FSRH consultation response: Capturing Clinical Changes in the NHS by NHS England and Improvement

29 June 2020

We are pleased to respond to a survey by NHS England and NHS Improvement on new and innovative ways of working that have been developed across the NHS during the COVID-19 pandemic.

1) What beneficial innovations/changes have occurred in your specialty/discipline and within patient pathways?

Community Sexual and Reproductive Healthcare is a multi-disciplinary Specialty. The 15,000 members of the Faculty of Sexual and Reproductive Healthcare (FSRH) include Specialists, GPs, nurses and other healthcare professionals working in the community and primary care.

What prompted the following positive changes was the need to ensure access to essential women’s healthcare continued throughout the COVID-19 pandemic in a manner that was safe for both patients and healthcare professionals. An important enabler of these changes has been guidance issued by professional membership bodies such as FSRH, providing recommendations for healthcare professionals and decision makers on which services should be prioritised throughout the pandemic, and how these should be delivered. Guidance has supported commissioners across Public Health and the NHS to implement these changes more confidently. All FSRH COVID-related guidance can be found here: https://www.fsrh.org/fsrh-and-covid-19-resources-and-information-for-srh/

Remote consultations for SRH care

One of the most striking innovations that have taken place is the more widespread use of remote consultations for Sexual and Reproductive Healthcare (SRH). According to a COVID-19 survey of our members with 1,000 respondents, remote consultations have risen from 18% from pre-pandemic levels to 89% currently. Some of our members expressed they had tried to move to remote consultations for many years, and that now “suddenly the red tape has vanished” (https://www.fsrh.org/policy-and-media/members-survey/).

However, the decreased availability of face-to-face consultations is having detrimental impacts on the SRH care of vulnerable groups. Without face-to-face consultations, picking up on safeguarding issues, domestic abuse and teenage pregnancy is more difficult. The availability of different modalities of consultation – face-to-face, remote and online – is vital to provide comprehensive SRH care for all women and girls now and beyond the pandemic.

Prescriptions and medication collections systems

FSRH members noted the positives of medication collection systems in our COVID-19 survey. Some methods of contraception, such as pills and patches, became more frequently prescribed electronically by GPs for collection at the local pharmacy, avoiding an unnecessary visit to the GP practice. Many contraceptive services are posting prescriptions or medication to patients’ homes. Currently, when medically appropriate and in accordance with FSRH guidance (https://www.fsrh.org/documents/fsrh-guidance-contraceptive-provision-changes-
covid-lockdown), healthcare professionals are issuing longer prescriptions for oral contraception and prescribing extended use of Long Acting Reversible Contraception (LARCs, the most effective methods) beyond their current license.

**Postpartum contraception**

Some Trusts, such as Imperial College Healthcare NHS Trust, have started to operate postpartum contraception programmes in maternity services, with pregnant women being given contraceptive counselling at 28 weeks’ gestation and offered a choice of the progestogen-only pill (POP) or contraceptive implant. Additionally, highly effective intrauterine contraception can be inserted during planned caesarean sections, removing the need for future invasive procedures.

**Telemedicine for abortion care**

Temporary changes to legislation in the light of the pandemic mean that women can obtain an early medical abortion at home if a pregnancy is under 10 weeks’ gestation in England and Wales. Furthermore, most services have switched almost completely to the use of telemedicine (i.e. use of remote consultations and, where available, remote prescriptions) in order to preserve physical distancing measures. This means that the majority of patients are counselled at home, and then are either able to receive pills by post or make one visit to the clinic where a surgical abortion is required. Vulnerable patients are identified through referral criteria and are offered more extensive support as appropriate.

2) Describe the impact of these innovations/ changes (so far)?

**Remote consultations for SRH care**

Through our survey ([https://www.fsrh.org/policy-and-media/members-survey/](https://www.fsrh.org/policy-and-media/members-survey/)), our members have reported impacts such as reduced waiting times; being able to more effectively triage who really needs to be seen in person and whether that service is right for patients; being able to plan for complex patients before they physically attend; staff being able to work from home; and some patients feeling less self-conscious over the phone. Remote consultations for SRH have advantages for women in rural areas or those who struggle to travel to a central clinic due to childcare responsibilities, disability, or financial constraints. Remote consultations can also save time for healthcare providers.

