards in SRH, guaranteeing high-quality SRH care and patient safety - e.g. the FSRH Service Standards on Sexual and Reproductive Healthcare.
- Under current arrangements as set out in the Health & Social Care Act 2012, PHE should have stronger enforcement powers so that it can act on the analyses it produces and to hold commissioners to account for their performance, developing more stringent accountability structures.
- FSRH calls for fully funded SRH services as well as the strengthening of the Sexual Health Local Authority mandate to specifically ensure services are delivered to [FSRH service standards](#).
- FSRH supports the HSC Committee's recommendation that LA Directors of Public Health should be required, in their statutory annual reports to PHE, to publish clear and comparable information for the public on the actions they are taking to improve public health, including contraception, and to provide regular updates on progress.

## Workforce

- FSRH recommends a ratio of 1 SRH Consultant per 125,000 of the population and for an increase in the number of training posts by one third to meet the supply gap.
- FSRH believes that all LAs should ensure that service specifications for SRH services are designed so as to include training requirements in their contracts and optimise the contraceptive services that the current SRH workforce can offer.
- 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 training of primary care clinicians to deliver LARC.

## Data

- It is essential that a reliable record is kept of the careers and qualifications of all staff who provide services, and for an improvement in the Electronic Staff Record. Reliable data should be available from across all sectors to inform workforce planning.
- FSRH recommends mandating all services providing contraceptive services to make a full report of their provision of this service against nationally specified criteria. This includes GP, online and pharmaceutical services.
- Public Health England should adopt in its Public Health Outcomes Framework (PHOF), an indicator for adult (i.e. post-18) Unplanned Pregnancy– following the long-established model of the London Measure of Unplanned Pregnancy (LMUP).
- Within the Public Health Outcomes Framework (PHOF), FSRH strongly recommends PHE amend their proposed indicator to monitor LARC, extending the category of women reported on from 44 to 55, in recognition of women's continuing fertility.

## Relationships and Sex Education (RSE)

- It is vital that RSE delivery is based on medically accurate and evidenced-based information and resources. With this in mind the [FSRH/RCOG Factsheet on Abortion and Abortion Care](#) is a valuable and free resource for professionals delivering RSE in secondary schools.
- Any external organisation which is involved in the delivery of RSE must be committed to and capable of presenting and discussing the full range of contraceptive choices.

## Section 1 - Commissioning: The Health & Social Care Act and the need for better integration

FSRH believes there is a need for SRH care to be more broadly integrated into women's healthcare pathways in the NHS. Holistic SRH care means integrating care around the needs of the individual, not institutional silos, with people able to get integrated/holistic advice and support across the breadth of SRH.

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

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<sup>1</sup>. 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
<ul style="list-style-type: none"> <li>✓ Contraception and advice on unplanned pregnancies in SRH services</li> <li>✓ LARCs in primary care</li> <li>▫ STI testing and treatment in SRH services and primary care; partner notification</li> <li>▫ HIV testing and partner notification</li> <li>▫ Sexual health specialist services incl. young people's services, outreach and promotion</li> <li>✓ Support for teenage parents</li> <li>✓ Chlamydia Screening</li> <li>▫ Sexual health aspects of psychosexual counselling</li> </ul>	<ul style="list-style-type: none"> <li>✓ Abortion services, incl. contraception, STI &amp; HIV testing in abortion pathway</li> <li>✓ Contraception for gynaecological purposes</li> <li>✓ Female sterilisation</li> <li>▫ Male sterilisation</li> <li>▫ Non-sexual health aspects of psychosexual health services</li> <li>▫ HIV testing when clinically indicated in CCG-commissioned services</li> </ul>	<ul style="list-style-type: none"> <li>✓ Contraception under GP contract</li> <li>✓ Cervical screening</li> <li>✓ Specialist foetal medicine services, incl. late termination of pregnancy for foetal anomaly between 13 and 24 gestational weeks</li> <li>▫ HIV treatment</li> <li>▫ STI &amp; HIV testing and STI treatment in general practice when clinically indicated / requested by patient</li> <li>▫ HIV testing when clinically indicated in NHSE-commissioned services</li> <li>✓ HPV immunisation</li> <li>✓ Sexual assault referral centres (SARCs)</li> <li>▫ Sexual health in secure and detained settings</li> <li>✓ NHS Infectious Diseases in Pregnancy Screening</li> </ul>

<sup>1</sup> RCGP, 2017. *Sexual and Reproductive Health Time to Act*. [pdf] London: RCGP. Available at: <http://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx>

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.

