APPG Sexual and Reproductive Health
Secretariat
FPA
23-28 Penn Street
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29th March 2019

Dear Colleague

APPG Enquiry on Contraception: Joint Submission from the Association of Directors of Public Health, Local Government Association and English HIV and Sexual Health Commissioners Group

We write jointly following your invitation to us as bodies representing commissioners in England. We are obviously happy to provide oral evidence in addition to this.

Key Points

We would want to make some points which we believe are key to ensuring an effective system for commissioning and provision of contraception moving forward.

1. We support a whole system approach bringing together reproductive health, sexual health and contraception which encompasses services and commissioning, strategic approach and health promotion.

2. It is vitally important that people are able to access good quality information on their reproductive health from sexual health services and that they can access the full range of contraceptive choices.

3. Contraceptive needs change across the life course and services should be able to support women and men throughout their lives:

4. The evidence base shows that the most reliable forms of contraception are long acting contraceptives – implants and coils. The strategy adopted by commissioners over recent years has been to promote and increase access to Long Acting Reversible Contraception (LARC) rather than user-dependent

methods of contraception and research suggests that the increased uptake of LARC has been a significant driver of reduced rates of teenage pregnancy.

5. For working aged adults, access to contraception remains important and needs to be universally accessible, recognising the need for access outside of working hours. It is concerning that whilst over the last 10 years, abortion rates have been decreasing for women under 25, they have been increasing for women aged 30 and over.

6. Finally, specific issues (such as natural decline in fertility, change in long term partners) place a continued need for tailored prevention advice and access to effective contraception for older people.

7. Sexual and reproductive health is about wellbeing, not just services. Education, personal capacity and resilience, good relationships and preventative actions are as important as the provision of high quality sexual and reproductive health services.

8. Commissioning, planning and providing sexual health services is undertaken in a challenging complex environment making relationships between services and systems critical.

    a. Demand for sexual health services including contraception services is continuing to grow (attendances at sexual health services have increased by three percent in the last year and by 13% over the last five years). The LGA recently published *Local Government Delivers* which provides more data on these, a copy of which we attach to this letter.

    b. At the same time public health funding in England will have been cut by £700 million between 2014/15 and 2019/20

    c. Councils are striving to manage the increasing demand and budget reductions so that they don't impact on service quality

    d. We know that investing in contraception services delivers a return on investment – every £1 spent on contraceptive services saves £9 across the public sector but the cuts by government are a totally false economy

    e. The Government must make significant and sustainable investment in public health a priority in the spending review

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9. We acknowledge that there is currently fragmentation in commissioning, it is important that commissioners work together to reduce fragmentation.

    a) Fragmentation was a feature of the system long before the transfer of services in 2013 and this was pointed out by a number of reports. Fragmentation has also created issues around commissioning and access to LARC for non-contraceptive purposes. Some areas have resolved this through joint commissioning arrangements between LAs and CCGs.

    b) In support of our assertion of this, we would draw your attention to several national reports on fragmentation prior to the transfer of responsibilities in 2013:

        i. In 2004 the National Manual for Sexual Health Advisers described a history of service fragmentation.

        ii. The Department of Health's 2008 *Gender and Access to Health Services Study* described fragmentation across services for many people, including reproductive and sexual health.

        iii. A 2010 report for NICE concluded there was fragmentation in sexual health and reproductive care for pregnant women.

        iv. The European Forum for Primary Care in 2010 concluded that sexual and reproductive health fragmentation was a problem across Europe.

        v. The Royal College of Obstetritians and Gynaecologists in 2011 concluded that Womens' Health especially reproductive and sexual health was fragmented and not joined up.

    c) We believe that moving responsibilities around for commissioning would be a false economy, a distraction and cost more in time and money than simply ensuring all partners agreed to work together around a pathway. We do not need structural reorganization, we need a collective change in the way commissioners behave.

10. Sexual health commissioning and services should embrace the introduction of evidence-based innovative technologies and digital services and this will require training, funding and evaluation.

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11. We would want to see an increased uptake of LARC.

A whole system approach

We believe that a whole system approach needs to be taken at both the local and national levels, covering prevention, improvement, promotion and protection, and spanning the three areas of sexual health, HIV and reproductive health including contraception. Attempts to tackle these issues in isolation will lead to silo working and will not be representative of people's experiences of sexual health, which are not divided into the three categories. This means that further transfer of commissioning responsibilities and re-organisation is not the answer.