**Prescriptions and medication collection systems**

In our survey, FSRH members noted changes to prescribing and medication collection systems have been particularly beneficial for repeat prescriptions. Furthermore, according to a recent survey by the Advisory Group on Contraception (AGC), women highlighted online consultations for prescription renewals as a positive development during the pandemic, avoiding an unnecessary trip to a GP practice or community service. Some women reported that prescriptions were issued to pharmacists more easily and quickly than usual.
Postpartum contraception

With GP practices and community clinics reducing or shutting down services due to COVID-19, it is more important than ever for the NHS to ensure consistent and effective provision of postpartum contraception. Maternity services are well-placed to provide effective contraception after birth, reducing the need for women to seek further care once they have left the maternity unit.

There is growing recognition in the UK that women’s needs for effective contraception in the period immediately after delivery may be underestimated. A 2018 study found that almost half of women surveyed would welcome provision of postnatal contraception, including Long Acting Reversible Contraception, on the postnatal ward, but they lacked the knowledge to make informed choices in this setting. It concluded there is a need for effective, tailored contraceptive choices discussions with every woman during pregnancy, as well as integrated planning for postnatal provision of the woman’s chosen method: https://srh.bmj.com/content/45/2/111

As such, for those women who want it, effective contraception should be started as soon as possible after childbirth as fertility returns rapidly. This allows individuals to plan any subsequent pregnancy and avoid short inter-pregnancy intervals, eliminating the risk of complications associated with an interpregnancy interval of less than 12 months. Guidelines by the National Institute for Health and Care Excellence (NICE) state that supporting women to make an informed choice about contraception after childbirth will reduce the risk of future unplanned pregnancies.

Telemedicine for abortion care

Recent changes to abortion legislation have had a particularly positive impact on access to safe abortion care. Remote consultations for abortion enable women to access care safely and in a timely manner, and to take abortion pills in their own home. Since lockdown, remote telemedical abortions now account for 78% of early medical abortions (EMAs) and around two thirds of total abortion procedures in England. The average waiting time for an abortion has decreased from 10 days in February to 4.46 days in June. The average gestation time at the time of the procedure has reduced from 8 weeks to 6.70 weeks. Though abortion at all stages is medically safe, abortion at a lower gestation is associated with a reduced risk of complications and better health outcomes. Additionally, NICE guidelines on abortion state there is strong evidence that substantial cost savings can be achieved if women present earlier for abortion. Most of this saving comes from women having a medical rather than a surgical abortion.

3) What is needed to sustain the change/innovation?

A number of actions are needed to sustain the positive changes outlined previously:

1) To ensure SRH services are properly restored and positive changes are captured, it is imperative services are adequately funded. Public health budgets have been cut by £700 million since 2015. Cuts have taken place in many areas with already existing poor health outcomes, whilst demand has been steadily rising. We believe that sustained cuts to the public health budget will prove a major challenge to the delivery of the NHS Long-Term Plan ambitions. The real-terms increase to the public health grant 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.

2) The lack of face-to-face consultations is having detrimental impacts on the SRH care of vulnerable groups. Without face-to-face consultations, picking up on safeguarding issues, domestic abuse and teenage pregnancy is more difficult. According to our COVID-19 members survey, just 31% of respondents were confident that vulnerable patients could access contraception and other SRH care during the pandemic. Therefore, the availability of different modalities of consultation - face-to-face, remote and online - is vital to provide comprehensive SRH care for all women and girls, and to deal with the increased demand for SRH care after services normalise. Remote and online services are a complement, not a substitute, to face-to-face consultations and, irrespective of consultation modality, best practice and guidelines must be observed to ensure safety and quality of care.

3) The development of a national digital service platform for SRH is required to sustain remote consultations for SRH services. This will serve as a one-stop point of access for the general public and will support the maintenance of access to essential care. This service should operate seamlessly with regional face-to-face services, providing effective triage and a streamlined care pathway for those patients referred for face-to-face treatment.

