

FSRH and RCOG response to the Health and Social Care Committee's Inquiry into the White Paper "Integration and Innovation: working together to improve health and social care" by DHSC

22 March 2021

1. **The Faculty of Sexual and Reproductive Healthcare (FSRH)** is the largest multidisciplinary professional membership organisation in the UK, representing more than 15,000 doctors, nurses, midwives and other healthcare professionals working at the frontline of sexual and reproductive healthcare (SRH). Our goal is to ensure that high standards in SRH are achieved and maintained through appropriate funding, commissioning and a highly-skilled workforce.

2. **The Royal College of Obstetricians and Gynaecologists (RCOG)** is a professional membership organisation made up of over 16,000 members worldwide. We work to improve health care for women, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's health care.

3. As professional membership organisations whose members deliver women's reproductive healthcare throughout the lifecourse across a range of clinical settings, including community and primary care, our response will focus on how Integrated Care Systems (ICSs) and legislative proposals may improve health and wellbeing outcomes for women via appropriate commissioning and accountability arrangements. Ultimately, we hope that ICSs will deliver sustainable change towards an integrated model of commissioning and delivery of women's health services.

Summary

4. The current commissioning arrangements for women's health cause significant barriers for many women and girls trying to access basic preventative healthcare. A lack of overall accountability and ownership in women's reproductive healthcare has led to variations in access and quality of care.

5. We believe the fragmentation of commissioning responsibilities will likely remain until there is only one, single accountable commissioner for women's health at system (ICS) and national (NHSE) levels, holding accountability for commissioning and outcomes in women's health.

6. There is consensus across the medical and non-medical healthcare professions that the commissioning and accountability landscape is not fit-for-purpose, with calls for integrated holistic commissioning of women's reproductive healthcare. We urge the Committee to [consider the joint position on integrated Sexual and Reproductive Healthcare commissioning by the Academy of Medical Royal Colleges \(AoMRC\), Royal Colleges and Faculties](#), which calls for women's reproductive healthcare to be more broadly integrated into women's health pathways in the NHS. Similar recommendations have also been made by the All-Party Parliamentary Group ([APPG SRH](#)) in its [Inquiry into Access to Contraception](#).

7. We believe the White Paper proposals on clinical leadership are too vague in remit. At national level (NHSE), accountability could be enhanced with the appointment of a National Clinical Director (NCD) for women's reproductive health or a National Specialty Adviser in Community Sexual and Reproductive Healthcare (CSRH). Alternatively, we would welcome an expanded remit for the NCD for the Maternity Review and Women's Health to cover women's Sexual and Reproductive Health.

8. At system level (ICSs), we would strongly welcome the appointment of a women's health lead at the ICS NHS Body Board or equivalent structure. We believe it is also crucial that a Sexual and Reproductive Healthcare lead is represented in Health & Care Partnerships' Boards.

9. We believe merging CCGs into ICSs might prove helpful to undo some of the commissioning barriers. However, the question of how the commissioning responsibilities of ICSs and those that stay with NHSE will work and interrelate in practice still remains.

10. The Government's intention to place a legal duty for NHS organisations and Local Authorities (LAs) to collaborate is welcome. However, we need more clarity. Would such a duty mandate collaborative commissioning and properly enshrine accountability across the NHS and LAs? FSRH and RCOG have consistently called for mandating collaborative commissioning as a means to tackle the deeply fragmented commissioning landscape.

11. As much as we understand the intention to avoid a one-size-fits-all approach in legislation so as to enable flexibility for local areas, we believe that voluntary arrangements will not tackle the systemic variation of service quality and outcomes in Public Health. Proposals for ICS Health and Care Partnerships governance arrangements seem to be quite vague, allowing '*systems to decide how much or how little to do at these different levels*'.

12. The White Paper leaves gaps in terms of proposals for the national reorganisation of Public Health. We expect that much of what has been left out, particularly around the future of PHE's health improvement functions, will be subject to a public consultation and continuous engagement with stakeholders.