We would argue that in the face of significant challenges, local authorities have attempted to ensure services continue to provide access within available resources. Public Health England in submitting evidence to the Health and Social Care Select Committee recently emphasised that there had been significant use of the local authority role and assets such as early years, youth services, substance misuse and community assets. These can be made to encourage the adoption of a positive approach to reproductive health, and investment is needed to ensure reproductive health continues to be well commissioned, and accessible.

Sustainability and Transformation Partnerships

Sustainability and Transformation Partnerships (STPs) in England provide an opportunity to take a systems approach to sexual health and work closely together to create a more coordinated service for patients, providing links into pathways for contraception services and other services such as early pregnancy assessment, abortion services, maternity services and health visiting.

General practice is often the first point of access to healthcare for people, this is also the case for many women accessing contraception services. The close collaboration between local authority and NHS commissioners to ensure that the full scope of contraceptive choice is available at GP surgeries is essential. There are good examples of joint working by local authority and CCG partners, particularly in ensuring a joined up approach to GP contraception services.

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It is important that surveillance systems continue to be supported and that the role of the voluntary sector partners in outreach services is promoted. Local authorities are well placed to commission and deliver a positive approach to sexual health and work more closely together to create a more coordinated approach to sexual health and create a more coordinated service for patients. Greater use of the local authority role and assets such as early years, youth services, substance misuse and community assets can be made to encourage the adoption of a positive approach to sexual health and contraception services.

Public health funding

Public health funding in England will be cut by 9.7 per cent by 2020/21, £331 million in cash terms, in addition to the £200 million in-year cut for 2015/16.15 Although Directors of Public Health (DsPH) have been acting to manage these cuts, through modernising services and introducing innovative online services, they have reached the limit of available efficiencies. Cuts to public health funding may result in cuts to sexual health services. In our Public Health System Survey 2017, we asked Directors of Public Health about recent and planned changes to services. 16 51 per cent of respondents had redesigned their sexual health services within the last year and 18 per centhad changed the provision. Sexual health services were the most commonly redesigned public health service and 50 per cent thought that redesigning or changing provision had had a positive impact on the service.

Current Situation

We believe the work we are doing is having a positive impact. We have seen increases in total prescribed LARC, GP prescribed LARC and SRH prescribed LARC at a national level. While we welcome this, we are seeing reductions to Government funding. At the same time:

1. There has been no significant increase in the total abortion rate

2. Teenage conception rates have continued to decrease and are now at the lowest recorded level

3. Greater moves towards more integrated sexual health services has improved access to SRH services and enabled more people to have their contraception and STI needs met in one service and/or in one appointment

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4. In a number of areas access to LARC has been increased through the delivery of LARC within primary care extended hours services provided by GP alliances and networks

Having said that, we recognise there remain some continuing challenges:

1. Anecdotal evidence from some areas that women are finding it increasingly difficult to access contraception in primary care (due to GP capacity) which is increasing demand for contraception on specialist SRH services

2. In response to PH Grant reductions some LAs have been forced to introduce age restrictions on pharmacy EHC services and/or concentrated resources into a smaller number of higher volume providers

3. Some GP LARC providers have stopped providing LARC in some areas due to other demands on primary care

Progress since the transfer of commissioning in 2013

Public Health England concluded that sexual health has more attention and focus in the local authority as it represents a large share of PH grant expenditure than it did within the NHS. Sexual health services accounts for over 25 per cent of the entire public health expenditure of English local councils There is therefore greater focus and scrutiny of spend, and significantly increased transparency, which has led to improved leadership, more innovation, improved access (through integration, digitalisation and co-location with other PH services in some areas) which has delivered improved sexual health outcomes and better value for money. A series of case studies showcasing these are currently being prepared for publication.

We believe that as a result of the transfer of commissioning:

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1. SRH Services are now better commissioned: with service specifications, performance monitoring and are more appropriately costed and funded.

2. There is greater integration with broader local authority services rather than just a focus on health service for example, exploitation, safeguarding, education, social care (LAC), youth service and youth offending services.

3. We have seen the development of and improved access to more modern integrated SRH services rather than former family planning services which were often seen as 'Cinderella services' within the NHS.

