FSRH Response to: Department of Health Consultation on Local Authority Public Health Allocations 2015/16: In-year Savings

The Faculty of Sexual and Reproductive Healthcare (FSRH) is a membership body of over 15,000 doctors and nurses delivering sexual and reproductive health (SRH) across the UK in both General Practice and Specialist Contraceptive Services. The FSRH is a charity whose aims include producing and promoting high standards in SRH, providing national qualifications in SRH and providing learning opportunities for its membership – ultimately to improve care to women and men using SRH services wherever they are provided. The majority of FSRH members are GPs – reflecting the bulk of SRH service provision in the UK.

The FSRH welcomes this consultation on Local Authority health allocations for in-year savings in 2015/16. We, however, would like to express our grave concerns regarding the impact of such cuts on sexual and reproductive health if the Government’s plans go ahead. We also acknowledge and support the response from BASHH with regards to this consultation.

The Faculty acknowledges the wider picture of public health this consultation seeks to examine, however in its capacity as specialist SRH organisation, the FSRH’s following response will consider the proposed savings in so far as they may impact on SRH services in England.

Summary of Main Concerns

1. The FSRH questions the financial efficiency of the projected savings. Contraceptive care is an extremely efficient investment, saving £11 in averted healthcare costs with every £1 spent on SRH services\(^1\). The Advisory Group on Contraception (AGC)\(^2\) have used this formula and calculated that if these savings are implements, this could result in additional costs to the NHS of up to £250million.\(^3\) The costs to local authorities of reduced access to contraceptive care are also likely to be significant. The FSRH remains


\(^2\) The AGC is an expert advisory group of leading clinicians and advocacy groups who have come together to discuss and make policy recommendations concerning the contraceptive needs of women of all ages. The AGC was formed in November 2010 with a focus on ensuring that the contraceptive needs of all women in England, whatever their age, are met.

\(^3\) See Annex 1
unconvinced that cuts to SRH represent a true saving, the forecasted costs suggest that they, in fact, represent a false economy.

2. The FSRH is gravely concerned that further SRH funding cuts will lead to an increase in the amount of patients seeking sexual and reproductive healthcare who are managed in a GP setting or referred to the acute sector. This will inevitably increase GP workloads, spread acute sector staff more thinly and increase patient waiting times in NHS services.

As evidenced in our reaction to Question 2, these added pressures to Primary Care leave room to question how the Government will manage the negative impact of SRH funding cuts and save the required £22 billion by 2020/21 as set out in the NHS Five Year Forward View.

3. As evidenced in the joint FSRH and British Association for Sexual Health and HIV (BASHH) Rolling Survey of Lead Clinicians and a dedicated FSRH member survey with specific regard to this Consultation, there is already significant evidence of existing disruption caused to SRH services by previously implemented cuts. The disruption is concentrated in three areas:

- Service provision
- Patient waiting times and experience
- Patient access to services

Further funding cuts will only serve to worsen the disruption caused to the aforementioned areas and further restrict access to contraceptive care in England.

4. The FSRH firmly believes that the planned £200million public health cuts are likely to have significant ethical and equality ramifications. Despite the Department of Health clearly stating that LAs should look to implement savings in a manner that does not negatively impact on protected characteristic groups, SRH funding cuts and by extension service restrictions undoubtedly restrict access to contraceptive care for at least two of these protected characteristics: age and sex. This severely compromises the ethos of ‘open access’ that is, for many, the foundation of effective SRH and directly contravenes the Equality Act (2010).

1. How should DH spread the £200 million saving across the LAs involved?

The Faculty believes that none of the options presented adequately tackle our principal concern that there should be no reduction in access to contraception for women. For the FSRH it is not a question of how to implement further savings in the public health sector, but rather a question of fully assessing the ramifications and impact these savings will have on sexual and reproductive health.

Evidence suggests that in some areas SRH budgets have already been reduced by up to 50% in the past 2 years, with Tower Hamlets reporting a 20% service funding cut and an expected cut of 50% in 2015.

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4 The joint FSRH and BASHH Rolling Survey (April 2015) collected responses from 270 FRSH and BASHH members in order to build a wider, more qualitative view of SRH delivery trends from a national perspective.

5 Upon the publication of this Consultation, the FSRH launched a dedicated survey of members in relation to the three principal questions the DH set out. We received a broad range of perspectives that shed much light on the potential impact of savings in both the local and national context.

FSRH and BASHH Joint Lead Clinician Rolling Survey (April 2015)
Ealing. We believe that a further £200 million in proposed cuts will only serve to exaggerate the pace and scale of such cuts to SRH service delivery in England and put increasing pressure on NHS Services as a result.

Recent funding restrictions have resulted in a reduction in staffing and the discontinuation of certain contraceptive procedures in SRH services. Without the “full quota” of contraceptive services and clinicians trained to carry out these procedures, patient access to preferred services is becoming more and more limited, going against Government policy.

