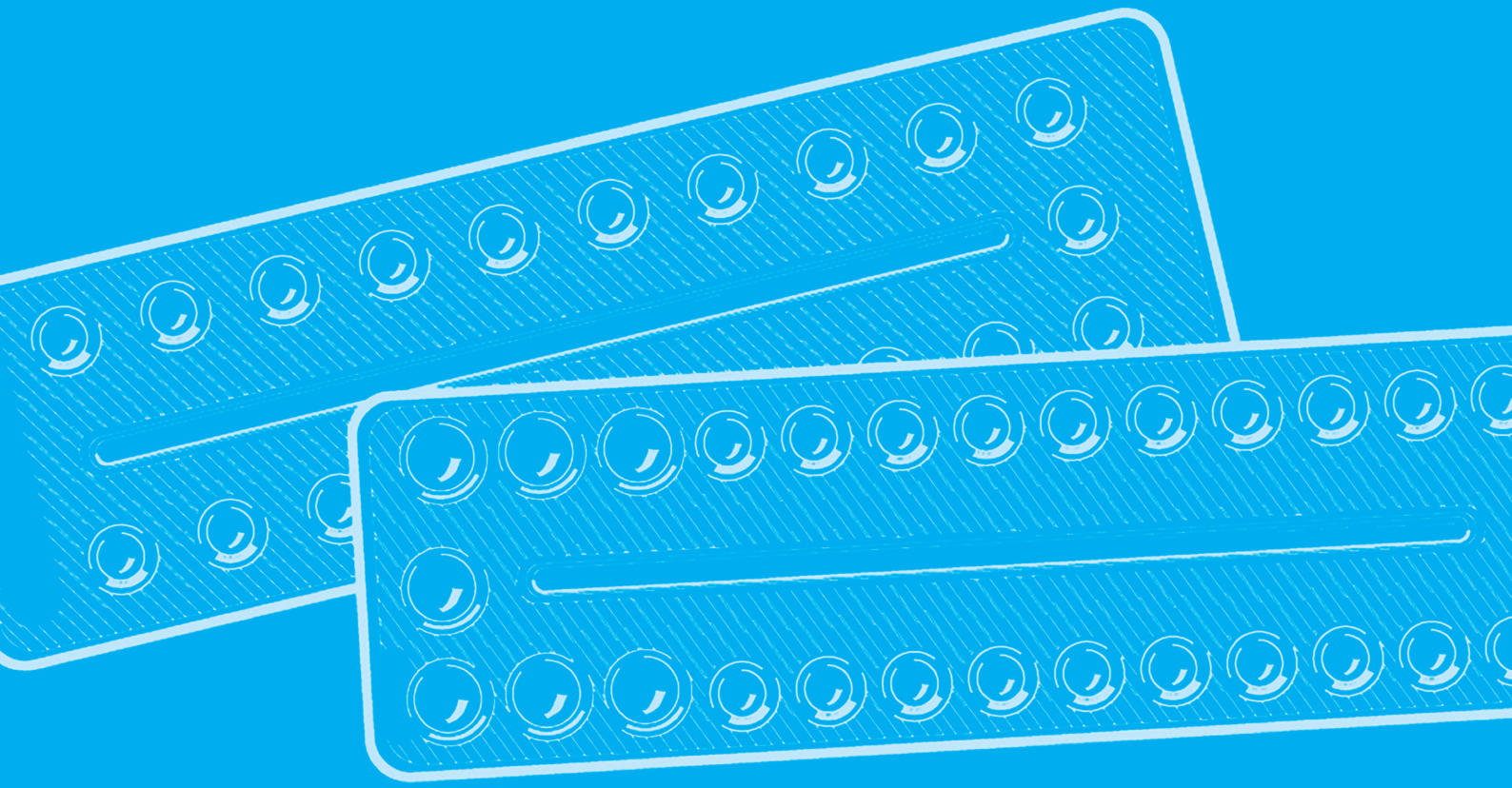
All-Party Parliamentary Group on
Sexual and Reproductive Health in the UK

# Healthy women, healthy lives?

## The cost of curbing access to contraception services



An Inquiry by the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK into restrictions in access to contraception services

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FPA acts as the secretariat to the APPG on Sexual and Reproductive Health in the UK. The Advisory Group on Contraception (AGC) provided administrative services only to the APPG Inquiry into access to contraceptive services. The secretariat of the AGC is provided by MHP Communications whose services are paid for by Bayer HealthCare. Editorial control rests with the APPG alone.

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# Foreword

The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPG) decided to conduct an Inquiry into access to contraception because we were concerned about the restrictions that we were hearing about through professional networks. The restrictions in access to contraception that we have heard of throughout the APPG Inquiry have shocked many of us who have worked in the field of sexual health.

Choice and access to contraception is an essential for most women. It enables them to control their reproduction, plan their lives and avoid unplanned pregnancy. Access to contraception services and contraception choice is a necessity, not a luxury.

It is clear that a lot of restrictions on contraceptives and contraception services are driven by funding decisions, though not always. However, we know that investment in contraception saves money, and cuts to these services is short-sighted and not in the best interest of women. I believe that while the funding situation may not change, the new commissioning system must be used as an opportunity to make services better and innovate access to contraception services.

Thanks to all those who submitted written evidence to the APPG Inquiry and those that gave up their time to give oral evidence as well. I would particularly like to thank the women from Walthamstow who came to Parliament to give evidence about their experiences, and my colleagues on the panel Baroness Massey of Darwen and Baroness Barker.

**Baroness Gould of Potternewton**
**Chair, All-Party Parliamentary Group on Sexual and Reproductive Health in the UK**

# Introduction

The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPG) is a group of cross-party Parliamentarians who aim to raise awareness in Parliament of the importance of improving all aspects of the sexual health of women and men, and the needs of women seeking abortion in the UK.[1]

In February 2012 the APPG held a meeting to discuss possible restrictions in access to sexual health services to residents-only and to people under 25 years old. During the meeting members of the Advisory Group on Contraception (AGC) presented the initial findings from a Freedom of Information (FOI) audit of primary care trusts (PCTs) which had found variations in access to contraceptive services and methods.

The APPG expressed concerns at the findings from the audit and decided to launch an Inquiry to find out more. The APPG was particularly concerned about:

- evidence of commissioners restricting access to contraceptive services on the basis of age or place of residence
- the impact that the drive for efficiency savings is having on women's choice of the full range of contraceptive methods
- some methods of contraception only being made available with a GP referral
- the impact of changes to the commissioning structures on the continuity and quality of contraceptive care.

The APPG Inquiry into restrictions in access to contraception was launched on Friday 20 April 2012. The full terms of reference for the Inquiry can be found in Appendix 1. The Inquiry issued a call for submissions of written evidence by 5pm on Friday 18 May 2012. Appendix 2 contains a list of written submissions received by the Inquiry.

The Inquiry also organised an oral evidence session on Tuesday 22 May 2012 with witnesses invited to give evidence. Witnesses included women who have experienced restrictions, clinicians, service providers and a patient representative organisation. See Appendix 3 of this report for a full list of witnesses at the oral evidence session.

The Parliamentary Under-Secretary of State for Public Health, Anne Milton MP, was invited to give oral evidence but was unable to attend. The Inquiry is disappointed the Department of Health did not send a representative to attend the oral evidence session. The APPG looks forward to reviewing the Department of Health's response to this Inquiry and the evidence presented.

**Recommendation:** The Government should consider all of the evidence and recommendations presented within this Inquiry and publish a response to it as soon as possible.

[1] FPA acts as the secretariat to the APPG on Sexual and Reproductive Health in the UK. The Advisory Group on Contraception (AGC) provided administrative services only to the APPG Inquiry into access to contraceptive services. The secretariat of the AGC is provided by MHP Communications whose services are paid for by Bayer Healthcare. Editorial control rests with the APPG alone.

# Executive summary

The APPG Inquiry into restrictions in access to contraception services received written and oral evidence from across the country. Restrictions in access to contraception focused on three key areas: age, residency and method.