13. The proposal to create a duty for the Secretary of State for Health and Social Care to publish a document setting out roles and responsibilities for workforce planning and supply each Parliament does not ensure transparency or accountability. We believe that workforce data and planning should be published annually, with a legal duty on a relevant body to do this. In addition, to provide accountability, there should be a legal duty for the Secretary of State for Health and Social Care to respond to that publication annually in Parliament.

Background

14. Current fragmentation in the way our healthcare services are designed and delivered means that many women are struggling to access basic services including contraception, abortion care and cancer screening. The consequences of this are shown in debilitating indicators:

- Almost half of British women experience poor sexual and reproductive health¹
- Around 45% pregnancies in Britain are unplanned or ambivalent².
- Abortions among women in older age groups have been steadily rising. Rates to women over 30 have been increasing over the last 10 years³. Abortion rates in 2019 were the highest on record, suggesting widespread unmet need for contraception.
- Prescriptions of long acting reversible contraception (LARC), the most effective methods to prevent unplanned pregnancies⁴, dispensed in the community have fallen by 8% since 2013 when commissioning responsibilities changed.

¹ Parkes, A., Waltenberger, M., Mercer, C. et al. 2020. Latent class analysis of sexual health markers among men and women participating in a British probability sample survey. [BMC Public Health 20, 14 \(2020\)](#)

² Wellings, K. et.al 2013. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). [Lancet 382\(9907\): 1807–1816.](#)

³ DHSC 2020. [Abortion Statistics, England and Wales: 2019](#)

⁴ LARCS are the intrauterine device (IUD), the intrauterine system (IUS, a hormonal IUD), the contraceptive implant and the contraceptive injection.

- More than a quarter of GPs responding to a survey by the Royal College of General Practitioners (RCGP) disagreed that patients who need LARC are always able to access it⁵. For many years now, fitting fees for LARC in primary care have not always covered the costs of delivering the service, training new staff and maintaining skills.⁶
- Late diagnosis of cervical cancer adversely impacts on survival rates. Cervical screening coverage for women aged 25 to 64 is now at 72.2%, significantly below the 80% national target⁷.

COVID-19 impact

15. Provisional statistics on contraceptive provision in community Sexual and Reproductive Healthcare (SRH) services covering April to September 2020 show a steep fall in access to emergency contraception and LARCs compared to the same period in 2019:

- 37% fall in contraception-related contacts with SRH services
- Overall contacts including for other SRH care have fallen by 35%
- Uptake of LARC has fallen to 43%, down from 46%
- 53% fall in emergency contraceptive items

Fragmented commissioning of services and accountability

16. The current fragmentation of governance and commissioning responsibilities in England has created confusion and barriers for women when trying to access women's reproductive healthcare. This is most acutely seen in SRH services, the commissioning of which is split between CCGs ("clinical" services); Local Authorities (services funded via Public Health grant); NHS England (primary care, screening and other "clinical" services) and Public Health England (information and health promotion services). This means there is no single body commissioning, or accountable for, women's health.

17. The current commissioning arrangements for SRH cause significant barriers for many girls and women trying to access basic preventative healthcare.⁸ A review of SRH commissioning by Public Health England (PHE) and the Association of Directors of Public Health (ADPH) has found that fragmented commissioning is threatening access to contraception and other services, indicating that "LARC and cervical cytology might suffer"⁹.

18. In 2020, the All-Party Parliamentary Group on SRH ([APPG SRH](#)), in its [Parliamentary Inquiry into Access to Contraception](#), formally welcomed by DHSC, PHE, Faculty of Public Health (FPH) and others, found that women in England are facing difficulty in accessing contraception, with many being bounced from service to service, which can result in more unplanned pregnancies and increased demand for maternity and abortion care.

