FSRH

FSRH written submission to the Health Devolution Commission call for evidence - n inquiry into the value and accountability of devolved health systems

16 March 2020

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to respond to the Health Devolution Commission Committee call for evidence. 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) care delivery. Our goal is to ensure that high standards in SRH care are achieved and maintained through appropriate funding and commissioning to ensure the population can access services which realise our Vision[1] for high-quality and holistic SRH across the life course.

1 WHAT DOES GOOD HEALTH DEVOLUTION LOOK LIKE?

a) In what ways does health devolution enable the building of healthier communities and promote the prevention of ill-health?

FSRH advocates for comprehensive, holistic sexual and reproductive healthcare (SRH) across the lifespan. In our Vision, holistic SRH care means *'integrating care around the needs of the individual, not institutional silos, with people able to get integrated/holistic advice and support across the breadth of SRH"'*[1]. Another key principle in our Vision is the importance of integration – '*establishing clear referral pathways between services so that care can be integrated around the needs of the individual'*[2].

Health devolution can support our Vision through the integration of healthcare services. The greatest barriers to integrated SRH care are lack of funding for Public Health, fragmented commissioning of SRH services, and lack of accountability across the system (see answer to question 1c). Devolution can offer the opportunity to address these system barriers and change the current healthcare system. In order to prevent ill-health, we must establish networks of care that share common goals, have clear leadership, and cross institutional boundaries that span health, public health, and social care.

Another opportunity created by devolved healthcare is the integration of care at a local level via the development of new models of care, such as Primary Care Networks (PCNs). These new models can present opportunities for healthcare commissioners and providers to work together as well as for workforce training and development. For example, an FSRH GP member accounts:

[1] FSRH 2015. Better care, a better future: a new vision for sexual and reproductive health care in the UK.
[2] *Ibid.*

FSRH

'Funding is being directed at [primary care] networks which is where collaborative delivery of care should be focused. This is such an opportunity to start pulling together care delivered to women - community services working with practices as a start and possibly pooling budgets. Locally my PCN has been slowly working on a Women's Health Hub. The size of our patient population means we have started conversations with our community and acute trusts as well as local authority about working together. This enables holistic oversight of what is happening to provision and hopefully a better understanding of the effects of cutting budgets on the local services for women.'

Therefore, devolution and new models of care can provide the opportunity to create a whole system approach to commissioning, where patients can access the full range of SRH services easily and locally.

c) Are there any barriers to the potential benefits of health devolution being realised; and if so how could these be addressed?

In relation to SRH, the greatest barriers to successful health devolution are lack of funding for public health, fragmented commissioning of SRH services, and lack of accountability across the system.

One of the principles of good SRH care in FSRH's Vision is that SRH must be *'fully-funded based on the needs of the population and the principles of an open-access service'* and *'patients must have access to the full choice of contraceptive methods and be able see a trained healthcare professional to discuss the full range of contraceptive options available to them'*[3]. However, since 2015, two thirds of councils have reduced or frozen their SRH budgets. In 2018/19, more than one in ten local councils reduced the number of contracts they held with GP surgeries to fit subdermal implants and intrauterine systems (IUS) and devices (IUD), the most effective methods of contraception.[4]

Funding shortages cannot be solely resolved through the devolution of healthcare. A sustainable long-term solution for the Public Health budget is needed to ensure the success of healthcare devolution. Without funding, health devolution simply puts increased pressure on local authorities and GP services to deliver positive health outcomes, without providing them with the capital they need to provide holistic, integrated care. If local authorities and GPs are to fulfil their Public Health functions, they must be adequately funded.

