Written evidence submitted by The Faculty of Sexual and Reproductive Healthcare (FSRH) (EPW0029)

1. **The Faculty of Sexual and Reproductive Healthcare (FSRH)** is the largest UK multidisciplinary professional membership organisation representing 15,000 members working on the frontline of Sexual and Reproductive Healthcare (SRH) in a range of settings in the community, primary and secondary care. Our members are SRH Consultants, SAS doctors, GPs, nurses, midwives, pharmacists and other healthcare professionals delivering services commissioned by local authorities, clinical commissioning groups (CCGs) and NHS England (NHSE).

2. We want to ensure that high standards in SRH are achieved and maintained through appropriate funding and commissioning of services and training to ensure access to SRH care and realise our Vision for high-quality and holistic SRH across the life course. We oversee the Community Sexual and Reproductive Healthcare (CSRH) specialty training programme, a six-year run through programme from ST1, creating CSRH Consultants who have been trained to deliver specialist SRH care and be systems leaders, designing and supporting services provided by the multidisciplinary SRH workforce.

3. As a professional membership organisation whose members deliver SRH / public health services across a range of settings, our response will focus on the pressing issues facing the sustainability of the SRH workforce.

4. In August 2021, we published a survey of our members across the UK, whose results we share in this submission. Between August 2021 and January 2022, we received more than 500 responses from members across England. More than half of respondents work in general practice, with others working in specialist SRH services, integrated contraceptive and genitourinary medicine (GUM) services within hospitals as well as in the independent and voluntary sectors.

Summary

5. We believe the commitment on staffing levels was not met in SRH services. 75% of respondents to our survey stated that their service was currently experiencing workforce shortages due to unfilled staff vacancies, staff sickness or unavailability due to both COVID and non-COVID related reasons and retirements. Around 42% of respondents to our survey have been unable to provide care to a patient because their service is not commissioned to provide that service and/or because fragmented commissioning makes it difficult.

6. From 2018 to 2021, half of advertised CSRH Consultant posts across England were unfilled due to a lack of appropriately skilled applicants. The Specialty is also facing an acute succession crisis. CSRH Consultants as well as Specialty and Associate Specialist (SAS) doctors working in SRH are retiring at a faster rate than CSRH trainees or CESR applicants are completing their training/certification. Currently, we have 117 CSRH consultants in the UK, and 50 of them are over 55 years of age.

7. Many areas of England, particularly deprived areas, do not have any CSRH Consultants in post. The south coast of England is a case in point for SRH, with a lack of CSRH Consultants in Kent, Surrey, and Sussex and no CSRH training posts in these counties. Shortages are also seen in the South West and North of England.

8. There are not enough CSRH Specialty training posts and therefore we are unable to meet demand for CSRH Consultant posts. Our CSRH Specialty training programme is oversubscribed; in the last round of interviews, we received 180 applications for 13 advertised posts.

9. The specialist SRH supply gap is the result of a chronic lack of funding for CSRH specialty training posts. CSRH specialty training posts are 50% funded by HEE and 50% by the service/local authority. Currently, we recruit at ST1 level and try to rotate trainees into areas where services are not Consultant-led. However, this is proving difficult as employing trusts tend to insist on trainees' clinical commitment to their training area. Even without rotation, it is often impossible for cash-strapped local authorities to match the 50% HEE funding locally.

10. Our plan to increase the number of CSRH Consultants is practical and achievable. **We would like to see one new CSRH training post per HEE region for the next three years, fully funded by HEE.** We would also like to be able to recruit trainees at ST3 level, attracting doctors from specialties with high attrition rates.

11. A lack of CSRH Specialty training posts has direct impact on the sustainability of the whole SRH workforce. A small number of CSRH Consultant posts unevenly spread across England leaves whole areas without any SRH leadership to support delivery of care to the population. It leaves the wider workforce delivering SRH in community and primary care without clinical support from specialists and limits training opportunities. This situation accentuates differences in quality and standards of patient care across the country, fuelling health inequalities.

12. There is consensus across the sector that more funding for CSRH specialty training posts is urgently required. We have developed the FSRH Hatfield Vision, a framework that sets out what needs to be achieved to improve reproductive health outcomes and tackle the inequalities that women and girls face across their lifetimes. The framework includes actions on workforce, supported by endorsing organisations such as the Association of Directors of Public Health (ADPH), the British Medical Association (BMA), Royal Colleges, Faculty of Public Health (FPH), amongst others. We would be glad to share a copy of the FSRH Hatfield Vision with the Expert Panel.