19. A lack of overall accountability and ownership in women's reproductive healthcare has led to variations in access and quality of care. It is unclear in the current system who holds final responsibility for ensuring access and improving health outcomes. The APPG SRH Inquiry has also heard of a significant lack of local and national accountability for ensuring access and improved health outcomes.¹⁰

⁵ RCGP 2017. [Time to Act](#)

⁶ PCWFF 2020. [LARC fitting in primary care – Survey results](#).

⁷ NHS Digital 2020. [Cervical Screening Programme, England - 2019-20 \[NS\]](#)

⁸ APPG SRH 2020. [Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic](#)

⁹ PHE 2017. [Sexual Health, Reproductive Health and HIV. A Review of Commissioning](#)

¹⁰ RCOG 2019. [Better for women](#)

White Paper: our view and recommendations

20. We welcome the White Paper and its proposal to give ICSs statutory footing. **We are pleased to see the introduction of a shared duty (“triple aim”) to apply to ICSs, NHSE and Trusts, particularly one focussing on population health.** We believe this will encourage NHS bodies and providers to work towards improving population health outcomes and consider public health interventions in the planning and delivery of their services.

Clinical Commissioning Groups (CCGs)

21. Alongside NHSE and LAs, CCGs are a key commissioner of women’s reproductive healthcare services. CCGs commission contraception as medical treatment for gynaecological conditions, abortion services, sterilisation, amongst others.

22. Whilst it is true that some local areas have been exploring ways of working more collaboratively between CCGs and NHSE, across CCGs, and between CCGs and LAs, the split of commissioning between CCGs, NHSE and LAs has broadly acted to restrict the delivery of comprehensive care to women. Therefore, **we believe merging CCGs into ICSs might prove helpful to undo some of the commissioning barriers.** We agree this has the potential to enhance accountability and the development of integrated approaches.

23. **However, the question of how the commissioning responsibilities of ICSs and those that stay with NHSE will work and interrelate in practice still remains.** We are concerned that, as helpful as ICSs can be, women’s health will still be left with too many siloed commissioners. **We call on the Government to work effectively at system level (ICS) and national level (NHSE) to integrate the women’s health services currently commissioned by CCGs with those commissioned by NHSE and LAs.**

24. The incentives for the NHS to get this right are clear. PHE estimates that for every £1 spent on publicly-funded contraception, £9 is saved in averted direct public sector healthcare and nonhealthcare costs (£3.68 in direct healthcare costs to the NHS, including birth costs, abortion costs, miscarriage costs and ongoing child health care costs)¹¹. The National Institute for Health and Care Excellence (NICE) estimates that fully implementing its guidance on long-acting reversible contraception (LARC), the most effective methods of preventing unplanned pregnancies, would save NHS England approximately £102 million per year¹².

Duty to collaborate

25. **The Government’s intention to place a legal duty for NHS organisations and LAs to collaborate is welcome.** A new statutory duty should be introduced on all partners to deliver against shared objectives and to incentivise greater joint working across health and Public Health. We acknowledge that some commissioners and providers of women’s health, including LAs, are already making progress towards effective collaborative arrangements; however, these are pockets of good practice at best, far from being the norm across the country. Therefore, we agree that the new duty enshrined in legislation could support stronger system working.

¹¹ PHE 2018. *Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England*. London: Public Health England. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730292/contraception_return_on_investment_report.pdf

¹² NICE 2005. *National cost-impact report: implementing the NICE clinical guideline on long-acting reversible contraception*. London: NICE

26. **However, we need more clarity. Would such a duty mandate collaborative commissioning and properly enshrine accountability across the NHS and LAs? FSRH and RCOG have consistently called for mandating collaborative commissioning** as a means to tackle the deeply fragmented commissioning landscape for women's health. History tells us that voluntary arrangements for commissioning and accountability between the NHS and LAs have not worked well, and the debilitating indicators in women's health, outlined in the introduction, are a testament to that. Co-commissioning can improve the quality and availability of women's health services, increase access and reduce inequalities, but only with clear lines of accountability. Furthermore, it is widely acknowledged that Health and Wellbeing Boards (HWPB) have not lived up to their original intent, and it is imperative that the same mistakes are avoided in new ICS arrangements.

