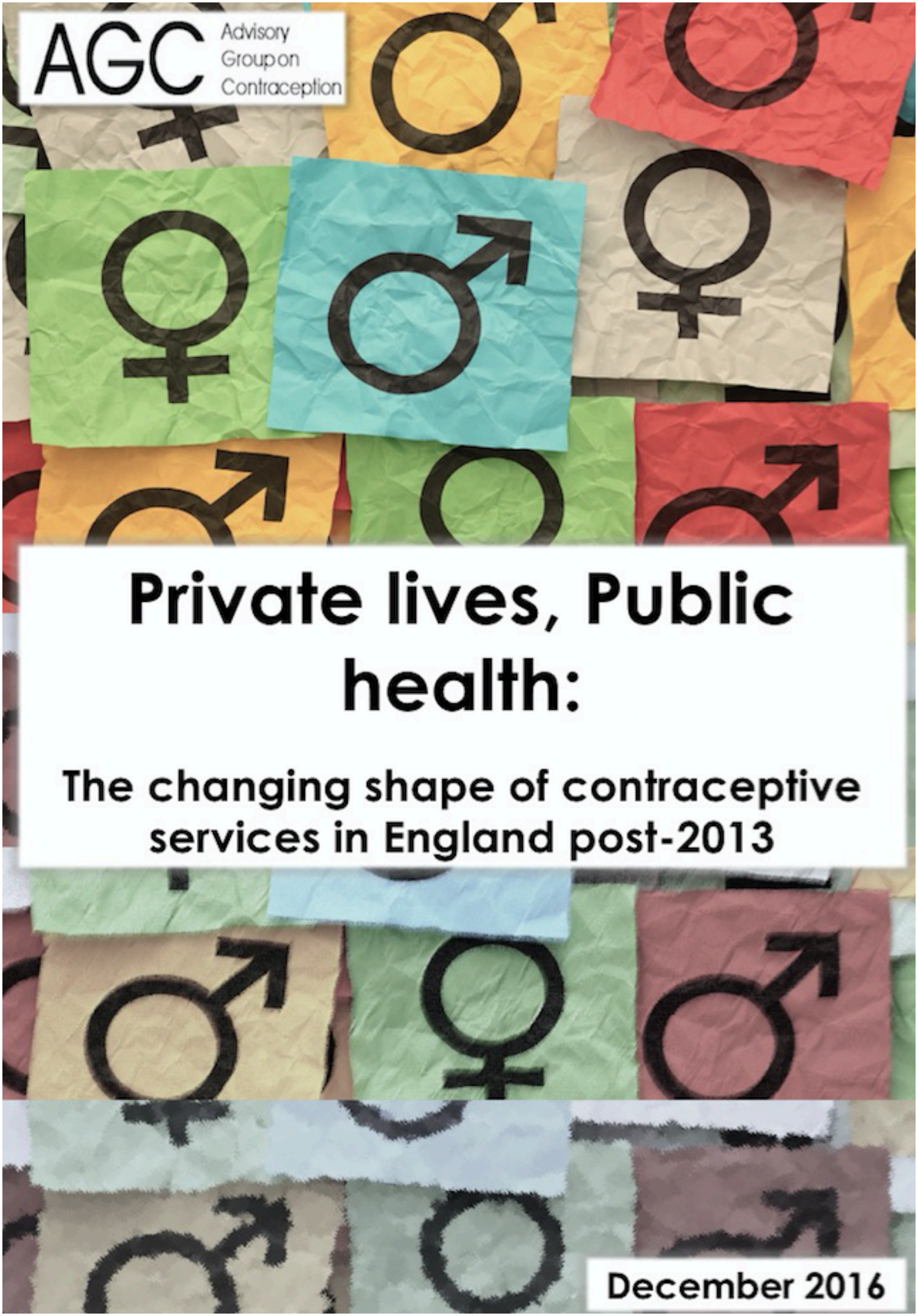

Private lives, Public health:

The changing shape of contraceptive services in England post-2013

December 2016

Executive summary

- Access to and choice from the full range of contraceptive methods is a fundamental right for all women of reproductive age. Enabling women to access the contraceptive method best suited to them helps prevent unplanned pregnancies and improve public health outcomes, and every £1 invested in contraception saves £11 in averted health outcomes[1]

- Since April 2013, local authorities have been responsible for providing full, open access contraceptive services through their new public health function, with the exception of contraception delivered as an additional service under the GP contract

- The delivery of contraceptive care in England is understood to be under acute and growing pressure, largely due to significant cuts in local authority budgets and pressure on general practice capacity and funding

- Government funding for the provision of public health has been significantly cut; first through a 6.2 percent (£200 million) in-year cut in 2015, followed by cuts by an average of 3.9 percent (£600 million) in real terms per annum over the course of this Parliament[2]

- Women's access to the full range of contraceptive methods has been especially vulnerable, with the fragmentation of commissioning of contraceptives, introduced in the Health and Social Care Act, compounding the growing crisis

- The expert Advisory Group on Contraception (AGC) has conducted an audit of the impact of funding cuts and commissioning reforms on contraceptive services in England by analysing the results of a Freedom of Information (FOI) request sent to all 152 upper tier and unitary councils

- The findings show a mixed but worrying picture. While some areas have so far managed to sustain current service provision, there are clear signs that – in line with the experiences of AGC members – full, open access contraceptive care and services are under increasing strain in many places

- Key findings include:

    - Approximately 3.9 million women of reproductive age live in areas with some form of restriction on access to contraception, either due to age or place of residency

    - More than one in six authorities (16 percent) decreased spend on contraceptive services *during* the financial year 2015/16 as a result of the unexpected £200m in-year cut to public health budgets in June 2015

    - There is wide variation in local authorities' willingness to pay for contraceptive care provided for their residents by providers located in another local authorities, with nearly half (46 percent) of councils saying they never pay invoices received for contraceptive services delivered out of area

    - Community settings (not including GP practices) delivering contraceptive care are being closed. One in seven of the councils (14 percent) who responded to this question have closed sites in 2015/16 or were planning to do so in 2016/17, affecting around 1.5 million women of reproductive age. A further 13 percent of councils stated they are considering site closures in 2016/17

