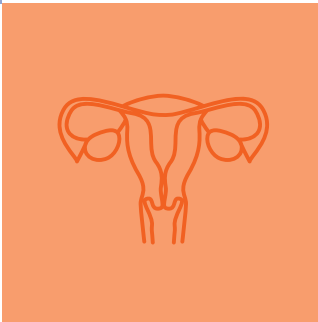
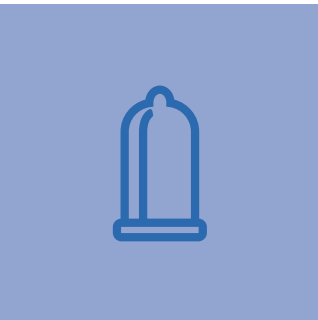
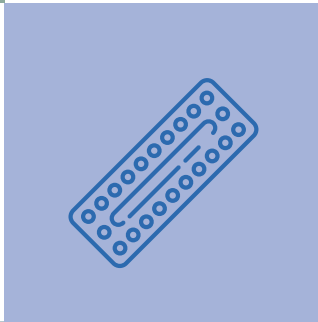
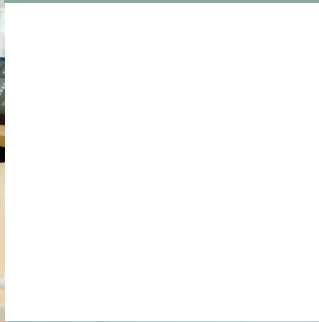
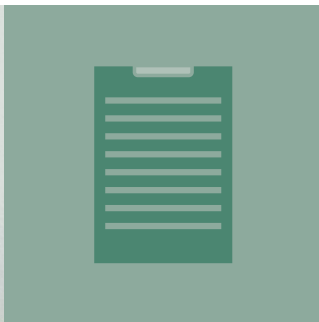




Royal College of
General Practitioners

Sexual and Reproductive Health TIME TO ACT



Executive summary

Sexual and Reproductive Health (SRH) services are at a turning point. Since 1998 the teen pregnancy rate in England and Wales has been halved and uptake of Long Acting Reversible Contraceptives (LARC) has increased over the past decade.^{1, 2}

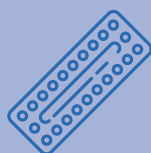
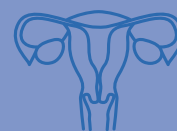
However, there has been an increase in the number of women under 40 seeking abortions; syphilis and gonorrhoea diagnosis rates increased by 20 and 11 per cent respectively between 2014 and 2015; and RCGP members have reported that a perfect storm of factors is reversing previous positive advances made in promoting sexual and reproductive health.^{3, 4} GPs across the UK are finding it harder to access the training needed to be able to give the most effective forms of contraception. In England payments to GPs for giving patients LARC often no longer cover the cost of administering them, while fragmented commissioning pathways and fewer specialist SRH services in England mean patients are not always able to access the best care for their needs.

This increased difficulty in accessing provision is creating health inequalities between those who are able to navigate the increasingly complex SRH system, and those who are not. Some of the most at-risk patients are the least able to reach the support they need due to cultural, language, financial or geographical difficulties. In some services, there is evidence of restriction of access to contraception and STI testing based on residency or age.⁵ Not only is the psychological and social burden of an unplanned pregnancy harmful from a patient perspective, but increased unplanned pregnancy rates create more demand for maternity and abortion services, costing the NHS more overall.⁶

Patients have the right to be provided with sufficient information to choose a method of contraception that is right for them, and then to be able to access the method of their choice without having to negotiate unnecessary hurdles.⁷ Indeed, this is backed up by government guidelines which in England say “all services, and interventions commissioned by local authorities and other service commissioners should be patient-centred and aimed at improving the health of individuals and the wider population”.⁸ Because of split commissioning responsibilities and little oversight of the system as a whole, SRH provision is no longer meeting this requirement.

It is essential that appropriate sexual and reproductive health provision is available for patients when they need it, wherever they seek support. Some patients want to visit their local GP, while others prefer the relative anonymity of a specialist SRH service. The current issues with fragmented commissioning in England and training across the whole of the UK are causing problems with patient choice, creating health inequalities, generating unnecessary cost for the NHS, and risking patients experiencing the psychological burden of unplanned pregnancy. We ask that these recommendations are considered and implemented as soon as possible.