Restrictions included: restricting access to oral contraception for women over 25 years old; restricting access to contraception services to residents-only; and restrictions on access to long-acting reversible methods of contraception (LARC) through GP referral only. It was clear from the evidence that it was women over the age of 25 years old who were bearing the brunt of these restrictions.

The Inquiry received evidence on the impact that restrictions in access to contraception had on women and healthcare professionals. The Inquiry heard from women in Walthamstow who talked about difficulties they had in accessing contraception due to the lack of services and other witnesses also talked about the impact they have on women.

Concerns were also raised about the impact restrictions would have on professional training and the future availability of training in contraception.

Much of the evidence the Inquiry received also raised concerns about the fragmentation of sexual health service commissioning and the lack of a detailed mandate for local authorities on what appropriate sexual health services would look like. Many submissions also raised queries about the delay in the publication of the sexual health policy document that was originally due in spring 2011.

> *"I work in the centre of Bradford … a lot of our young women, if we put barriers in the way, won't be able to get round those barriers, and they certainly won't be able to afford the bus fare to the next clinic."*
>
> **Dr Anne Connolly, Inquiry oral evidence session**

Below sets out the recommendations which have been agreed by this Inquiry.

## Improving the lives of women

1. All women must have access to a full choice of contraceptives and contraceptive services, including comprehensive information and advice that enables them to choose the method which is best for them. Any restrictions on access on the basis of age, residence or method should be removed as a matter of urgency.

## Government

2. The Government should consider all of the evidence and recommendations presented within this Inquiry and publish a response to it as soon as possible.

3. The Department of Health should publish the sexual health policy document as soon as possible.

4. The Department of Health's forthcoming sexual health policy document should take a life course approach, including addressing the needs of people over the age of 20.

5. The Department of Health's sexual health policy document should set out how contraceptive services will be commissioned under the new arrangements. The document should signpost commissioners to clinical best practice and medical evidence.

6. The Government should consider re-evaluating its commissioning of sexual health services to ensure that commissioning responsibility is being delegated in the most appropriate way. The forthcoming Department of Health consultation to determine the best long-term commissioning arrangements for abortion, vasectomy and sterilisation sets a precedent for this.

7. Working with Public Health England and the NHS Commissioning Board, the Department of Health should provide further clarity about how the mandate on local authorities to provide 'appropriate access to sexual health services' is implemented at a local level.

8. Public Health England, working with the Department of Health and the NHS Commissioning Board, should consider establishing regional sexual health networks to help monitor the commissioning of open-access services, including contraceptive services, at a sub-national level. These networks should ensure services are effectively integrated.

9. The NHS Commissioning Board and the Department of Health should publish an update on how local enhanced services (LESs) and the sexual health tariff will be implemented under the new arrangements.

## Public Health England, Health Education England and NICE

10. Public Health England should undertake an assessment of the indicators relating to sexual and reproductive health in the Public Health Outcomes Framework on how they are delivering the 'life course approach'.

11. In the absence of any indicators relating to sexual and reproductive health for post-teen women, the Department of Health, working with Public Health England, should establish what national levers can be put in place to ensure local commissioning decisions do not have a perverse impact on a group of people in their area.

12. Public Health England and the NHS Commissioning Board should develop national guidance for all commissioners of contraceptive services around integrated working and delivery of services, including models for referral pathways in contraception.

13. Health Education England should undertake a regular audit of professionals who are trained to deliver specific contraceptive services, including LARC methods. This information should be made publicly available at a local and national level to help inform commissioning decisions.

14. Health Education England, working with associated member organisations, should take steps to improve the provision of nurse training in contraception, with a view to creating a national, coordinated model.

15. Public Health England, working with Royal Colleges and associated organisations, should undertake a review looking at how the *Making Every Contact Count* initiative could be implemented for contraceptive services, including in pharmacy and other community settings.

16. National Institute for Health and Clinical Excellence (NICE) should prioritise the development of the quality standard on contraceptive services (including emergency contraception) to help set out the national standards for how care should be delivered.

## Commissioners

17. Commissioners identified within this report as having a restriction in place on contraceptives or contraceptive services should, as a matter of urgency, undertake a review of these restrictions and take steps to remove them as soon as possible.

18. Commissioners of contraceptive services must ensure that the contraception, and other sexual health services, that are commissioned in local areas, reflect the life course approach.

19. Health and wellbeing boards should undertake a review of the commissioning arrangements of contraceptive services in their area while developing their joint health and wellbeing strategy to ensure they do not create a perverse impact on particular groups of people.

20. NHS North East London and NHS London should undertake an urgent review of contraception provision in Walthamstow, particularly for women over the age of 25 years old. The APPG looks forward to receiving the results of the review and an action plan for how services are going to be improved.

21. Waltham Forest Council's health and wellbeing board should hold an urgent meeting with commissioners, providers and service users to discuss how a comprehensive, open-access contraceptive service can be commissioned within the new arrangements from April 2013.

# The importance of access to contraception choice

The APPG believes that access to the full range of contraception choice is a fundamental right for women and men. We support the principle of open-access sexual health services and believe that people should have access to contraception services at times, and in places, that are convenient to them.

The terms of reference of the APPG Inquiry into restrictions in access to contraception services specifically focused on the impact that restrictions are having on women's choice of the full range of contraceptive methods. This section looks at why access to a choice of the full range of contraceptive methods is important. Through the evidence received by the Inquiry it is clear that access to contraception choice is important because restrictions in choice impact on women's lives, patient choice, professional development and have an economic impact.

## Good practice in contraception provision

There are many contraception services throughout the country that provide excellent contraception access and advice to women. Aspects like providing clear information about opening times, different methods of contraception provided and whether the service is walk-in or by appointment go some way to providing a good contraception service to women. Having accurate advice and information that women can take away also helps.

Open-access services are also a crucial aspect of contraception provision. The APPG understands open-access contraception services to be services where access to the service is not restricted by postcode. See below for some examples of good practice in contraception access:

### Case study

The British Pregnancy Advisory Service (bpas) morning-after pill in the post scheme ran during the Christmas period 2011. The scheme gave women access to free emergency hormonal contraception (EHC) in advance of need via post following a telephone consultation with a nurse. It was run over the Christmas period as bpas identified women as experiencing particular problems accessing EHC at this time of year.

Case study

An initiative led in Hull sought to improve women's access to information about different LARC methods. Every woman of reproductive age who accesses a family planning clinic or participating GP practice received a handout. The handout includes, on one side, a scripted introduction to LARCs and, on the other, a tiered contraceptive effectiveness chart. Laminated versions of the handout are available for all counselling and examination rooms and after an initial trial have resulted in significant increases in uptake of LARC methods within the area.

## Impact on women

Access to contraception is a fundamental part of sexual and reproductive health services and it is women's, and men's, fundamental right to be able to access the full range of contraception choice.

*Improved access to contraceptive service providers and a choice of contraceptive has been one of the key ingredients in this recent success [significant improvements in rates of unintended pregnancies]. Women need a choice of contraceptive provider and need to be able to access contraception, including emergency contraception, when away from their borough of residence. Furthermore, women should have access to the method that suits them best; this is associated with better compliance. Women also need a full choice of the range of contraceptive methods as some women cannot use certain methods for medical reasons.*

**Extract from Faculty of Sexual and Reproductive Health (FSRH) written submission**

Access to contraception choice really matters for women. It impacts on their ability to control their fertility and feel confident in their contraception which in turn impacts on their use of contraception. Women who have a choice of contraception and are confident with their chosen contraception are more likely to use it effectively, protecting themselves against an unplanned pregnancy and its emotional and financial impact.

*I asked my GP for the pill with the 12 hour window for taking it as it doesn't matter if you don't always remember on time, which I knew sometimes I wouldn't. I got given the 3 hour window one [half the price of contraceptive requested]. Now I'm pregnant.*

**Extract from bpas written submission**

Evidence submitted to the Inquiry showed that restrictions in access to contraception choice and adequate services can also impact on women's general wellbeing, their family and their sex life.

The APPG heard from a group of women from Walthamstow, London who had been restricted in accessing contraception services locally. We thank these women for giving up their time and sharing their experiences with the APPG.

