

Holistic Integrated Commissioning of Sexual & Reproductive Healthcare

AoMRC, RCOG, FSRH, RCGP, RCM, RCN, RCPATH, RCPCH and FPH Position

With the restructuring of Public Health England (PHE), vital areas such as prevention and health improvement risk being lost without ownership and accountability across the system.

The Secretary of State for Health and Social Care has stated that the role of the NHS has to change from a focus on disease to one of prevention, and that health improvement remains a Government priority.

We, therefore, reiterate our previous call for Sexual and Reproductive Healthcare (SRH) to be integrated with the wider NHS. We believe the reorganisation of the public health system poses a good opportunity to tackle the commissioning challenge in Sexual and Reproductive Healthcare.

Key messages

- **We are calling for integrated holistic commissioning of SRH, with one body maintaining oversight and holding accountability for all commissioning decisions.** Notably, SRH services are quite unique in that, unlike other public health services, they are clinical services just like other NHS services, and therefore warrant further consideration as to whether the NHS is best placed to have this responsibility.
- **We strongly recommend that any review of SRH commissioning responsibility should focus on women's health.** Women's health has stood to suffer the most from the reorganisation of NHS services that ensued with the implementation of the Health & Social Care Act in 2013. Where once women could have all their reproductive health needs met in one place and one go, women are now subjected to disjointed, non-holistic, disintegrated care.
- **We believe there is a need for SRH care to be more broadly integrated into women's healthcare pathways in the NHS.** Holistic integrated SRH care means integrating care around the needs of the individual, not institutional silos, with people able to get integrated/holistic advice and support across the breadth of SRH including contraception.

Consensus for this position

There is consensus that the SRH commissioning landscape is not fit-for-purpose. In addition to the signatories of this paper, the All-Party Parliamentary Group on Sexual and Reproductive Health (APPG SRH) has recommended a single accountable SRH commissioner to hold oversight across the system in its final report of the [Inquiry into Access to Contraception](#).

The Inquiry's findings are based on over 70 separate evidence submissions from individuals and organisations including the Minister for Women, Public Health England and the Department of Health and Social Care. The report was formally welcomed by representatives from the DHSC, PHE, NHS England, RCGP, RCOG, FSRH, RCM and FPH.

The Inquiry into Access to Contraception was launched in 2019 in response to reports that cuts to budgets, fragmented commissioning and workforce issues were affecting women's ability to access contraception in a way that meets their holistic reproductive health needs. It collected evidence both prior to and during the Covid-19 pandemic.

The NHS Long Term Plan & the future of SRH commissioning

In the NHS Long Term Plan (Para 2.4, Page 33) it states that:

“the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services”

We would like to see holistic integrated commissioning of sexual and reproductive healthcare because of the negative impact of the current situation for women.

The current situation: The Health & Social Care Act and the need for better integration

We believe there is a need for reproductive healthcare to be more broadly integrated into women’s healthcare pathways in the NHS. Holistic SRH care means integrating care around the needs of the individual, not institutional silos, with people able to get integrated/holistic advice and support across the breadth of SRH.

In particular, we support any move towards establishing a more collaborative, co-ordinated and joined-up health and care system. This is because since the 2012 Health & Social Care Act came into force, there has been inherent system fracture, which has meant that holistic care for many women has been effectively blocked.

The below table demonstrates quite clearly why by-design the current system has inherent faults across SRH, whereby there is not a single body vested in ensuring the holistic needs of women are being met¹. To underline how this fractured system does not meet the needs of women, we have highlighted the split in women’s reproductive health commissioning responsibilities with a ✓.