RCGP Patient and Carers Participation Group

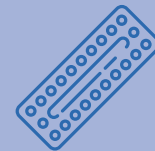


Scope

The RCGP exists to promote quality in general practice. Quality SRH should enable patients to have a choice of contraceptive methods delivered by well-trained professionals without fear of harassment or stigma. This service should be fully integrated, with clear referral pathways to create a seamless experience including contraception, reproductive healthcare and STI care.⁹

However, RCGP members report that current circumstances are preventing GPs from delivering a fully patient-centred service producing the best outcomes. This paper identifies issues in SRH across the UK and signals a warning to politicians and NHS decision-makers that action is needed. This paper will concentrate on i) summarising concerns about current commissioning in England, where fragmented commissioning pathways and reduced funding is pushing SRH provision to the brink; and ii) access to quality training in SRH and how it affects patients and clinicians in all four nations of the UK.

In 2014, the RCGP published a position paper on SRH highlighting the risks to the system in England caused by the Health and Social Care Act 2012.¹⁰ Reduced availability of LARC in primary care and the difficulty of retaining training qualifications were both highlighted. RCGP members, polled in October 2016, are clear that that these concerns have been realised, and SRH provision as a whole is at risk of collapse.¹¹ By the time this downturn is more fully reflected in official figures these problems will have become entrenched and more difficult to reverse. We are therefore recommending the immediate implementation of the following recommendations:



Recommendations



R

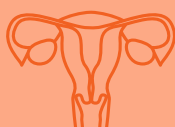
England

- i. Commissioners from Clinical Commissioning Groups (CCGs), local authorities and NHS England should work through Sustainability and Transformation Partnerships (STPs) to agree joint plans for SRH, with the aim of maximising choice and creating the best outcomes for patients, according to assessed local need;
- ii. Review the contracts and payment systems used to commission SRH and Genitourinary medicine (GUM) services so that they focus on integration, incentivising prevention and early intervention;
- iii. Introduce a public health indicator which measures the availability of LARC through GPs' surgeries;
- iv. The Department of Health should give Public Health England responsibility for responding to the data collected around SRH, and mandate the organisation to make recommendations for action when outcomes decline;
- v. Regulations should be amended to enable the introduction of statutory guidance on the number, type, and specifications of SRH services which local authorities must provide;
- vi. Introduce public health indicators which cover the whole care pathway for SRH and include over 25s;
- vii. The Department of Health should review the Framework for Sexual Health Improvement in England and establish an indicator set to monitor progress against it.

R

UK

- viii. Specialist SRH services should meet the requirements of the Service Standards for Sexual and Reproductive Healthcare, outlined by the Faculty for Sexual and Reproductive Healthcare and equivalent standards should be developed for GUM services, drawing on sources such as the British Association for Sexual Health and HIV (BASHH) clinical guidelines;
- ix. Training for local GPs, medical students and nurses must be a mandatory part of specialist SRH services' contracts;
- x. Health Education England, The Northern Ireland Medical and Dental Training Agency, NHS Education for Scotland and Wales Deanery must work with Local Education and Training Boards (LETBs) or deaneries to assess local need for training in SRH and the best way to meet it.



Background in England: Fragmentation in funding and commissioning

The 2012 Health and Social Care Act led to the fragmentation of the commissioning responsibilities for sexual and reproductive health provision in England. As the excerpt below from Public Health England (PHE)'s report "Making it work" shows, there are three different commissioners for SRH provision, providing a variety of different services.