The main issue for a lot of the women was that their GP surgery did not provide contraception on religious grounds and the nearest clinic for women over 25 years old was difficult to get to for some of them. Their experiences ranged from waiting outside a clinic that opened late and without a doctor, refusal of provision of emergency contraception, and being told that they couldn't have an IUD fitted because they hadn't had a child. The impact of these restrictions included having to wait with their baby in a clinic because they couldn't get an appointment, having to go private for their service, being confused about the service they were accessing and being forced to access a contraception service in another area of London.

*"I was all very confused at this point, I didn't really know what was going on."*

*"I needed to be somewhere safe, I needed to be somewhere confidential, the process I wanted was invasive and I needed to be safe and comfortable and I ended up having to go privately, which is not an acceptable solution, I don't feel."*

*"And so for me it meant, instead of having contraception when my child was eight weeks old, I got it a week ago, because it was the first time I could get into a situation where me and my partner could go together."*

**Quotes from the Inquiry oral evidence session**

The experiences of these women and the quotes above show why access to contraception choice and good services are so important to women to ensure they are able to genuinely choose a method of contraception that is right for them.

Many of the written submissions the APPG received talked about the impact of contraception choice on public health issues such as the teenage pregnancy rate and the abortion rate. The Advisory Group on Contraception (AGC) written submission included findings from its report on Freedom of Information requests to PCTs. Its report found that almost one third of women in England aged 15–44 (3.2 million) are living in areas where a fully comprehensive contraceptive service is not provided. Furthermore, the AGC report found that those PCTs restricting access to contraceptives or contraceptive services had a higher abortion rate than the national average.[2]

[2] Advisory Group on Contraception, *Sex, Lives and Commissioning: An Audit by the Advisory Group on Contraception of the Commissioning of Contraceptive and Abortion Services in England*, April 2012.

# Impact on patient choice

The Inquiry has found that contraception choice and access to high-quality services are important because they promote patient choice and personal responsibility.

> *"If you empower people to make choices and have good access and knowledge about improving their sexual health then it will raise the standard of sexual health."*
>
> **Dr Anne Connolly, Inquiry oral evidence session**

The APPG has received written submissions and representations through the oral evidence session that women's access to contraception services is being restricted by age. The main issue, where restrictions to services are age-related, is that in some areas there do not seem to be services available for women over the age of 25 years old. Some areas are also restricting access to contraceptive methods for women over the age of 25 years old to GP only.

These types of restrictions often mean that women don't have a choice when it comes to their contraception. Restricting access to GP only can often doubly restrict women who are trying to access contraception. Firstly, many women simply do not want to access sexual health services and contraception from their GP. Secondly, contraception services from GPs can often be restricted themselves to certain brands of oral contraception or oral contraception only. Again, this further restricts women in their choice of contraception simply because they are over the age of 25 years old.

These double restrictions can leave women with no genuine choice over their contraception and this is not acceptable.

The APPG is deeply concerned that restrictions in access to the full range of contraception are impeding people's ability to make an informed choice about their contraception. This goes against the principles of patient choice enshrined in the NHS Constitution which states that:

- "You have the right to access NHS services. You will not be refused access on unreasonable grounds."
- "You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age."[3]

**Recommendation:** All women must have access to a full choice of contraceptives and contraceptive services, including comprehensive information and advice that enables them to choose the method which is best for them. Any restrictions on access on the basis of age, residence or method should be removed as a matter of urgency.

[3] NHS, *The NHS Constitution; the NHS Belongs to us All*, March 2012.

## Economics of contraception

The Inquiry also found that effective choice in contraception is important because investment in contraception saves money.

Many written submissions to the APPG Inquiry talked about the health economics of contraception. Bayer HealthCare's written submission for example stated that *"Investment in contraceptive services represents good value to the NHS; it is estimated that every £1 spent on contraceptive services saves the health service £12.50"*.

We received many submissions that stated that the short-term cuts to contraception services will only lead to longer term costs from higher unintended pregnancy rates which ultimately will cost the NHS more.

The Inquiry has demonstrated that restrictions in access to contraception choice and services have a negative economic impact and, in the long-term, end up costing more to the health service.

## Impact on workforce training and development

Many of the written submissions to the Inquiry raised concerns about the impact of restrictions on professionals' access to training and continued professional development in contraception.

The majority of training in contraception takes place in community contraception clinics. This means that in areas where there is little community provision training will be difficult to come across for professionals like GPs who want to develop their skills.

*The LMC is concerned about the impact this [restriction] will have upon the training of doctors and nurses and will also reduce the experience of trainers which could lead to poor quality training.*

**Extract from Haringey Local Medical Committee written submission**

*There is often a very real difficulty for them [GPs] to obtain their initial training due to the lack of CaSH clinics in Leeds in which to train. As a result of this there are still many practices unable to provide full contraceptive services to their patients.*

**Extract from clinician in Leeds' written submission**

The APPG is deeply concerned that the restrictions in access to the full range of contraception methods means that fewer clinicians will develop skills and learning in the full range of methods. This could mean that some methods will gradually become unavailable throughout the country and skills and expertise are lost and not replaced.

The Inquiry found that access to contraception choice is important because it enables people to make informed choices about their contraception needs and ultimately take control of their reproduction. If women are happy with their choice of contraception they are more likely to use it effectively meaning fewer unintended pregnancies and negative consequences for women, and lower expenditure for the NHS.

# Evidence of restrictions in access to contraception

The APPG Inquiry received oral and written evidence of policies which appear to be placing restrictions on women trying to access contraceptive services. These restrictions are based on:

- age
- residence
- method.

More importantly, these restrictions appear to be arbitrary and driven by cost considerations, rather than clinical need.

The AGC, who submitted evidence from its recent audit of the current commissioning environment for contraceptive services, *Sex, Lives and Commissioning*, found that nearly a third of women aged 15–44 do not have access to a fully comprehensive contraceptive service. Restrictions uncovered by the audit included:

- four PCTs saying they had a restrictive policy in place in relation to access to services, ranging from services only being available within geographical boundaries, to women over the age of 25 not being able to access contraceptive pills from their local contraception and sexual health (CaSH) service and having to go to their GP
- 34 per cent of PCTs saying they have a restriction on the prescribing or availability of contraceptives. (The AGC has estimated that this means one third of women in England are living in an area where a fully comprehensive contraceptive service is not provided.)[4]

These findings are supported by recent audits undertaken by bpas and FPA through their enquiry service. bpas recently audited the experience of women speaking to its nurse specialists in contraceptive counselling. 40 per cent of the 3,000 women with unwanted pregnancies who have used bpas' contraceptive counselling telephone service since last year have reported problems with contraceptive access from GP practices and CaSH clinics.[5] These include clinic closures, reduced opening hours that are inconvenient for working women and restrictions on methods available.

FPA has also found increasing evidence that women are experiencing restrictions in accessing contraceptive services on the basis of age, residence, method and GP referral. From its database of clinics, the FPA has submitted information on the areas where services have the most restrictions. These are set out in Table A.