Fragmentation of commissioning is a further barrier to healthcare devolution. Women's reproductive healthcare has suffered the most from the re-organisation of NHS services that followed the implementation of the Health and Social Care Act in 2013. Commissioning of SRH services is currently split between CCGs, NHSE and local authorities. This fragmentation of governance and commissioning responsibilities has created confusion and barriers for women when trying to access healthcare. For instance, women cannot usually now get cervical screening, STI screening, and repeat contraception prescription at the same visit. Instead, they must book multiple appointments, or be referred to another service to receive

---

[3] *Ibid.*

[4] Advisory Group on Contraception 2018. *At tipping point: An audit of cuts to contraceptive services and their consequences for women*.

part of their care. This process wastes time and resources and is detrimental to women's health. These barriers to service integration must be removed to ensure the success of healthcare devolution.

e) To what extent does health devolution accelerate integration within the NHS and between health and social care services, and help make the NHS Long Term Plan a reality?

The Health and Social Care Act 2012 limits integration between the NHS and other health and social care services, because it is based on the principles of competition, not collaboration, which is out of touch with the urgent need to (re)build a sustainable health and social care system that will meet growing demand and care for a vastly ageing population. The Act set out the duty of NHS, CCGs and other bodies to ensure that care was delivered in an integrated way. The duties of competition and integration, however, have often been in conflict, impacting negatively on the delivery of patient care. NHSE and NHS Improvement have recognised this and made recommendations to Government and Parliament for an NHS Bill that addresses the need for the different parts of the system to work together more easily, and speeding up implementation of the NHS Long-Term Plan. It called for repealing section 75 of the Health and Social Care Act 2012, which would remove the presumption of automatic tendering of NHS services[5], a recommendation we support and believe could aid integration and implementation of the NHS Long Term Plan in a devolved environment.

Prevention of ill-health is the cornerstone of the NHS Long Term Plan. In the current system, however, clinicians cannot offer preventative care if they are not commissioned to do so. An FSRH member explains the impact of the fragmentation in the provision of preventative services:

"I see a woman in my contraception clinic who requires a difficult fitting of the coil. She is also due her cervical smear test. This is the perfect opportunity to provide both services, however my clinic is not commissioned to provide smears so I am unable to do so. That's two appointments and two vaginal examinations for something that could be done straight away. It is expensive, frustrating for me as a doctor and unfair for the woman."

Through the co-commissioning of SRH services, the devolution of healthcare has the potential to remove the arbitrary boundaries between which body provides which service, enabling the creation of a vision for what services should look like, and how services should be delivered in an integrated and holistic way. We address this issue in more detail in our answer to question 2 a) and b).

[5] NHS 2019. *The NHS's recommendations to government and garliament for an NHS bill. September 2019*.

FSRH

2 HOW CAN CHALLENGES OF ACCOUNTABILITY, POWER AND CONTROL BE ADDRESSED IN DEVOLVED AND INTEGRATED HEALTH SYSTEMS?

a) What is the relationship between central government, NHSE and devolved health areas? In what way is the Secretary of State for Health and Social Care and NHSE held accountable for improving a community's health as well as NHS performance in devolved health and social care systems?

Fragmented commissioning in SRH

Commissioning of SRH services in England is currently split between CCGs, NHS England, and local authorities. The below table demonstrates quite clearly why by-design the current system has inherent faults across SRH[6]. To underline how this fractured system does not meet the needs of women, we have highlighted the split in women's reproductive health commissioning responsibilities with a ✓.

Local Authorities	Clinical Commissioning Groups (CCGs)	NHS England
✓ Contraception and advice on unplanned pregnancies in SRH services ✓ LARCs in primary care ▫ STI testing and treatment in SRH services and primary care; partner notification ▫ HIV testing and partner notification ▫ Sexual health specialist services incl. young people's services, outreach and promotion ✓ Support for teenage parents ✓ Chlamydia Screening ▫ Sexual health aspects of psychosexual counselling	✓ Abortion services, incl. contraception, STI & HIV testing in abortion pathway ✓ Contraception for gynaecological purposes ✓ Female sterilisation ▫ Male sterilisation ▫ Non-sexual health aspects of psychosexual health services ▫ HIV testing when clinically indicated in CCG-commissioned services	✓ Contraception under GP contract ✓ Cervical screening ✓ Specialist foetal medicine services, incl. late termination of pregnancy for foetal anomaly between 13-24 gestational weeks ▫ HIV treatment ▫ STI & HIV testing and STI treatment in general practice when clinically indicated / requested by patient ▫ HIV testing when clinically indicated in NHSE-commissioned services ✓ HPV immunisation ✓ Sexual assault referral centres (SARCs) ▫ Sexual health in secure and detained settings ✓ NHS Infectious Diseases in Pregnancy Screening