27. We welcome the proposal for the Secretary of State for Health and Social Care to issue guidance on what delivery of this duty means in practice for different kinds of services. **We urge DHSC to work with organisations such as FSRH and RCOG when issuing guidance relative to women's health services, and to make the guidance statutory.**

28. The system needs care pathways designed around the needs of the patient, not existing institutional siloes. **We urge the Government to not let the commissioning and governance of women's reproductive health services fall through the cracks amongst major ongoing restructurings** such as the implementation of ICSs and the national reorganisation of the Public Health system.

Accountability and clinical leadership

29. **We believe the fragmentation of commissioning responsibilities will likely remain until there is only one, single accountable commissioner for women's health at system (ICS) and national (NHSE) level, holding accountability for commissioning and outcomes in women's health.** A single accountable commissioner at both system and national levels would ensure that services are more joined up for women, meeting their healthcare needs across the lifecourse. It would also ensure a multidisciplinary workforce is better supported and resourced.

30. Above all, **we consider that commissioning needs to go further than what is outlined.** Harnessing accountability for women's reproductive health within ICSs can be a good means to improve outcomes; however, this is not a substitute for the formal integration of women's reproductive healthcare within the NHS.

31. There is consensus across the medical and non-medical healthcare professions that the commissioning and accountability landscape is not fit-for-purpose, with calls for integrated holistic commissioning of women's reproductive healthcare. **We urge the Committee to [consider the joint position on integrated Sexual and Reproductive Healthcare commissioning by the Academy of Medical Royal Colleges \(AoMRC\), Royal Colleges and Faculties](#)**, which calls for women's reproductive healthcare to be more broadly integrated into women's health pathways in the NHS. Similar recommendations have also been made by the [APPG SRH in its Inquiry into Access to Contraception](#).

32. **We believe the White Paper proposals on clinical leadership are too vague in remit. At national level (NHSE), accountability could be enhanced with the appointment of a National Clinical Director (NCD) for women's reproductive health or a National Specialty Adviser in Community Sexual and Reproductive Healthcare (CSRH). Alternatively, we would welcome an expanded remit for the NCD for the Maternity Review and Women's Health to cover women's Sexual and Reproductive Health.**

33. **At system level (ICSs), we would strongly welcome the appointment of a women's health lead at the ICS NHS Body Board or equivalent structure.** Whilst we understand that these Boards will not feature broad representation, it is crucial for there to be clinical leadership representing the unique needs of 51% of the population.

34. Because women's reproductive health sits at the intersection of clinical care and Public Health, **we believe it is also crucial that a Sexual and Reproductive Healthcare lead is represented in Health and Care Partnership Boards,** to ensure leadership at place level works towards commissioning for outcomes at patient and population health levels.

ICS Health and Care Partnerships

35. We welcome the proposal for Health and Care Partnerships to develop plans cutting across systems' health and Public Health, and that ICS NHS Bodies and LAs would need to *'have regard to that plan when making decisions'*. However, it is proposed that Partnerships *'would not impose arrangements that are binding on either party, given this would cut across existing local authority and NHS accountabilities'*, raising the question of whether there would be a legal duty for the ICS as a whole to implement the plan, and who would have overall accountability for outcomes.

36. As much as we understand the intention to avoid a one-size-fits-all approach in legislation so as to enable flexibility for local areas, **we believe that voluntary arrangements will not tackle the systemic variation of service quality and outcomes in Public Health. Proposals for ICS Health and Care Partnerships governance arrangements seem to be quite vague, allowing 'systems to decide how much or how little to do at these different levels'**.

