Written evidence submitted by The Faculty of Sexual and Reproductive Healthcare (DEL0175)

1) Background to the Organisation

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest UK multidisciplinary professional membership organisation representing more than 15,000 doctors and nurses working at the frontline of Sexual and Reproductive Healthcare (SRH) in community and primary care. Our goal is to ensure that the population can access high-quality and holistic SRH services across the life course, and that essential SRH services remain available to the population during and after the COVID-19 pandemic.

2) Summary

FSRH believes the post-pandemic landscape offers significant opportunities to tackle the commissioning challenge that has hindered the delivery of effective person-centred SRH care post Health and Social Care Act 2012, whereby delivery of services is fractured between NHSE, Local Authorities and CCGs. To enable positive change to last, it is imperative to revisit the question of whether SRH services should be brought back under NHS auspices.

There is consensus across the medical profession that current commissioning structures are not fit for purpose. Despite acknowledging the findings of the HSC Committee's inquiry into sexual health 2019, we reiterate our previous call for consideration to be given as to whether NHS England (NHSE) is best placed to have responsibility for SRH care and services. There is consensus across the medical profession that current commissioning structures are not fit for purpose, and we call on the Committee to have regard for our joint position on holistic, integrated SRH commissioning endorsed by the Academy of Medical Royal Colleges (AoMRC)[1].

The outbreak of COVID-19 has resulted in significant disruption to SRH services in the UK. To better understand the impact of the COVID-19 pandemic on SRH service provision, FSRH released a rolling survey to our members and received 850 responses at time of writing. The results are outlined below.

In the following sections, we also outline our current position on contraceptive provision when changes to the Covid-19 lockdown are introduced, as well as recommendations to ensure positive changes are here to stay in areas such as remote care; regulatory change in abortion and contraceptive care; postpartum contraception; and digital infrastructure.

3) Introduction

The redeployment of staff from already understaffed SRH services has resulted in service closures, and clinicians are concerned that patients will no longer be able to access the care that they need. Funding and commissioning challenges have led to an overstretched and underfunded SRH service that was not sustainably supported to provide care to women and girls either before or during a pandemic.

SRH services are needed to help women avoid unplanned pregnancies. Almost half of pregnancies in Britain are unplanned or where women are ambivalent.[2] Abortion rates have generally increased by 4% since 2017, and it is estimated that more than half of unplanned pregnancies in Britain end in abortion.[3]

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[1] FSRH 2019. Holistic Integrated Commissioning of Sexual & Reproductive Healthcare AoMRC, RCOG, FSRH, RCGP, RCPath and RCPCH Position.
[2] Wellings, K. et.al, 2013. *The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)*.
[3] Department of Health & Social Care & ONS, 2019. *Abortion Statistics, England and Wales: 2018. Summary*

In recent years, women's reproductive healthcare has been detrimentally impacted by cuts to Public Health services. Since 2015, two thirds of councils in England have reduced or frozen their SRH budgets adversely affecting provision in general practice and community services. Eight million women of reproductive age now live in an area where their local council has reduced their SRH budget since 2016/2017.[4] Demand for services has risen by 13% since 2013, and the Local Government Association (LGA) has warned that services are at a "tipping point"[5]. Furthermore, deep fragmentation of commissioning of SRH services has created barriers for women to access healthcare, as well as around who holds accountability for SRH services across the healthcare system.

We believe the COVID-19 pandemic will put unprecedented financial pressure on public service budgets for years to come. In light of this future strain, contraceptive services in primary and community care are more important than ever. Public Health England (PHE) estimates that every £1 spent on contraception saves the public sector £9 over ten years, before considering the wider societal cost and impact.[6] This makes contraception the most cost-effective Public Health service.

4) SRH during COVID-19 - balancing coronavirus with ordinary healthcare demand

We believe that essential SRH services must continue to be delivered as comprehensively as possible. For this reason, early in the outbreak of the pandemic, FSRH released guidance[7] for providers and commissioners regarding the provision of essential SRH services during the pandemic. These services include emergency contraception; supporting the continued use of Long-Acting Reversible Contraception (LARCs - intrauterine contraception, implants and injections, the most effective methods of contraception); abortion; sexual assault care; contraception for vulnerable groups; and extending the use of online services.

The impact - FSRH members survey

To better understand the impact of the COVID-19 pandemic on SRH service provision, we released a rolling survey for our members[8]. At time of writing, the survey has received 1,000 responses from GPs and other members working in sexual health clinics, sexual and reproductive healthcare (SRH) services, integrated SRH and sexual health and abortion care.