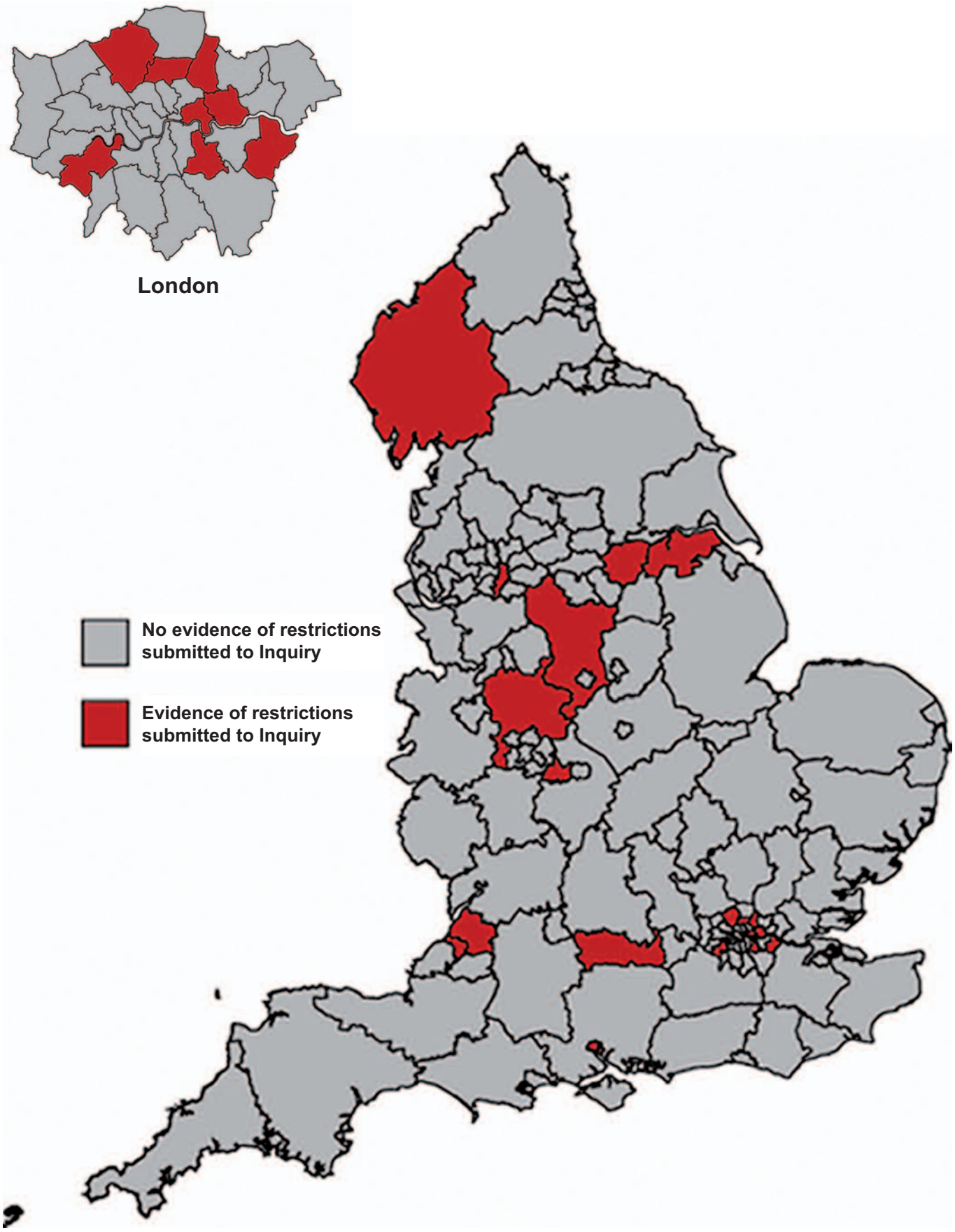
4 Advisory Group on Contraception, *Sex, Lives and Commissioning: An Audit by the Advisory Group on Contraception of the Commissioning of Contraceptive and Abortion Services in England*, April 2012.

5 bpas, *bpas finds nearly half of women with unplanned pregnancies experiencing difficulties accessing contraception*, 10 May 2012, accessed 14 June 2012. <www.bpas.org/bpasknowledge.php?year=2012&npage=0&page=81&news=488>

**Table A: FPA data on services with restrictions it is aware of (collected in early 2012)**

| Out of London PCTs: clinics with restricted service access | Type of restriction |
|---|---|
| South Staffordshire PCT | Clinics in Cannock, Lichfield, Tamworth and Stafford *all* restricted to the under-25s. Rugeley appears to be the only open-access service in the area (9 hours per week) |
| NHS Cumbria | Abortion referral by GP only at *all* services |
| Solihull NHS Care Trust | For the Solihull clinics clients need a GP referral for contraception if they are over 25 |
| NHS North Lincolnshire | Scunthorpe and Immingham see under-25s only. GPs to provide *all* contraception for the over-25s |
| NHS Doncaster | Main clinic is open access but all other clinics are age restricted |
| NHS Berkshire West | Reading – only a single 2½ hour open-access session, there are two large clinics for under-25s only |
| **London PCTs: clinics with restricted service access** | **Type of restriction** |
| Bexley Care Trust | 11 clinics listed; only two open-access sessions per week (total of 5 hours) *all* remaining sessions are restricted to the under-20s (total of 64¾ hours per week) |
| NHS Barnet | Over-25s to see GPs for abortion referral, contraceptive pills and cervical screening |
| NHS Tower Hamlets | Residents only |
| NHS Newham | Residents only |
| NHS Waltham Forest | Residents only |
| NHS Richmond | LARC methods available for residents only |
| NHS Haringey | Over-25s are restricted as to where they can access different contraceptive methods |

**Map A: PCTs with restrictions in place on access to contraceptive services and methods as identified to the Inquiry**



Data submitted by Bayer HealthCare from its *Contraception Atlas*, reported wide variations in spending on contraception, uptake of LARCs and access to all methods of contraception.

Dr Connie Smith also submitted data showcasing the variations in the uptake of LARCs in London. Despite there being more women of fertile age in London and the abortion rate (per 1,000 resident women) being much higher than in the rest of England, the rate of LARC GP prescriptions is markedly lower. Despite the fact that there has been a one third increase in LARC prescribing overall, the rest of the country has not caught up.

These findings can be explained and are supported by the healthcare professionals who submitted examples of the types of restrictions being experienced locally. The Royal College of Physicians (RCP) submitted evidence that Bristol and South Gloucestershire were restricting the insertion of LARCs for some women by age. The RCP notes that women in Bristol and South Gloucestershire under the age of 18 who attend a CaSH/integrated sexual health service will be offered a LARC regardless of their current method of contraception. However, the same service is not offered to women over 18, unless a GP practice has no provision for LARC fitting.

> *"One is the restriction of more expensive formulations of pills, a second is a restriction of actual methods, so there are certain places where if you wanted a patch or a ring, or if you indeed wanted an IUD fitted, that wouldn't be commissioned for certain segments of the population. And then there are restrictions which are people over 25 don't get into this service. So there are all three levels of restriction operating across London."*
>
> **Dr Connie Smith, Inquiry oral evidence session**

A clinician from Tower Hamlets PCT reported that family planning services were restricted to under-25s. This was impacting on women who work because GPs are not offering early morning, evening or weekend appointments for contraception. They reported that contraception is not managed as an 'on-the-day' request and therefore patients are expected to book in advance, which discourages uptake of some LARCs and potentially impacts on emergency contraception requests and unwanted pregnancy. They added that there was a wait of up to three months for some LARCs.

Two organisations from Haringey submitted evidence on the restrictions being imposed and the impact that this was having on patients. Haringey CaSH stated that in March 2011 NHS Haringey imposed a financial cut to services within Haringey CaSH which consisted of:

- restricting the provision of contraception excluding long-acting methods to patients aged over 25 years
- patients requiring non-LARC methods were to be referred to their GP
- short-term provision was not commissioned; patients aged over 25 years could only have LARC
- short-term use of hormonal contraception to manage side effects of LARC (for example, irregular vaginal bleeding) was allowed.

The Haringey LMC raised concern over the decision by NHS Haringey to cease providing oral contraceptives to over-25s in October 2011 as a result of budget cuts and noted its opposition. Haringey LMC said it was of the view *"that this restriction of access to such services is wrong and should be removed"*.

**Recommendation:** Commissioners identified within this report as having a restriction in place on contraceptives or contraceptive services should, as a matter of urgency, undertake a review of these restrictions and take steps to remove them as soon as possible.

**Recommendation:** Commissioners of contraceptive services must ensure that the contraception, and other sexual health services, that are commissioned in local areas genuinely meet the needs of the women that live there.

## Reasons for restrictions

The Quality, Innovation, Productivity and Prevention (QIPP) agenda means the NHS is being required to find an unprecedented £20 billion of efficiency savings by 2015. In part, these restrictions appear to have been driven by cost consideration as commissioners are looking for ways to do more with less. Evidence submitted to the committee reveals that this is impacting upon women's access to the full range of contraceptive methods.

