FSRH Response to Health Select Committee Inquiry into Primary Care

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 FSRH comprises of approximately 10,000 GP members – reflecting the bulk of SRH service provision in the UK.

In its capacity as a specialist SRH organisation, the FSRH welcome the opportunity to outline to the Health Select Committee the challenges that are facing the delivery of contraceptive care in the primary care setting, both in the strict sense of General Practice clinics and the ways in which restrictions on Specialist Contraceptive Services are negatively impacting upon GP workload.

Evidence suggests that, in the current climate of financial savings and budget cuts, SRH budgets have already been reduced by up to 50% in the past two years, with Tower Hamlets reporting a 20% funding cut¹ and an expected cut of 50% in Ealing.² This increasingly restrictive framework for Local Authorities is heavily impacting upon primary care, which already provides 75-80% of the nation’s contraceptive provision and is the most frequently chosen first point of contact for people with SRH concerns.

With this in mind, the FSRH believes that the Health Select Committee should thoroughly assess the negative potentiality that the Government’s projected £200m in public health savings could possess in relation to SRH and contraceptive primary care. Our findings ultimately suggest that these funding cuts are a false economy, only serving to exacerbate the existing challenges that primary care faces with the need to provide more appointments for Long Term Condition Management and the demand to reduce the demands on out-of-hours and emergency care.

¹ FSRH and BASHH Joint Lead Clinician Rolling Survey (April 2015)
² “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.”
Executive Summary

- Funding cuts to Local Authority SRH and contraceptive care provision is resulting in an increase in referrals to primary care, increasing GP workloads, waiting times and pressure on NHS services.
- There is an under-prioritisation of SRH in primary care. GPs lack incentives to focus their clinics and training on SRH, reducing the quality of contraceptive care available in GP settings.
- Funding for LARC fitting in primary care beyond 2015 is uncertain, and insufficient service payments are resulting in a loss of LARC trained clinicians, reducing access.
- The projected £200 million in Public Health cuts is a false economy that will perversely incur more costs to primary care and NHS services.
- Commissioning and the loss of SRH services is resulting in increased referrals to primary care and the acute sector where treatments are more costly due to a lack of appropriate facilities and practitioners.
- Increased referrals to primary care are negatively impacting upon the patient experience and may result in patients abandoning these pathways to contraceptive care. This could result in unintended pregnancies and an increased demand for termination services stretching the budgets of CCGs.
- The SRH skill mix in the primary care workforce is stagnating due to under-prioritisation in favour of Long Term Condition Management and a reluctance to invest in uncertain training outcomes.
1. **Quality and Standards of Care**

1.1 Drawing upon data collected in the Joint FSRH and British Association of Sexual Health and HIV (BASHH) Rolling Survey,³ the FSRH is concerned that the quality of contraceptive care is suffering and having a negative knock on effect on primary care.

“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)⁴

1.2 Members highlighted that key elements of contraceptive care are no longer being funded, which is consequently restricting patient choice and access to the “full choice” of contraceptive care and driving them to seek contraceptive methods in a GP setting.

1.3 A survey 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. She states that without further funding this clinic will close and in turn patients will be forced to consult their general practice for access to these contraceptive methods. Thus, restrictions in Local Authority SRH provision will directly result in an increase in GP workloads, waiting times and pressure on NHS services.

Prioritisation

1.4 In response to this consultation, Dr Anne Connolly, Chair of the Primary Care Women’s Health Forum (PCWHF), comments that there is an under prioritisation of SRH in primary care, with nurse training focusing on Long Term Condition Management rather than contraceptive care. This disproportionate emphasis on Long Term Condition Management risks reducing the quality of contraceptive care available, hindering the planning of families and creating missed opportunities to improve the health and social outcomes of both mother and child.

1.5 Likewise, she notes the under-prioritisation of SRH and contraceptive care on the GP Quality Outcomes Framework, with only 7 points out of in excess of 500 being dedicated to SRH and contraceptive care. In this sense, it is easy to see how GPs lack incentives to focus their clinics on SRH and contraceptive care. Ultimately, this lack of impetus reduces the quality and variety of SRH care available in GP settings and results in missed opportunities to improve maternal and pregnancy outcomes through family planning. For example, better prioritisation of contraceptive care in the primary care setting would allow for the full optimisation of the health of the mother, which can improve both medical and social outcomes, saving on future health and social spends.

1.6 The FSRH is particularly concerned by this under-prioritisation as it appears to overlook the importance attributed to preventative health care in the *NHS Five Year Forward View*:

“The future health of millions of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.”

