



FSRH written submission to the consultation on the Prevention Green Paper by the Cabinet Office and DHSC

11 October 2019

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to respond to the consultation on the Prevention Green Paper. 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 health (SRH) care delivery.

FSRH is responding to this inquiry in its capacity as an organisation whose members deliver public health services funded by the public health grant. We are also responding to this inquiry in our capacity as the UK organisation providing national qualifications in SRH and overseeing the Community Sexual and Reproductive Healthcare (CSRH) Specialty Training Programme.

Our goal is to ensure that high standards in SRH care 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.

How can we make better use of existing assets -across both the public and private sectors - to promote the prevention agenda?

Investing in public health and Sexual and Reproductive Health (SRH) care is cost-effective. Prevention and early intervention are effective in improving or maintaining health and represent good value for money. 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”. Recent analysis by the University of York estimates that, overall, spending through the public health grant is up to four times as cost-effective as NHS spending.

Unintended pregnancies can also accrue increased costs to the NHS, contributing to higher demand for maternity services and abortion care. Public Health England (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). 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 year.

Local action

What more can we do to help local authorities and NHS bodies work well together?

We agree that the move towards ICSs can create opportunities to co-commission an integrated SRH service. FSRH will launch a report this month about embedding SRH services in new models of care. The report is based on an audit of models that have emerged in the last few years and features case studies on successful initiatives in which commissioners and providers took a forward-looking approach and re-designed services to better cater to the needs of the local population. We would be pleased to meet with DHSC to discuss how to embed SRH into new models of care.

Collaborative commissioning of SRH services

FSRH, RCGP, RCOG, and the entire Academy of Royal Medical Colleges are clear that there is a long way to go in order to achieve holistic integrated services when it comes to reproductive healthcare. We strongly recommend having regard to our Joint Statement on this issue when considering collaborating of SRH services, which can be found here:

<https://www.fsrh.org/documents/fsrh-rcog-rcgp-position-holistic-integrated-srh-commissioning/>

Women's reproductive health has suffered the most from the re-organisation of NHS services that followed the implementation of the Health & Social Care Act in 2013. Women's access to contraceptive care in England – and reproductive healthcare more broadly - has been jeopardised by a lack of prioritisation of prevention across the healthcare system and a deeply fragmented commissioning landscape split between local authorities, Clinical Commissioning Groups (CCGs) and NHS England.

We acknowledge the outcome of DHSC's review into commissioning arrangements for SRH, which concluded that responsibility for commissioning SRH services should remain with local authorities. We agree with the Government's view in this paper that whilst "there are some inspiring examples of success, this is too often dependent on the efforts of particular individuals or favourable local circumstances" and that, "[a]s a result, the extent and nature of collaborative commissioning arrangements varies dramatically".

We fully support the Government's call, in this paper, for collaborative commissioning in SRH to "become the norm" requiring local authorities and the NHS to work closely together at both national and local level. We support the call for the NHS and local authorities to "work more closely together on these services to deliver joined-up care for patients". We believe CCGs, NHS England and local authorities must work together and plan services based on patient and population need while embedding workforce planning in any service model. However, we believe that relying on voluntary initiatives for collaborative commissioning of SRH services alone will not suffice.

Collaborative commissioning is not a new idea per se; both the [Department of Health's 'A Framework for Sexual Health Improvement in England 2013'](#)¹ and PHE's '[Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV](#)' 2014² advocated a collaborative and whole-system approach to commissioning. In the view of our 15,000 members who work in the frontlines of service delivery, co-commissioning can improve the quality and availability of SRH services, increase access and reduce inequalities, but only with clear lines of accountability across the system.

A 2015 inquiry into system accountability in Sexual Health, Reproductive Health and HIV services by All-Party Parliamentary Group on Sexual and Reproductive Health (APPG SRH)³, which took evidence from the then Public Health Minister, NHS England, PHE, Local Government Association (LGA), Association of Directors of Public Health (ADPH), amongst others, concluded that a lack of accountability was directly impacting patients and urged the then Department of Health to consider national accountability for Sexual Health, Reproductive Health and HIV to be a priority action.

¹ DH, 2013. *A Framework for Sexual Health Improvement in England*. [pdf] London: DH. Available at: <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

² PHE, 2014. *Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV*. [pdf] London: PHE. Available at: <https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services>

³ <http://theagc.org.uk/wp-content/uploads/2015/07/APPG-SRH-UK-Breaking-down-the-barriers.pdf>

The above recommendation couldn't be more relevant today. We call on DHSC, together with NHSE, to appoint a National Clinical Director (or equivalent role) for women's reproductive healthcare who would lead on the proposed Sexual and Reproductive Health Strategy. The National Clinical Director (or equivalent role) would ensure co-commissioning in SRH works to a better standard and is a consistent practice across England. The National Clinical Director could ensure that nationally-recognised standards in SRH are met in co-commissioning arrangements and that Integrated Care Systems (ICSs) and Primary Care Networks (PCNs) are reaching their potential for co-commissioning in SRH. Additionally, this would help to mainstream the concept, throughout the NHS, that prevention and public health are also NHS' business.

Sexual and reproductive health

What are the top 3 things you'd like to see covered in a future strategy on sexual and reproductive health?

Number 1: *accountability in co-commissioning of SRH services – please our answer to the question on “Local Action” in Chapter 3*

Number 2: *improving access to tackle the unmet healthcare need for contraceptive services and women's reproductive health care*

Women's reproductive health must be at the core of the proposed Sexual and Reproductive Health Strategy. This is because women's reproductive health has suffered the most from the re-organisation of NHS services following the Health & Social Care Act in 2013. Women's access to contraceptive care in England – and reproductive healthcare more broadly – has decreased exponentially due to a combination of factors including cuts to Public Health funding, a fragmented commissioning landscape and a lack of strategic prioritisation of women's reproductive health across the healthcare system.