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

Conversely, there are policy decisions being undertaken through the NHS, which demonstrate a lack of holistic planning, e.g. contraception has no clear workstream pathway under the NHS's Maternity Transformation Programme. The devolution of healthcare provides potential

[6] Royal College of General Practitioners 2017. *Sexual and reproductive health: Time to act*.

FSRH

to restructure this relationship between local authorities, CCGs and NHSE. The collaborative commissioning of services encourages each of these groups to consider their impact on one another, and to work together to ensure that women have access to the highest quality of care.

Accountability in co-commissioning

Overarching accountability for SRH services has not been clearly established since the introduction of the Health and Social Care Act 2012, resulting in a lack of oversight of service quality and health outcomes. This has created a system where there are few incentives to work collaboratively, since the consequences of decreased access transfer to someone else's budget or balance sheet. In the devolved nations, different pathways for the commissioning of SRH have attempted to avoid the fragmentation seen in England. In Scotland and Wales, challenges remain. In Wales, there is no overall set structure to SRH service design, leading to unclear service pathways for patients[7]. This is evidence that health devolution alone is not enough to ensure consistent and holistic care. Clear lines of accountability must be established to ensure that both clinicians and patients understand healthcare service pathways. To avoid the challenges faced in Scotland and Wales, services must be fully-funded and consistently commissioned, and clear lines of accountability must be established.

Collaborative commissioning is not a new idea per se; both the *Department of Health's 'A Framework for Sexual Health Improvement in England 2013*'[8] and PHE's '*Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV*'[9] advocated a collaborative and whole-system approach to commissioning. PHE advocates principles for commissioners to adopt, which FSRH wholeheartedly supports, including patient-centred commissioning with care pathways designed around the needs of the individual; collaboration among commissioners across boundaries as required by the care pathway and ensuring contractual arrangements for the commissioned services support the delivery of seamless pathways in the most effective and efficient manner.

NHSE can also have a strong role to play in strengthening accountability in SRH outcomes. As part of enhanced roles, particular NHSE National Clinical Directors and regional-based National Specialty Advisers, who have a focus on prevention and women's health, can ensure that co-commissioning in SRH works to a higher standard and is consistent across England. They can ensure that nationally recognised standards in SRH are met in co-commissioning arrangements and that Integrated Care Systems (ICSs) and PCNs are reaching their potential for co-commissioning in SRH.

[7] Royal College of Obstetricians and Gynaecologists 2019. *Better for women report.*
[8] Department of Health 2013. *A framework for sexual health improvement in* England.
[9] Public Health England 2014. *Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV*.

FSRH

b) How can local leaders in devolved health systems be held accountable locally and nationally at the same time for the performance of locally integrated services?

Accountability mechanisms such as joint meetings to review population health outcomes and the performance of the local system against clearly designed objectives could be established to support accountability of local leaders. These meetings could bring together different commissioners, local authorities, Directors of Public Health and medical directors of health systems (PCNs medical directors, for instance), reporting to national commissioning leads/medical directors and DHSC.

We agree with the Government's view in the Prevention Green Paper that whilst there are some instances when co-commissioning of SRH services has been successful, this '*is too often dependent on the efforts of particular individuals or favourable local circumstances'* and that, '*the extent and nature of collaborative commissioning arrangements varies dramatically*'[10]. We support the Government's call for collaborative commissioning in SRH to "become the norm" requiring local authorities and the NHS to work closely together at national and local level. We believe CCGs, NHSE and local authorities must work together and plan services based on patient and population need while embedding workforce planning in any service model.