Around 66% of respondents stated that they have been forced to end or limit the provision of SRH services. Of those responding stating that they have been forced to end or limit the provision of SRH services, 55% were not confident their patients would be able to access this care elsewhere, neither in GP practices nor community services. On average, respondents stated that 12% of their consultations were carried out remotely prior to the COVID-19 pandemic. This has now risen to 87% of consultations.

This reduction is due to the necessity to limit services requiring face-to-face consultation, and partly due to staff redeployment, illness and self-isolation. Respondents to our survey stated that 20% of their staff had been redeployed, and that a further 17% of staff were absent from work due to COVID-19 or non COVID-19 related illnesses. Of respondents working in community clinics, a quarter stated they had not been supplied with adequate Personal and Protective Equipment (PPE).

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information from the abortion notification forms returned to the Chief Medical Officers of England and Wales.
[4] Advisory Group on Contraception, 2019. *At tipping point: An audit of cuts to contraceptive services and their consequences for women.*
[5] LGA, 2017. Sexual health services at tipping point warn councils. *Local Government Association*. [online]. Available at: https://www.local.gov.uk/about/news/sexual-health-services-tipping-point-warn-councils
[6] Public Health England, 2018. *Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England.*
[7] FSRH, 2020. *Essential Services in Sexual and Reproductive Healthcare*.
[8] A full report with interim results can be accessed here.

Members reported that over 100 SRH clinic sites across the UK had closed since the outbreak. SRH clinics are most commonly used by young people, and by those at greater risk of poor SRH.[9] Respondents noted that SRH clinic closures disproportionately impact the most vulnerable patients. When asked whether they were confident that vulnerable patients could access SRH care during the COVID-19 pandemic, 39% said they were not. They worried that patients may be afraid to attend their local GP:

> *"The young people we see are usually very reluctant to attend their own GPs for contraception and feel that a drop-in service is most appropriate as they can attend without their parents/carers knowing"*

> *"I worry that many vulnerable groups will have had reduced access, either because they do not know services remain open, or because they are not allowed out to visit the service, or do not have the privacy to contact services if others in the house may be listening"*

In particular, respondents worried about domestic abuse, contraceptive coercion, and their limited ability to identify signs of abuse through remote consultations:

> *"Concerned that remote methods are more likely to miss domestic violence and safeguarding concerns."*

Around 14% of respondents stated that they used to provide outreach services prior to the outbreak. Of these, 39% stated that they were no longer providing these services. Examples of continuing outreach services included proactive telephone calls to vulnerable populations and using a reconditioned ambulance for outreach services in areas where service provision is no longer available.

As the evidence clearly shows, the closure of sites and lack of face-to-face consultations are having detrimental impacts on SRH care of vulnerable groups and women generally, and we call on for a reversal of closures and gradual reinstatement of face-to-face consultations in a manner that is safe for both patients and healthcare professionals.

5) Ensuring positive changes are not lost

5.1 Remote Methods of Consultation

Remote consultations, provided either via telephone or video, can be an effective and safe way to respond to increased demand for services if carried out according to high standards of safety and governance. Our survey respondents noted the positive aspects of remote methods of consultation:

> *"I have been trying to move to remote consultations for years - suddenly the red tape has vanished - suits the majority of patients"*

[9] BMJ Sexual Health, 2018. *Where do women and men in Britain obtain contraception? Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3).*

"Very positive form of communication with patients and waiting times reduced. Only see patients who really need to be seen"

Members have highlighted the advantages of phone consultations for oral contraception, suggesting stations for self-measurement of BMI and blood pressure could be introduced, sparing women from having to see a clinician just to report on these figures for repeat prescriptions. They have also stressed the benefits of text services, remote counselling for LARC as well as dispense and collect systems for medication.

Balancing out remote and face-to-face consultations

Taken together, these findings demonstrate that the availability of different modalities of consultation are necessary to provide comprehensive SRH care for all women and girls, and to deal with the increased demand for SRH services after services normalise. Remote consultations can enable individuals to access healthcare services in situations where they are unable to physically attend a service. Childcare responsibilities, distance from clinics, and abusive partners place significant barriers on women and girls' access to SRH care. The availability of remote and online consultations reduces this barrier.

However, remote and online services are a complement, not a substitute, to face-to-face consultations and, irrespective of consultation modality, best practice and guidelines must be adhered to at every user contact to ensure safety and quality of care. In our *Standards for Online and Remote Providers of Sexual and Reproductive Health Services*,[10] we outline the ways in which providers can ensure a safe and effective approach to risk identification, assessment analysis and response in remote consultations to ensure clinical excellence, governance, safety and high-standards of care are maintained.