Local authorities

Comprehensive sexual health services:

1. Contraception and advice on preventing unintended pregnancy, in specialist SRH services and LARC provision in primary care (GP and community pharmacy) commissioned under local public health contracts
2. Sexually transmitted infection (STI) testing and treatment in specialist SRH services and primary care commissioned under local public health contracts, the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV

3. Sexual health aspects of psychosexual counselling
4. Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmacies

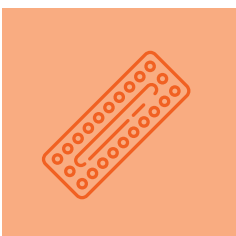
Social care services (for which funding sits outside the Public Health ringfenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:

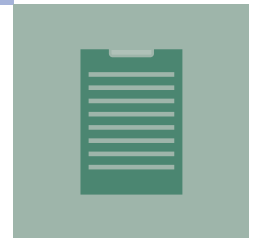
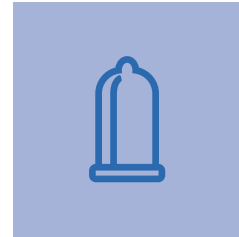
1. HIV social care
2. Wider support for teenage parents

CCGs

- Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway
- Female sterilisation
- Vasectomy (male sterilisation)
- Non-sexual health elements of psychosexual health services

- Contraception primarily for gynaecological (non-contraceptive) purposes
- HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments)





NHS England

- Contraceptive services provided as an "additional service" under the GP contract
- HIV treatment and care services for adults and children, and cost of all antiretroviral treatment
- Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients, where provided as part of "essential services" under the GP contract (not part of public health commissioned services, but relating to the individual's care)
- HIV testing when clinically indicated in other NHS England-commissioned services
- All sexual health elements of healthcare in secure and detained settings
- Sexual assault referral centres
- Cervical screening in a range of settings
- HPV immunisation programme
- Specialist fetal medicine services, including late surgical termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks
- NHS Infectious Diseases in Pregnancy Screening Programme ¹²

Therefore, from a GP perspective, reimbursement for contraception provision from primary care is complicated:

- Core contraception (pills and injections) payments changed following the 2003/4 contract, are not separately ringfenced, and make up part of the global sum
- The funding for enhanced LARC services is from the public health budget
- The same procedure may be commissioned from a different source, depending on its purpose. For example, enhanced services for intra-uterine system insertion for contraceptive purposes are commissioned and funded by public health, whereas insertions for gynaecological purposes are reimbursed by CCGs, even though this distinction is meaningless in many clinical circumstances. Where there is a dual purpose for a treatment like this the incentive is created to claim back costs from the commissioner who will reimburse more



A dysfunctional system and reduced access

The apportioning of SRH commissioning responsibilities between CCGs, local authorities and NHS England disrupts patient pathways in SRH because services are shaped by the source, availability and amount of funding rather than by patient need.

Changes to methods of accessing contraceptives are being motivated by financial or systemic reasons, without consideration of patients being at the core of commissioning decisions.¹³

Varied local visions mean that providers are generally delivering a medical model of service, which limits individual patient choice and does not always link appropriately with other services to tackle local needs for improved population outcomes.¹⁴

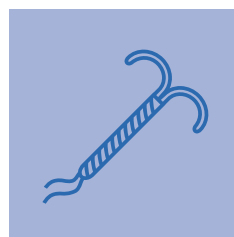
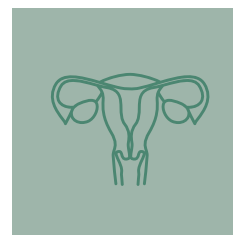
There is no communication or outreach from the clinic which is the other side of a town 20 miles away. Effectively there is no availability of copper coils for contraception, although it is in our service description delivering it is impossible when we are 1.5 FTEs of GP time short in a two-site rural practice.

GP in England

We provide a weekly LARC and drop in service at our practice but struggle with maintaining funding in practices rather than centrally. For our patients, services close to home are much better suited and this has become more of an issue since the city centre service closed only leaving a service on the other side of the city.

GP in England

For example, CCGs commission abortion services, while local authorities 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. Furthermore, according to the Faculty of Sexual and Reproductive Healthcare (FSRH), during the reshuffle in staff that took place in 2013 following the implementation of the Health and Social Care Act 2012, anecdotal evidence suggests a large proportion of experienced abortion service commissioners moved to local authorities, in some areas leaving less-experienced CCG commissioners stipulating contract targets and service specifications that may not be conducive to achieving high quality standards of care.



The impact of budget cuts and insufficient funding

Meanwhile, public health budgets are becoming more and more stretched. In 2015 commissioners saw £200m in-year cuts, which were followed by further ongoing reductions announced in the Spending Review, along with the announcement of the reduction in grants to local authorities.