4. There has been an increased development of more one-stop shops. While some clinics may have closed, this has often led to better quality services and improved access often out of hours e.g. evenings and weekends, which were not a feature of former services in the main.
5.
6. We have seen more Nurse led provision which is also more cost-effective.

7. We have seen a significant increase in digital provision and targeting of more vulnerable residents, including those accessing services for the first time.

8. We have seen more collaborative commissioning between local authority and CCGs.

Local Authorities have had to take leadership of the local sexual health commissioning system. This has been successful in some areas where relationships between commissioning organisations are strong but performing less well in others, particularly where there are large numbers of CCGs and/or where relationships between organisations are complex and under-developed. The key to resolving this is to ensure there is investment in public health, and to make sure everyone works together, not to produce a further reorganisation of commissioning responsibilities.

Key issues and barriers that need to be addressed

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1. Lack of transparency, accountability and performance management of GP contraception provision as part of NHS GP contracts leading to geographical variation.

2. Lack of engagement from NHS England and the CCGs in some areas due to other pressing priorities.

3. Some CCGs making decisions in relation to the provision of vasectomy and female sterilisation services which increases demand for LA commissioned contraception services.

4. Some CCGs making decisions not to include the provision of contraception within termination of pregnancy services.

5. Out of area cross charging for contraception remains complex and contentious, particularly as services become more integrated, as this was not previously cross charged within the NHS system.
6.
7. Cervical screening within SH services is problematic in many areas.

8. NHS England commissioning is too distant at a local level and there has been a lack of effective engagement with LAs in the commissioning of HIV treatment, cervical screening, Sexual Assault Referral Centres (SARC) Service and prison sexual health services.

9. More progress has been made with CCG commissioned sexual health services as they are commissioned at a local level.

A further challenge is where investment/spend by one organisation (e.g. LA) leads to savings being received within another organisation (e.g. CCG, NHSE). Gain share agreements could be a potential solution to this

Solutions

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We believe there are readily available solutions to these, provided the investment in public health and contraception is secured:

1. Investment in public health must be increased. Cuts to public health budgets must be reversed and public health needs to be funded both sustainably and adequately in line with local population health need.

2. The recommendations of the *Sexual Health, Reproductive Health and HIV: A Review of Commissioning* report need to be fully implemented. At the national level this will include revising current commissioning guidance, facilitating sexual health networks, developing a framework for sector-led improvement (SLI) for sexual health and enhancing commissioning support tools.

3. In England, a clearer national approach should be introduced to fund out of area activity for both genitourinary medicine (GUM) and contraception with payment systems that support accountability and reduced administrative processes.

4. National bodies should prioritise support for the introduction of innovative technologies and digital services, building on successes such as self-sampling HIV testing. This will require adequate training and adequate funding.

5. All providers and commissioners/service planners should work together locally to promote a whole systems approach to:

    a) Develop models for integrated commissioning, and service provision
    b) Seamless, affordable service pathways
    c) Strong area-based networks and partnerships
    d) Address barriers to primary care
    e) Promote system led improvement

6. All sexual health commissioners and service planners should address health inequalities and cultural and behavioural influences on health choices such as

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the stigma associated with sexually transmitted infections and diseases, such as HIV.

7. At the local level, implementation of the *Sexual Health, Reproductive Health and HIV: A Review of Commissioning* report will involve developing a model of 'lead integrated commissioning' in each locality and testing models of local delivery based on local practice. This may include:

   a) Development of more Strategic SRH Commissioners Groups over several LAs and CCG areas, where this makes local sense.
   b) Collaborative Commissioning groups established in some areas to address issues and barriers including the use of statutory instruments to transfer sexual health commissioning functions or responsibilities between organisations, where appropriate.

   c) Development and use of Section 75 agreements between local authorities and CCGs for the provision of LARC for both contraception and non-contraceptive purposes.

8. Actions should be taken to put into place effective preventative strategies such as integrating GUM, HIV and contraceptive services to reduce the incidence of STIs contraction and promote contraceptive choice.

9. Further integration of Contraception and Termination of Pregnancy of services .

10. Development of gain share agreements in some areas between LAs and CCGs.

We remain committed to ensuring effective access to contraception. We believe we have delivered some improvements despite cuts in funding which would not have happened without the transfer to local authorities.

It is also evident that if we wish for good contraception services, everyone with an interest needs to call on government to ensure these are properly funded. Moving deckchairs and responsibilities is not the most important solution. Funding is.

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Yours sincerely

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