5.2 Regulatory change

Abortion care

There are positive regulatory changes that have emerged out of the response to the pandemic - abortion care is a case in point. The Department of Health and Social Care (DHSC) approved temporary measures in England to ensure access to early medical abortion at home, allowing women seeking an early medical abortion up to 10 weeks of gestation to have their consultation performed remotely. Home use of the first drug for early medical abortion, mifepristone, was also permitted.

Reduced availability of operating theatre time has massively decreased the availability of surgical abortion to women in lockdown. More women than usual are failing to attend their appointments for surgical abortion in some services; this may be due to long waiting times with women finding alternatives and failing to cancel the previous appointment. Most women are opting for medical abortion.[11] Data from independent providers, which provide 72% of all abortions under NHS contract[12], show an upward trend in the uptake of telemedical abortion and that the number of early medical abortions is increasing in real terms and as a proportion of overall abortion procedures since the beginning of lockdown. BPAS reports that currently 97% of its treatments are being done remotely.

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[10] FSRH, 2020. *Standards for Online and Remote Providers of Sexual and Reproductive Health Services*

[11] British Society of Abortion Care Providers, 2020. Submission to the Women and Equalities Committee Inquiry Unequal Impact: Coronavirus (COVID-19) and the impact on people with protected characteristics.

[12] DHSC, 2019. Abortion Statistics, England and Wales: 2018

This suggests the temporary measures have had a positive impact on timely access to early abortion care.

FSRH has welcomed the temporary measures, and now urges the Government and DHSC to allow home use of mifepristone and telemedicine for early medical abortion permanently, ensuring women have easy and timely access to this essential healthcare service.

Contraception

Regulatory change is also essential to alleviate the pressure on contraceptive services in general practice and SRH community services. FSRH endorses work being undertaken by the Medicines and Healthcare Products Regulatory Agency (MHRA) to reclassify the progestogen-only pill (POP) from 'prescription-only' to 'pharmacy product', thereby making them easily accessible over the counter in pharmacies, while reducing any unnecessary pressures on GPs and enabling women who are not registered with a GP to access contraception more easily.

POP is one of the most popular methods of contraception, a safe, relatively easy-to-use contraceptive. In our guidance, we have recommended POP as a reliable bridging method if it is not possible for women to access their preferred method during the pandemic[13].

It is expected that, following the current period of Covid-19 lockdown, there will still be an ongoing requirement for social distancing. Therefore, reclassification of POP is even the more urgent. We urge MHRA to work closely with DHSC to expedite the reclassification of POP. This will make it easier for women to avoid unplanned pregnancies and access contraception in the heart of communities during and post-Covid-19.

5.3 Postpartum contraception

Programmes at Imperial College Hospital and Manchester Foundation Trust are paving the way for contraceptive provision in maternity services, with pregnant women being given contraceptive counselling pre-birth. Additionally, highly effective intrauterine contraception can be fitted during planned caesarean sections, removing the need for future invasive procedures. Yet, despite the evident link between maternity and contraception services, and necessity for them to work together, these examples are rare.

There is support from across professions to roll out programmes such as these consistently. Together with the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM), FSRH has launched joint guidance on the provision of contraception by maternity services after childbirth during the Covid-19 pandemic[14].

With GP practices and contraceptive clinics significantly reducing or shutting down services due to Covid-19, it is more important than ever for NHSE to ensure consistent and effective provision of post-partum contraception. Maternity services are well-placed to provide effective contraception after birth, reducing the need for women to seek further care once they have left the maternity unit. We call on NHSE and DHSC to have regard for our guidance and successful frontline experiences, introducing commissioning of contraception in maternity services.

5.4 Scaling up Digital Infrastructure

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[13] FSRH 2020. FSRH CEU clinical advice to support provision of effective contraception during the COVID-19 outbreak.
[14] FSRH, RCOG & RCM, 2020. Provision of contraception by maternity services after childbirth during the Covid-19 pandemic.

Increased investment into digital infrastructure is required across the country. We recommend that a national digital service platform be developed for SRH across the UK, which will serve as a one-stop point of access for the general public and will support the maintenance of access to essential care – including contraception and abortion care. This service should operate seamlessly with regional and local face-to-face services – providing effective triage and a streamlined care pathway for those patients referred for face-to-face treatment.