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.<sup>2</sup>

As such, FSRH strongly recommends 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.

## Section 2 - Funding

This narrative of disjointed care 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<sup>3</sup>. 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.<sup>4</sup> Services providing sexual health advice, prevention and promotion have been among the biggest losers from the decrease in public health spending<sup>5</sup>. 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.<sup>6</sup>

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<sup>7</sup>.

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<sup>2</sup> PHE 2018. Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England. [pdf] London: PHE: [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](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)

<sup>3</sup> Buck, D. 2018. Prevention is better than cure – except when it comes to paying for it <https://www.kingsfund.org.uk/blog/2018/11/prevention-better-cure-except-when-it-comes-paying-it>

<sup>4</sup> Written parliamentary evidence by the King's Fund. <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/sexual-health/written/91508.html>

<sup>5</sup> King's Fund 92018) Sexual health services and the Importance of prevention <https://www.kingsfund.org.uk/blog/2018/12/sexual-health-services-and-importance-prevention>

<sup>6</sup> LGA, 2017. Sexual health services at tipping point warn councils. *Local Government Association*. [online]. Available at: <https://www.local.gov.uk/about/news/sexual-health-services-tipping-point-warn-councils>

<sup>7</sup> Time to Act <https://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx>

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<sup>8</sup>. 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 members that fragmented commissioning of services is threatening access to contraception and other sexual health services<sup>9</sup>. PHE and ADPH specifically indicate that “LARC and cervical cytology might suffer”<sup>10</sup>.

### Section 3 - System-wide effects on women

These findings corroborate much of what FSRH's members have been reporting on the ground. Our members' survey<sup>11</sup> collects views and experiences of our 15,000 members, many of whom express concern about the ability to deliver safe, effective SRH to an increasing number of patients with reduced funding:

- 38% reported reduced provision of SRH services, saying that patients were unable to access particular services
- 38% reported a reduction in the variety of available SRH services provided by their practice
- 65% reported increased demand for services
- 48% reported poorer patient experience as an impact of these changes
- 49% reported poorer staff morale
- 47% reported reduced staffing levels
- 58% predicted that in the future access to services would be further reduced. The reasons advanced for this include reduced funding - reported by 61% of respondents and reduced clinical capacity - reported by 46% of respondents.
- Many areas report a reduction in the variety of contraceptive provision, particularly a reduction in LARC provision. The closure of specialist centres has squeezed the time available to GPs. Waiting times are increasing, with some patients having to wait more than 4 months for an appointment.
- Women over 25 are being adversely affected by a reduced variety of services. Sexual health service cuts for the over 25s, elimination of menopause services, elimination of fitting the intrauterine system (IUS) are all examples.

The above data is confirmed by the research of other organisations, including PHE and RCGP, which have identified a range of problems:

- *Long Acting Reversible Contraception (LARC)*. At the same time as funding for contraception is being cut, prescriptions for 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<sup>12</sup>. This is despite the Government and NICE recommending increasing uptake of LARC methods.

<sup>8</sup> Time to Act <https://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx>

<sup>9</sup> PHE, 2017. *Sexual Health, Reproductive Health and HIV. A Review of Commissioning*. [pdf] London: PHE. Available at: <https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-commissioning-review>

<sup>10</sup> PHE, 2017. *Sexual Health, Reproductive Health and HIV. A Review of Commissioning*. [pdf] London: PHE. Available at: <https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-commissioning-review>

<sup>11</sup> The data refers to the previous 12 months. The survey can be accessed here:

<https://www.fsrh.org/policy-and-media/members-survey/>

<sup>12</sup> RCGP 2017 op.cit.