These limitations in access are by no means uncommon. Our Rolling Survey of Lead Clinicians indicates a rise in the number of patients who, despite attempting to make use of existing SRH services, are increasingly being managed in a GP setting or referred to the acute sector- neither of which are the preferred service providers for the patients in question. Consequently, the FSRH is particularly concerned that further cuts to SRH services will further restrict patient access to SRH-based provision, resulting in an increase in GP workloads, patient waiting times and pressure on NHS services.

“Patients are being advised we are unsure what service may be available to them in future months. I consider the uncertainties have made staff less settled and unsure so have tended to refer patients back to general practice when previously they have dealt with their needs.”

(FSRH member, South West England)

The Government’s NHS Five Year Forward View seeks to achieve efficiency savings of £22 billion by 2020/21 and envisages an improvement in the quality and responsiveness of care that patients receive. The review explicitly states that the Government aims for all patients to receive:

“…the right care, at the right time, in the right setting, from the right caregiver.”

This however begs the question as to how these objectives are going to be achieved if the projected cuts to SRH services further restrict patient access to SRH services and, as such for many, the preferred service providers. As evidenced above, ultimately, the implementation of more cuts will result in the NHS stretching their staffing capacity, whilst incurring unanticipated costs and increasing patient waiting times to compensate for service restrictions. In this sense, the vision set out for the NHS in the Conservative Manifesto of improved frontline services and frontline staffing is severely compromised. These savings, in fact, become a contradiction in terms. Any savings made in public health cuts are returned in the consequent NHS costs incurred.

Setting the health and social consequences of unintended pregnancy aside, financially speaking, the efficiency of contraceptive care as a health spend speaks for itself. The Department of Health has

7 “We are proposing to commission from 2016 a new model of community contraception and sexual health services releasing anticipated savings of £0.534m over 3 years. The annual budget is £1.068m in 2014/15.” http://www.ealing.gov.uk/download/downloads/id/9275/changes_to_ealings_public_health_services-consultation_document p.3
8 FSRH and BASHH Joint Lead Clinician Rolling Survey( April 2015)
stated that every £1 invested in contraception saves £11 in averted outcomes. The Advisory Group on Contraception (AGC) has calculated that should the proposed savings be implemented equally across public health, the NHS will face additional costs of up to £250 million. In simple terms, these savings amount to a false economy. Therefore, the FSRH question the efficacy of the proposed savings and the extent to which the Government can legitimately categorise these savings as an example of a ‘drive [in] efficiency and productive investment.’

2. **How can DH, PHE and NHS England help LAs implement saving and minimise possible disruption to services?**

In light of our views in response to Question 1, the FSRH encourages system stewards such as the DH, PHE, and NHS England to implement measures that do not reduce women’s access to all contraception, including long-acting reversible measures (LARCs). We fully support recommendations made about the accountability of system stewards in the All-Party Parliamentary Group on Sexual and Reproductive Health’s *Breaking down the Barriers* (July 2015) report and would like to support the APPG’s recommendation that the Department of Health should require that Directors of Public Health scrutinise the quality of local service provision against the ambitions outlined in the DH’s *Framework for Sexual Health Improvement in England*, in this specific context in relation to the impact of funding cuts on SRH services.

Moreover, given the marked negative impact existing cuts are already having on SRH services, as set out throughout this response, in England, we believe that all system stewards have a duty to prevent rather than facilitate further cuts to contraceptive care. Following our dedicated Consultation and Rolling Survey distributed to our clinical leads, the FSRH has concluded that funding restrictions are already causing significant disruption in three main areas:

- **Service provision**
- **Patient waiting times and experience**
- **Patient access to preferred services**

The following examples are indicative of the breadth of responses the FSRH has received.

**Service Provision**

A respondent based in South West England spoke of how funding cuts have resulted in her clinic discontinuing their level 2 and 3 sexual and reproductive health/genitourinary service, and replacing this with asymptomatic STI screening only. She states that without further funding this clinic will close in 2015.

Likewise, a clinician based in the London in an integrated SRH/contraception service, highlighted that overall attendance to the service has dropped by nearly 10,000 between 2012/13 and 2014/15. This fall is attributed to staff shortages due to funding cuts resulting in overcrowding and patients being turned away from centres. In the same vein, a London -based clinician has reported that access to

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11 *NHS Five Year Forward Review* (October 2014) p.35
services is becoming increasingly restricted, with clinics being forced to close early when maximum capacity is reached.

Respondents to our Rolling Survey in the West Country area also raised the issues that key service elements were no longer being funded:

“We are no longer funded for cervical cytology [as part of the NHS Cervical Screening Programme]...this is a backwards step as we are ideally placed for opportunistic screening where a woman [is due a smear but] has slipped through the net.”