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  - Around one in 13 councils will have fewer contracts in place with general practice to fit and remove LARC methods such as intrauterine devices (IUD) and intrauterine systems (IUS) in 2016/17 than in the previous year

  - Nearly a quarter (24 percent) of councils could not confirm the number of IUS and IUD contracts held with GPs in their area for 2016/17, but indicated that these services were under review

- This report combines these findings with the increasing body of evidence showing that contraceptive care and provision is under considerable strain, in spite of the efforts being made by many local authority commissioners, contraceptive providers and GP practices who are fighting to maintain good provision for women

- The AGC is concerned that the lack of national focus on the impact of sustained cuts to public health budgets, broader local authority funding, and the squeeze on general practice will affect more and more women's access to contraception

- The AGC is also keen to ensure that contraceptive care is considered in the development and roll out of new opportunities, such as place-based Sustainability and Transformation Plans (STPs) and new models of care for general practice and community care

- While progress has been made over the past decade in reducing the number of abortions and teenage pregnancies, it will not take long for that progress to reverse if women of all ages cannot access the contraceptive options they want and need. This is particularly pressing in light of recent abortion statistics, which show an increase in the number of older women requiring abortion services[3]

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Summary of recommendations

Funding for contraceptive services

1. Commissioners (NHS England, local authorities and clinical commissioning groups) and the Department of Health should work together to ensure that women are able to access the full range of contraceptive care in their area

2. The Department of Health – in its allocations to Public Health England and NHS England – should commit to provide sufficient funding to support local authorities and primary care – particularly general practice – to deliver the full range of contraceptive services to women of all ages

3. HM Treasury should undertake a detailed impact assessment of contraceptive services if the public health ring-fenced funding was removed and local authorities were expected to use business rates to fund public health activity

4. As STP footprints develop their plans they should have regard to the importance of contraception and ensure that as these plans are implemented systems are in place to enable women to access the full range of contraceptive services

Contracting arrangements between local authorities for provision of contraceptive services

5. The Department of Health should remind local authorities of their responsibility to provide women with open access contraceptive and reproductive health services regardless of their age or place of residence

6. The Department of Health should commission a review of contraceptive services across England and develop clear guidelines on cross-charging between local authorities, including clarifying what services should be covered in cross-charging arrangements

Restrictions on access to contraceptive services

7. The Department of Health should commit to review and monitor commissioning arrangements for contraceptive services across England to identify any restrictions in access to contraceptive services, for example on the basis of age or demography

8. Commissioners should be supported to address restrictions on the provision of the full range of contraceptive options and to put in place appropriate funding and training arrangements to ensure that women's access to services is not restricted

Delivery of contraceptive services – community, specialist and primary care

9. Prior to decommissioning any contraceptive and reproductive health services, commissioners should conduct and publish an impact assessment of how service changes will impact on women's access to contraceptive services and potential health outcomes, including consulting with local service users

10. The Department of Health and Health Education England should publish guidelines that make it clear where the lines of responsibility lie for the funding (or commissioning of) the training of health providers across key areas such as the fitting and removal of LARC methods, consultation skills and clinical leadership

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Introduction

The Advisory Group on Contraception (AGC) is an expert advisory group of leading clinicians and advocacy groups working together to highlight the impact of policy reforms on women's access to contraception. Comprehensive, open access sexual and reproductive health services are essential in improving public health outcomes by preventing ill health, improving wellbeing and addressing inequalities. The AGC believes that all women should have open access to high quality services that offer them information about, and a choice of, the full range of contraceptive options.

Investment in good contraceptive services should be central to a locality's public health strategy. Between 2015 and 2025 the healthcare costs associated with current rates of unintended pregnancy have been estimated as high as £9.051 billion.[4] A conservative estimate of the cost to the non-health public sector of unplanned births is almost £120 million per year.[5] Yet investment in sexual health and contraceptive care is one of the most cost effective 'buys' for healthcare commissioners, with every £1 invested in contraception saving £11 in averted costs.[6]

However, the AGC's research over recent years has shown that women experience significant and unwarranted variation in access to contraceptive care.[7] This local variation has been compounded following major reforms to the commissioning landscape that took place as part of the Health and Social Care Act in 2012. The reforms shifted the majority of responsibility for the commissioning of contraceptive services from NHS Primary Care Trusts to local government public health commissioners, and in turn, created a complex and fragmented system of commissioning across national and local bodies (see Figure 2).

Women's access to the full range of contraceptive methods has been especially vulnerable to the fragmentation of commissioning. As well as broad mandate to provide 'open access contraceptive services' to the local population, local authorities now have responsibility for commissioning all LARC provision in general practice and other settings. The complexities of the current commissioning landscape and the potential effect on women seeking contraception are outlined in Figure 1 below.

The move from the NHS to local government has had particular impact on public health funding. While the 2015 Spending Review protected NHS budgets, other health spending – including public health budgets – was not. This will result in significant cuts to public health budgets – estimated to be up to 9.6 percent cash reductions over the next five years.[8]

While the delivery of open access contraceptive services is mandated for all local authorities, commissioners have warned that the present funding settlement jeopardises their ability to discharge their statutory responsibilities. The cuts to public health budgets coincided with broader local authority funding constraints and reduced resource for general practice as a proportion of the total NHS budget, even as demand for primary care has risen.

With anecdotal evidence surfacing of contraceptive services being merged, scaled back or closed as a result of lack of budget, the AGC determined to undertake a rigorous stock-take of the impact of public health cuts on local services, which focused on four key areas:

- Funding for contraceptive services
- Contracting arrangements between local authorities for provision of services
- The provision of open access contraceptive services
- The delivery of contraceptive services in community, specialist and primary care settings

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This report focuses on measuring reductions in funding, spending and sites providing contraceptive services. Moving forward, the AGC would be keen to see better and more standardised data on reproductive health to enable comparisons to be made between areas in a more meaningful way. This should include better data on whether pregnancies are planned or unplanned, the pregnancy outcome and spacing between children.

