

## **FSRH response to DHSC's consultation on the reform of the national Public Health System**

26th April 2021

**The Faculty of Sexual and Reproductive Healthcare (FSRH)** welcomes the opportunity to submit a response to the consultation '*Transforming the public health system: reforming the public health system for the challenges of our times*' by the Department of Health and Social Care (DHSC).

FSRH is the largest UK multidisciplinary professional membership organisation representing more than 15,000 members working at the frontline of Sexual and Reproductive Healthcare (SRH) in a range of settings in the community and primary care. Our members are SRH specialists, GPs, nurses, midwives, pharmacists and other healthcare professionals delivering services commissioned by local authorities, Clinical Commissioning Groups, NHS England (NHSE) and Public Health England (PHE). Our goal is to ensure that high standards in SRH are achieved and maintained through appropriate funding and commissioning to ensure the population can access services which realise [our Vision](#) for high-quality and holistic SRH across the life course.

As a professional membership organisation whose members deliver women's reproductive healthcare and preventative services throughout the lifecourse across a range of settings, our response will focus on the future of health improvement as well as how we can strengthen the national and local response via appropriate funding, commissioning and accountability arrangements. Ultimately, we hope the reorganisation of the Public Health system will deliver sustainable change towards an integrated model of commissioning and delivery of women's health services.

### **Improving our Health**

#### **Question 1: Within the structure outlined, how can we best safeguard the independence of scientific advice to Government?**

FSRH supports the proposals to separate health improvement from health protection functions at national level. To a certain extent, health improvement has been shadowed by a focus on health protection. These dynamics play out quite clearly in the fields of Sexual Health and Reproductive Health (SRH), leading to the de-prioritisation of preventative women's reproductive healthcare.

We support the creation of the Office for Health Promotion. A single source of advice and evidence at the heart of national decision-making would warrant greater ownership and accountability by the Government. We agree the Office must be a multidisciplinary unit housing diverse expertise, including in areas such as SRH. We urge DHSC to prevent the loss of expertise in women's reproductive health currently housed under PHE, and to invest in embedding additional expertise.

We welcome the proposal for direct accountability of the Office for Health Promotion into the Chief Medical Officer (CMO). CMO accountability may represent an opportunity for ownership of Public Health at whole-system level, as well as to integrate women's health across Public Health and the NHS. However, the brief seems to be broad, and with COVID-19 dominating agendas, we need to ensure that health improvement, and SRH, are not neglected in terms of policy focus and funding.

To enhance independence and accountability, we call for transparency in decision-making processes and disclosure of scientific advice and evidence. We propose the establishment of an independent advisory group composed of experts in different areas such as SRH. Members could be drawn in from existing PHE advisory groups such as the Sexual Health, Reproductive Health & HIV External Advisory Group and the Reproductive Health Systems Leadership Forum, which should also continue to exist in their own right.

Teams within the Office must be empowered to conduct independent analysis of Public Health policy impacts, outcomes and implementation without the risk of politicisation and/or co-optation.

**Question 2: Where and how do you think system-wide workforce development can be best delivered?**

We support the principles outlined by the Academy of Medical Royal Colleges (AoMRC) in its submission to the inquiry into DHSC's White Paper by the Health and Social Care Committee (HSC). These relate to transparency on workforce data and a clear process by which Government is required to respond to jointly agreed recommendations on workforce numbers<sup>1</sup>.

We call for workforce data and planning to 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. The proposals in DHSC's 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.

To ensure SRH services can continue to develop new care models with multidisciplinary teams, we need the right supply of Consultants. However, the Specialty is going through a succession crisis, with specialists retiring and a chronic lack of funding for Trainee posts. One quarter of SRH Consultant vacancies in England were left unfilled in 2020. Health Education England (HEE) has recognised that training numbers are small and unlikely to provide the service required for the future<sup>2</sup>. As a result, a small number of Consultant posts unevenly spread across the country leaves whole areas without leadership to develop the wider SRH workforce.

SRH Trainee posts are 50% funded by HEE and 50% by local authorities. It is often impossible for local authorities and employers to find the 50% local funding to match HEE's, despite large demand for Specialty training. We urge DHSC to work with HEE to provide SRH Trainee posts that are 100% funded by HEE just like other Specialties.

**Question 3: How can we best strengthen joined-up working across government on the wider determinants of health?**

We welcome the proposed cross-government ministerial Board on prevention with the aim of driving forward action and accountability on the wider determinants of health.