(FSRH member, West Country)\(^{13}\)

**Waiting Times and Experience**

Various respondents drew attention to the increases in waiting times for patients, both in terms of accessing appointments and receiving test results, again, largely due to reductions in staffing capacity.

“…our appointment line is overly busy and many wait a long time to get through.”

(FSRH member, Midlands)\(^{14}\)

Similarly, a South West-based respondent cited a 2-3 month wait for Long Acting Reversible Contraception (LARC) fittings and raised concerns that in the likely event of the clinic’s closure in 2015, and that some provision will have to be referred to the acute sector leading to a significantly greater cost to the NHS CCG commissioners. As discussed above, this will likely lead to further increases in patient waiting times and ultimately, the FSRH believes, an increase in costs to the NHS and women themselves.

**Patient Access**

Many of our respondents stated that patients were finding it increasingly difficult to access some providers. This appears to be directly related to an increase in waiting times, a general lack of capacity and reductions in staffing.

For example, a member based in London stated that the percent of centre attendees living outside of the locality rose from 24% in 2013/12 to 27.5% in the 2014/15. This figure is assumed to reflect a lack of capacity elsewhere and an overspill of patients into the centres of neighbouring localities.

In addition, in South West England a member reported a “huge loss” of experienced staff following a recent tendering process. These were replaced by staff with little or no SRH experience, directly impacting on the availability of certain contraceptive services.

With these figures in mind, the FSRH is gravely concerned that the implementation of further cuts will only add to existing Specialist Contraceptive Service disruption and GP workloads, hampering of the quality of contraceptive care available and women’s ability to access it.

\(^{13}\) FSRH and BASHH Joint Lead Clinician Rolling Survey (April 2015)

\(^{14}\) Ibid.
3. How best can DH assess and understand the impact of the saving?

In the context of financial savings in public health, the most pertinent way to assess the impact of the proposed cuts is, as previously touched upon, in terms of financial efficiency. That being said, we should not overlook the very real health and social consequences of these public health savings, not least pertaining to increases in unintended pregnancy. On top of the projected costs we have already cited, *Unprotected Nation*\(^{15}\), an examination of the financial and economic impacts of restricted SRH Services, predicts that if there is worsened access to SRH services, the additional cost of unintended pregnancies and STIs to the NHS could reach up to £10 billion. Whereas NICE calculated that if the Government invested to fully implement their guidance on long-acting methods of reversible contraception (LARCs) the NHS would save up to £102 million per year. \(^{16}\) In addition, the Government would have to provide welfare services to provide support for a proportion of children from unintended pregnancies, which could account for up to 15% of the UK’s welfare spending, a cost of an extra £7.2 billion in extra social welfare. \(^{17}\) In this sense, cuts to SRH funding represent a financial double edged sword; the term ‘saving’ becomes a discursive veneer that overlooks the multifaceted, adverse financial impact of worsened access to SRH services.

**Impact on Equalities**

The FSRH notes that in this consultation the Department of Health takes care to highlight that under the Equality Act (2010) \(^{18}\) it is the duty of all Local Authorities to implement savings in a manner that does not negatively impact on protected characteristic groups (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation, sex). However, upon closer inspection it becomes apparent to the FSRH that funding cuts risk restricting access to contraceptive care for several of the aforementioned group, specifically women.

We would like to draw particular attention to the case of Tower Hamlets, which has already experienced a 20% funding cut. Given the locality’s large Muslim population, this raises concerns that cuts to SRH funding will further restrict access to SRH, as contraceptive care is already a taboo subject in the certain communities. If additional cuts are implemented, this will only serve to compound the attitudinal factors that restrict access to SRH services in these communities with further limitations to access and provision of contraception including LARC, especially if constituents are no longer able to discretely access in-area services.

According to the World Health Organization (WHO), a woman’s reproductive age spans between 15-44 years of age. However, we are already witnessing examples of ageist SRH services that are skewed in favour of younger people and undermining open access provision. The campaign group the Women of Walthamstow have been campaigning for significant improvements to Contraceptive Services in the E17 London postcode in this particular respect – over 25s were only able to be

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prescribed the contraceptive pill as opposed to any LARC methods. Moreover, it is reported that unintended pregnancies amongst older people are on the rise and further cuts to funding of contraception will only serve to widen the gulf between service provision and the needs of women of all ages for effective contraception.

In the NHS Achieving Age Equality in Health and Social Care practice guide it is stipulated that “good” age-equal practice in SRH can be achieved through age-specific outreach work, publicity and the deployment of age-specific services with older workers. With cuts in funding reducing service provision and staff numbers it is easy to see how these initiatives may be considered financially unjustifiable and disproportionate in relation to the demand for SRH services amongst younger age groups. This is extremely pertinent given the importance attributed to young people by indicators in sexual and reproductive health in Public Health England’s Outcomes Framework. Yet, noticeably, the Public Health England’s Outcomes Framework completely lacks specific indicators for the over25s in relations to SRH and contraceptive care.