Methodology

The findings of this report are primarily based on the responses of local authorities to a series of freedom of information (FOI) requests submitted by the AGC to all 152 upper tier and unitary councils in England in March 2016. The information requested included:

- Budget allocations for contraceptive services across the years 2014/15, 2015/16 and 2016/17
- Planned in-year cuts
- Plans to restrict access to contraception
- Provision of emergency hormonal contraception (EHC) and condom distribution
- Information on the number of sites or contracts for the delivery of contraceptive services in specialist, community or primary care settings

A full list of the FOI questions sent to local authorities can be found in Appendix 2.

The AGC received responses from 146 local authorities – a response rate of 96 percent. A full list of the local authorities that submitted or did not submit a response can be found in Appendix 3.

Most responses were submitted within the statutory period for responding to a FOI request. A number of local authorities submitted a joint response on behalf of a neighbouring local authority. For instance, Dorset County Council's response covered Poole Borough Council and Bournemouth Borough Council. Where a joint response was received this has been indicated in Appendix 3.

Although local authorities were supplied with the same FOI questions, they responded in different formats, meaning that the data were not always directly comparable. One council did not submit any response, in breach of its statutory responsibility. For this council we were unable to evaluate their plans for the commissioning of contraceptive services.

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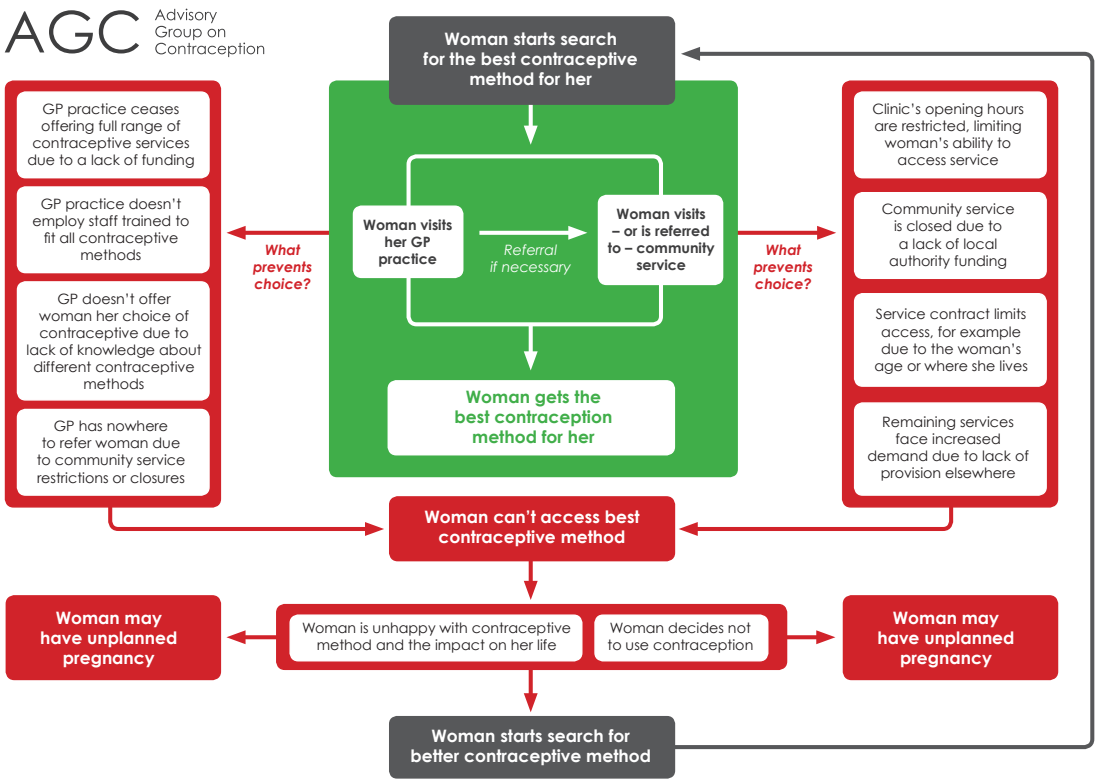
Figure 1. A woman's contraceptive journey

Women of different ages and circumstances will engage with health services in different ways and it is important that contraceptive services are configured in such a way as to address this. For example, a woman may not wish to discuss her contraceptive needs with her GP particularly where this is a GP in a single-handed practice. In some cases, other sexual and reproductive health services in the community may be more or less accessible. The complexities of this, and the potential for a range of factors to restrict women's choice of contraceptive method, are illustrated in Figure 1.



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Funding for contraceptive services

Context

The passing of the Health and Social Care Act in 2012 had a significant impact on the commissioning of contraceptive services. Prior to these reforms the majority of contraceptive services were commissioned from NHS Primary Care Trusts. When implemented, the Health and Social Care Act resulted in a complex and fragmented system of commissioning across national and local bodies. The responsibilities across different commissioners are described in Figure 2.

Figure 2. Commissioning and governance responsibilities for contraception and abortion services[9]

Local authorities	Clinical commissioning groups	NHS England
Comprehensive sexual health services, including: Contraception, including implants and intra-uterine contraception and all prescribing costs, including contraception provided as an enhanced service under the GP contract Sexually transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing Sexual health aspects of psychosexual counselling Any sexual health specialist services, including young people's sexual health, outreach, HIV prevention and sexual health promotion, services in schools, colleagues and pharmacies	Most abortion services Sterilisation Vasectomy Non-sexual health elements of psychosexual health services Gynaecology, including any use of contraception for non-contraceptive purposes	Contraception provided as part of core general practice delivered through the GMS contract (not including implants and intra-uterine contraception) HIV treatment and care (including drug costs for post-exposure prophylaxis after sexual exposure) Promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs Sexual health element of prison health services Sexual Assault Referral Centres Cervical screening Specialist foetal medicine services

In the context of contraceptive services, as shown in Figure 2, the Health and Social Care Act transferred the responsibility for the commissioning of many key contraceptive services over to local authorities. This includes the provision of specialist and community contraceptive services and the fitting and removal of LARC methods, such as IUD, IUS or the contraceptive implant, through general practice. NHS England also commissions contraceptive services through general practices, including user dependent forms of contraception such as oral contraceptives, condoms and injectable forms of LARC. The focus of this report is on those forms of contraception commissioned by local authorities.