Recent figures show that almost 800,000 women used a community SRH service for contraception in England in 2018/19, a drop of 15% since 2014/15. More than 8 million women of reproductive age now live in an area where the local council has reduced their SRH budget. A review of commissioning of SRH services by Public Health England (PHE) and the Association of Directors of Public Health (ADPH) in 2017 concluded that fragmented commissioning is threatening access to contraception and other SRH services, indicating that access to LARC might “suffer”.

This unmet healthcare need for contraceptive services is evidenced in debilitating indicators in women's reproductive health. Almost half of pregnancies in Britain are unplanned or ambivalent. Abortion rates have generally increased by 4% since 2017 and are now the highest number on record. Prescriptions for Long-Acting Reversible Contraception (LARCs), the most effective methods of contraception, have declined by 11% in the last three years. Around 27% of GPs in England responding to a survey by the Royal College of General Practitioners (RCGP) in 2017 disagreed that patients who need LARC were always able to access it.

Improving access to contraceptive and other SRH services is needed to help women avoid unplanned pregnancies. Addressing the unmet need for high-quality contraceptive care across England would ensure improved long-term health outcomes for women and their children. 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.

There is a need for SRH care to be more broadly integrated into women's healthcare pathways in the NHS, and the proposed Sexual and Reproductive Health Strategy represents an opportunity to

address that. The Chief Medical Officer's 2014 annual report has called for the integration of pregnancy prevention, pre-conception, antenatal and intra- and interpartum care with SRH services. However, despite the ambition, there has not been the necessary focus from within Government to deliver on this vision. 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' Maternity Transformation Programme.

Unintended pregnancies are also acknowledged as both a cause and a consequence of socioeconomic inequality among the population. Tackling the unmet need for contraception would contribute with addressing health inequalities and regional variation in access to SRH care, speaking to prevention as the cornerstone of the NHS Long-Term Plan (LTP). The LTP Implementation Framework calls for local systems to prioritise actions to reduce health inequalities and unwarranted variation and to monitor the impact of prevention activities on health inequalities. Access to contraceptive care would support the delivery of these ambitions and must be at the core of a preventative approach to health.

Number 3: sustainable, long-term funding for public health services

Public health budgets have witnessed substantial cuts since 2015. Councils' public health grant has been reduced by £331 million from 2016/17 to 2020/21. This followed a £200 million in-year reduction in 2015/16. By 2019/20, public health budgets will have been cut by a total of £700 million.

Pressure on public health budgets have seen around 61% of local councils in the quartile with the highest social deprivation cut or freeze their SRH budgets between 2016/17 and 2017/18, and 89% are planning to further freeze or cut budgets in the next financial year. Cuts to SRH services are taking place in many areas with already existing poor health outcomes, suggesting a mismatch between cuts and local population needs. This could deepen existing inequalities, increase the rates of unplanned pregnancies and demand for maternity and abortions services as well as diminish access to other essential SRH services such as cervical screening.

Cuts have taken place in a context of increasing demand and a large unmet healthcare need for contraceptive services as described above. Demand for sexual health services has risen by 13% since 2013, and the Local Government Association (LGA) has warned that sexual health services are now at a "tipping point". The FSRH members survey collects views and experiences of our 15,000 members, doctors and nurses working in the frontlines of SRH service delivery. More than a third reported reduced provision and variety of SRH services. Around 65% reported increased demand and almost half, poorer patient experience.

We believe that sustained cuts to the Public Health budget will prove a major challenge to the delivery of the proposed Sexual and Reproductive Health Strategy and NHS Long-Term Plan ambitions. The real-terms increase to the Public Health grant recently announced in the one-year Spending Round is welcome. However, this small increase is far from being sufficient to fill the funding gap and it is not a long-term solution. We believe that the postponement of the comprehensive Spending Review has made it harder for local authorities to plan for the long-term, delaying the investment boost that public health services desperately need.

The Health Foundation estimates that an extra £3.2bn of funding per year is needed to restore real-terms losses and re-allocate the public health grant. It argues that even this additional funding will not go far enough and "is far short of the update called for in the NHS Five Year Forward View". We call on the Government to commit to drastically uplift the Public Health grant taking into account such estimates. We call for the Public Health grant to be prioritised as a cost-effective, fundamental healthcare spend that includes responsibility for clinical services.



There is consensus that an increase in public health spending is necessary to support a sustainable health and social care system. A large portion of the medical profession has already recognised that without long-term investment in public health building upon the NHS funding settlement, the NHS risks failing to meet demand. In June this year, more than 80 health and local government organisations including FSRH, the Local Government Association (LGA), The Association of Directors of Public Health (ADPH), NHS Clinical Commissioners, NHS Providers, medical royal colleges and civil society organisations called on the Government to increase investment in public health to prevent ill health and reduce health inequalities.

It is crucial to note that the Government announced, in 2017, that it would start funding public health services through business rates retention, and a final decision on implementation has not yet been made as noted in the Prevention Green Paper. FSRH believes that relying solely on business rates to fund local authorities' public health activity will compound health inequalities in socio-economically deprived areas. The public health grant has expenditure conditionalities, one being local authorities' obligation to have regard to the need to reduce inequalities in their area. Funding public health services with business rates does not seem to support local authorities in exercising their duty to reduce inequalities, and it might negatively impact on the success of well-established public health strategies and the implementation of the NHS Long-Term Plan.

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