- *Contraception for gynecological purposes*: many women choose to see their GPs when they have a gynaecological issue, but 39% of GPs in England surveyed by RCGP have reported experiencing cuts to the funding for LARC<sup>13</sup>. Women used to be treated cheaply and effectively in the community but are now being sent to gynaecologists in hospitals, despite the much higher cost of this and inconvenience to the patient.
- *Abortion and unintended pregnancies*: abortion rates for women over 30 have been increasing over the last 10 years<sup>14</sup>. Whilst there is no evidence of direct causation, FSRH is concerned that the increase in terminations of pregnancies for those aged 30 and over may indicate an unmet need for contraception. Additionally, the practice whereby CCGs commission abortion services, while LAs commission contraceptive care creates a break in the care pathway: 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<sup>15</sup>.

#### **Section 4 - Unevenness and inequalities**

Poverty exacerbates this narrative of reduced provision, increased demand and inefficient care. The British Medical Association (BMA) has found that cuts to sexual health services are taking place in many areas which already have poor health outcomes, suggesting a mismatch between cuts and local population need<sup>16</sup>. There is “*unacceptable variation in the quality and quantity of services available to the public*”<sup>17</sup>.

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 quartile with the highest social deprivation cut or froze their SRH budgets between 2016/17 and 2017/18 and of these 89% are planning to freeze or cut budgets in the next financial year.<sup>18</sup>

As the APPG has previously noted, in some areas there is evidence that commissioning decisions are not being taken in accordance with the notion that contraceptive services should be open to all, regardless of age or place of residence. For example, some areas only provide services to residents in their local authority and restrict non-residents, while other areas have put in place age restrictions on accessing schemes offering emergency contraception. The AGC found that in 2016 approximately 3.9 million women of reproductive age were living in an area with some form of restriction on access to contraception, either due to age or place of residence<sup>19</sup>.

<sup>13</sup> RCGP, 2017. *Sexual and Reproductive Health Time to Act*. [pdf] London: RCGP. Available at: <http://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx>

<sup>14</sup> Abortions among the 30-34 age group increased from 15.1 per 1,000 women in 2007 to 18.2 in 2017, while rates for women aged 35 and over increased from 6.9 per 1,000 women in 2007 to 8.5 per 1,000 women in 2017 resident in England and Wales. DHSC 2018. *Abortion Statistics, England and Wales: 2017. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales*.

<sup>16</sup> BMA, 2018. *Feeling the squeeze. The local impact of cuts to public health budgets in England*. [pdf] London: BMA. Available at: <https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/public-health-budgets>

<sup>17</sup> Ibid. A useful case in point is Dorset: ‘Dorset sexual health service was handed a three-year budget cut of 20% in 2016. Vacant posts are frozen. Clinics have cut opening times or stopped taking walk-in patients, extending waits and journey times. There are already long waits for routine contraception appointments. [...] There are, however, certain areas with particularly high sexual and reproductive health needs that are likely to be disadvantaged as a result of these changes. In the district of Weymouth and Portland, for example, rates of under-18 conception are 24.5 (per 1000)’ (BMA 2018)

<sup>18</sup> AGC, 2018. ‘At tipping point: An audit of cuts to contraceptive services and their consequences for women. Available at: [http://theagc.org.uk/wp-content/uploads/2018/11/At\\_tipping\\_point\\_AGC\\_Nov\\_18.pdf](http://theagc.org.uk/wp-content/uploads/2018/11/At_tipping_point_AGC_Nov_18.pdf)

<sup>19</sup> AGC, 2016 *Private lives, Public health*. Available at: <http://theagc.org.uk/wp-content/uploads/2016/12/Private-lives-public-health-Final.pdf>

## Section 5 - Workforce

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

### *The SRH Consultant workforce*

A single SRH consultant can provide leadership in service provision to a population of at least 125,000<sup>20</sup> and will support the restructuring of services to ensure they are patient-centred, efficient and based on public health principles. SRH consultants are trained to provide clinical support in complex matters to a range of healthcare professionals, across what is usually a large geographical area. 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 Primary care healthcare professionals. They play a pivotal role in supporting the nursing and general practice workforce to deliver all aspects of contraceptive care, especially complex contraception. However, 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.<sup>21</sup>