Likewise, SRH/contraception funding cuts can be seen as disproportionately affecting 50% of the UK population based on their sex: women. The restrictions in contraceptive care caused by funding cuts could equate to the indirect discrimination of women and their right to contraceptive choice.

Figures suggest that unintended pregnancy has a negative effect on the earnings potential, future employment prospects and consequently, social mobility of the mother. Thus, in broader terms, cuts to SRH/contraception funding negatively impacts both the health and social outcomes of women, indirectly discriminating against women.

**Conclusion**

The FSRH strongly believes that the implementation of further savings to SRH/contraception equates to a financial contradiction in terms; a false economy. Based on the evidence collated from the impact of existing cuts to SRH, further savings will negatively impact on SRH service provision, Primary Care, secondary care and perhaps most importantly, impede the nation’s overall access to contraceptive care. Given the long-lasting individual and societal implications of unintended pregnancy, the FSRH advocates a thorough assessment into the negative potentiality of further cuts to SRH and contraceptive care and urges the Government to reconsider the wider reaching impact of its public health saving allocations for the coming year.

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19 Access the Women of Walthamstow blog here: [https://wowstow.wordpress.com](https://wowstow.wordpress.com)
21 Young women who become mothers in their teens are:

- More likely to have no qualifications by age 33.
- More likely to be in receipt of non-universal state benefits at age 33.
- Likely to be on substantially lower incomes in their 30s than any other group, with nearly half in the bottom fifth of the income distribution.
- If working, more likely by mid 20s to be in semi-skilled or unskilled manual occupations.
- Less likely to be home owners by the age of 33.
- More likely to have divorced or separated by the age of 33.
- More likely to have large families by the age of 33 (20 per cent had four or more children by the age of 33).

Annex 1: Briefing sent to Chancellor of the Exchequer in June 2015

Briefing to support AGC’s calculations on the financial impact on the NHS of £200m cuts to public health budgets

Background

On 4 June 2015 the Chancellor, George Osborne, announced a £200m cut in public health budgets devoted to local authorities. It is unclear how these cuts will be divided, but it is likely that contraceptive services will be affected. The Advisory Group on Contraception (AGC) has raised concerns that cuts to contraceptive care and services will lead to an estimated increased cost of £250m to the NHS.

This briefing provides the background to the calculations used to reach the £250m.

**Step 1: contraceptive care expenditure as a proportion of the total public health budget**

The total public health spend for 2014/5 is £2,649,869,000 (the most recent figures available). The total spend on contraceptive care for 2014/5 is £287,881,000.

This is made up of:
- Contraception (prescribed functions) = £184,105,000
- Advice, prevention and promotion (non-prescribed functions) = £103,776,000

Therefore contraceptive care is approximately 10% of the total public health spend.

**Step 2: the impact of £200m cuts to contraceptive care if applied evenly across public health expenditure**

The revised total public health spend following the £200,000,000 reduction announced on 4 June is £2,649,869,000.

Making the assumption that public health spending cuts are distributed evenly across all public health budgets, the revised spend on contraceptive care will be 10% of this new total figure. This equals £264,986,900.

By subtracting the new contraceptive spend figure from the original contraceptive spend figure, we can establish how much would be cut from local authorities’ existing contraceptive care budgets.

Current spend (£287,881,000) – 10% of reduced public health spending (£264,986,900) = £22,894,100.

That equates to an in-year reduction of 8% of current spend.

The meetings of the AGC are funded by Bayer. The secretariat for the AGC is provided by Incisive Health, whose services are also paid for by Bayer. Members of the AGC receive no payment from Bayer for attending meetings, except to cover appropriate travel costs.
Step 3: using Department of Health estimate savings from contraceptive care to establish total lost savings to NHS

The Department of Health’s Framework for Sexual Health Improvement states that for every £1 spent on contraception, £11 in costs is averted¹.

Multiplying £22,894,100 by the £11 saving per £1 spent could therefore result in an overall cost to the NHS of £251,835,100.

Summary

It is therefore possible to conclude that the projected cuts could – perversely – result in additional costs of £250m, the majority of which will occur in this financial year.

Cutting contraception services is the definition of a false economy. Reductions in public health expenditure will be returned many times in NHS costs.

This is on top of the health, social and consequences of unintended pregnancy for women and their families.

For more information about these calculations or the work of the AGC more generally, please contact the AGC secretariat via agc@incisivehealth.com.

¹ HM Treasury, Chancellor announces £4.5 billion of measures to bring down debt, 4 June 2015. Available at: https://www.gov.uk/government/news/chancellor-announces-45-billion-of-measures-to-bring-down-debt

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