The APPG took evidence from Dr Chris Wilkinson, President of the Faculty for Sexual and Reproductive Health (FSRH) who reported that a survey of its lead clinicians across the UK in the last 18 months had found that almost 60 per cent of clinicians reported budget cuts as PCTs seek to make savings. 16 per cent of clinicians responding to the survey reported restrictions on LARCs and of these 78 per cent were based purely on financial reasons.

The AGC's audit found evidence that prescription of contraceptives was being set on the basis of cost rather than choice or quality. For example, NHS Barnet stated that *"In 2010 the PCT introduced a restriction on over-25s accessing integrated services for generic contraceptive advice ... Only patients within this age group who have complex needs can be seen by an integrated service"*.

A number of organisations and individuals who submitted evidence reported that the impact of these cuts was that hours and services are being reduced. A clinician from Lewisham Healthcare NHS Trust reported that the impact of cutbacks had led to opening hours being reduced so that all clinics are closed by 8pm and to reduced access to medical staff, as they are not being replaced when they leave.

Derbyshire Community Health Service is planning to impose savings of around £200,000 recurrently each year for the next four years from the sexual health services budget of around £2.4 million. A clinician said: *"This 20 per cent cut is resulting in closures to our contraception, STI and menopause services in Staveley, Ilkeston, Belper and Matlock and cuts to doctors and nurses in Chesterfield, Killamarsh and Dronfield"*.

The Royal College of Physicians reported that the 17 separate contraceptive services in Southampton have now been reduced to eight following integration to deliver efficiency savings.

A clinician from Stockport NHS reported that the service specification for integrated sexual health services for the whole of Greater Manchester being prepared by the Greater Manchester Commissioning Group was looking to impose the following restriction: *"Commissioners expect that patients are referred back to primary care for routine contraceptive needs which are funded under existing contracts."*

The reasons stated by commissioners are that the health economy cannot afford to pay twice for services and that repeat pill-prescribing is already covered under the primary care contract. They noted that this conflicts with the principle of open access and self-referral and will have the greatest impact upon young people, ethnic minorities and women from deprived areas, who are greater users of CaSH services for their contraceptive care.

The APPG received evidence on the perverse consequences of these cuts to services. Bayer HealthCare noted in its submission that the cost of unintended pregnancies is £755 million a year. It also noted the correlation it found in its *Contraception Atlas* between those PCTs who spend most per head on abortion and unintended and unwanted pregnancy across all age groups. As has been noted earlier in the report, it added that £1 spent on contraceptive services saves the NHS £12.50.

A clinician from Derbyshire reported that although these cuts will result in short-term savings, the health community will face greater costs in the medium and longer term from the resulting increase in unwanted pregnancy, sexually transmitted infections and menopause morbidity rates.

> *"I think bottom line it's funding. Short-term funding issues. No recognition of the long-term."*
>
> **Dr Anne Connolly, Inquiry oral evidence session**

However, there is also evidence that some of the restrictions stem from the lack of prioritisation of contraceptive services by commissioners. Enhanced services allow commissioners to expand which services are made available within primary care. For contraceptive services, this includes enhanced services which allow LARC methods to be made available within these settings.

The AGC's audit found variation in the number of GP practices signed up to the enhanced service for the delivery of fitting and care of sub-dermal implants and/or intrauterine contraceptive methods in primary care. In addition, nine PCTs have chosen not to put an enhanced service in place for fitting LARC methods.

The FSRH reported that in a survey of its clinicians, *"About 30 per cent of boroughs do not have ESs in place and 6 per cent were discontinuing them. In some areas the ESs [enhanced services] are capped to reduce cost."* This means that GPs are less likely to provide LARC services as they receive no remuneration for them.

During the transitional period the Department of Health should clarify the role of enhanced services within the new system and how currency for sexual health services will be implemented.

**Recommendation:** The NHS Commissioning Board and the Department of Health should publish an update on how local enhanced services (LESs) and the sexual health tariff will be implemented under the new arrangements.

## Impact on healthcare professionals

The APPG received evidence from a number of organisations and individuals on how the restrictions were impacting on healthcare professionals.

A GP and member of the local clinical commissioning group from Leeds, said that the reduction in CaSH clinics in Leeds meant that GPs and nurses were now struggling to get access to training. This was echoed by Haringey LMC, which felt that the restrictions on oral contraceptives for women over 25 years of age would reduce the experience of trainers and were concerned about the impact this would have on the experience of doctors and nurses.

### Box 1 Clinical dilemmas at Haringey CaSH

*"[A] 30-year-old woman is having irregular bleeding post the Depo provera injection or post TOP. She can't be given the combined pill to regulate her cycle and provide contraception."*

*"28-year-old patient is on the combined pill. She attends the clinic (on a Friday evening) as she has run out of pills and is on the last day of her pill-free interval. She would like the IUCD inserted but there are no more clinic slots for IUCD insertion that evening. The clinician gave her a box of the combined pill to cover her till she has her IUCD inserted and gives her an appointment slot for this. However this is acting against the service restriction but is clinically right."*

*"33-year-old woman is having an IUCD fitted. She has never had a cervical smear done as although she has received letters to attend her GP surgery for smears she has been too afraid to do this. A smear cannot be done because of the restriction. This means the woman will have two examinations (provided she is brave enough to attend her GP surgery after the IUCD has been inserted)."*

Haringey CaSH, which offers training for healthcare professionals, noted that, as a result of the restrictions, trainees would not gain *"practical experience in managing clinical scenarios such as the contraception needs of the peri-menopausal woman, sterilisation assessments and referrals, managing patients with complex medical conditions"*.

Haringey CaSH also submitted evidence on the clinical dilemmas quoted by staff as a result of the restriction. Some examples are set out in the box above. Clearly, these will also have impacted on service users' experience and outcomes.

In some cases, the restrictions are due to a lack of staff training as a result of financial pressures rather than a direct restriction on services. The same survey by the FSRH found that 28 per cent of respondents reported a decline in training often because of the need to focus staff time on service delivery. One respondent to the survey reporting on the reduced availability of LARCs said: *"We still do not have enough fitters, ultimately everything is financial, and training is not free"*.

> *IUD/S provision has been restricted by the availability of trained personnel and this has led to patients waiting for this procedure longer than they would have for other interventions. This may limit the option for an emergency IUD procedure.*
>
> **Extract from FSRH written submission**

**Recommendation:** Health Education England should undertake a regular audit of professionals who are trained to deliver specific contraceptive services, including LARC methods. This information should be made publicly available at a local and national level to help inform commissioning decisions.

**Recommendation:** Health Education England, working with associated member organisations, should take steps to improve the provision for nurse training in contraception, with a view to creating a national, coordinated model.

**Recommendation:** Public Health England, working with royal colleges and associated organisations, should undertake a review looking at how the Making Every Contact Count initiative could be implemented for contraceptive services, including in pharmacy and other community settings.

## Impact on service users

The Inquiry received evidence from eight women from Walthamstow who were unable to access contraception at one of the largest practices in their area. The women explained that the practice does not do any family planning on religious grounds.

One of the women gave evidence to the APPG on the impact that this had on her:

*"You travel to the Leyton … to the football ground, where there's a poly clinic, and you can go in there… there's restricted time access to the service but … part of the reason I'm late today is because I have a young child, so rather than going five minutes up the road to my nearest doctor, I have to travel … it's about a ten minute walk to get the bus, then 20 minutes on the bus, then I had to wait an hour last time I went, so I had to breastfeed my child in the clinic as well, which is actually quite a good way of encouraging contraception, generally for the people waiting.*

*But it's just very difficult and my personal view is that I don't think a practice should be able to deny that service – I think at least one person in that practice should have to be able to provide it."*

**Recommendation:** NHS North East London and NHS London should undertake an urgent review of contraception provision in Walthamstow, particularly for women over the age of 25 years old. The APPG looks forward to receiving the results of the review and an action plan for how services are going to be improved.

**Recommendation:** Waltham Forest Council's health and wellbeing board should hold an urgent meeting with commissioners, providers and service users to discuss how a comprehensive, open-access contraceptive service can be commissioned within the new arrangements from April 2013.

# Commissioning of contraception services in the new world

The evidence presented to this Inquiry demonstrates a clear disconnect between a national ambition for open-access contraceptive services and local delivery. This Inquiry has received evidence of unacceptable examples where contraceptive services are being restricted to women on the basis of age, residence or type of contraceptive method.