### *Training*

#### *1. Community Sexual and Reproductive Healthcare (CSRH) Specialty training programme*

The current predicted output of the Community Sexual and Reproductive Healthcare (CSRH) Specialty training programme falls well-short of replacing the vacancies that will arise due to consultant retirement let alone addressing the fact that current consultant numbers relative to population numbers are inadequate. Health Education England (HEE) indicates that current training numbers are small and unlikely to provide the service required for the future: whatever increase there has been is insufficient<sup>22</sup>.

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

#### *2. Continued Professional Development (CPD)*

The problems are not only at Consultant level. IUS/IUD and implants require healthcare professionals to be appropriately trained and certified<sup>23,24,25</sup>. The RCN and RCOG, alongside FSRH, have raised concerns about training and qualifications in this area. Members of these organisations have reported that they are often expected to fund their own training in their own time. It is concerning that Local Authorities do not have to stipulate or fund continued professional development (CPD) in service specifications for SRH healthcare professionals.

**Recommendation:** LAs should be mandated to include training requirements in service specifications in order to optimise the contraceptive services that the current SRH workforce can offer.

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<sup>20</sup> 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).

<sup>21</sup> HEE, 2015. *Small Specialty Community Sexual and Reproductive Health*.

<sup>22</sup> HEE, 2015. *Small Specialty Community Sexual and Reproductive Health*.

<sup>23</sup> RCN (2018) *Sexual and Reproductive Health*.

<sup>24</sup> RCGP (2017) *op cit*.

<sup>25</sup> FSRH (2018) *FSRH Consultation Response: Health and Social Care Committee (HSC) inquiry into sexual health*.

### 3. LARC and General Practice

Similarly, 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.

**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 training of primary care clinicians to deliver LARC.

## Section 6 – Data

### *Workforce data*

The above issues regarding workforce planning are complicated by an incompleteness of data. FSRH would welcome a census of the SRH workforce, with an improvement in the Electronic Staff Record (ESR). The ESR is used to understand workforce supply, retention and to support workforce planning. However, the ESR is limited in assessing supply and demand in community services and those provided by the third sector, with some staff not visible in either data source<sup>26</sup>.

**Recommendation:** At the present time, when many SRH services are delivered by non-NHS providers, it is essential that a reliable record is kept of the careers and qualifications of all staff who provide services. Reliable data should be available from across all sectors to inform workforce planning.

### *NHS Digital data*

Alongside incompleteness, there are other issues regarding data collection and management. Current NHS Digital datasets prevent an accurate understanding of how many people are accessing SRH, particularly contraception. At present, there is no requirement for a number of services (e.g. General practice, pharmaceutical and online services) to report their provision of contraceptive advice, support and care.

**Recommendation:** In order to fill the gaps of knowledge this has caused, FSRH recommends mandating all services providing contraceptive services to report their provision of this service. Such a move would act as a significant step in enabling PHE to meet one of its key objectives of ensuring that the evidence base for sexual and reproductive health promotion is strengthened<sup>27</sup>.

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<sup>26</sup> HEE, [Sexual health, reproductive health and HIV workforce scoping project report](#), September 2018

<sup>27</sup> Health promotion for sexual and reproductive health and HIV Strategic action plan, 2016 to 2019  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/488090/SRHandHIVStrategicPlan\\_211215.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488090/SRHandHIVStrategicPlan_211215.pdf)

## Public Health England (PHE) data

In addition to amending existing forms of data collection, FSRH strongly recommends new indicators to monitor and improve access to contraception effectively. With this in mind, we recently responded to a PHE consultation on their “2019/2020 Public Health Outcomes Framework (PHOF)”. The PHOF is a set of metrics intended to enable measurement of the extent and effectiveness of public health provision. In our response we recommended the following:

### 1. An indicator for unplanned pregnancy

**Recommendation:** FSRH recommends PHE adopt an indicator for adult (i.e. post-18) Unplanned Pregnancy – following the long-established model of the London Measure of Unplanned Pregnancy (LMUP).<sup>28</sup>

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.”<sup>29,30</sup> Yet there is no nationally established metric to support this ambition. The absence of such an indicator overlooks the intention to reduce unplanned pregnancies across all age groups, 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.<sup>31</sup> 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.<sup>32</sup>

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.<sup>33</sup> These financial ramifications could be significantly reduced by increasing the access to contraception for all women of fertile age. This presents a strong case for developing an indicator to measure unplanned pregnancy, across a woman’s life-course. Furthermore, as acknowledged by the recent Public Health Minister<sup>34</sup>, 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.<sup>35</sup>

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<sup>28</sup> London Measure of Unplanned Pregnancy <http://measure.ascody.co.uk/index.htm>

<sup>29</sup> Department of Health [and Social Care], *A Framework for Sexual Health Improvement in England* (March 2013). Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW\\_ACCESSIBLE.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf)

<sup>30</sup> Public Health England, *Making it Work: A guide to whole system commissioning in sexual health, reproductive health and HIV* (September 2014). Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/408357/Making\\_it\\_work\\_revised\\_March\\_2015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf)

<sup>31</sup> DHSC (2018) Abortion Statistics, England and Wales: 2017

<sup>32</sup> The Third National Survey of Sexual Attitudes and Lifestyles (2013) Findings available at: [http://www.thelancet.com/journals/lancet/issue/vol382no9907/PIIS0140-6736\(13\)X6059-3](http://www.thelancet.com/journals/lancet/issue/vol382no9907/PIIS0140-6736(13)X6059-3)

<sup>33</sup> Development Economics “Unprotected Nation: The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services” (January 2013). Available at: <http://www.fpa.org.uk/news/unprotected-nation-cuts-sexual-health-services-cost-uk-%C2%A3136-billion>

<sup>34</sup> 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>

<sup>35</sup> 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>

## 2. PHE's proposed indicator for inclusion: total prescribed LARC rate per 1000 females 15-44

**Recommendation:** Taking the above evidence into account, while also welcoming PHE's recent proposal to adopt as a new indicator: "*total prescribed LARC rate per 1000 females 15-44*", FSRH would like to see an extension of the range of this indicator to women 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.<sup>36</sup>

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 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.

## Section 7 - Links between information provision (including Relationships and Sex Education (RSE) in schools) and access to contraception

Educating those likely to benefit from contraceptive advice and care is also of significant value. FSRH welcomes the statement in the DfE's statutory guidance that secondary school students should be taught "*the facts about the full range of contraceptive choices, efficacy and options available*". Young people who report receiving RSE are more likely to use contraception, and young women under the age of 18 who report receiving RSE are less likely to become pregnant.<sup>37</sup>

**Recommendation:** It is vital that DfE guidance is followed in secondary schools of all types, and that any external organisation which is involved in the delivery of RSE is committed to and capable of presenting and discussing the full range of choices.<sup>38</sup> Secondary schools must ensure factually based, medically accurate and open-ended education contraception. With this in mind, the [FSRH/RCOG Factsheet on Abortion and Abortion Care](#) – which also sets out factual information on emergency contraception and post-abortion contraception – is a valuable resource for providers of RSE.<sup>39</sup>

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<sup>36</sup> ONS (2019) Births by parents' characteristics 2017. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsbyparentscharacteristics>

<sup>37</sup> PHE, 2018, Teenage Pregnancy Prevention Framework [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/708932/teenage\\_pregnancy\\_prevention\\_framework.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/708932/teenage_pregnancy_prevention_framework.pdf)

<sup>38</sup> FSRH, 2018 Joint submission on behalf of FSRH and RCOG to DfE Consultation on Relationships and Sex Education Guidance. <https://www.fsrh.org/documents/fsrh-rcog-response-department-education-rse-consultation-2018/>

<sup>39</sup> FSRH and RCOG, 2019, Abortion care factsheet. <https://www.fsrh.org/documents/fsrh-and-rcog-abortion-care-factsheet-to-support-rse-lessons-in/>

## Section 8 - Further action for DHSC, PHE and LAs

### 1. Strengthening the SRH mandate

In our previous submission to the call for evidence on local authority (LA) public health prescribed activity by DHSC, FSRH called for fully funded SRH services as well as the strengthening of the Sexual Health Local Authority mandate. This is even more important in a climate of uncertainty surrounding the replacement of the ring-fenced Public Health grant with local business rates (BBR) to fund LAs locally from 2020.