Local Authorities	Clinical Commissioning Groups (CCGs)	NHS England
<ul style="list-style-type: none"> ✓ Contraception and advice on unplanned pregnancies in SRH services ✓ LARCs in primary care (for contraceptive purposes) ▫ STI testing and treatment in SRH services and primary care; partner notification ▫ HIV testing and partner notification ▫ Sexual health specialist services incl. young people’s services, outreach and promotion ✓ Support for teenage parents ✓ Chlamydia Screening ✓ Sexual health aspects of psychosexual counselling 	<ul style="list-style-type: none"> ✓ Abortion services, incl. contraception, STI & HIV testing in abortion pathway ✓ Contraception for gynaecological purposes including LARCs ✓ Female sterilisation ▫ Male sterilisation ✓ Non-sexual health aspects of psychosexual health services ▫ HIV testing when clinically indicated in CCG-commissioned services 	<ul style="list-style-type: none"> ✓ Contraception under GP contract ✓ Cervical screening ✓ Specialist foetal medicine services, incl. late termination of pregnancy for foetal anomaly between 13 and 24 gestational weeks ▫ HIV treatment ▫ STI & HIV testing and STI treatment in general practice when clinically indicated / requested by patient ▫ HIV testing when clinically indicated in NHSE-commissioned services ✓ HPV immunisation ✓ Sexual assault referral centres (SARCs) ✓ Sexual health in secure and detained settings ▫ NHS Infectious Diseases in Pregnancy Screening

¹ RCGP 2017. [Time to Act](#)

Although so many of the downstream benefits of preventing unplanned pregnancy are felt in the NHS (costs to maternity services, abortion pathways etc), it has been particularly difficult to engage Local Authorities to prioritise commissioning for benefits which are realised under NHS auspices, not least at a time where the public health budgets of Local Authorities are being severely cut. Conversely, 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's Maternity Transformation Programme.

This makes little economic sense – access to SRH care can be highly cost-saving. PHE has recently commended that for every £1 spent on publicly-funded contraceptive services, £9 is saved, most of which is realised in the NHS.² As such, we strongly recommend that any review of SRH commissioning responsibility should focus on women's health. Women's health has stood to suffer the most from the reorganisation of NHS services that ensued with the implementation of the Health & Social Care Act in 2013. Where once women could have all their reproductive health needs met in one place and one go, women are now subjected to disjointed, non-holistic, disintegrated care.

Context of cuts

This narrative of disjointed care has been compounded by cuts to funding, notably cuts to SRH services which local authorities have been mandated to provide. In fact, there will have been a £700m real-terms reduction in the public health grant between 2014/15 and 2019/20³. Further, the Kings Fund estimates that between 2014/15 and 2018/19 there was an 18 per cent real-terms reduction in spending on sexual health services.

Cuts were set to deepen to a 25 per cent real-terms reduction in sexual health spend between 2014/15 and 2019/20.⁴ Services providing sexual health advice, prevention and promotion have been among the biggest losers from the decrease in public health spending⁵. At the same time, the Local Government Association has reported that there is a record demand for sexual health services, a demand which has risen by 13 per cent since 2013. As a result, services are at tipping point, and a lack of capacity is leading to people being turned away.⁶

Where cuts are made to the public health-funded elements of SRH provision, the impact and increased cost is often felt in other parts of the system paid for by different commissioners. So LA-driven reductions in specialist SRH services increases the workload on GPs and other core contraceptive providers, while the consequent reduced access increases the need for CCG-funded maternity and abortion services. Around 41% of GPs in England responding to an RCGP survey from 2017 agreed that appointments for contraceptive advice have increased over the past year⁷.

The apportioning of SRH commissioning responsibilities between CCGs, LAs and NHSE also disrupts patient pathways in SRH because services are shaped by the source, availability and amount of funding rather than by patient need⁸. In addition to finding that LAs cannot maintain the current levels of service provision due to cuts, the review of commissioning by PHE and ADPH has also confirmed the experience of FSRH, RCOG and RCGP members that fragmented commissioning of services is threatening access to contraception and other sexual health services. PHE and ADPH specifically indicate that "LARC and cervical cytology might suffer"⁹.