13. The fragmentation of commissioning responsibilities in SRH has created disincentives for the training and education of the specialist and non-specialist SRH workforce. The split in commissioning means that responsibility for training is, at best, unclear. In England, specialist SRH service contracts used to specify that they were required to train local GPs, medical students and nurses, but a lack of funds from Public Health has resulted, in many cases, to this requirement disappearing. We believe that all local authorities must be financially supported to ensure that service specifications for SRH services include training.

15. Primary care has a vital role in the provision of contraceptive care, with 80% of women accessing contraception from their GP. Yet access to Long-Acting Reversible Contraceptives (LARC), the most effective contraceptive methods to prevent unplanned pregnancies, is restricted as a result of a lack of funding available for its provision and reduced capacity in general practice. Fewer GPs and practice nurses are training or retaining essential skills in this area.

16. Half of respondents to our members' survey reported experiencing feelings of work-related burnout currently or in previous waves of the COVID-19 pandemic. At present, a quarter of respondents are experiencing burnout. Worryingly, more than a third of respondents did not feel that they were given adequate support by their employer when they reported feeling burned out.

Full response

Policy Area: 1) Planning for the Workforce

Government Commitment: Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs

Was the commitment met overall?

17. We believe the commitment was not met regarding current staffing levels in SRH services. 75% of respondents to our survey stated that their service was currently experiencing workforce shortages due to unfilled staff vacancies, staff sickness or unavailability due to both COVID and non-COVID related reasons and retirements. Apart from funding and commissioning barriers, workforce shortages are the main factor leading to decreased access to SRH care for patients according to our members survey. The COVID-19 pandemic has worsened the problem.

18. From 2018 to 2021, half of advertised CSRH Consultant posts across England were unfilled due to a lack of appropriately skilled applicants. Regarding the appointments that were made, some posts had to be advertised more than once because the employer could not attract enough applications, leaving the posts vacant after the previous post holder had left. There are currently 6 unfilled CSRH consultant posts in London alone.

19. In 2021, we received 13 job descriptions for review and approval. Of the seven that recruiters were able to recruit to, five were recruited from the pool of professionals already in the system working as consultants, generating more vacancies for the posts these individuals have left. In 2021, only two jobs were taken up by CSRH trainees that had recently completed their training. It is important to note that the problem is likely underestimated, as not every trust looking to employ CSRH consultants will approach us for job description review and approval.

20. The Specialty is also facing an acute succession crisis. CSRH consultants as well as Specialty and Associate Specialist (SAS) doctors working in SRH are retiring at a faster rate than CSRH trainees or CESR applicants[1] are completing their training/certification. Currently, we have 117 CSRH consultants in the UK, and 50 of them are over 55 years of age. When we look at consultants who are over 50 years of age, then this number rises to 78. In our 2018 workforce mapping survey, one fifth of consultant respondents stated that they intended to retire by 2023. Many FSRH consultant members have told us that they don't feel they can retire because there is no one available to fill their post. Some have opted to return to their posts to keep services running.

21. Currently, many areas of England, particularly deprived areas, do not have any CSRH consultants in post. As the recent annual report by the Chief Medical Officer (CMO) on the health of coastal towns demonstrated, coastal communities face challenges with access to services as well as with service delivery, where they struggle to reach the critical mass needed to sustain specific services. The south coast of England is a case in point for SRH, with a lack of CSRH consultants in Kent, Surrey, and Sussex and no CSRH training posts in these counties. Shortages are also seen in the South West and North of England.

22. There are not enough CSRH Specialty training posts and therefore we are unable to meet demand for CSRH consultant posts. Our CSRH Specialty training programme is oversubscribed; in the last round of interviews, we received 180 applications for 13 advertised posts.

23. Doctors working towards specialist status via the Certificate of Eligibility for Specialist Registration (CESR) with the GMC need more support. The CESR route can be quite expensive and difficult to navigate. We would welcome work to streamline the CESR process to ensure it is straightforward.

[1] The Certificate of Eligibility for Specialist Registration (CESR) is one of two routes available for those who wish to gain specialist registration in CSRH, the other being Specialty training.

Why is leadership in SRH important? Will (or have) staff, patients or service users benefit(ted) directly, indirectly or both?

24. A lack of CSRH Specialty training posts has direct impact on the sustainability of the whole SRH workforce. A small number of CSRH Consultant posts unevenly spread across England leaves whole areas without any SRH leadership to support delivery of care to the population. It leaves the wider workforce delivering SRH in community and primary care without clinical support from specialists and limits training opportunities. This situation accentuates differences in quality and standards of patient care across the country, fuelling health inequalities.