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³ The FSRH and BASHH Joint Lead Clinician Rolling Survey (April 2015) collected responses from 270 FSRH and BASHH members in order to build a wider, more qualitative view of SRH delivery across England

⁴ FSRH and BASHH Joint Lead Clinician Rolling Survey (April 2015)
2. Demand and Access

LARC Service Provision
2.1 Due to uncertainty about Local Authority enhanced service payments, GPs are unable to plan for LARC service provision, which results in a loss of clinicians trained in LARC fitting and therefore restrictions in LARC accessibility for patients in primary care. In a recent survey conducted by the Primary Care Women’s Health Forum (PCWHF) (October 2014) 25% of clinicians surveyed reported that there had been a significant reduction in local arrangements to implement such LARC training and over 80% were unclear about LARC funding beyond 2015. With this in mind, 25% of respondents stated that local training arrangements for LARC had been significantly reduced and 80% said there were no plans to improve existing training arrangements. 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 access the contraceptive pill as opposed to any LARC methods in their general practices. The FSRH has also learnt that some enhanced payments to GP are not sufficient enough to fund the equipment and clinician time required to prioritise the work of LARC. In this sense, LARC service provision is being funded, but not to the extent where it can be effectively actioned within the primary care setting.

3. Funding
3.1 In terms of funding, as well as insufficient service payments in primary care, responses from our FSRH/BASHH Joint Rolling Survey broadly indicate that the financial situation is becoming more challenging for SRH and contraceptive services. If the proposed £200m savings are implemented by the Department of Health this is only set to worsen and, perversely, return costs, rather than savings, to NHS services and primary care.

3.2 Setting the health and social consequences of unintended pregnancy aside, financially speaking, the efficiency of contraceptive care as a health spend speaks for itself: every £1 invested in contraception saves £11 in averted outcomes. The Advisory Group on Contraception (AGC) has used this formula to calculate that, should the proposed savings be implemented equally across public health, the NHS will face additional costs of up to £250 million if they cut funding to SRH and contraceptive care. In simple terms, the Department of Health’s proposed funding cuts with specific regard to SRH and contraceptive care amount to a false economy. Therefore, the FSRH urge the Health Select Committee to 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’ for primary care.

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5 Primary Care Women’s Health Forum (October 2014) *PCWHF Survey on Primary Care LARC Service* Available at: [http://www.pcwhf.co.uk/images/LARC_Survey.pdf](http://www.pcwhf.co.uk/images/LARC_Survey.pdf)
6 Ibid.
7 Access the Women of Walthamstow blog here: [https://wowstow.wordpress.com](https://wowstow.wordpress.com)
9 *NHS Five Year Forward Review* (October 2014) p.35
4. Commissioning

4.1 In Public Health England’s *Making it Work: A guide to whole service commissioning for sexual health, reproductive health and HIV*, it is stated that commissioning ‘…should allow integration [of services] to flourish around the specific needs of communities.’\(^{10}\) However, this appears to be a rather utopic vision of a commissioning process that is undermined by its day-to-day reality.

4.2 Chris Wilkinson, FSRH President, said that there is an “…urgent need to acknowledge that splitting the commissioning of SRH care across local authorities and different NHS commissioning bodies has led to some consequences (including the threat of funding cuts that the NHS has been protected from as a whole) that do not bode well for comprehensive accessible SRH care.”\(^{11}\)

4.3 This example is verified through the example of a clinician in the South East, who reported that, when the local council lost its service contract to a private company last year, to reduce costs the company restricted service provision, only providing Level 1 and basic Level 2 SRH. This has meant that the more complex SRH cases have to be referred to the acute sector or GP clinics (e.g. missing contraceptive coils for removal). Not only is this adding to GP workload and NHS costs under the guise of cheap service provision, but it is compromising standards of care as without the appropriate facilities and practitioners, GPs increasingly have to refer patients to more costly acute gynaecology units. The lack of expertise in these units involves more costly intervention and risks associated with the requirement for general anaesthesia and in-patient treatments.

Impact on Terminations and Budget of CCGs

4.4 The increasing number of patients referred to primary care due to uncertainty in SRH service provision adds a significant amount of psychological distress to the service user who, upon not being able to access their preferred pathway to contraceptive care, may have to spend extra money, travel further and wait longer than originally anticipated to access contraceptive care in a GP setting. Consequently, this distress has the potential to dissuade some service users from pursuing contraceptive care all together, leading to an increase in unintended pregnancies and in turn, an increased demand for terminations. This increased demand for terminations will therefore impact on CCG budgets as to cater for increased demand they will have to commission extra termination of pregnancy services.