² PHE 2018. [Contraception: Economic Analysis Estimation of the Return on Investment \(ROI\) for publicly funded contraception in England](#). [pdf] London: PHE
³ Buck, D. 2018. [Prevention is better than cure – except when it comes to paying for it](#)
⁴ [Written parliamentary evidence by the King's Fund](#).
⁵ King's Fund (2018) [Sexual health services and the importance of prevention](#)
⁶ LGA, 2017. [Sexual health services at tipping point warn councils](#). Local Government Association. [online].
⁷ RCGP 2017. [Time to Act](#)
⁸ Ibid.
⁹ PHE, 2017. [Sexual Health, Reproductive Health and HIV. A Review of Commissioning](#). [pdf] London: PHE.

Impacts on access to women's health

- Contraception:** at the same time as funding for contraception is being cut, prescriptions for Long Acting Reversible Contraception (LARC) are declining. Data shows that the number of prescriptions for LARC has reduced by 8% across England between 2013 and 2018. More than a quarter (27%) of GPs in England responding to a RCGP survey disagreed that patients who need LARC are always able to access it. Out of 86% of GPs in England who provide LARC in their practice, 39% said they have experienced cuts to the funding for this service¹⁰. This is despite the Government and NICE recommending increasing uptake of LARC methods.
- Contraception for gynaecological purposes:** many women choose to see their GPs when they have a gynaecological issue, but 39% of GPs in England surveyed by RCGP have reported experiencing cuts to the funding for LARC¹¹. Women used to be treated cheaply and effectively in the community and are now being sent to gynaecologists in hospitals despite the much higher cost of this and inconvenience to the patient.
- Cervical screening:** despite being provided by some SRH services, cervical screening is not a mandated requirement for LA commissioning and is not included in most SRH service specifications. Cuts to services, fragmentation of commissioning and the absence of a national budget line for cervical screening have had a knock-on effect on the capacity of primary care, where most screening is provided, to deliver this life-saving test. Coverage for women aged 25 to 64 is now at 71.9%, significantly below the 80% national target. Even lower are rates in the younger age bracket (25-49), when there is higher risk for cervical abnormalities, with coverage at only 69.8%¹². FSRH members have been consistently reporting that women are being turned away from SRH services, too stretched to manage to deliver what is currently in their service specifications, which often do not include cervical screening.
- Abortion:** abortion rates to women over 30 have been increasing over the last 10 years¹³. Whilst there is no evidence of direct causation, FSRH, RCOG and RCGP are concerned that the increase in terminations of pregnancies for those aged 30 and over may indicate an unmet need for contraception. Additionally, CCGs commission abortion services, while LAs commission contraceptive care. This creates a break in the care pathway which means that the patients who access abortion services are not automatically referred to contraceptive advice and treatment through the same care pathway, leaving them at risk of further unintended pregnancy.

Conclusion

Outcomes of reduced access, and inefficient provision are not coherent with the focus on prevention championed by the Secretary of State, nor with an NHS service that aims to provide integrated care as envisioned in the NHS Long Term Plan.

Above all, women, who make up half of the population, are being failed by a fragmented system. The UK's population behaviour continues to change, with a widening of the gap between when people start having sex and the age when they have their first child. Women are, therefore, spending a longer time preventing unplanned pregnancies and a lifetime of managing their reproductive and post-reproductive health. The current system, which inherently fosters siloed commissioning across sexual and reproductive healthcare does little to support this reality.

We are calling for integrated holistic commissioning of SRH, with one body maintaining oversight and holding accountability for all commissioning decisions.

Notably, SRH services are quite unique in that, unlike other public health services, they are clinical services just like other NHS services, and therefore warrant further consideration as to whether the NHS is best placed to have this responsibility.

¹⁰ RCGP 2017. [Time to Act](#)

¹¹ Ibid.

¹² [NHS Digital](#)

¹³ DHSC 2020. [Abortion Statistics, England and Wales: 2019](#)