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The AGC welcomed the Department of Health's 2013 *Framework for Sexual Health Improvement in England*, which provided an early steer to commissioners on the division of responsibilities and national priorities on reproductive health. The clear aspiration was that commissioners would collaborate closely to ensure care was *'comprehensive, high quality and seamless'.* In our 2014 *Sex, Lives and Commissioning II* report, the AGC stated that "*Ensuring any fragmentation of services is addressed or prevented will be a key measure of success for the Government's public health reforms."*[10]

Since the introduction of the new arrangements, a number of organisations, including the AGC and our members, have developed resources to support local commissioners in their efforts to navigate and coordinate provision.[11,12,13]

However, part of the challenge of the new system is that assessing success or failure when responsibility is so fragmented is difficult. Oversight of the system across the three commissioning bodies is almost impossible and it is still unclear how different parts of the system work together to provide joined-up care and support for women.

With respect to joint working, it is possible that the new vehicle for 'place-based' approaches to local health and care planning, Sustainability and Transformation Plans (STPs)[14], will aid this process. The 44 STP footprint areas that cover the whole of England have been tasked with developing comprehensive plans, agreed by local health and care stakeholders (including, crucially, local government) for making local services sustainable.[15]

Background on Sustainability and Transformation Plans

STPs were first announced in the December 2015 NHS Shared Planning Guidance and are seen as a key mechanism for implementing the *Five Year Forward View* set out by NHS England.

To develop these plans each of the key stakeholders (commissioners, providers, local authorities) within each of the 44 STP footprints must work together to create a local blueprint to cover the period October 2016 to March 2021, describing how each area will collaborate to close three nationally identified gaps:

- The health and wellbeing gap
- The care and quality gap
- The finance and efficiency gap

STP footprints will have responsibility for overseeing regional planning across the health and care system to meet the needs of a local population, including reconciling the different and often competing interests of individual organisations.

However, the involvement of local government in the STP planning process has been inconsistent and local government leaders have expressed frustration at being shut out of discussions on STPs.[16] Nevertheless, while public health did not feature as heavily in planning processes as the AGC would like, the re-introduction of an intermediary organisational level may be a potential avenue for joined-up, integrated commissioning and provision in the future.

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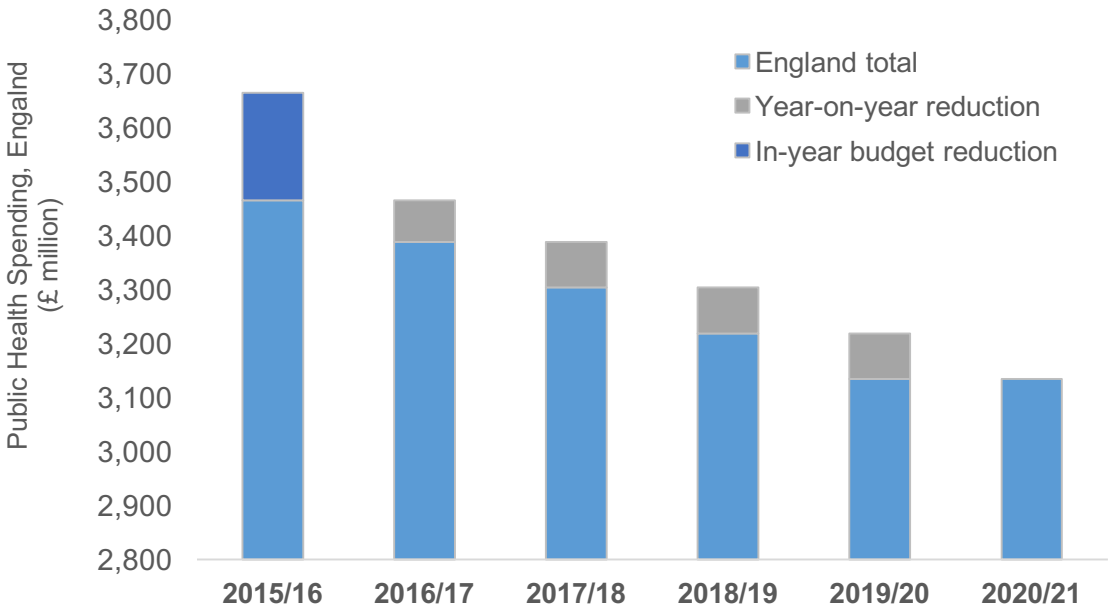
Cuts to public health budgets

The challenges of fragmented responsibility in sexual and reproductive health are compounded by reductions in the resource allocated to public health from central government. As shown in Figure 3, in the years since responsibility for public health passed from the NHS to local government, the resource allocated (or projected to be allocated) to public health has fallen.

Figure 3. Public health allocations in England from 2015/16 to 2020/21



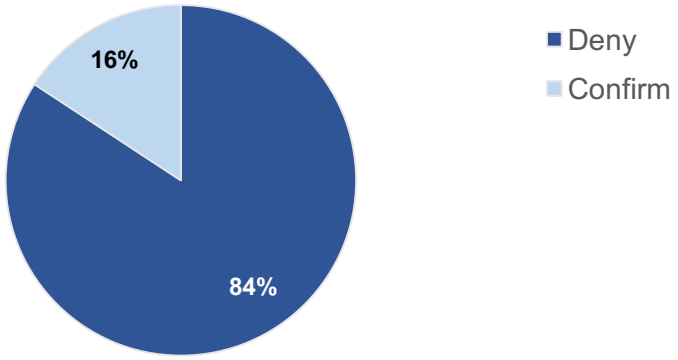
Unlike the budget for the NHS, public health allocations were not protected in the 2015 Spending Review.[17] Under the terms of the Spending Review, public health budgets will be cut by an average of 3.9 percent in real terms per annum until 2020. This equates to a reduction in cash terms of 9.6 percent over the same period and represents a real-term reduction of at least £600 million in public health spending across this period.

