

FSRH response HEE Strategic Framework Call for Evidence 2021

01 September 2021

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to submit a response to the call for evidence “Strategic Framework Call for Evidence 2021” by Health Education England (HEE).

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 most pressing issues facing the sustainability of the Sexual and Reproductive Healthcare (SRH) workforce.

Demand and supply gaps over the next 15 years

23.23. Please provide details of where you feel the greatest workforce demand and supply gaps will be over the next 15 years. Where possible please be precise with regards to workforce groups/professions, services/pathways and place (geographic area), as well as timescales.

The Sexual and Reproductive Healthcare (SRH) workforce crisis

The SRH workforce is facing a supply crisis. The Speciality has experienced a decade-long deficit in training numbers. Community Sexual and Reproductive Health (CSRH) has been challenged by insufficient Trainee numbers since its establishment in 2010. In 2011, the Centre for Workforce Intelligence (CfWI) recommended the introduction of 35 Specialty training posts to secure a sustainable specialist workforce; however, only 20 were funded then. HEE has recognised that training numbers are small and unlikely to provide the service required for the future.

As evidenced in the 2020 report of the Parliamentary Inquiry into access to contraception by the All-Party Parliamentary Group on SRH, 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. This unwarranted variation in access and quality of SRH care will not be resolved if we do not have the right leadership in place to plan and deliver integrated, preventative SRH services for all.

Unfilled posts, retirements and geographic gaps

Apart from funding and commissioning issues, workforce shortages are the main factor leading to decreased access to SRH care for patients.

From 2018 to 2020, more than half of advertised CSRH Consultant posts across England were left unfilled because they did not have applicants, or because applicants from other specialties did not have the competences required. Regarding the appointments that were made, some posts had to be advertised more than once because the employer could not attract enough applications, leaving the posts vacant after the previous post holder had left. For the past months of 2021, there are ongoing vacant posts in Jersey, Cumbria, London, and Dorset.

The CSRH Consultant workforce is also retiring at a larger rate than CCTing Trainees. In a workforce mapping survey we conducted in 2018, more than one fifth of respondents stated they intended to retire by 2023. Our Specialty team has heard from many FSRH Consultant members that they don't feel they can retire because there is no one that will be able to fill their post.

Many geographic areas, particularly deprived areas, do not have any CSRH Consultants in post. As the recent annual report by the Chief Medical Officer (CMO) on the health of coastal towns rightly points out, coastal communities face challenges with access to services as well as with service delivery, where they struggle to reach the critical mass needed to sustain specific services. The South coast is a case in point for SRH, with a lack of Consultants in Kent, Surrey, and Sussex. Shortages are also seen in the South West and North of England. This entrenches differences in quality and standards of patient care across the country, fuelling health inequalities.

A small number of Consultant posts unevenly spread across England leaves whole areas without any SRH leadership to support delivery of care to the population. It leaves the workforce delivering SRH in community and primary care settings without any clinical support from senior clinicians and limits their training opportunities.

Funding for Specialty Training posts

The Specialist workforce supply gap is a result of a chronic lack of sufficient funding for Specialty training posts. Specialty training posts are 50% funded by HEE and 50% by the service / Local Authorities. Currently, we recruit at ST1 and try to rotate Trainees into areas where services are not Consultant-led. However, this is proving difficult as Local Authority-commissioned employing Trusts tend to insist on Trainees' clinical commitment to their area. Even without rotation, it is often impossible for cash-strapped Local Authorities to match the 50% HEE funding locally.

This barrier to fund CSRH Specialty training posts has direct impacts on the sustainability of the whole SRH workforce. This is because SRH Consultants are trained both to deliver specialist clinical care themselves, but also to be systems leaders who design and support services provided by others – whether they are GPs, nurses, healthcare assistants or other professionals. Investment in CSRH Consultant posts is an investment in the whole SRH workforce.

In addition, SRH Consultants have received extensive training in public health to ensure that the design of services is rooted in prevention, health promotion and fit with the wider attempts to tackle health inequalities. SRH consultants champion a model of care that is closer to home, outside of hospital settings, which deliver higher efficiencies than acute care models.

Tackling the supply gap

Our plan to increase the supply of Consultants is practical and achievable, and we capacity to deliver it. We would like to see one new or extra fully funded training post per HEE region each year for 3 years. This would allow recruitment at ST3, attracting doctors from Specialties with high attrition-rates such as Obstetrics & Gynaecology as well as those who have completed training in General Practice, but would like to pursue a career as leaders in women's health.

Establishing training posts on the same funding basis as Public Health and opening recruitment at ST3 level would greatly improve the opportunities open to trainees in CSRH. This approach would also support the delivery of the recommendations in the CMO's annual report, particularly around HEE's geographical redistribution programme and increasing "Specialty training placements (including public health) in coastal areas".

SAS doctors

Before the closure of the Associate Specialist Grade in 2008, many medical service lead positions in SRH were filled by AS doctors who fulfilled a vital role in leading services where no consultant was available.

SAS doctors are vital to the sustainability of SRH services. SAS doctors make up a large proportion of doctors working within SRH, with many often taking up senior roles. Data from the General Medical Council (GMC) shows that SAS doctors are performing enhanced roles, with a majority having responsibility for training others. However, more than a third of SAS doctors themselves report difficulties in accessing continued professional development (CPD) opportunities and often do not have the same support for career development and progression.