The case for change is clear. However, these restrictions are in place at a time when the health service is going through significant structural change and when the NHS is being required to make unprecedented efficiency savings over the coming Parliament.

The passing of the Health and Social Care Act means that the way in which contraceptive services are commissioned will change in less than a year's time. Although these reforms do present challenges, many of them highlighted in the evidence received by the Inquiry, they also present opportunities to change and improve the way services are delivered.

Using the evidence presented to the Inquiry, this chapter explores key areas of the Government's health reforms and makes recommendations for how they can deliver better outcomes for women across the country.

## Sexual health policy document

The Inquiry heard from individuals and organisations that highlighted the importance of the forthcoming sexual health policy document, and the opportunity it presented for the Department of Health to address much of the uncertainty relating to how services are going to be commissioned within the new world.

First announced following the publication of the public health white paper *Healthy Lives, Healthy People* in November 2010, the Parliamentary Under-Secretary for Public Health, Anne Milton MP, has said that the document *"will set sexual health in the context of the proposed new commissioning arrangements and will promote the evidence base for improving sexual health"*.[6] In addition, the document is set to *"signpost [local authorities] to existing guidance including clinical guidelines and standards developed by professional bodies and organisations such as the National Institute for Health and Clinical Excellence"*.[7]

6 *Hansard*, House of Commons, 20 February 2012, c686W.

7 *Hansard*, House of Commons, 24 May 2012, c860W.

The sexual health policy document was initially planned for publication in spring 2011 but has since been delayed until some point during 2012. Some witnesses to the Inquiry raised concerns about the delay in publishing the sexual health policy document and the impact this may be having on how services are being commissioned – particularly during the transitional period.

In their written submission a clinician raised concerns about the lack of detail about the new commissioning arrangements and stated that it was not clear if local authorities will wish to restrict their services to local residents only. They added that uncertainty persisting around the sexual health tariff, due to start in July 2012, was making planning very difficult for providers who do not know whether they will be on a block contract or on tariff (and if they are on tariff whether the Trust will give them a fixed income or will allow it to reflect gains/losses from using the tariff).

Dr Anne Connolly, also told the Inquiry that *"right now a lot of areas are still waiting for this policy document to come – we don't have anything to work with"*.

Evidence presented by the AGC to the Inquiry noted the impact the delay was having on PCTs implementing their own strategies to reduce the level of unintended pregnancies in their area.

For example, NHS Brent said in its response to an audit carried out by the AGC that it was awaiting clarity on the commissioning of sexual and reproductive health services before putting a formal local strategy in place. NHS Barking and Dagenham said *"despite having a strategy in place, the PCT's updated sexual health strategy is in draft form and will remain this way until the Department of Health publishes the forthcoming sexual health policy document"*.

The APPG is concerned at the Department of Health's delay in publishing the sexual health policy document and the impact this may be having on local service delivery at a time of considerable change – in particular any rise in the level of unintended pregnancies.

**Recommendation:** The Department of Health should publish the sexual health policy document as soon as possible.

## Integration

One of the central principles of the Government's health and social care reforms has been ensuring integration across services. The APPG welcomes this focus on integration and recognises its importance within contraceptive services.

However, the evidence to this Inquiry has showed that, currently, there are examples where services are fragmented – with poor user referrals and a lack of accountability. This fragmentation can have a negative impact on outcomes and lead to a rise in the level of unintended pregnancies.

*I think some of the problem that we don't really understand is what's the best time to have [conversations about contraception after a women has an abortion] and what we're not seeing is integrated pathways for those women, so we're seeing fragmentation, so women often, post a termination of pregnancy, just want to leave the centre but actually our concerns are around who's following those women up – where do they end up? Many of them won't have GPs, or if they do have a GP they don't want to go and talk to them.*

**Tracey McNeill, Marie Stopes International, Inquiry oral evidence session**

Implementation of the Health and Social Care Act means elements of contraceptive services will fall under the responsibility of different bodies within the health system. During the Inquiry some organisations and individuals, while welcoming the commissioning of community contraception services by local authorities, expressed concerns that the complex nature of the new system could lead to the fragmentation of services.

However, concerns were also raised by witnesses about the future commissioning of sexual health and contraception services through public health overall. For example, Diane Abbott MP raised concerns about the accountability of the decisions that directors of public health will be making and the distribution of the ring-fenced funding. Simon Blake OBE, CEO of Brook, also raised concerns about the accountability and transparency in the new commissioning structure.

Dr Chris Wilkinson, President of the Faculty of Sexual and Reproductive Healthcare, added: *"The abortion and sterilisation commissioning issues are going to be looked at in consultation later on this year, and I do think there's an argument to actually look at sexual health commissioning as part of that process. It just seems sensible to do that."*

The Inquiry recognises these points and would recommend that the Government addresses the concerns raised by witnesses in relation to the future commissioning arrangements of sexual health and contraception services as soon as possible.

To address the current fragmentation of services and ensure they are truly integrated, the Department of Health should use the forthcoming sexual health policy document to set out the roles and responsibilities of each commissioning body that will be expected to help provide a comprehensive, open-access sexual and reproductive health service. In its recent report *Sex, Lives and Commissioning*, the AGC has laid out the commissioning and governance responsibilities of sexual health services in the new world (Table B overleaf). A similar table of responsibilities should be laid out by the Department.

Following the publication of the NHS Future Forum's first report, the Department of Health pledged to retain and expand clinical networks as bodies to drive good practice and integration of services. The role of clinical networks in areas such as cancer and stroke has helped to deliver improvements in outcomes and the quality of care.

**Table B: Commissioning and governance responsibilities for contraception and abortion services, as set out in the Health and Social Care Bill[8]**

| | |
|---|---|
| Department of Health | ■ Development of sexual health policy document<br>■ National strategy for sexual health workforce education and training |
| NHS Commissioning Board | ■ Commissioning of general practice contraceptive services<br>■ Commissioning of contraception within other specialist services<br>■ Commissioning of HIV treatment and care<br>■ Development of all age outcome indicators for sexual health (in conjunction with PHE)<br>■ Development of tariff for sexual health services (in conjunction with PHE) |
| Public Health England (PHE) | ■ Development of model pathways for sexual health and contraception<br>■ Development of all age outcome indicators for sexual health (in conjunction with the NHSCB) |
| Clinical Commissioning Groups (CCGs) | ■ Commissioning of sexual health education and training for general practice staff<br>■ Commissioning of termination of pregnancy services (fully integrated services offering full range of contraception, STI testing and treatment)<br>■ Commissioning of vasectomy and female sterilisation |
| Local Authorities (LAs) | ■ Commissioning of:<br>- Community contraceptive services<br>- Pharmacy contraceptive services<br>- Testing and treatment of STIs (including HIV testing and opportunistic Chlamydia testing)<br>- STI partner notification activity<br>- Sexual health outreach<br>- Sexual health education and training for community services |

[8] Advisory Group on Contraception, *Sex, Lives and Commissioning: An Audit by the Advisory Group on Contraception of the Commissioning of Contraceptive and Abortion Services in England*, April 2012.

In sexual health, the Inquiry heard recommendations from witnesses about the role of sub-national bodies in supporting and ensuring the commissioning of open-access contraceptive services – particularly in London where individuals are likely to travel across boroughs.

Dr Chris Wilkinson, Lead Consultant, Margaret Pyke Centre, said that there was *"great disparity at the moment"* and there were examples of people having *"to go out of their borough to get their contraceptive care, because of local commissioning decisions".* Accordingly, he said he would like to see *"some guidance around commissioning at levels greater than the locality level"* and pointed to the role of regional bodies below Public Health England.

Public Health England, working with the Department of Health and the NHS Commissioning Board, should consider establishing regional sexual health networks to help monitor the commissioning of open-access services including contraceptive services.

**Recommendation:** The Department of Health's sexual health policy document should set out how contraceptive services will be commissioned under the new arrangements. The document should signpost commissioners to clinical best practice and medical evidence.