Unplanned pregnancies can have a negative impact on women and children. Evidence suggests increased risk of obstetric complications for unintended pregnancies that end in birth, with associated low birthweight for the baby and poorer mental health outcomes for the mother<sup>3</sup>.

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<sup>1</sup> AoMRC 2021. [Inquiry into the DHSC's white paper on health and social care](#)

<sup>2</sup> HEE 2018. *Improving the Delivery of Sexual Health Services: Sexual Health, Reproductive Health and HIV Workforce Scoping Project Report*. Leeds: HEE. Available at: <https://www.hee.nhs.uk/our-work/sexual-health-reproductive-health-hiv-workforce>; HEE, 2015. *Small Specialty Community Sexual and Reproductive Health*

<sup>3</sup> Mann, Sue 2018. *Health Matters: Reproductive health and pregnancy planning*. London: Public Health England.

Available at: <https://publichealthmatters.blog.gov.uk/2018/06/26/health-matters-reproductive-health-and-pregnancy-planning/>; 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. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3898922/>

Unintended pregnancies are acknowledged as both a cause and a consequence of socioeconomic inequality among the population. Therefore, tackling the unmet need for contraception would improve long-term health outcomes for women and children, addressing wider determinants of health and tackling health inequalities. Access to contraceptive care supports the delivery of these ambitions, and we call on the Board to prioritise women's reproductive health amongst competing policy agendas, placing it at the core of a preventative approach to health.

We also propose the Board leads on the development of a funded cross-government strategy to reduce health inequalities in collaboration with the Inequalities in Health Alliance (IHA), a coalition of more than 170 organisations lead by the Royal College of Physicians (RCP), of which FSRH is a member. The coalition has come together to campaign for action on health inequalities following the publication of "Health Equity in England: The Marmot Review 10 years on", which found that improvements to life expectancy have declined for the poorest 10% of women, and that the health gap has grown between wealthy and deprived areas.

Research by the RCP in 2020 shows widespread public support for action. More than 80% of respondents agreed there should be a UK government strategy to reduce inequalities in health. Along with medical and non-medical Colleges, we have previously called on the Prime Minister to develop this strategy<sup>4</sup>, and hereby we reiterate our call.

#### **Question 4: How can we design or implement these reforms in a way that best ensures prevention continues to be prioritised over time?**

To ensure that system reform is effective, fragmented commissioning and accountability in women's health need to be addressed.

Fragmented commissioning causes significant barriers for many girls and women trying to access basic preventative healthcare.<sup>5</sup> This is most acutely seen in SRH services, whose commissioning is split between CCGs, Local Authorities, NHSE and PHE.

There is consensus across health professions that the commissioning and accountability landscape is not fit-for-purpose. We urge DHSC to adopt [the joint position on integrated SRH commissioning by the 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.

The fragmentation of commissioning responsibilities will likely remain until there is only one, single accountable commissioner for women's health, holding accountability for commissioning and outcomes in women's health. At national level, accountability could be enhanced with the appointment of a National Clinical Director (NCD) for women's reproductive health or a National Specialty Adviser in SRH. Alternatively, we would welcome an expanded remit for the NCD for the Maternity Review and Women's Health to cover women's SRH. We would also welcome the appointment of a women's health lead at ICSs NHS Body Boards or equivalent and SRH leads in Health and Care Partnership Boards.

Finally, unintended pregnancies accrue increased costs to the NHS, contributing to higher demand for maternity and abortion care. PHE estimates that for every £1 spent on publicly funded contraception, £9 is saved, with the NHS being the biggest beneficiary of those savings (£3.68 in direct healthcare costs to the NHS, including birth, abortion, miscarriage and child healthcare), despite the NHS itself being seldom financially incentivised to invest in the provision of contraceptive care. For prevention to be prioritised, different parts of the system need incentivising over time.

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<sup>4</sup> RCP 2021. [Inequalities in Health Alliance](#)

<sup>5</sup> APPG SRH 2020. [Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic](#)

## Strengthening our local response

### Question 1: How can we strengthen the local authority and Director of Public Health role in addressing the full range of issues that affect the health of local populations?

