FSRH Response to the Health and Social Care Select Committee Inquiry: Workforce burnout and resilience in the NHS and social care

04th September 2020

1) Background to the Organisation

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest UK multidisciplinary professional membership organisation representing more than 15,000 doctors and nurses working at the frontline of Sexual and Reproductive Healthcare (SRH) in community and primary care. Our goal is to ensure that everyone can access high-quality and comprehensive SRH care across the life course, and that essential SRH services remain available to the population during and after the COVID-19 pandemic.

FSRH is responding to this consultation in its capacity as the UK organisation setting clinical, service and educational standards in SRH. We provide national qualifications in SRH care and oversee the Community Sexual and Reproductive Healthcare (CSRH) Specialty Training Programme. We publish evidence-based service standards and clinical guidance to support safe, consistent SRH care in the UK.

2) Summary

- A lack of funding and the fragmentation of commissioning responsibilities have created disincentives for the training and education of the SRH workforce.
- Despite the large demand for Specialty training, successive cuts to Public Health and education and training budgets make it increasingly hard for Trainee posts in SRH to be funded. This barrier to fund CSRH Specialty training posts has direct impacts on the sustainability and resilience of the whole SRH workforce.
- Lack of funding for Specialty training posts is at odds with demand for SRH Consultants. Health Education England (HEE) has recognised that training numbers are small and unlikely to provide the service required for the future. One third of CSRH Consultant vacancies in England were left unfilled in 2019.
- A small number of Consultant posts unevenly spread across England leaves whole areas without any SRH leadership. It also leaves the wider SRH workforce without specialist support and limits their training opportunities. All local authorities must be financially supported to be able to ensure that service specifications for specialist SRH services are designed to include training requirements in their contracts.
- We recommend a ratio of 1 Consultant per 125,000 inhabitants, a figure recognised by HEE and the Department for Health and Social Care (DHSC)[1]. In this scenario, HEE estimates a need for 440 WTE SRH Consultants in England. We recognise that 440 might not be a feasible number and recommend increasing the number of training posts by 1/3 to meet the supply gap. This would be an additional 16 training places per year from 2022 for 3 years, totalling 76 training posts.
- Fewer general practice staff are able to train and maintain skills in the provision of Long-Acting Reversible Contraception (LARC), the most effective methods of contraception. In 2017/18, between 13% and 15% of Local Authorities reduced the number of contracts with general practice to fit LARCs. This means that some practices have reduced or ended provision of LARCs, with staff left with fewer opportunities for training.

[1] See the following reports: HEE, 2015. *Small Specialty Community Sexual and Reproductive Health* and DH, RCOG & FSRH 2008. *Developing Specialties in Medicine – The case for recognition of Sexual and Reproductive Healthcare as a new CCT specialty*.

- Practices are often not reimbursed the full costs of providing a LARC fitting service, which should include the cost and time requirements of training and maintaining healthcare practitioners with the qualifications to fit LARC. 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.
- There are also growing concerns that many GPs trained to fit LARCs are due to retire soon. The fragmented commissioning environment and pressures on primary care mean there is little incentive for younger GPs and practice nurses to replace them.
- The pandemic has had a detrimental impact on the SRH workforce. The redeployment of staff from already understaffed SRH services has resulted in service closures, and clinicians are concerned that patients will no longer be able to access care.
- At the height of the pandemic in April, 27% of SRH specialist staff were redeployed, and a further 17% were absent from work according to our members survey. Though capacity has improved, this initial drop created a backlog for the provision of SRH care, especially LARC.
- The pandemic has also had an impact on SRH providers' mental health. 22% of survey respondents stated that they had no mental health support available. Some respondents noted that they were overworked, while others stated that changes to service provision left them feeling disrespected and underutilised.

3) The operating conditions of the SRH workforce pre-COVID-19

Workforce has been singled out by many as one of the biggest, if not the biggest, challenges to the sustainability of the NHS. The Health Foundation considers workforce challenges in the NHS in England as "the single-biggest threat to delivery of the Long-Term Plan"[2]. FSRH supports the call in the NHS Long-Term Plan Implementation Framework for workforce planning to encourage workforce growth including in primary and community care.

As is the case with Public Health, uncertainty surrounding funding and cuts to education and training budgets remain. Central investment in education and training has dropped from 5% of health spending in 2006/7 to 3% in 2018/19. Had the previous share of health spending been maintained, investment would be £2bn higher[3].