Where overall funding cuts have been made to local authority budgets, money has in some areas been taken from the public health budget to fund other services - such as sport and leisure centres, trading standards, domestic abuse services, citizens' advice bureau, parks and green spaces, and housing - which is having a knock-on effect on the availability of specialist SRH services.¹⁵ Comparing the availability of these services in the four nations of the UK highlights the disparities that exist. According to our research, while 91% of our small sample of GPs in Scotland, Wales and Northern Ireland agree that they are able to access specialist support when they need it, only 74% of GPs in England agree this is the case, and 13% disagree.

[The] new provider of [the local] CASH [Contraception and Sexual Health] service seems to be struggling [with a] long waiting list, [they have] cut back on outlying clinics, so [they are] hard to access for our rural population. We want to be able to provide a better service in Primary Care, however due to pressure on our core services, SRH provision is seen as much lower priority [and there is] not sufficient financial incentive. The disconnect between [the] public health contract for LARC & CCGs commissioning [termination of pregnancy is] frustrating.

GP in England

The Five Year Forward View highlighted the need for a "radical upgrade in prevention and public health".¹⁶ It is hard to see how this will happen with cuts to public health budgets continuing as they are.

As the amounts of money available to pay providers for specialist SRH services have reduced, demands on these providers have had to reduce as well. According to FSRH, there are concerns that cuts to the public health budgets will result in a 'dumbing down' of SRH services, and commissioning less complex care, for example user-dependent contraceptive provision as opposed to the full range of long acting and complex contraceptive care, or without appropriate leadership. These funding reductions risk quality of care. In August 2016, one private

provider suspended some abortion services as it reviewed procedures following concerns raised by the CQC.¹⁷ Moreover, the short timescale over which these services are now commissioned means that it is more difficult for providers to commission for the future.

There is about to be a new contract which on current information will be a worsening of the service which will come in about 18 months – [we expect] less clinics [and] do not know if there will be redundancies in the SRH service. [It will] not be able to do cervical smears [or be] able to fit Mirena for non-contraceptive purposes.

GP in England

Where cuts are made to the public health-funded elements of SRH provision, the impact and increased cost is often felt on other parts of the system paid for by different commissioners. So local authority-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. The Primary Care Women's Health Forum reports that 37% of their GP members have experienced a recent increase in women seeking appointments for contraception as SRH clinic appointments become harder to obtain.¹⁸ GPs in England responding to our survey are experiencing the same trends, with 41% agreeing that appointments for contraceptive advice have increased over the past year. Because they do not shoulder the burden of the consequences of cutting specialist SRH services, local authority budget holders do not benefit financially from taking a preventative approach to commissioning.

According to the Family Planning Association, if the current level of cuts to public health spending continue over the next five years, every £1 lost to SRH could cost the public purse up to £86 overall.¹⁹ These figures come from the Unprotected Nation report which has also predicted that by 2020 public health cuts could cause up to an extra £8.295 billion in costs related to unintended pregnancies and an extra 72,299 STI diagnoses, equating to a cost of £363 million.

Moreover, the impact of this reduction in the number of services provided by SRH clinics is more complex than simply financial. When sexual and reproductive health provision is working well, different parts of the system work together to strengthen the whole. For example, because each GP practice provides small scale contraception they depend on local specialist SRH services for training and updating, care of the complex patient, and emergency cover for smaller practice services (for example implant fitting when the fitter is sick or emergency IUDs when the fitter is on leave). Specialist SRH services also have access to technology not available to the average GP practice, which facilitates more complex procedures such as the use of an ultrasound scan in difficult clinical situations. Moreover, contraceptive care has increased in medical complexity over time, meaning that even the most experienced GPs often need to refer patients to specialist care.

Last time I called [the local specialist SRH services] for advice about a complicated LARC issue [I] was told I would get a call back/email within 24hrs, this didn't happen and patient had to go to gynae for treatment.