37. It is widely acknowledged that Health and Wellbeing Boards (HWB) have not lived up to their original intent, and it is imperative that the same mistakes are avoided in new ICS arrangements. It is also unclear how ICS Health and Care Partnerships' remit will differ in scope to local Health and Wellbeing Boards (HWB), and how needs assessments and strategies developed by HWBs will differ to the ICS Health and Care Partnership plan. More clarity is needed on how these elements will fit together.

Public Health & health inequalities

38. The White Paper covers few targeted Public Health interventions, leaving gaps in terms of proposals for the national reorganisation of Public Health. We understand that such interventions are intended to complement wider reforms. Nevertheless, **we expect that much of what has been left out, particularly around the future of PHE's health improvement functions, will be subject to a public consultation and continuous engagement with stakeholders.**

39. With COVID-19 laying bare the deep inequalities faced by different places and communities when accessing care, there is a **missed opportunity to propose a cross-government strategy on health inequalities tackling the wider determinants of health.** Research commissioned by the Royal College of Physicians (RCP) for the launch of the Inequalities in Health Alliance (IHA) shows widespread concern over health inequalities and support for action. Almost two thirds of respondents felt that governments across the UK should be doing more to address the issue, and 81% agreed that there should be a UK government strategy to reduce inequalities in health. Along with RCP and other medical and non-medical Colleges, we have called on the Prime Minister to develop a cross-governmental health inequalities strategy¹³.

¹³ RCP 2020. [Inequalities in Health Alliance](#)

40. Another missed opportunity, or rather, barrier to the success of plans developed by the ICS Health and Care Partnerships is the lack of adequate long-term funding for Public Health. **We believe ICSs would only be able to work effectively with LAs when there is sustainable funding for Public Health.** FSRH's view on Public Health funding is set out in our representation to the Treasury on the Budget 2021¹⁴.

Workforce

41. **We believe proposals on workforce do not go far enough.** Workforce is one of the biggest, if not the biggest, challenges to the sustainability of the NHS. The Health Foundation considers workforce challenges as “the single-biggest threat to delivery of the Long-Term Plan”¹⁵.

42. We support principles outlined by the Academy of Medical Royal Colleges (AoMRC), in its submission to this Inquiry, on transparency and agreement on existing workforce data, with sharing of all relevant data; and a clear process by which the Government is required to respond to jointly agreed recommendations on workforce numbers.

43. The proposal to create a duty for the Secretary of State for Health and Social Care to publish a document setting out roles and responsibilities for workforce planning and supply each Parliament does not ensure transparency or accountability. **We believe that to provide transparency, workforce data and planning should be published annually, with a legal duty on a relevant body to do this (such as Health Education England).** In addition, to provide accountability, **there should be a legal duty for the Secretary of State for Health and Social Care to respond to that publication annually in Parliament.** We note that the proposals in the White Paper include greater powers of direction for the Secretary of State over the NHS, and we believe this proposal is in line with those stated intentions, which are to improve accountability to Parliament.

44. To date, we have seen instalments of the NHS People Plan with no funding to back them. **We believe it is imperative that a long-term workforce strategy is developed, reported on annually and provided with sufficient funding to enable implementation.**

Collaboration as the new organising principle of the NHS

45. Finally, we agree that changes to the existing legislative framework to embed collaboration instead of competition as an organising principle of the health and care system are necessary. **We support the legislative proposals to remove the current procurement rules which apply to NHS and public health commissioners, eliminating the need for competitive tendering.** We need a system that supports commissioners to discharge their rules in the best interests of patients and the local population when arranging services, rather than on competition to drive improvements.

For further information please contact

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¹⁴ FSRH 2021. [FSRH representation to the HM Treasury on the 2021 Budget](#)

¹⁵ The Health Foundation 2019. [Health Foundation response to the Public Accounts Committee's inquiry on NHS Financial Sustainability.](#)