4) To ease pressure on services, we endorse work being undertaken by the Medicines and Healthcare Products Regulatory Agency (MHRA) to reclassify the progestogen-only pill (POP) from ‘prescription-only’ to ‘pharmacy product’, thereby making it easily accessible in pharmacies, while reducing unnecessary pressures on GPs. POP is a reliable bridging method if it is not possible for women to access their preferred method while the requirement for social distancing remains, making reclassification of POP even more urgent.

5) The temporary changes to abortion legislation have had a positive impact on timely access to early medical abortion care. We have welcomed such measures, and now urge the Department of Health and Social Care (DHSC) to allow home use of mifepristone and telemedicine for early medical abortion permanently, ensuring women have easy and timely access to this essential healthcare service.

4) What, if anything, hasn't worked so well?

Access to Long Acting Reversible Contraception (LARC)

Services for Long Acting Reversible Contraception (LARC), the most effective methods of contraception (coils, implants and injections), have been most detrimentally impacted by the pandemic. This is particularly worrying as LARC provision has declined in many areas of the country in recent years. The closure of specialist centres has put pressure on GPs to provide LARC services. However, a combination of system fracture, reduced funding, and a lack of financial incentives for GPs to provide LARC has also led to a reduction in the availability of LARCs in general practice. As a result, women reported waiting up to four months for LARC fittings prior to the pandemic. According our survey, 70% of GPs and 46% of specialists have limited or ended the provision of emergency IUDs since the COVID-19 outbreak. To ensure that LARC services resume and can improve after the pandemic, we recommend the inclusion of a LARC indicator within the Primary Care Quality Outcomes Framework (QOF). This would act as a significant step in counteracting the challenges threatening the training of primary care clinicians to deliver LARC.
Vulnerable populations

Furthermore, vulnerable populations are particularly at risk during the COVID-19 pandemic. According to our COVID-19 members survey, just 31% of respondents were confident that vulnerable patients could access contraception and other SRH care during the pandemic. Of the 21% of respondents who provided outreach services for vulnerable groups prior to the COVID-19 outbreak, 37.5% were no longer providing these services. Several respondents were no longer providing routine LARC to vulnerable populations, while others stated that their satellite sites had closed, or that they could not reach vulnerable patients. Respondents noted that there is a walk-in culture in many disadvantaged areas, and that a shift towards remote consultations could create barriers to access for vulnerable groups. To ensure that vulnerable women and girls can access contraception, it is imperative that SRH services are adequately funded, and that dedicated services are available to these individuals.

SRH commissioning

Finally, we believe the post-pandemic landscape offers significant opportunities to tackle the commissioning challenge once the health and social care system is stabilised. The pandemic has exposed further the inherent faults in the SRH commissioning system. Fragmented SRH commissioning has hindered the delivery of effective person-centred care post Health and Social Care Act 2012, whereby delivery of services is fractured 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 women when trying to access healthcare, as well as around who holds accountability for SRH services across the healthcare system. 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 fragmentation of services (https://www.fsrh.org/documents/fsrh-rcog-rcgp-position-holistic-integrated-srh-commissioning/). To enable positive change to last, we will need to go further than restoration, effectively rehabilitating the fractured commissioning of SRH services.

For example, maternity services are often not commissioned to provide contraception. In many cases the individual action of leads from across the NHS, CCGs and local authorities has made this concept work on local basis, e.g. Gloucestershire Hospitals NHS Foundation Trust. These examples demonstrate the way in which commissioning can overcome this barrier to patient-centred care.

If SRH were more broadly integrated into women’s healthcare pathways, healthcare providers would not need to circumnavigate commissioning structures in order to provide holistic care. We therefore call on NHSE to have regard for FSRH guidance on the provision of contraception by maternity services after childbirth during the Covid-19 pandemic and to introduce contraceptive care in maternity services consistently across the UK. We also urge NHSE to work together with the Department of Health and Social Care, local authorities and other commissioners to broadly integrate SRH into women’s healthcare pathways in the NHS going forward.