GP in England

A coordinated approach to commissioning of SRH, pooling policy and shared aims, would not only improve patient pathways but would also make the entire system more robust to budget cuts. Collaborating in this way would bring oversight for these plans under the supervision of Health and Wellbeing Boards which would make them more accountable to local populations. Leadership must come from commissioners within STPs who will need to devise ways of collaborating across CCGs and with Local Authorities to provide these services. Delivery of SRH is one of the services mentioned in the Local Health and Care Planning: Menu of Preventive Actions produced by PHE.²⁰ This list highlights just six high-impact interventions, giving the provision of effective contraception, HIV and STI services the same profile as public health interventions around tobacco and alcohol. According to PHE these interventions have been proven in the STPs which have implemented them and are also based on NICE guidelines. PHE has estimated that if 1,000 women were to change their method of contraception from oral contraceptive to LARCs, this would prevent 291 unplanned pregnancies in 5 years. When budgets are considered as a whole this would mean an average net saving to the NHS of £29 per woman changing her contraception method to LARC, equating to total net savings of £143 over 5 years.²¹

As well as the savings gained from collaborating on care pathways, there are also potential savings from the changes in the nature of HIV and GUM provision. Many of these services are becoming less complex as technology improves. It is now possible to carry out screening for STIs and HIV remotely using home testing or home sampling and many GPs and specialist services are using these capabilities in an innovative way. If commissioners pool SRH resources then any savings from such changes could be used to strengthen the quality of services in other parts of the SRH care pathway.

R

Recommendation

Commissioners from CCGs, local authorities and NHS England should work through their STPs to agree joint plans for SRH, with the aim of maximising choice and creating the best outcomes for patients, according to assessed local need.

Specialist SRH services should meet the requirements of the Service Standards for Sexual and Reproductive Healthcare, outlined by the Faculty for Sexual and Reproductive Healthcare,²² and equivalent standards should be developed for GUM services, drawing on sources such as the BASHH clinical guidelines.²³

Furthermore, it is essential that the contracts used to commission particular services do not distort delivery. In some areas of the country, SRH is funded using a block payment while GUM services within the same specialist SRH service are paid per activity delivered.²⁴ The All Party Parliamentary Group on SRH has found that this creates an incentive for services to prioritise GUM as it can bring in additional funding.²⁵ This risks services being disproportionately focussed on GUM which may not reflect the needs of patients. Services should be delivered using the same type of contract, or the London Integrated Tariff, which was developed to tackle these issues and drive best practice.²⁶

R

Recommendation

Review the contracts and payment systems used to commission SRH and GUM services so that they focus on integration, incentivising prevention and early intervention.

Not only are public health budgets as a whole being cut, but the payments GPs receive for LARC from public health budgets are insufficient to cover both level of patient demand and the cost to GPs of providing the service in terms of both clinician time and equipment. Consequently, this allocation of public health funding reflects neither patient need nor GP expenditure.

GPs are fitting IUDs for insufficient money in our area at the moment. This is unsustainable as other members of the practice team point out what other activities the contraceptors should rather be contributing to.

GP in England

General practice is already experiencing the strain of the steadily increasing demand for appointments, an increasing burden of administration, an ageing population with more than one long term condition and increased complexity of workload. Therefore, pressures caused by cuts to the funding for LARC enhanced services are even more impactful, causing them to have to reduce service provision.²⁷ According to the Primary Care Women's Health Forum survey 2016 68% of GPs questioned in February were not sure whether LARC services would continue to be funded in the financial year 2016/17. Some women are having to travel long distances to access LARC where their own GP service does not provide the service and local SRH clinics have been decommissioned.²⁸ This creates the disincentive for patients to choose LARC, even though it may be the best form of contraception for them, not only putting the patient at risk of unplanned pregnancy but also creating potential cost in maternity or abortion services.



Our survey of GPs highlighted the huge contrasts in provision of LARC through GP practices across the UK, with England suffering the most harmful and widespread funding cuts. All but one of our small sample of GPs in Scotland, Wales and Northern Ireland agreed that all patients whose best option was LARC are able to access it, whereas in England just 62% of GPs told us this was the case, with more than a quarter (27%) of GPs in England disagreeing that patients who need LARC are always able to access it. 86% of GPs in England provide LARC in their practice, and 39% said they have experienced cuts to the funding for this service. Almost a third – 29% - of English GPs taking part in our survey believe that their LARC service will get worse in the next year.

The local authority is continuing to fund GP provision of LARC services, however it is unlikely this will continue from April 2017 so I don't know whether we will be able to continue to provide it after this.