25. CSRH Consultants are trained to deliver specialist care themselves, but also to be systems leaders who design and support services delivered by GPs, nurses, midwives, healthcare assistants and other professionals. Having an experienced CSRH Consultant enables the multidisciplinary SRH workforce to provide high quality SRH care more confidently, and it facilitates their training and clinical supervision. Around 80% of SRH care is undertaken in General Practice, and it is vital that a specialist SRH workforce is available to train and support Primary Care healthcare professionals. Investment in CSRH consultant posts is, therefore, an investment in the whole SRH workforce.

26. Additionally, CSRH Consultants receive extensive training in public health and ensure that SRH services champion health promotion and fit with the wider attempts to tackle health inequalities. CSRH consultants champion new, community-based models of care outside of hospital settings, which deliver more cost-effective services.

27. There is consensus across the sector that more funding for CSRH specialty training posts is urgently required. We have developed the FSRH Hatfield Vision, a framework that sets out what needs to be achieved to improve reproductive health outcomes and tackle the inequalities that women and girls face across their lifetimes. The framework includes actions on workforce and calls for increased funding for CSRH specialty training. The FSRH Hatfield Vision has been endorsed by 25 organisations across the sector, including the Association of Directors of Public Health (ADPH), BMA, relevant Royal Colleges, Faculty of Public Health (FPH), amongst others. We would be glad to share a copy of the FSRH Hatfield Vision with the Expert Panel.

SAS doctors

28. SAS doctors are vital to the sustainability of SRH services. SAS doctors make up a large proportion of doctors working within SRH, with many taking up senior roles. Data from the General Medical Council (GMC) shows that SAS doctors are performing enhanced roles, most having responsibility for training others. However, more than a third of SAS doctors themselves report difficulties in accessing CPD opportunities and do not have adequate support for career development and progression.

29. Our vision is a fit-for-purpose SRH workforce led by Consultants and SAS doctors, whose commitment to high standards of care is recognised by the medical profession as well as across Government and arms-length bodies with responsibility for workforce planning and development.

Was the commitment effectively funded (or resourced)? How has this commitment been interpreted in practice at local authority/care provider/trust level?

30. We welcomed the Interim NHS People Plan[2], but were disappointed that the People Plan 2020/21 did not come with any funding attached to it, and that no substantial settlement for workforce featured in the Spending Review 2021[3].

[2] NHS 2019. *Interim NHS People Plan*

31. The recent increase in medical school places is welcome, but there is a significant lag time between entry into medical school and the completion of CSRH Specialty training. The increase in student places must be matched by expansions to the number of CSRH specialty training places, enabling a smooth flow through the training pipeline.

32. The specialist SRH supply gap is the result of a chronic lack of funding for CSRH specialty training posts. The CSRH specialty has experienced a deficit in training numbers since its establishment in 2010. In 2011, the Centre for Workforce Intelligence (CfWI) recommended the introduction of 35 training posts to secure a sustainable specialist workforce; however, only 20 were funded. Since the introduction of the Specialty, the deficit in training numbers was never fully tackled, with HEE acknowledging that training numbers were few and unlikely to provide the CSRH service required for the future.

33. CSRH specialty training posts are 50% funded by HEE and 50% by the service/local authority. Currently, we recruit at ST1 level and try to rotate trainees into areas where services are not Consultant-led. However, this is proving difficult as employing trusts tend to insist on trainees' clinical commitment to their training area. Even without rotation, it is often impossible for cash-strapped local authorities to match the 50% HEE funding locally. Local authorities, who are commissioners of SRH services funded via the Public Health grant, do not believe they have responsibility for commissioning CSRH training.

34. Our plan to increase the number of CSRH consultants is practical and achievable, and we have capacity to deliver it. **We would like to see one new CSRH training post per HEE region for the next three years, fully funded by HEE.** We would also like to be able to recruit trainees at ST3 level, attracting doctors from specialties with high attrition rates such as Obstetrics & Gynaecology as well as those who have completed training in general practice, but would like to pursue a career as leaders in women's healthcare. In order to do that, a larger number of CSRH training posts, fully funded by HEE, is needed.

35. Establishing training posts on the same funding basis as Public Health and opening recruitment at ST3 level would reduce training time and greatly improve the opportunities open to potential Trainees.

36. Doctors working towards specialist status via the Certificate of Eligibility for Specialist Registration (CESR) with the GMC need more support. CESR is an important route to increase the number of CSRH consultants in the medium term. However, the CESR route can be quite expensive and difficult to navigate. We would welcome work to streamline the CESR process to ensure it is straightforward.