Further, fragmented commissioning has hindered the delivery of effective person-centred care post Health and Social Care Act 2012, whereby commissioning of SRH services was split between NHS England, Local Authorities and Clinical Commissioning Groups (CCGs) in England. This fragmentation of governance and commissioning responsibilities has created confusion and barriers for patients when trying to access healthcare, as well as around who holds accountability for SRH services across the healthcare system. 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. There is consensus across the medical and non-medical profession that current commissioning structures are not fit for purpose, with calls for an end to fragmented commissioning.

[2] The Health Foundation 2019. *Health Foundation response to the Public Accounts Committee's inquiry on NHS Financial Sustainability*. Available at: https://www.health.org.uk/sites/default/files/2019-04/pac_inquiry_on_nhs_sustainability_final.pdf

[3] The Health Foundation 2019. *Health Foundation response to the Public Accounts Committee's inquiry on NHS Financial Sustainability*. Available at: https://www.health.org.uk/sites/default/files/2019-04/pac_inquiry_on_nhs_sustainability_final.pdf

Specialist SRH training

Cuts to education and training budgets make it increasingly hard for Specialty Trainee posts in SRH to be funded. Posts in Community Sexual and Reproductive Health (CSRH) are 50% funded by HEE and 50% by Local Authorities. Given the successive cuts to both Public Health and education and training budgets, it is often impossible for Local Authorities and services to find the 50% local funding to match the 50% HEE funding. This is despite the large demand for Specialty training - CSRH is the second most competitive Specialty programme, with a 20:1 ratio of applicants. Moreover, Local Authorities with stretched budgets can be reluctant to invest in training, an area some believe should not be their responsibility in the first place.

Lack of funding for CSRH training posts is at odds with demand for SRH Consultants. HEE has recognised that training numbers are small and unlikely to provide the service required for the future[4]. One third of CSRH Consultant vacancies in England were left unfilled in 2019, and HEE estimates that one third of the current CSRH Consultant workforce could retire within the next five years[5]. 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 also leaves the workforce delivering SRH in community and primary care settings without any clinical support from specialist Consultants and limits their training opportunities.

This barrier to fund CSRH Specialty training posts has direct impacts on the sustainability and resilience of the whole SRH workforce. This is because SRH Consultants are trained both to deliver specialist 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 SRH Consultant posts is, therefore, an investment in the whole SRH workforce. 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.

In addition, SRH Consultants are trained 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.

SRH training in general practice

The majority of women access contraception from their GPs. In general practice, Long-Acting Reversible Contraceptives (LARCs), the most effective methods of contraception, are commissioned by Local Authorities if used for contraception. LARCs are also clinically indicated to treat heavy periods and manage the menopause, and they are commissioned by CCGs if used to treat these gynaecological conditions. This split in commissioning in general practice means that responsibility for LARC training is, at best, unclear.

[4] 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*

[5] HEE 2015. *Small Specialty Community Sexual and Reproductive Health*

From 2015/16 to 2017, 45% of Local Authorities reduced the number of LARCs fitted and removed in general practice. In 2017/18, between 13% and 15% of Local Authorities reduced the number of contracts with general practice to fit LARCs. This means that some practices have reduced or ended provision of LARCs, with fewer and fewer general practice staff able to train and maintain skills in LARC provision. This adds further pressure on community SRH clinics, but there is no evidence of a corresponding increase in contractual support for them, including on workforce training[6]. Uncertainty around the future of the LARC service and a lack of meaningful communication with Public Health commissioners are reducing incentives for GPs to continue to keep up their training qualifications, again resulting in reduced care for patients. Further, practices are often not reimbursed the full costs of providing a LARC fitting service, which should include the cost and time requirements of training and maintaining qualifications to fit LARC[7]. LARC fitting fees also vary considerably across England.

The Royal College of General Practitioners (RCGP) and the Royal College of Nursing (RCN) have raised concerns about training and maintaining qualifications to fit LARCs[8]. Only 18% of GPs responding to a 2017 survey by the RCGP agreed that LARC training was easy to access; 27% of GPs disagreed that patients who need LARC are always able to access it[9]. 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[10]. There are also growing concerns that many GPs trained to fit LARCs are due to retire soon. The fragmented commissioning environment and pressures on primary care mean there is little incentive for younger GPs and practice nurses to replace them.

GPs responding to the same RCGP survey found that vulnerable patients are being excluded from accessing the full range of contraceptive methods, and that health inequalities are being widened as a result. As most women choose to access contraception in primary care, it is paramount that women are able to access the full range of contraceptive methods, and that clinicians working in primary care have adequate opportunity to gain competencies and maintain their qualifications in contraceptive care.