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

Only so much can be achieved by local authorities and DPHs without sufficient funding. Public Health budgets were cut by a total of £800 million between 2015 and 2020<sup>6</sup>. However, investing in Public Health is highly cost-effective. As previously mentioned, for every £1 spent on publicly funded contraception, £9 is saved in direct public sector costs<sup>7</sup>, with the NHS being the biggest beneficiary of those savings. A systematic review on the effects of cuts to Public Health spending concluded that they were misconceived and that '*local and national public health interventions are highly cost-saving*'<sup>8</sup>. Prevention is effective in improving health and represents good value for money<sup>9</sup>. Spending through the Public Health grant is up to four times as cost-effective as NHS spending<sup>10</sup>.

While the Public Health grant rose with inflation in 2020, far greater investment is needed to restore sustainable Public Health funding. There is consensus that an increase in Public Health spending is necessary to support a sustainable health and social care system<sup>11</sup>. In this climate of uncertainty with the absence of a long-term funding settlement, the reorganisation of the Public Health system and COVID-19, we call for Public Health to be fully funded. The Public Health grant must be prioritised as a cost-effective healthcare spend that includes responsibility for clinical services.

### Question 2: How do we ensure that future arrangements encourage effective collaboration between national, regional and local actors across the system?

We were pleased to see in DHSC's White Paper the introduction of a shared duty to apply to ICSs, NHSE and Trusts. This will encourage NHS bodies and providers to work together towards improving population health outcomes and consider public health interventions in the planning and delivery of services.

The Government's intention to place a legal duty for NHS organisations and local authorities to collaborate is welcome. A new statutory duty should be introduced on all partners to incentivise greater joint working across health and Public Health. We acknowledge that some commissioners and providers of women's health, including local authorities, 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.

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<sup>6</sup> The Health Foundation, 2020. [Today's public health grant announcement provides some certainty, but more investment is needed over the longer-term.](#)

<sup>7</sup> PHE, 2018. [Contraception: Economic Analysis Estimation of the Return on Investment \(ROI\) for publicly funded contraception in England.](#) London: Public Health England

<sup>8</sup> Masters, R., et. al., 2017. [Return on investment of public health interventions: a systematic review.](#) *Epidemiol Community Health* 2017 (71), pp. 827–834.

<sup>9</sup> PHE, 2018. [Health matters: health economics - making the most of your budget.](#) *Public Health England.* [online]

<sup>10</sup> Martin, S., Lomas, J. & Claxton, K., 2019. [Is an Ounce of Prevention Worth a Pound of Cure? Estimates of the Impact of English Public Health Grant on Mortality and Morbidity.](#) CHE Research Paper 166. York: University of York.

<sup>11</sup> FSRH, 2019. [FSRH endorses consensus statement calling for more public health funding.](#) FSRH.

We welcome the proposal, in the White Paper, for Health and Care Partnerships to develop plans cutting across systems' health and Public Health, for which ICS NHS Bodies and local authorities would need to have regard. 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 who would have overall accountability for outcomes.

As much as we understand the intention to avoid a one-size-fits-all approach, we believe that voluntary arrangements will not tackle the systemic variation of quality and outcomes in Public Health. FSRH and the Royal College of Obstetricians and Gynaecologists (RCOG) have consistently called for mandating collaborative commissioning to tackle the fragmented commissioning landscape for women's health. History tells us that voluntary arrangements for commissioning and accountability between the NHS and local authorities have not worked well. 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.

**Question 3: What additional arrangements might be needed to ensure that regionally focussed public health teams best meet the needs of local government and local NHS partners?**

As previously stated, incentivising different parts of the system so that they can see the accrued benefits of investing in prevention will also be key for improved outcomes at local level. Unintended pregnancies accrue increased costs to the NHS, contributing to higher demand for maternity services and abortion care. Yet every £1 spent on publicly funded contraception £9 is saved in averted direct public sector healthcare and nonhealthcare costs. The National Institute for Health and Care Excellence (NICE) estimates that fully implementing its LARC guidance would save the NHS approximately £102 million per year, underscoring the value of offering the full range of contraceptive methods to both women and the NHS.

Regions should play a key role in housing system leaders. A strong regional role will help support statutory ICSs. However, the White Paper proposals on clinical leadership are too vague in remit. At regional level (ICS level), 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.

Because women's reproductive health sits at the intersection of clinical care and Public Health, we believe it is also crucial that a SRH 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.

Finally, to date, there has not been a national focus on the opportunity of Primary Care Networks (PCNs) for women's reproductive health. With 1,200 PCNs across England, a greater focus on how local areas can support women's health services is needed, including on how to involve NHS and Public Health commissioners.

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