**Recommendation:** Public Health England, working with the Department of Health and the NHS Commissioning Board, should consider establishing regional sexual health networks to help monitor the commissioning of open-access services, including contraceptive services, at a sub-national level. These networks should ensure services are effectively integrated.

**Recommendation:** Public Health England and the NHS Commissioning Board should develop national guidance for all commissioners of contraceptive services around integrated working and delivery of services, including models for referral pathways in contraception.

## Implementing the mandate and delivery of national standards

Providing a clear definition of comprehensive, open-access contraceptive services within the new health system is important given the pace of reforms and, as set out above, the complexity of the new system.

During its passage through Parliament, the Department of Health confirmed that the Health and Social Care Act would make the commissioning of sexual health services mandatory. Within this, local authorities *"will be mandated to commission comprehensive, open access contraception advice and services"*.[9]

Although the Inquiry welcomes this inclusion within the legislation, evidence presented to this Inquiry highlights concerns among members of the sexual health community about whether this mandatory requirement will be sufficient.

9 *Hansard*, House of Commons, 16 May 2012, c145W.

*"People are recognising that the mandate gives an awful lot of room for manoeuvre. And it's almost worse having one which people can ignore, than not having one at all. So that mandate and what it contains is a really important instrument, which I think we should work on getting tightened up."*

**Simon Blake OBE, Inquiry oral evidence session**

Diane Abbott MP, Shadow Public Health Minister, told the Inquiry that *"even though local authorities are mandated to provide certain sexual health services, they have a lot of leeway as to what they choose to deem public health"* within the ring-fenced budget. She added: *"I think when it comes to sexual health the Department of Health has to provide a much more detailed mandate in relation to sexual health that doesn't allow Directors of Public Health any room to slip into error"*.

The APPG welcomes the decision to make the commissioning of sexual health services mandatory but recognises the concerns raised by witnesses to the Inquiry about how this will be implemented at a local level. As a result, the Department of Health should consider addressing these concerns within the sexual health policy document and setting out what open-access sexual health services should look like. Public Health England should also have a clear role in supporting local authorities commissioning open-access sexual health services by providing specific guidance and examples of good practice.

The APPG also welcomes the decision of the National Institute for Clinical Excellence (NICE) to develop a quality standard on contraceptive services (including emergency contraception).[10] Within the new health system quality standards will play an important role in setting out what high-quality contraceptive care looks like and in shaping how services are structured.

**Recommendation:** Working with Public Health England and the NHS Commissioning Board, the Department of Health should provide further clarity about how the mandate on local authorities to provide 'appropriate access to sexual health services' is implemented at a local level.

**Recommendation:** National Institute for Health and Clinical Excellence (NICE) should prioritise the development of the quality standard on contraceptive services (including emergency contraception) to help set out the national standards for how care should be delivered.

## Delivering the life course approach

The Department of Health's public health white paper, *Healthy Lives, Healthy People: Our strategy for public health in England* set out a commitment to adopt a life stage approach to public health, based on a recognition that people's health needs will change at different times of their lives. This approach to commissioning public health has been broadly welcomed and, for sexual and reproductive services, is particularly important.

[10] National Institute for Health and Clinical Excellence, *123 New Quality Standards Announced*, 21 March 2012, accessed 14 June 2012. <www.nice.org.uk/newsroom/news/123NewQualityStandardsAnnounced.jsp>

For women, lifestyle changes and personal relationships will vary throughout their lives, and this will have an impact on their contraceptive choices. Over the past decade there has been a strong focus on tackling unintended pregnancies among young people, which has helped to see a dramatic fall in the pregnancy and abortion rates among this age group. However, evidence submitted to this Inquiry warned that this national focus *"had the perverse consequence of allowing older women's contraceptive needs to be neglected"*.

In its submission to the Inquiry, Bayer HealthCare said the abortion statistics for 2010 *"demonstrate a significant level of unmet need amongst women over the age of 20, with 79 per cent of all abortions taking place amongst this age group in England and Wales"*. This level of unmet need has been reflected again in the abortion statistics for 2011 which showed that the overwhelming majority of abortions continued to take place in women over the age of 20 and the abortion rate for this age group had increased from 2010.[11]

As set out in this report, the Inquiry has been presented with a number of examples where contraceptive services are being restricted on the basis of a woman's age. For example, FPA has had representation through its helpline that women accessing community clinics in Solihull need a GP referral for contraception if they are over the age of 25 years old.

While the national focus on young people over the past decade has been welcomed by the Inquiry, the subsequent impact this has had on local decision-makers in the NHS is of concern. Nevertheless, the reforms and the new levers within the system do create an opportunity to address this.

The Department of Health must ensure the forthcoming sexual health policy document sets out, in detail, how the contraceptive needs and outcomes of older women should be improved in order to deliver on the life course approach.

The updated public health outcomes framework, *Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency*, which was published in January 2012, contained indicators relating to the rate of under-18 conceptions. Again, while this has been welcomed, representation received by this Inquiry notes that the indicators continue to focus on young people. The Department of Health and Public Health England should therefore work together to establish what national levers can be put in place to ensure local commissioners avoid making decisions which are likely to have a perverse impact on a group of people in their area.

**Recommendation:** The sexual health policy document should take a life course approach, including addressing the needs of people over the age of 20 years old.

**Recommendation:** Public Health England should undertake an assessment of the indicators relating to sexual and reproductive health in the Public Health Outcomes Framework on how they are delivering the 'life course approach'.

[11] Department of Health, *Abortion Statistics England and Wales*, May 2011, accessed 14 June 2012. <http://transparency.dh.gov.uk/2012/05/29/abortion-statistics-2011/>

**Recommendation:** In the absence of any indicators relating to sexual and reproductive health for post-teen women, the Department of Health, working with Public Health England, should establish what national levers can be put in place to ensure local commissioning decisions do not have a perverse impact on a group of people in their area.

**Recommendation:** Health and wellbeing boards should undertake a review of the commissioning arrangements of contraceptive services in their area while developing their joint health and wellbeing strategy to ensure they do not create a perverse impact on particular groups of people.

## Making every contact count for contraceptive services

In its report on the public's health, the NHS Future Forum highlighted the opportunity presented to improve people's health and wellbeing through the everyday contact people have with GPs, nurses, pharmacists and others. However, in order to take advantage of this opportunity, the NHS Future Forum recognised the need to change how people come into contact with healthcare professionals.

As a result, one of the central recommendations within the NHS Future Forum's report on the public's health was for all healthcare professionals to *"make every contact count"* in order to maintain or improve people's physical and mental health.[12]

The Department of Health accepted the NHS Future Forum's recommendations in full, saying: *"it should be the role of all healthcare workers in the NHS to make use of those contacts wherever appropriate, with the aim of improving the public's health and wellbeing and reducing health inequalities."*[13] To achieve this, the Department of Health confirmed plans to take forward the NHS Future Forum's recommendations, including:

- proposing amendments to the NHS Constitution to reflect the principle of *"making every contact count"*
- calling on Public Health England, Health Education England and the NHS Commissioning Board to develop a programme of action for taking the initiative forward
- for professional bodies to promote this broader role to their members and the public, and issuing guidance about the responsibilities it entails.[14]

The Inquiry welcomes this initiative and recognises its potential to provide different settings and opportunities for women to discuss their contraceptive needs with healthcare professionals.

**Recommendation:** Public Health England, working with Royal Colleges and associated organisations, should undertake a review looking at how the *Making Every Contact Count* initiative could be implemented for contraceptive services, including in pharmacy and other community settings.

12 NHS Future Forum, *Summary Report – Second Phase*, January 2012.

13 Department of Health, *Response to NHS Future Forum's Second Report*, January 2012.

14 Department of Health, *Response to NHS Future Forum's Second Report*, January 2012.

# Recommendations

Throughout the written evidence that was submitted to the APPG and the oral evidence session there were many recommendations put forward for improving access to contraception choice and services. The recommendations which have been agreed by this Inquiry are set out below:

## Improving the lives of women

1 All women must have access to a full choice of contraceptives and contraceptive services, including comprehensive information and advice that enables them to choose the method which is best for them. Any restrictions on access on the basis of age, residence or method should be removed as a matter of urgency.