GP in England

A further 9% of GPs in England said they used to provide a LARC service which had closed in the past five years. These closures all occurred since 2014 and the introduction of the Health and Care Act 2012.

GPs are an essential provider of contraception and are seeing increasing numbers of patients about this issue. Patients have the right to receive the best form of contraception for them, and with the reduced access to specialist SRH services – particularly in rural areas – the accelerating reduction in LARC services delivered through GP practices risks creating a perfect storm which will reduce previous positive trends in unplanned pregnancy.

R

Recommendation

Introduce a public health indicator which measures the availability of LARC through GPs' surgeries.

Indicators, data and accountability

Although, as already discussed, following the implementation of the Health and Social Care Act 2012, responsibilities for SRH commissioning were split between CCGs, NHS England and public health, the overall accountabilities for local systems have never been established. Without this oversight and accountability there is inadequate stimulus for collaboration and it is essential that this is addressed in order for commissioners to come together.²⁹

The Public Health Outcomes Framework indicators – particularly around conception, focus on women under the age of 25, reducing the incentive for commissioners to provide services for women over this age. As such, where reductions in service are made, they tend to target services for over 25s, despite the fact there is an unmet need for contraception in this demographic demonstrated by the increase in abortion rates among this group over the past ten years.³⁰ Indeed, the rate of conception among women aged over 40 has more than doubled since 1990 from 6.6 to 14.5 conceptions per thousand women.³¹

Local SRH services are very much geared to < 25 yrs so general practice is the preferred place for older women. With this demand and GP recruitment at crisis point there is a perfect storm for SRH provision to decrease. SRH takes up a lot of my time clinically and with the decrease in reimbursement my partners cannot be forgiven for questioning whether it is a service we can afford to continue to provide.

GP in England

Moreover regulations for commissioning contraceptive services through public health budgets do not set out when, where and how contraception advice and other services should be offered, just that local authorities should arrange for the provision of a broad range of contraception and advice on preventing unintended pregnancy, and all contraception supplied must be free to the patient.³² These regulations must be amended so that there is statutory guidance with detailed service specifications to ensure access to the right provision for all patients, no matter their age nor locality.

Dedicated clinics are far away from many clients living in rural areas. This is especially a problem for the younger population - particularly if they don't want their parents involved.

GP in England

R

Recommendation

Regulations should be amended to enable the introduction of statutory guidance on the number, type, and specifications of SRH services which local authorities must provide.

Introduce public health indicators which cover the whole care pathway for SRH and include over 25s.

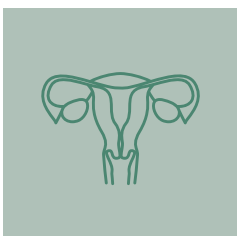
In 2013 the Department of Health published its Framework for Sexual Health Improvement in England.³³ However, progress against this framework is not being assessed and the amount of data collected on the uptake of different SRH interventions locally and nationally is currently insufficient.³⁴ PHE collect this information – and it shows great variation across the country - but lack the formal powers to act upon the findings of its data collection and hold commissioners to account.³⁵ Moreover, although there is data from those visiting SRH services, this is not linked with data held by GP services, meaning that pressures on GP services are not being recorded.

R

Recommendation

The Department of Health should review the Framework for Sexual Health Improvement in England and establish an indicator set to monitor progress against it.

The Department of Health should give PHE responsibility for responding to the data collected around SRH, and mandate the organisation to make recommendations on remedial action when outcomes decline.



Training

In addition to the financial and structural barriers highlighted above, some GPs across the UK say they are now struggling to access the training they need to become and stay qualified in SRH, particularly LARC, delivery with significant regional variability. Only 18% of UK GPs who took our survey agree that LARC training is easy to access.

We are fortunate in that we have a weekly community drop-in sexual health clinic, run by secondary care colleagues in our practice. Three of the GPs in my practice provide Nexplanon but none of us are trained in coil fitting.

GP in Scotland

With GP recruitment so difficult now, gone are the days when a new GP had to have SH qualifications. Over the last few years our preference for a new GP has gone from ' DFRSH and IUD/SDI fitter a requirement ' to it being an 'ideal' and our last 2 appointments do not have SRH experience. I am now the sole LARC fitter to a practice population of 11,500 and aim to retire in a few years' time.