Our vision is a fit-for-purpose SRH workforce led by Consultants and SAS doctors, whose commitment to high standards of care is recognised by the medical profession as well as across Government and arms-length bodies with responsibility for workforce planning and development.

We support the introduction of a new specialist grade in the SAS contract reform. This will provide new opportunities for progression within a SAS career, acknowledging the invaluable contribution made by this part of the SRH workforce. The introduction of this new grade will help to recruit, motivate and retain SRH doctors.

SRH primary care workforce

The fragmentation of commissioning responsibilities has created disincentives for the training and education of the SRH workforce, who work across various settings in community and primary care. This split in commissioning means that responsibility for training is, at best, unclear.

GPs and their teams play a vital role in the provision of contraceptive care to patients in their local communities, with 80% of women accessing contraception at their local GP surgery. Yet access to long-acting reversible contraceptives (LARC), the most effective methods to prevent unplanned pregnancies, is restricted as a result of fragmented commissioning, a lack of funding available for its provision and reduced capacity in general practice, with fewer GPs and practice nurses training or retaining essential skills in this area.

Primary care provision of LARC) is commissioned by local authorities, who, as noted previously, are under severe budgetary pressure. LARC dispensed in the community have fallen by 8% since 2013 when commissioning responsibilities changed. Around 11% of councils reduced the number of contracts with GPs to fit LARC in 2018/19. Cuts mean less incentive and opportunities for GPs and practice nurses to train in complex contraception care.

The Royal College of General Practitioners (RCGP) and the Royal College of Nursing (RCN) have raised concerns about training and maintaining qualifications to fit LARCs¹. There is evidence of frontline staff who have been dissuaded from accessing training because they are often expected to self-fund training in their own time. This has led to a situation where healthcare professionals are unable to maintain qualifications.

The fee paid to GPs for fitting LARCs varies significantly across the country and is often too low to cover the cost of providing the service, training new staff or maintaining skills. The APPG SRH Inquiry heard that practices in Hampshire were paid £80 for the provision of LARC. This is meant to cover staff time for the consultation, fitting, follow-up and removal of LARC, as well as funding for the necessary chaperone. Evaluation in another area suggested that the true cost was nearer to £140. Without the funds to adequately train staff, surgeries cannot provide high quality patient care.

Finally, in England, specialist SRH service contracts used to specify that they were required to train local GPs, medical students and nurses, but a lack of funds from public health to pay for these courses means that in many cases this clause has now disappeared. We believe that all local authorities must be financially supported to be able to 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.

COVID-19

The SRH workforce crisis has now been exacerbated by the COVID-19 pandemic.

In August this year, we published an all-member survey for our member across the UK to better understand restoration of services and its impact on the workforce. We have received a little over 300 responses from members based in the East of England, London, the Northwest, South West and Yorkshire and the Humber. More than half of the respondents work in General Practice, and the remainder work in specialist SRH services, integrated GUM/ contraceptive services, hospitals, independent sector and the voluntary sector.

A third of respondents said that not all staff who had been redeployed were able to return to their services yet. Some have stated that staff are still unwell or isolating due to medical conditions. Respondents also felt that their clinic had become the “hospital bank service to facilitate the staff shortages at the main hospital in the city”, underlining the tensions brought about by redeployment from already stretched services.

Around 80% of respondents said their service is currently experiencing workforce shortages, with the most common reasons being “staff sickness or unavailability due to self-isolation (COVID-related)”; “unfilled staff vacancies”; “staff sickness or unavailability (non-COVID)”. Nearly a third said the shortages were due to staff retirement, and 10% stated budget cuts as the reason for shortages. A common issue was that many had lost staff due to cuts, and many others were not able to provide the full range of SRH services as there was not enough funding to train staff up or to cover the actual cost of procedures (LARC fittings).

Staff Burnout

Around 60% of respondents stated they had experience feelings of work-related burnout during the course of the pandemic. A third of respondents said they are currently experiencing feelings of work-related burnout. Concerningly, many respondents commented that they had felt unable to report it to their employer.

a.23.a. Please provide any web links to supporting evidence below.

APPG SRH 2020. *Women's Lives, Women's Rights. Strengthening Access to Contraception Beyond the Pandemic* <https://www.fsrh.org/documents/full-report-december-womens-lives-womens-rights/>

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*

RCN 2018. *Sexual and Reproductive Health. RCN report on the impact of funding and service changes in England*. Available at: <https://www.rcn.org.uk/professional-development/publications/pdf-006962>

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>

RCN 2018. *Sexual and Reproductive Health. RCN report on the impact of funding and service changes in England*. Available at: <https://www.rcn.org.uk/professional-development/publications/pdf-006962>

Primary Care Women's Health Forum, LARC fitting in primary care – Survey results, June 2020
https://pcwhf.co.uk/resources/larc-fitting-in-primary-care-survey-results/?utm_source=Primary+Care+Women%27s+Health+Forum&utm_campaign=1af61e2b72-EMAIL_CAMPAIGN_2019_05_29_03_16_COPY_01&utm_medium=email&utm_term=0_9f6eea8a01-1af61e2b72-165490549

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