## Government

2 The Government should consider all of the evidence and recommendations presented within this Inquiry and publish a response to it as soon as possible.

3 The Department of Health should publish the sexual health policy document as soon as possible.

4 The Department of Health's forthcoming sexual health policy document should take a life course approach, including addressing the needs of people over the age of 20.

5 The Department of Health's sexual health policy document should set out how contraceptive services will be commissioned under the new arrangements. The document should signpost commissioners to clinical best practice and medical evidence.

6 The Government should consider re-evaluating its commissioning of sexual health services to ensure that commissioning responsibility is being delegated in the most appropriate way. The forthcoming Department of Health consultation to determine the best long-term commissioning arrangements for abortion, vasectomy and sterilisation sets a precedent for this.

7 Working with Public Health England and the NHS Commissioning Board, the Department of Health should provide further clarity about how the mandate on local authorities to provide 'appropriate access to sexual health services' is implemented at a local level.

8 Public Health England, working with the Department of Health and the NHS Commissioning Board, should consider establishing regional sexual health networks to help monitor the commissioning of open-access services, including contraceptive services, at a sub-national level. These networks should ensure services are effectively integrated.

9 The NHS Commissioning Board and the Department of Health should publish an update on how local enhanced services (LESs) and the sexual health tariff will be implemented under the new arrangements.

## Public Health England, Health Education England and NICE

10 Public Health England should undertake an assessment of the indicators relating to sexual and reproductive health in the Public Health Outcomes Framework on how they are delivering the 'life course approach'.

11 In the absence of any indicators relating to sexual and reproductive health for post-teen women, the Department of Health, working with Public Health England, should establish what national levers can be put in place to ensure local commissioning decisions do not have a perverse impact on a group of people in their area.

12 Public Health England and the NHS Commissioning Board should develop national guidance for all commissioners of contraceptive services around integrated working and delivery of services, including models for referral pathways in contraception.

13 Health Education England should undertake a regular audit of professionals who are trained to deliver specific contraceptive services, including LARC methods. This information should be made publically available at a local and national level to help inform commissioning decisions.

14 Health Education England, working with associated member organisations, should take steps to improve the provision for nurse training in contraception, with a view to creating a national, coordinated model.

15 Public Health England, working with Royal Colleges and associated organisations, should undertake a review looking at how the *Making Every Contact Count* initiative could be implemented for contraceptive services, including in pharmacy and other community settings.

16 National Institute for Health and Clinical Excellence (NICE) should prioritise the development of the quality standard on contraceptive services (including emergency contraception) to help set out the national standards for how care should be delivered.

## Commissioners

17 Commissioners identified within this report as having a restriction in place on contraceptives or contraceptive services should, as a matter of urgency, undertake a review of these restrictions and take steps to remove them as soon as possible.

18 Commissioners of contraceptive services must ensure that the contraception, and other sexual health services, that are commissioned in local areas genuinely meet the needs of the women that live there.

19 Health and wellbeing boards should undertake a review of the commissioning arrangements of contraceptive services in their area while developing their joint health and wellbeing strategy to ensure they do not create a perverse impact on particular groups of people

20 NHS North East London and NHS London should undertake an urgent review of contraception provision in Walthamstow, particularly for women over the age of 25 years old. The APPG looks forward to receiving the results of the review and an action plan for how services are going to be improved.

21 Waltham Forest Council's health and wellbeing board should hold an urgent meeting with commissioners, providers and service users to discuss how a comprehensive, open-access contraceptive service can be commissioned within the new arrangements from April 2013.

# Conclusion

This Inquiry believes it is a fundamental right of all women and men to have access to a full range of contraception and contraceptive services, including information and advice that enables them to choose the method which is best for them. However, what this Inquiry has demonstrated is that this right is not being fulfilled for millions of men and women across the country.

The evidence presented to this Inquiry highlights a clear disconnect between national ambition and local delivery. The evidence and personal stories in this report are of unacceptable restrictions in access on the basis of age, residence or type of method. The potential impact this is having on outcomes and people's health and wellbeing is deeply concerning, particularly any potential rise of unintended pregnancy.

It is vital these restrictions are addressed and removed. However, the Inquiry is acutely aware that these restrictions are in place at a time when the health service is going through a significant restructure and having to deliver an unprecedented £20 billion of efficiency savings by 2015.

This report finds clear concerns among clinicians, providers and advocacy groups about the potential impact the health reforms could have on the provision of services. Witnesses spoke of uncertainty about the future commissioning and funding arrangements and how responsibility for contraceptive services will be divided up. This is compounded by additional concerns relating to the potential fragmentation of services and the impact this may be having on women.

However, this report also highlights the potential of the reforms to address the current variation in provision and deliver improvements in the quality and outcomes of contraceptive services. In particular, the forthcoming sexual health policy document is an opportunity to reaffirm what open-access contraceptive services look like and how they should be delivered in the new commissioning environment.

The purpose of this Inquiry and report is to make recommendations for how restrictions can be addressed and services improved. The Inquiry looks forward to working with the Department of Health, Public Health England and commissioners in taking these forward and improving the wellbeing of women across the country.

# Appendix 1 – Terms of reference for the Inquiry

1. Assessing the current commissioning environment for contraceptive services and how this affects:
   - women's access to a choice of the full range of contraceptive services and methods
   - the ability of the NHS to promote equality and tackle inequalities in access to healthcare
   - commissioners' ability to deliver efficiency savings
   - improvements in outcomes and the health and wellbeing of local populations
   - the Government's choice agenda.

2. How the changes to commissioning arrangements as a result of the Health and Social Care Act will affect:
   - women's access to a choice of the full range of contraceptive services and methods
   - the ability of new and existing commissioners to deliver high-quality contraceptive services
   - the funding of contraceptive services
   - healthcare professionals' ability to engage with local commissioners in shaping the design and delivery of contraceptive services.

3. What the Department of Health's sexual health policy document should address:
   - inequalities in access to the full range of contraceptive services and methods
   - fragmentation of contraceptive services at a local and national level
   - commissioner prioritisation of the delivery of high-quality contraceptive services
   - improvements in the outcomes and quality of contraceptive services for women of all ages.

# Appendix 2 – Written submissions received by the Inquiry

## Organisations

1 Advisory Group on Contraception (AGC)
2 Bayer HealthCare
3 Brook
4 British Pregnancy Advisory Service (bpas)
5 Faculty of Sexual and Reproductive Healthcare (FSRH)
6 Family Planning Association (FPA)
7 Haringey Local Medical Committee (LMC)
8 Haringey Contraception and Sexual Health Service (CaSH)
9 HRA Pharma
10 Royal College of Physicians

## Professionals

11 Sexual and reproductive health clinician, Lewisham
12 Contraception clinician, Exeter
13 Sexual and reproductive health clinician, York
14 Sexual and reproductive health clinician, West Sussex
15 Contraception and sexual health clinician, Stockport
16 Family planning clinician, Haringey
17 Sexual and reproductive health clinician, Chesterfield
18 Sexual and reproductive health clinician, Leeds
19 General practitioner, Leeds
20 Sexual and reproductive health clinician, London

## Other

21 Anonymous submission

# Appendix 3 – Witnesses at the Inquiry oral evidence session, 22 May 2012

1 Public Health Minister, Anne Milton MP (invited but unable to attend)
2 Shadow Minister for Public Health, Diane Abbott MP
3 Julie Bentley, Chief Executive of FPA
4 Simon Blake OBE, Chief Executive of Brook
5 Ann Furedi, Chief Executive of bpas
6 Tracey McNeill, Vice President and Director of UK and Europe, Marie Stopes International
7 Dr Connie Smith, Consultant in Family Planning and Reproductive Health Care
8 Dr Chris Wilkinson, Lead Consultant, Margaret Pyke Centre and President, Faculty of Sexual and Reproductive Health
9 Dr Anne Connolly, The Ridge Medical Practice and Clinical Lead for Women's and Sexual Health, NHS Bradford and Airedale
10 Women who have experienced restrictions in access to contraception in Walthamstow

# All-Party Parliamentary Group on Sexual and Reproductive Health in the UK

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