6) Restoring services: FSRH's position after changes to Covid-19 lockdown

While social distancing remains in place, it is recommended that most contraceptive consultations continue to be done remotely. This includes support with choice of contraceptive method, information-giving prior to any procedure and provision of information to support ongoing use. Local protocols must be followed to minimise risk of transmission of Covid-19 at the time of any procedure.

Local services should consider how best to ensure that those individuals at highest risk of unplanned pregnancy have access to the most effective contraceptive method that is acceptable to them. This should include individuals attending abortion and maternity services.

Local pathways for urgent referral from vulnerable groups including via social services, sexual assault referral centres (SARCs), BAME groups and young peoples' outreach must be maintained. Those who have problems with their existing contraception should also be prioritised.

Access to emergency contraception, including, where possible, the emergency copper IUD, should continue to be prioritised. LARCs, the most effective contraceptive methods (IUDs, IUS, implants and injections), should be prioritised where possible when lockdown restrictions are eased, and where it is considered that benefit outweighs risk of Covid-19 transmission.

Contraceptive care to treat gynaecological conditions such as heavy menstrual bleeding should be reintroduced more consistently across the country, as well as menopause care (hormonal replacement therapy), cervical screening and psychosexual therapy.

6.1 Beyond the pandemic

Tackling SRH commissioning

FSRH believes the post-pandemic landscape offers significant opportunities to tackle the commissioning challenge that has hindered the delivery of effective person-centred SRH care since the Health and Social Care Act 2012 devolved public health functions to local authorities, and commissioning responsibilities for SRH were split between NHSE, CCGs, and local authorities.

An example of disjointed SRH care reflecting artificial commissioning boundaries is contraception for gynaecological treatment - specialist gynaecology clinics can prescribe the IUS to treat heavy menstrual bleeding but not for contraception, whereas a woman attending a GP appointment for contraception who also complains of heavy bleeding cannot be offered effective treatment (the IUS) if the practice is not commissioned to do so.

The pandemic has exposed even more the inherent fractures in the SRH commissioning system. To enable positive change to last, it is imperative to revisit the question of whether SRH services should be brought back under NHS auspices. Unlike other Public Health services, SRH services are unique in

that 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.

Women disproportionately experience poor SRH[15]. Whilst local authorities have achieved good results with constrained budgets, women's SRH has stood to suffer the most post Health & Social Care Act 2012. Where once women could have all their reproductive health needs met in one place and one go, women are now subjected to disjointed, piecemeal care. This point is acknowledged in the findings of the Health and Social Care Select Committee's inquiry into sexual health (2019), which recognised that in many areas commissioning is not working well[16].

There is consensus across the medical profession that current commissioning structures are not fit for purpose, with calls for an end to fragmentation of services[17]. We hereby reassert our previous call for consideration to be given as to whether NHSE is best placed to have responsibility for SRH services. We call on the Committee to have regard for our joint position on holistic, integrated SRH commissioning endorsed by the Academy of Medical Royal Colleges (AoMRC)[18].

Ensuring access to a mix of consultation modalities

As evidence from the FSRH members survey clearly shows, the lack of face-to-face consultations is having detrimental impacts on SRH care of vulnerable groups. Without face-to-face consultations, opportunities to pick up on safeguarding issues, domestic abuse and teenage pregnancy are lost.

Our survey findings demonstrate that the availability of different modalities of consultation - face-to-face, remote and online - is vital to provide comprehensive SRH care for all women and girls, and to deal with the increased demand for SRH services after services normalise. Therefore, we call for the restoration of SRH services that include all such modalities of consultation, including face-to-face, in a manner that is safe for both patients and healthcare professionals when moving beyond the pandemic.

Remote and online services are a complement, not a substitute, to face-to-face consultations and, irrespective of consultation modality, best practice and guidelines must be observed to ensure safety and quality of care.

[15] Parkes, A., Waltenberger, M., Mercer, C. et al. 2020. Latent class analysis of sexual health markers among men and women participating in a British probability sample survey. *BMC Public Health* 20, 14 (2020). Available at: https://doi.org/10.1186/s12889-019-7959-7
[16] Health and Social Care Committee 2019. Sexual Health. Fourteenth Report of Session 2017–19.
[17] FSRH, RCOG & RCGP, 2019. FSRH, RCOG and RCGP respond to sexual health report from the Health and Social Care Committee
[18] FSRH, RCOG, RCGP, RCPath, RCPCH & AoMRC, 2019. Holistic Integrated Commissioning of Sexual & Reproductive Healthcare AoMRC, RCOG, FSRH, RCGP, RCPath and RCPCH Position.