**Recommendation:** SRH must be fully-funded based on the needs of the population and the principles of an open-access service. Patients must also have access to the full choice of contraceptive methods and be able see a trained healthcare professional to discuss the full range of contraceptive options available to them. It is the belief of FSRH that the best means of achieving this goal is for a single national body to maintain oversight of and accountability for all commissioning decisions.

### 2. Improving standards, and improving accountability

**Recommendation:** Beyond receiving adequate funding and oversight, SRH services must also be mandated to be delivered in accordance with nationally recognised standards in SRH, guaranteeing high-quality SRH care and patient safety.

The development and practical implementation of these standards is central to the FSRH's work and its [vision](#) document defines the fundamental principles that should underpin SRH provision for all to ensure that providers and commissioners are held to account and service users can access high quality SRH.<sup>40</sup> To enable the realisation of this vision, FSRH has constructed [Service Standards on Sexual and Reproductive Healthcare](#) specifically to support providers and commissioners in providing safe, high-quality SRH services. The Standards are recommended for use by all providers commissioned or contracted by LAs who provide and manage all aspects of contraception and sexual health.<sup>41</sup>

**Recommendation:** To better enable these Standards being adopted, and to allow for adequate action to improve the effects caused by system fracture and reduced funding, FSRH believes PHE should have stronger enforcement powers to enable the agency to act on the analyses it produces and to hold commissioners to account for their performance, developing more stringent accountability structures.

FSRH supports the HSC Committee's recommendation that LA Directors of Public Health should be required, in their statutory annual reports to PHE, to publish clear and comparable information for the public on the actions they are taking to improve public health and to provide regular updates on progress<sup>42 43</sup>. This is one of the means by which access to contraception can be made equitable, and high quality service provision ensured.

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<sup>40</sup> FSRH 2015. *Better care, a better future: a new vision for sexual and reproductive health care in the UK*. [pdf] London: FSRH. Available at: <https://www.fsrh.org/about-us/our-vision/>

<sup>41</sup> FSRH, 2016. *Service Standards for Sexual and Reproductive Healthcare*. [pdf] London: FSRH. Available at: <https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-sexual-and-reproductive-healthcare/>

<sup>42</sup> FSRH, 2018, FSRH Consultation Response: Health and Social Care Committee (HSC) inquiry into sexual health, <https://www.fsrh.org/news/fsrh-consultation-response-fsrh-provides-evidence-on/>

<sup>43</sup> Health Select Committee (2016) *Public health post-2013: Second report of the Session 2016-17* Available at: <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/140/140.pdf>

## Annex 1: An example of good practice – Greenwich Integrated Service

### Case study – SRH leadership in service redesign

Despite the challenges current commissioning structures and reduced funding have led to, there are examples of local good practice, which could be replicated elsewhere:

Service configuration led by an SRH consultant in the Royal Borough of Greenwich has created a one-stop shop model of service, so that patients can access basic and specialist SRH services on site and close to home.

The overarching principle of this model of care is to increase capacity through cost efficiencies from effective reorganisation and to reinvest these savings into community-based services to improve overall access to sexual and reproductive healthcare – including contraceptive care - for the local population.

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.

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

- Digital self-managed care via online access, highlighting the role digital health can play in improving accessibility ([www.greenwichsexualhealth.org](http://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.
- Efficiencies for the local health economy and care close to home – the tariff for community gynaecology is 30% lower 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, and enabled a £400,000 increase in the envelope for community services, whilst allowing the Local Authority to continue making savings against the Public Health budget.