The cuts announced in the Spending Review came shortly after an unexpected in-year cut of 6.2 percent (amounting to around £200 million) to the public health budget that was announced in the post-election summer budget in July 2015. The AGC was extremely concerned about the impact of this cut and highlighted the false economy of reducing access to contraceptive services, with any resultant increase in unintended pregnancies likely to result in considerably higher costs than the proposed cuts.[18]

These cuts to public health have come on top of reductions in overall funding for local authorities who, between 2010/11 and 2015/16, have had to cut spending in real terms by 27 percent.[19] This has pushed many local authorities to make difficult decisions about the services they offer.

Although the in-year cuts were not specifically targeted at contraceptive services, our audit revealed that more than one in six authorities (16 percent) made in-year cuts to contraception or sexual and reproductive health budgets as a result (Figure 4).

Figure 4. Percentage of local authorities that confirmed or denied implementing in-year cuts (for 2015/16) for contraception and/or sexual and reproductive health services



The size and extent of the in-year cuts varied significantly. For example, Dorset County Council stated that a 6 percent reduction was '*applied to contracts between April 2016 and December 2016'*, which aligns with the 6 percent cut to public health handed down from the government. However, many other respondents were not able to pinpoint the effect on budgets for contraception specifically, as they have an integrated sexual health services contract.

A number of councils used the language of 'savings' rather than 'cuts', and stressed that the impact should be minimal due to the focus on efficiency or integration. Coventry City Council stated that £190,000 was cut from its budget, but that *'these savings did not impact upon service capacity as they were mainly related to performance based payments'.* In other instances, budget reductions arose following a procurement process. For instance, Wakefield Metropolitan District Council stated that budget for sexual and reproductive health services was reduced in November 2015, '*equating to a 11.8% budget reduction',* but that the *'reduction was achieved due to the re-procurement of the service from 1st November 2015*'.

While these cuts are concerning (particularly as, by their nature, in-year cuts are likely to be less strategic than planned cuts), the AGC was heartened by the number of councils that look to have found ways to protect sexual and reproductive health budgets in this round of cuts. This may in part be due to the fact that the majority of contraceptive services are locked into contracts with external providers and that terminating these contracts early would cost more than the savings sought. It may also indicate that local authority commissioners see contraceptive services as a cost-effective investment to make.

The AGC was also keen to understand how local authority funding for contraception has changed over the period of time they have had responsibility for public health. Since 2013, public health budgets have been allocated to local authorities through a ring-fenced budget. Councils are able to disburse the budget as they choose. However, the law requires local authorities to provide or make arrangements to secure the provision of open access sexual health services in their area – one of the few defined mandated services for public health.

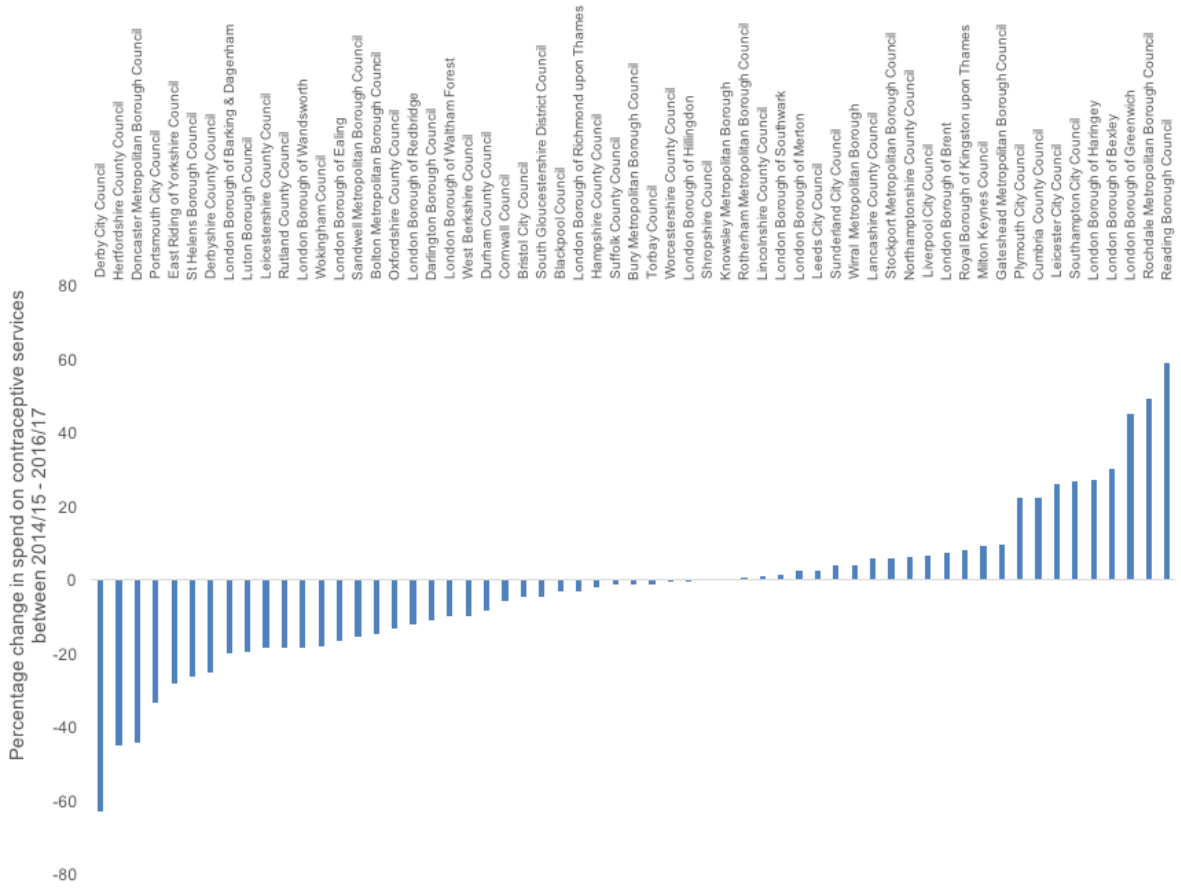
The AGC requested information on the budget allocated by local authorities to contraceptive and all sexual and reproductive health services in the financial years 2014/15, 2015/16 and 2016/17. With respect to this data, the information provided by local authorities was highly varied. In terms of responses, less than half (47 percent) of the local authorities who responded to our audit provided data for contraceptive services across all three years requested. Of those who did not provide data for all three years, nine percent indicated that

their budgets for 2016/17 were under review or had not been signed off at the time of submitting their FOI response.