GP in England

GPs in Scotland have highlighted the expense and the difficulty accessing training there because of high demand. RCGP East Faculty organises a sexual health update day every year and according to feedback from our members this is one of the best attended courses in Tayside because of the lack of accessibility of other SRH courses. Some Health Boards in Scotland are organising GP training for GP Registrars in sexual health. However, similar training is not currently provided for established GPs.

Training is an issue. [Local] courses are often very lengthy and go "out of date" very quickly... the cost falls to the individual clinician or the practice depending on circumstance.

GP in Scotland

At the same time in England, uncertainty around the future of the service and a lack of meaningful communication with public health commissioners are reducing incentives for GPs to continue to keep up their training qualifications, again resulting in reduced services.³⁶ There are examples where intra-uterine device insertion for contraceptive purposes has been decommissioned by public health, so the skills of the clinician are not maintained to insert these for gynaecological (heavy menstrual bleeding) reasons. This makes no financial sense and provides additional hurdles for women to navigate.³⁷

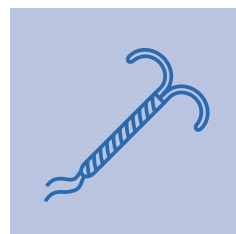
Some of those providing contraceptive advice through primary care have not had specialist training. Working practice nurses often do not have the funding or time allocated from GP practices to attend the courses previously run for SRH care. In England, where specialist SRH services contracts used to specify that they were required to train local GPs, medical students and nurses, a lack of funds from public health to pay for these courses means that in many cases this clause has now disappeared.

R

Recommendation

Training for local GPs, medical students and nurses must be a mandatory part of specialist SRH services' contracts.

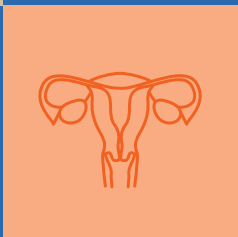
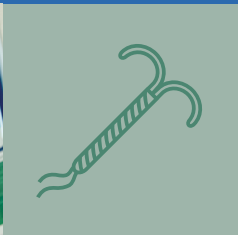
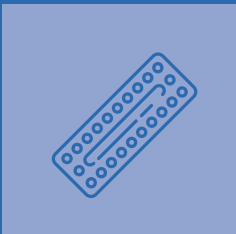
Health Education England, The Northern Ireland Medical and Dental Training Agency, NHS Education for Scotland and Wales Deanery must work with Local education and training boards (LETBs) or deaneries to assess local need for training in SRH and the best way to meet it.



Conclusion

The RCGP's position as a membership body for GPs across the UK puts us in the privileged position of being able to anticipate future trends in health outcomes.

SRH is an area which is suffering as a result of current health policy in all areas of the UK, and which needs to be tackled with particular urgency in England. We ask that the governments of the UK reflect on and implement our recommendations in order to preserve the positive progress the UK has been making in this field.