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\(^{11}\) FSRH Press Release (July 2015) FSRH Comment on: APPG REPORT: Breaking down the barriers - The need for accountability and integration in sexual health, reproductive health and HIV services in England
5. Workforce: Current and Future Challenges

5.1 The FSRH has concerns over the current and future skill mix of the SRH and contraceptive care workforce in primary care.

Training

5.2 As Dr Anne Connolly underscored above, nurse training is becoming increasingly centred around Long Term Condition Management and is creating a shortfall in primary care of trained SRH and contraceptive care practitioners. This is negatively impacting on the quality of and access to certain contraceptive methods in a general practice setting, whilst increasing the risks of women being provided with methods of contraception that may not be appropriate to the individual and ultimately cause further health problems.  

5.3 As previously illustrated, uncertainty over enhanced service payments is resulting in a lack of commitment from general practices to train clinicians to fit LARC. In simple terms, practices do not want to risk investing in uncertain outcomes. For example, a participant in our Rolling Survey noted a loss of LARC trained clinicians in their locality following a recent commissioning process. The commissioner in question does not intend to provide the remaining clinicians with further training to replenish the skillset of the local primary care workforce, in turn restricting patient access to such contraceptive methods in primary care.

5.4 With such fissures in the skill mix of the primary care workforce, the FSRH supports the All-Party Parliamentary Group on Sexual and Reproductive Health’s assertion (July 2015) that there is a clear need to better assess the training needs of the current workforce in order to ensure efficient SRH and contraceptive care provision, both in the short term and long term. At present, in specific regard to assessing the capacity and competencies of the primary care workforce, the FSRH have established that the figure of GPs or nurses in primary care that are trained to deliver LARC methods is unknown, and consequently, so are the figures of LARC methods available to service users. In addition, the Advisory Group on Contraception (AGC) found that 64% of the total councils that the group surveyed had not undertaken any assessment as to the local need for additional contraceptive training in order to provide certain contraceptive methods in public health or primary care. Therefore, the Faculty endorse the APPG’s recommendation for the establishment of a more national direction in terms of the SRH and contraceptive care training. Non-specialists with adequate SRH education and training offer whole system benefits, therefore, the monitoring of SRH provision, particularly in general practice, is greatly needed to account for and improve standards of SRH and contraceptive care.

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12 Paula Elizabeth Briggs (January 2013) Impact of UK Medical Eligibility Criteria implementation on prescribing of combined hormonal contraceptives Available at: http://jfprhc.bmj.com/content/early/2013/01/07/jfprhc-2012-100376.full
6. **Patient Experience**

6.1 Ultimately, barriers and reduced access to contraception in the primary care setting will further compromise those who already have an increased risk of unplanned and unintended pregnancy. The challenges to those who currently do not have the funding to travel to access SRH services, or who are culturally restricted to attend such services, will be compounded. This leaves room to question the ethical and equality implications of the aforementioned restrictions to SRH and its under-prioritisation in primary care.

7. **Conclusion**

7.1 As evidenced in the above submission, the FSRH is concerned that existing cuts to funding are negatively impacting on the quality of SRH and contraceptive care that is available to patients, consequently restricting patient access and choice in this area of care. Our data suggests that this is having a marked, knock on effect on GP clinics and acute sector referrals, adding further strain to NHS services and staffing capacity at a time where the NHS Five Year Forward View has itself set aims to achieve efficiency savings of £22 billion by 2020/2021.\(^{15}\) In this context, the FSRH believes that the Health Select Committee should thoroughly assess the negative potentiality that the projected £200m in public health savings could possess in relation to SRH and contraceptive primary care. Evidence suggests that these funding cuts are a false economy that will only serve to exacerbate the existing challenges that SRH and contraceptive care are facing, particularly in the GP setting.

7.2 In terms of commissioning, feedback from our members has underscored that the uncertainty involved in these processes is leading to fraught relationships both horizontally, between competing service providers themselves, and vertically, between service providers and service users. These uncertainties are leading to an increasing reliance on GP clinics that do not possess adequately trained staff to cope with demand. In turn, our concerns as to the current and future professional development of the primary care workforce in SRH and contraceptive care leads the Faculty to advocate an in-depth reassessment of the training needs of the entire primary care workforce. High levels of non-specialist training will ensure better coordination between multidisciplinary teams and providers, creating seamless SRH pathways and improving health outcomes for the commissioning process as a whole.

7.3 Fundamentally, providing high quality, accessible SRH and contraceptive provision through primary care offers women the opportunity to plan their families and optimise their future health and social, improving overall patient experience in both the short and long term.

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