With respect to the information supplied, analysis revealed further variation in local commissioning arrangements. For example, some local authorities indicated that they provide services through a block contract while others revealed that they commission via a tariff-based arrangement, or that contraceptive services are part of an integrated contract that also covers other sexual and reproductive health services. Where contraceptive services were commissioned as part of an integrated contract, a number of local authorities indicated they were unable to provide a split of costs for the different services covered under the contract. The variability in commissioning approaches, coupled with not all local authorities supplying all the data requested makes a comprehensive national comparison of local authority contraception budgets difficult to undertake.

Of the councils who provided comprehensive responses there was a wide variation in how authorities have invested in contraceptive services over the three-year period, as set out in Figure 5.

Figure 5. Percentage change in local authority budgets for contraceptive services between 2014/15 to 2016/17, in ascending order



For the period of 2014/15 to 2016/17 our analysis revealed that half (51 percent) of the councils who provided data for all three years decreased their budgetary allocation on contraceptive services. In some instances, the change in spend on contraceptive services was considerable.

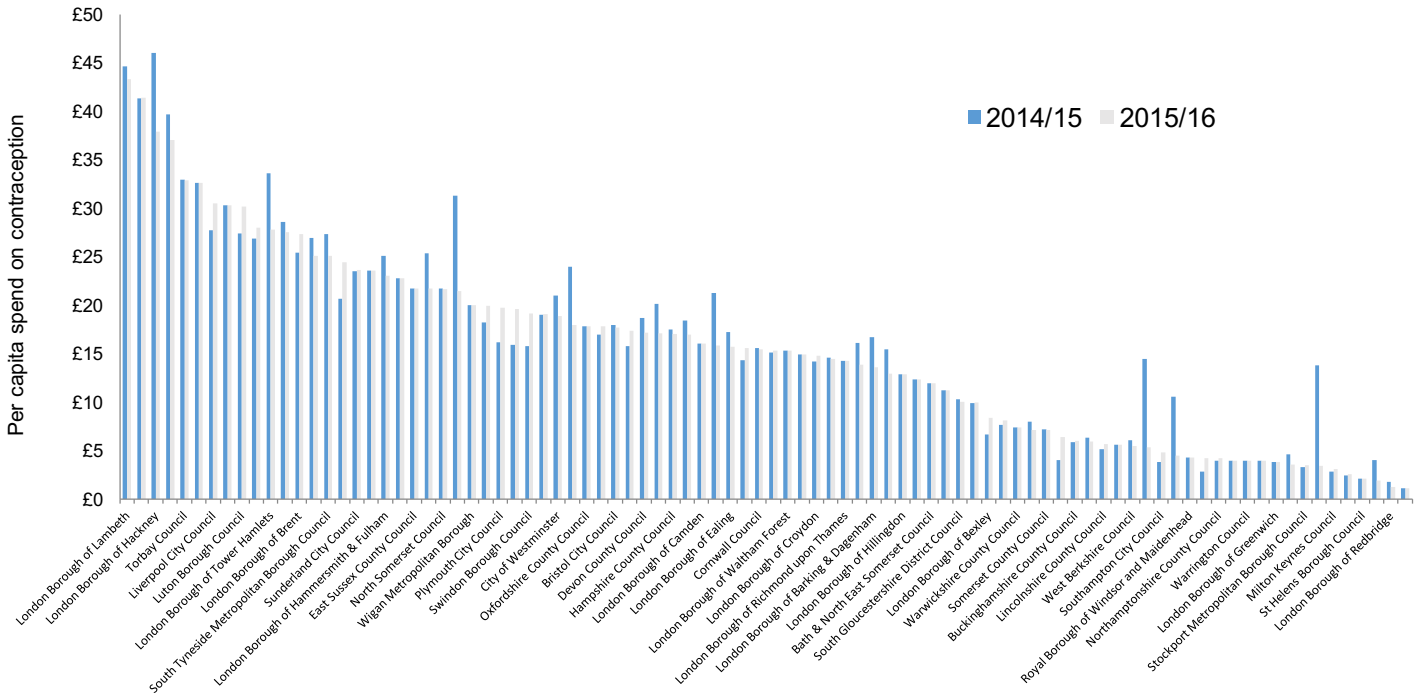
For example, the figures supplied by Portsmouth City Council suggest a decrease of a third in their contraception budget, while the figures supplied by St Helens Council suggest a

budget decrease of over a quarter. Derbyshire County Council's response to the audit also revealed a 25.2 percent budget reduction on contraceptive services between 2016/17 and 2014/15.

The AGC was interested to find that over the period of 2014/15 to 2016/17 some local authorities had increased their spending on contraceptive services. Southampton City Council, for example, increased its budget allocation for contraceptive services by almost 27 percent. Similarly, Reading Borough Council's response to the audit revealed they increased their budget for contraceptive services by almost 60 percent (even though their overall budget for sexual and reproductive health services has decreased by over 38 percent across the same period).

By using local population data of the number of women of reproductive age (15-44) in an area,[20] the AGC also compared the per capita spend on contraception. While there is not a consistent definition of what is covered under the budgets being compared, Figure 6 below is useful in providing insights about the variation in the amount spent on contraceptive services per woman by each local authority in different parts of the country.

Figure 6. Per capita spend on contraception in women of reproductive age (15-44) for those local authority areas that submitted financial information for the years 2014/15 and 2016/17



As demonstrated in Figure 6 there is a vast difference in what areas are choosing to spend on contraceptive services per woman. While this might be explained by a variation in need, it may also reveal that some local authorities (particularly those with low per capita spends) do not see contraceptive services as something to be prioritised. Although a greater per capita investment does not automatically equate to better services, the AGC would call on commissioners to reassure the sexual and reproductive health community that the outcomes for women do not decline where per capita spend is lower.