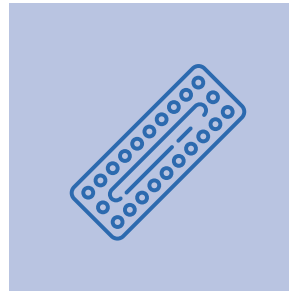


References

- 1 23 women in every 1000 under 18s fell pregnant in 2014 compared to 47 in every 1000 in 1998
- 2 <http://www.content.digital.nhs.uk/catalogue/PUB21969/srh-serv-eng-15-16-rep.pdf>
- 3 Office for National Statistics 'Conceptions in England and Wales 2014': <http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2014#main-points>
- 4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/534601/hpr2216_stis.pdf 5 July 2016
- 5 Breaking down the barriers: The need for accountability and integration in sexual health, reproductive health and HIV services in England, All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015 p23
- 6 <http://www.fpa.org.uk/sites/default/files/unprotected-nation-2015-executive-summary.pdf>
- 7 Response to the Health Select Committee's inquiry into public health post-2013 from the Primary Care Women's Health Forum
- 8 Commissioning Sexual Health Services and Interventions: Best Practice for Local Authorities (Department of Health, 2013) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144184/Sexual_Health_best_practice_guidance_for_local_authorities_with_IRB.pdf
- 9 <https://www.fsrh.org/about-us/our-vision/>
- 10 RCGP Position Statement: The commissioning of sexual & reproductive healthcare in England (March 2014)
- 11 163 GPs from across the UK (133 from England, 17 from Scotland, 5 from Northern Ireland, 4 from Wales) took part in our internet survey between 14 and 31 October 2016. They were recruited through email and social media. Results of this survey are indicative, limited by sample size, and further research would be needed to assess the full impact of changes in SRH provision across the four nations. Minor edits have been made to GP comments for clarity, though these are clearly marked.
- 12 Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV, Public Health England, March 2015
- 13 Response to the Health Select Committee's inquiry into public health post-2013 from the Primary Care Women's Health Forum
- 14 Roundtable : Sexual and Reproductive Health and HIV Clinical Workforce
- 15 Raiding the public health budget (BMJ, 2014) <http://www.bmj.com/content/348/bmj.g2274>
- 16 <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> p3
- 17 <https://www.theguardian.com/world/2016/dec/21/marie-stopes-uk-abortion-clinics-women-at-risk-cqc-report>
- 18 Response to the Health Select Committee's inquiry into public health post-2013 from the Primary Care Women's Health Forum p9
- 19 <http://www.fpa.org.uk/sites/default/files/unprotected-nation-2015-executive-summary.pdf> p6
- 20 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf
- 21 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf p55
- 22 <http://www.fsrh.org/documents/consultation-service-standards-for-sexual-and-reproductive/service-standards-for-srh-consultation.pdf>
- 23 <https://www.bashh.org/guidelines> British Association for Sexual Health and HIV
- 24 Block contracts: a service is commissioned for a fixed sum of money. While commissioners know how much they will be spending, this means there is less opportunity for innovation by service providers, and if more patients use an open service than is expected, there is no remuneration for this. National Tariff/Payment by results: GUM services have traditionally been funded through payment by results. This means that the funding is available for providers to give these treatments to everyone who needs them.
- 25 <http://www.fpa.org.uk/sites/default/files/breaking-down-the-barriers-report-appg-srhuk.pdf>
- 26 <http://sexualhealthtariff.pathwayanalytics.com/about-the-integrated-tariff> (accessed 4/11/16)
- 27 Response to the Health Select Committee's inquiry into public health post-2013 from the Primary Care Women's Health Forum p8
- 28 Response to the Health Select Committee's inquiry into public health post-2013 from the Primary Care Women's Health Forum
- 29 <http://www.fpa.org.uk/sites/default/files/breaking-down-the-barriers-report-appg-srhuk.pdf> p4
- 30 Department of Health: Abortion statistics in England and Wales 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/529344/Abortion_Statistics_2015_v3.pdf
- 31 ONS: Statistical bulletin: Conceptions in England and Wales: 2014 Annual statistics on conceptions covering conception counts and rates, by age group including women under 18. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2014#age-at-conception>
- 32 Commissioning Sexual Health Services and Interventions: Best Practice for Local Authorities (Department of Health, 2013) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144184/Sexual_Health_best_practice_guidance_for_local_authorities_with_IRB.pdf paragraph 35
- 33 <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>
- 34 <http://www.fpa.org.uk/sites/default/files/breaking-down-the-barriers-report-appg-srhuk.pdf>
- 35 <http://fingertips.phe.org.uk/profile/sexualhealth/data#page/0/gid/8000059/pat/6/par/E12000004/ati/102/are/E06000015>
- 36 Response to the Health Select Committee's inquiry into public health post-2013 from the Primary Care Women's Health Forum
- 37 Response to the Health Select Committee's inquiry into public health post-2013 from the Primary Care Women's Health Forum



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Authors

Prof Helen Stokes-Lampard
Eleanor Thompson
Helen Gracie

Acknowledgements

This paper was developed with the help of the internal RCGP SRH reference group whose input was invaluable in informing the paper. Thank you also to members of the RCGP's Patient Groups for your input.



This report is officially endorsed by the Faculty of Sexual and Reproductive Healthcare (FSRH)

Royal College of General Practitioners

30 Euston Square
London NW1 2FB, UK
T +44 (0)20 3188 7400
F +44 (0)20 3188 7401
E policy@rcgp.org.uk
www.rcgp.org.uk

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