3) The impact of the COVID-19 pandemic on the SRH workforce

The pandemic has had a detrimental impact on the SRH workforce. The redeployment of staff from already understaffed SRH services has resulted in service closures, and clinicians are concerned that patients will no longer be able to access the care that they need. Funding and commissioning challenges have led to an overstretched SRH service that was not sustainably supported to provide care to women and girls either before or during a pandemic.

To better understand the impact of the COVID-19 pandemic on SRH service provision, we released a rolling survey for our members[11]. At time of writing, the survey has received more than 1,000 responses from GPs and other members working in sexual health clinics, sexual and reproductive healthcare (SRH) services, integrated SRH and sexual health as well as abortion care.

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[6] See AGC 2017. *Cuts, Closures and Contraception*. Available at: http://theagc.org.uk/our-work/

[7] RCGP 2017. *Time to Act*. Available at: https://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx

[8] RCGP 2017. *Time to Act*. Available at: https://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

[9] RCGP 2017. *Time to Act*. Available at: https://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx

[10] 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

[11] A full report with interim results can be accessed here.

At the height of the pandemic in April, 27% of SRH specialist staff were redeployed, and a further 17% were absent from work according to our survey. Though capacity has improved, this initial drop created a backlog for the provision of SRH care, in particular LARCs. Our survey respondents suggested that increases in funding are required to alleviate these backlogs:

> *"If the LARC fitting fee was increased to reflect the extra time and PPE required for fitting this may persuade my practice to pay for locums which would allow me time away from being 'hot' Dr or urgent Dr and free up capacity to resume fitting LARCS. I currently have a waiting list of over 30 women who need a coil fitting or refitting and am unable to do any for the next 6 -8 weeks at least due to no capacity."*

Due to high levels of redeployment and absence among specialists, some SRH providers who are shielding must put their own safety at risk in order to provide care to their patients:

> *"I am currently shielding so this is a great cause of anxiety for me, but no-one else in my surgery provides these services, so I feel I must restart now."*

The pandemic has also had an impact on SRH providers' mental health. 22% of survey respondents stated that they had no mental health support available. Some respondents noted that they were overworked, while others stated that changes to service provision left them feeling disrespected and underutilised.

> *"We are all exhausted with the amount of change and the unmet demand waiting out there."*

> *"My role has become very narrow - I feel de-skilled and under-used. It is bad for my self-esteem, very frustrating, I feel disrespected by my employers and means I'm looking for other jobs."*

In order to improve stress levels and service capacity, SRH service providers require additional training and resources. 15% of GPs and 29% of specialists who responded to our survey stated that they needed additional training to effectively provide SRH services beyond the pandemic. This training included for LARC fittings and for Sayana Press, the self-injectable LARC. 20% of GPs and 62% of specialists stated that they needed additional resources to effectively provide SRH services beyond the pandemic. These resources included blood pressure monitors to enable patients to self-monitor blood pressure and training for telephone consults. Specialists, in particular, noted the need for increased IT infrastructure – including the need for laptops with cameras for video consultations, updated software, technology to securely record consultations, and updated clinical systems.

4) The future - to what extent there are sufficient numbers of SRH professionals in training for service planning

Due to the crude reality of services being understaffed and/or lacking staff with the right skills, service planning in SRH care tends to be based, to a greater extent, on workforce availability rather than population need.

As outlined in section 3, "*Specialist SRH training",* training numbers are small. By end of 2020, there will be 46 SRH training posts. This figure is far from supplying a sustainable number of Consultants to counter the imminent retirements, the geographic gaps, the increasing demand for SRH services and a growing population.

Currently, there are around 100 SRH Consultants working in England. 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. There are regions with large Consultant gaps, such as the South West and the North of England. There is a particular shortage of Consultant posts in Devon and Cornwall. Further, HEE estimates that one third of the SRH Consultant workforce could retire within the next five years[12]. One third of SRH Consultant vacancies in England were left unfilled in 2019, despite the Specialty Programme being the second most competitive, with a 20:1 ratio of applicants.

We recommend a ratio of 1 Consultant per 125,000 inhabitants, a figure recognised by HEE and DHSC[13]. In this scenario, HEE estimates a need for 440 WTE SRH Consultants in England. We recognise that 440 might not be a feasible number and recommend increasing the number of fully-funded training posts by 1/3 to meet the supply gap. This would be an additional 16 training places per year from 2022 for 3 years, totalling 76 training posts.

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[12] HEE 2015. *Small Specialty Community Sexual and Reproductive Health*

[13] See the following reports: HEE, 2015. *Small Specialty Community Sexual and Reproductive Health* and DH, RCOG & FSRH 2008. *Developing Specialties in Medicine – The case for recognition of Sexual and Reproductive Healthcare as a new CCT specialty*.