37. The 2021 SAS contract is an important milestone for the specialist workforce. We support the introduction of a new specialist grade. This will provide new opportunities for progression for SAS doctors, acknowledging the valuable contribution made by this part of the SRH workforce. The introduction of this new grade will help to recruit, motivate and retain SRH doctors.

Do healthcare and social care stakeholders view the funding as sufficient?

[3] See: The King's Fund 2021. *The Autumn Budget and Spending Review 2021: what was announced and what does it mean for health and care spending?* and Smith, C. et.al. 2021. Autumn budget 2021: Sunak's splurge of the century heralds end to Tory austerity. *The Times*

38. There is consensus across the sector that more funding for CSRH specialty training posts is urgently required.

39. We have developed the FSRH Hatfield Vision, a framework that sets out what needs to be achieved to improve reproductive health outcomes and tackle the inequalities that women and girls face across their lifetimes. The framework includes actions on workforce and aims to leverage commitment and accountability at national level. We would be glad to share a copy of the FSRH Hatfield Vision with the Expert Panel. The FSRH Hatfield Vision has been endorsed by 25 organisations in the sector, including the Association of Directors of Public Health (ADPH), BMA, relevant Royal Colleges, Faculty of Public Health (FPH), amongst others, who support the Vision's call to action on Specialty training which reads:

"Community SRH Specialty training posts are fully funded, with one new fully funded specialty training post per Health Education England region for the next three years, to provide local leadership, training and governance to SRH workforce and services."

To what extent has the Covid-19 response affected progress?

40. Apart from funding and commissioning barriers, workforce shortages are the main factor leading to decreased access to SRH care for patients according to our members survey. The COVID-19 pandemic has worsened the problem. A respondent to our survey explains:

> *"We are constantly under-recruiting/ chasing our tail- moderately high turnover of staff; staff off long term sick with mental health and long COVID issues and other staff may request to reduce sessions, so the recruitment is always less than we need."*

41. Around 75% of respondents stated that their service was currently experiencing workforce shortages due to COVID and non-COVID related reasons. Around 20% of staff who were redeployed in previous waves of the pandemic have not returned to work at their SRH service yet. Our members explain:

> *"Many staff who have been redeployed have not returned. Lack of skilled practitioners already trained putting a small team under more pressure to train new staff."*
>
> *"Several community clinics closed during pandemic and not re-opened, staff shortages due to sick leave, lack of nurses trained to fit LARC."*
>
> *"Capacity issues at times due to COVID and long-term understaffing has meant very increased waiting times."*

How has a lack of funding and investment in the workforce affected patients?

42. Around 42% of respondents to our survey have been unable to provide care to a patient because their service is not commissioned to provide that service and/or because fragmented commissioning makes it difficult. More than half of respondents said that their service did not receive adequate funding to provide a full range of SRH care. Our members explain:

> *"No full contraceptive services available at the practice or in immediate area and difficult, at times impossible to access in wider town."*
>
> *"Capacity issues at times due to Covid and long-term understaffing has meant very increased waiting times"*
>
> *"Access is poor, hard to get funding to train nurses and doctors to give contraception"*

"The young people's service has been taken over and all the staff have left so in effect there is no young people's service."

"Recent teenage pregnancies at 15 never used to happen when workforce capacity was higher".

"Only 1 GP in the surgery fits coils so access to emergency coil fittings will depend on her availability"

"We do not have an emergency IUD fitter available every day. And when one is off (annual leave or quarantined as COVID contact are the two main reasons!) then we are unable to provide the service."

"Funding not sufficient to cover costs of an immediate access emergency contraceptive service."

43. Our data reflects the findings evidenced in the 2020 report of the Parliamentary Inquiry into Access to Contraception by the All-Party Parliamentary Group on SRH[4]. The inquiry found that women in England are facing difficulty in accessing contraception, which will result in more unplanned pregnancies and increased demand for maternity, abortion care and child services.

44. This unwarranted variation in access and quality of SRH care across the country will not be resolved if we do not have the right leadership and workforce in place to plan and deliver SRH services.

Policy Area: 2) Building a Skilled Workforce

Government Commitment: Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead.

45. Staff contracts must provide sufficient time to allow for education and training, supervision, research, continuing professional development (CPD) and other professional duties, as well as clinical responsibilities, thus allowing meaningful, rewarding and varied workloads. Our members have been telling us that this is not always the case in SRH.

46. The fragmentation of commissioning responsibilities in SRH has created disincentives for the training and education of the specialist and non-specialist SRH workforce. The split in commissioning means that responsibility for training is, at best, unclear.

47. In England, specialist SRH service contracts used to specify that they were required to train local GPs, medical students and nurses, but a lack of funds from Public Health has resulted, in many cases, to this requirement disappearing. We believe that all local authorities must be financially supported to ensure that service specifications for SRH services include training.