However, we believe that relying on voluntary initiatives for collaborative commissioning of SRH services alone will not suffice. In the view of our 15,000 members who work in the frontlines of service delivery, co-commissioning can improve the quality and availability of SRH services, increase access and reduce inequalities, but only with clear lines of accountability across the system. In the case of SRH, this means that SRH services need to be mandated to commission against FSRH Standards. SRH commissioners such as local authorities need to be held to account for health outcomes through accountability mechanisms that go beyond just the election ballot.

The local authority mandate to deliver Public Health services can also be enhanced and strengthened. This requires mainstreaming standards of care at the local level. FSRH's Service Standards on Sexual and Reproductive Health have been developed specifically to support providers and commissioners in providing safe, high-quality SRH services, ensuring patient safety[11]. It is essential that all outcomes are collected and recorded, so that local authorities can determine what impact the changes are having on patient outcomes, experience and financial efficiency.

A 2015 inquiry into system accountability in Sexual Health, Reproductive Health and HIV services by the All-Party Parliamentary Group on Sexual and Reproductive Health[12], which took evidence from the then Public Health Minister, NHSE, PHE, amongst others, concluded that a lack of accountability was directly impacting patients and urged the Department of Health to consider national accountability for Sexual Health, Reproductive Health and HIV to be a priority action.

---

[10] Cabinet Office & Department of Health and Social Care 2019. *Advancing our health: prevention in the 2020s – consultation document*

[11] FSRH 2016. Service standards for sexual and reproductive healthcare.

FSRH

c) What is the nature of the relationships between local clinical leaders (health commissioners and providers) and civic (professional and elected) leaders? What decisions are each responsible for in a devolved and integrated system?

In a devolved and integrated system, local clinical leaders work together with civic leaders to create a vision for what services should look like, and how they should be delivered. In Manchester, for example, a community-based medical gynaecology service has been developed to provide convenient access and safe services for women.[13] This service is consultant lead, which has enabled an expansion of the range of services available, and has ensured that robust governance and training are in place. Close links and two-way communication between GPs and consultants have reduced the need for patients to travel to repeat appointments. There are also robust pathways into secondary and tertiary care. The strong relationship between the service and their CCG commissioners has developed an excellent service. The service is monitored regularly against KPIs set out in the service specification. A collaborative, flexible approach means innovation is promoted and service developments implemented quickly.

d) How does health devolution affect policies to empower individuals to have more control over their health and social care services and outcomes?

According to the World Health Organisation, individuals are empowered when they have control over decision and actions related to their health.[14] Due to fragmented commissioning, individuals currently have little control over the SRH services provided to them. For example, specialist gynaecology clinics can prescribe the IUS, one of the most effective contraceptive methods, for heavy menstrual bleeding but not for contraception, whereas a woman attending a GP appointment for contraceptive advice who also complains of heavy bleeding cannot be offered an IUS if the practice is not commissioned to do so. This is because the provision of long-acting reversible contraception (LARC) in primary care is split between local authorities and CCGs, and GPs are not incentivised to perform insertions in their surgeries.

The devolution of healthcare provides the opportunity for NHSE, CCGs and local authorities to deliver an integrated approach to commissioning by ending the fragmentation of services and ensuring that women can get their SRH needs met in one place. This includes the full range of SRH services, such as contraception, cervical screening, and treatment and advice about the menopause. This approach gives women the power to decide when and where to access services, rather than being limited by the commissioning arrangements of service providers.

For further information please contact Camila Azevedo, External Affairs Manager, at externalaffairsmanager@fsrh.org / 02037945309

[13] FSRH 2019. *Opportunities to embed sexual and reproductive healthcare services into new models of care: A practical guide for commissioners and service providers*

[14] World Health Organisation 2009. *WHO guidelines on hand hygiene in health care: First global patient safety challenge clean care is safer care*.