It is also important to consider that many local authority commissioners have been very successful at redesigning services and contracts to minimise impact on local populations.

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However, Directors of Public Health have warned that it will likely be impossible to absorb the scale of the upcoming cuts without starting to fundamentally cut core services.[21]

RECOMMENDATIONS

1. Commissioners (NHS England, local authorities and clinical commissioning groups) and the Department of Health should work together to ensure that women are able to access the full range of contraceptive care in their area

2. The Department of Health – in its allocations to Public Health England and NHS England – should commit to provide sufficient funding to support local authorities and primary care – particularly general practice – to deliver the full range of contraceptive services to women of all ages

3. HM Treasury should undertake a detailed impact assessment of contraceptive services if the public health ring-fenced funding was removed and local authorities were expected to use business rates to fund public health activity

4. As STP footprints develop their plans they should have regard to the importance of contraception and ensure that as these plans are implemented systems are in place to enable women to access the full range of contraceptive services

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Contracting arrangements between local authorities for provision of services

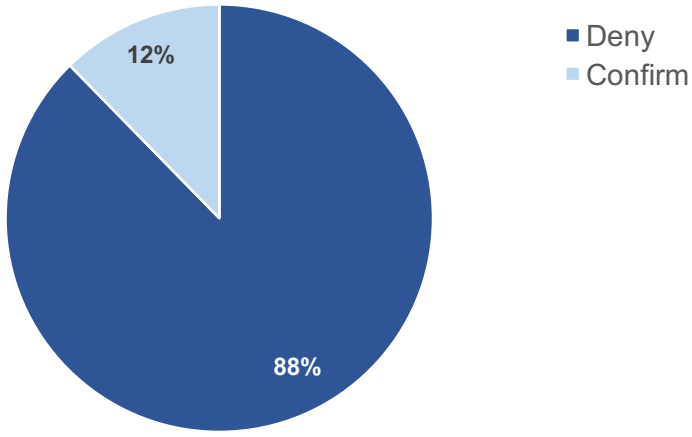
Providing contraceptive services to non-residents

Councils are mandated to commission confidential, open access services for contraception. This has been defined by Department of Health guidance to mean that "*anyone who is in an area is entitled to use the services provided in that area"* regardless of their age, gender or sexual orientation.[22] The guidance goes on to state that services cannot be restricted only to *"people who can prove that they live in the area, or who are registered with a local GP"* or on the grounds that they are only visiting the area.[26]

However, AGC members have become aware that some local authorities are not providing this full, open access service to all women and that a variety of approaches are being taken to secure reimbursement for services provided to women from out of area. Members were keen to understand whether restrictions are being put in place.

As shown in Figure 7, 88 percent of the councils that responded to the audit confirmed that they do not put in place restrictions that prevent out of area residents from accessing contraceptive services. However, there was evidence that restrictions are being put in place across some areas of the country. 18 councils (equating to around 12 percent of all councils to respond to our audit) confirmed that contrary to Department of Health guidance, they have policies or contracts in place that mean that non-residents do not have full access to contraceptive services. This is especially worrying given that there is no routine monitoring in place of local authorities' compliance with this requirement, as noted above.

Figure 7. Percentage of local authorities that confirm or deny they have in place a policy and/or requirement to treat non-residents



Detail was provided by a number of councils. For example, Warwickshire County Council state that their "*contract for integrated sexual health is for residents only for all SH services".* North Tyneside Council said that contraceptive services are only provided to residents of the area. Nottingham City Council said that *"Our contracts do not state the service should not treat non-residents. However, for secondary care contracts with a tariff payment mechanism, the local authority will not pay for the services where the patient is a resident from a different local authority."*

Nine councils specifically noted that they have restrictions in place on who can access LARC methods, such as IUD, IUS or the contraceptive implant. Durham County Council, for

instance, indicated that IUD and contraceptive implants are not available to women '*who are not registered to a GP practice in County Durham*'. Similarly, Rotherham Metropolitan Borough Council indicated that only '*patients registered with contracted GP*' could access LARC.

These findings are particularly troubling given that LARC methods are more cost-effective than other user-dependent methods and NICE guidance states that increasing uptake of LARC methods will reduce the number of unintended pregnancies.[23]

Cross charging arrangements for the provision of contraceptive services across England

The AGC sought to understand the extent to which cross-charging arrangements for the provision of contraceptive services across England are in place. By enabling councils to enter into commissioning arrangements with other local authorities to recover the cost of providing services to non-residents, cross-charging arrangements are a vital financial mechanism for ensuring that women can access a full range of services regardless of their place of residence.

The Department of Health has published principles on cross-charging for sexual health services, which state that:

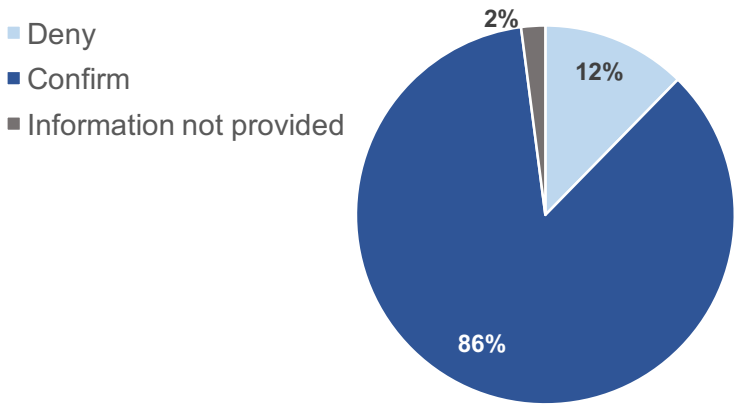
> *"Councils may wish to consider the use of contracts procured, let and managed by more than one commissioning authority to take a joined up approach and, where possible, share risk and manage demand*".[24]

However, there are no fixed guidelines for how these arrangements should work in practice, and AGC members understand that there is a variety of approaches being adopted by different authorities across the country.

This plurality of approaches to cross-charging was confirmed by the AGC's audit, wherein councils were asked to confirm if they had received invoices for contraceptive services provided to residents of their local authority that had been undertaken out of their local area in the past 12 months.