48. Primary care has a vital role in the provision of contraceptive care with 80% of women accessing contraception from their GP. Yet access to Long-Acting Reversible Contraceptives (LARC), the most effective contraceptive methods to prevent unplanned pregnancies, is restricted as a result of fragmented commissioning; a lack of funding available for its provision; and reduced capacity in

[4] APPG SRH. Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Covid-19 Pandemic

general practice. As a result, fewer GPs and practice nurses are training or retaining essential skills in this area. Responding to our survey, our members have told us the following:

> *"The pressures on general practice are enormous. Our family planning trained nurse is leaving and she has done most of our implant work."*
>
> *"GP contract does not encourage partners to provide increased services for LARC."*
>
> *"Not enough sessions to provide LARC appointments - it is rationed due to contracts - I am only allowed to offer 4 intrauterine contraception appointments a week (4-month wait currently!)."*
>
> *"I am the only GP providing coil removal and fitting. I have been off sick for 14 weeks and now returning. The volume of work exceeds my capacity."*
>
> *"We are unable to manage short notice LARC requests as I am the only intrauterine device (IUD) fitter and work one day a month in this role as a locum."*

49. Primary care provision of LARC for the purposes of avoiding unplanned pregnancies is commissioned by local authorities, who have been under severe budgetary pressure for the past decade. Around 11% of councils reduced the number of contracts with GPs to fit LARC in 2018/19[5]. Uncertainty around the future of LARC services and a lack of communication with public health commissioners reduces the incentive for GPs to train or maintain their LARC qualifications, again resulting in reduced provision for patients. Cuts mean less incentive and opportunities for GPs and practice nurses to provide contraceptive care, as evidenced by our members:

> *"The level we are commissioned and paid to provide is less than that required by our population. If we overperform we don't get paid."*
>
> *"Have max number of patients we can see per year due to capped contract."*

50. The Royal College of General Practitioners (RCGP) and the Royal College of Nursing (RCN) have raised concerns about training and maintaining qualifications to fit LARCs[6]. There is evidence of frontline staff being dissuaded from accessing training because they are often expected to self-fund training and do it in their own time. There are also growing concerns that many GPs trained to fit LARCs are due to retire soon. The fragmented commissioning environment and capacity pressures on primary care mean there is little incentive for younger GPs and practice nurses to replace them, as illustrated by the quote below:

> *"Lack of funding for training new LARC providers when older GPs retire. Succession planning made very difficult."*

51. There is consensus across the sector on the need for resourcing primary care so that it is able to deliver SRH care. The FSRH Hatfield Vision endorsing organisations support the Vision's call to action on primary care:

[5] AGC 2017. *Cuts, Closures and Contraception*

[6] RCN 2018. *Sexual and Reproductive Health. RCN report on the impact of funding and service changes in England*; RCGP 2017. *Sexual and Reproductive Health Time to Act*.

"The primary care workforce is adequately resourced to provide LARC fittings, removals and training. Local contracts should fully cover the costs of provision, training and maintaining access to this essential service."

Policy Area: 3) Wellbeing at Work

Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services

52. Workplace stress and mental health issues play a significant role in driving staff away from the sector. Despite an incredible show of resilience throughout the COVID-19 pandemic, under-funding, increased demands and insufficient staff numbers has proved very challenging for the SRH workforce, as shown in a member's quote below:

> *"Members of admin and clinical staff moving away from employment in NHS due to stress/new opportunities in private work."*

53. As noted in the 2021 Health & Social Care Committee's report of the inquiry into workforce burnout and resilience in the NHS and social care, "*Burnout is a widespread reality in today's NHS and has negative consequences for the mental health of individual staff, impacting on their colleagues and the patients and service users they care for."*

54. Our members' survey corroborates this view, with half of respondents experiencing feelings of work-related burnout currently or in previous waves of the COVID-19 pandemic. At present, a quarter of respondents are experiencing burnout. Worryingly, more than a third of respondents did not feel that they were given adequate support by their employer when they reported feeling burned out.

55. We fully support the recommendation in the Health & Social Care Committee's inquiry report that "*chronic excessive workload is a key driver and must be tackled as a priority*", and that this "*will not happen until the service has the right number of people, with the right mix of skills across both the NHS and care system*."

56. Additional support provided to health staff during the COVID-19 pandemic should be maintained during the recovery period and beyond, to stop further staff from leaving. Furthermore, employers and the Department of Health and Social Care (DHSC) need to ensure that SRH services are accessible to all who need them.

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