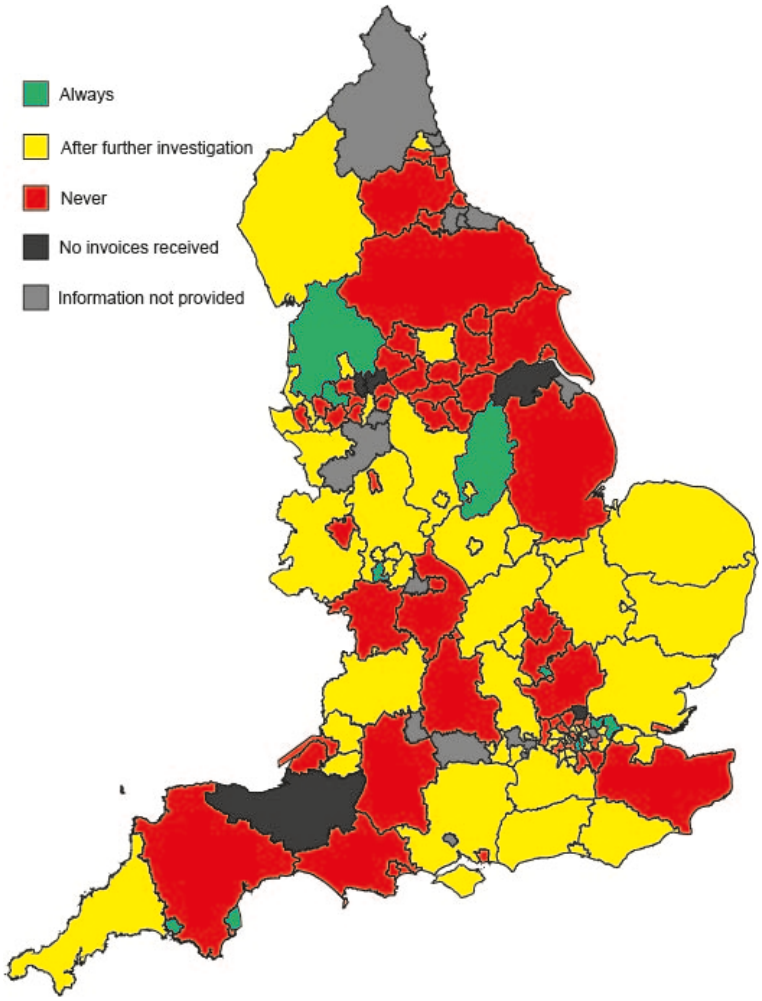
As shown in Figure 8, most councils (86 percent) confirmed that they had received invoices from other areas for contraceptive services provided to their residents. 18 councils (12 percent) said that they had not received invoices from providers in other authorities in the past year for contraceptive services.

Figure 8. Percentage of local authorities that confirm or deny receiving invoices cross-charging for contraceptive services for out of area patients



The diversity of approaches taken by councils to cross-charging can be seen in Figure 9, which shows whether or not councils always pay invoices, pay after undertaking further investigation or never pay invoices.

Figure 9. Map showing local authorities responses to the payment of invoices for the provision of contraceptive services undertaken out of area



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Of the councils who confirmed they received invoices from providers outside of their local authorities boundaries, as shown in Figure 9, only a small number (nine percent) indicated that they 'always' paid invoices received. In contrast 45 percent indicated that they only paid invoices 'after further investigation'. Most concerning, however, was the finding that nearly half (44 percent of respondents) of local authorities 'never' paid invoices received for contraceptive services delivered out of area. As highlighted in Figure 9 this appears to be particular feature of the North East and South West of England.

The observation that local authorities in the North East of England never pay invoices for contraceptive services is likely to reflect an arrangement on sexual health cross-charging between by the Yorkshire & Humber Public Health Regional Sexual Health Commissioning Group to "not reimburse invoices for contraception activity".[25]

It is difficult to evaluate the impact of this on women's ability to access services. For instance, councils who commission contraceptive services through a block contract may not put cross-charging arrangements in place. However, as noted by AGC members, should contraceptive services go onto a tariff arrangement, the impact of cross-charging arrangements may become more evident and more areas may stop paying for the provision services to residents from out of the area.

Although there is nothing untoward about local authorities investigating invoices, the lack of clear national guidelines about what services should be paid for makes understanding the overall landscape difficult. A small number of councils provided some hints on the criteria used to assess whether to pay invoices or not. For instance, Hertfordshire County Council stated: '*There is no arrangement to pay invoices for this provision [of contraceptive services], only for GUM [genitourinary medicine] services.'*

There was also evidence that local authorities are reviewing their policies for the treatment of non-residents, or have recently changed their policy. For instance, Calderdale Council stated that they had changed their policy on cross-charging in the current financial year, moving from payment to non-payment in 2016/17. This change may represent a reaction to funding constraints across the system or could be symptom of cross-charging arrangements between local authorities breaking down. Irrespective of the cause, such a move will affect women by making it more difficult for them access contraceptive care.

The AGC is concerned that, as the effects of local authority budget cuts take hold, more councils may evaluate their policy on the provision and/or payment of services for out of area residents with a view to putting restrictions in place. Any such restrictions undermine the fundamental principle of open access and must be challenged. At present there is no system in place to ensure that councils deliver open access services and the Department of Health has indicated that it relies on the sexual health community to flag concerns about restrictions.[26]

RECOMMENDATIONS

5. The Department of Health should remind local authorities of their responsibility to provide women with open access contraceptive and reproductive health services regardless of their age or place of residence.

6. The Department of Health should commission a review of contraceptive services across England and develop clear guidelines on cross-charging between local authorities, including clarifying what services should be covered in cross-charging arrangements.

Restrictions on access to contraceptive services

In its two previous reports, the AGC found evidence of commissioners putting in place restrictions on contraceptive services on the basis of age, residence and/or the type of method being prescribed.[27,28] Similar to these earlier publications, the AGC audit again found evidence that local authorities are putting in place barriers to access based on women's age and/or place of residence.

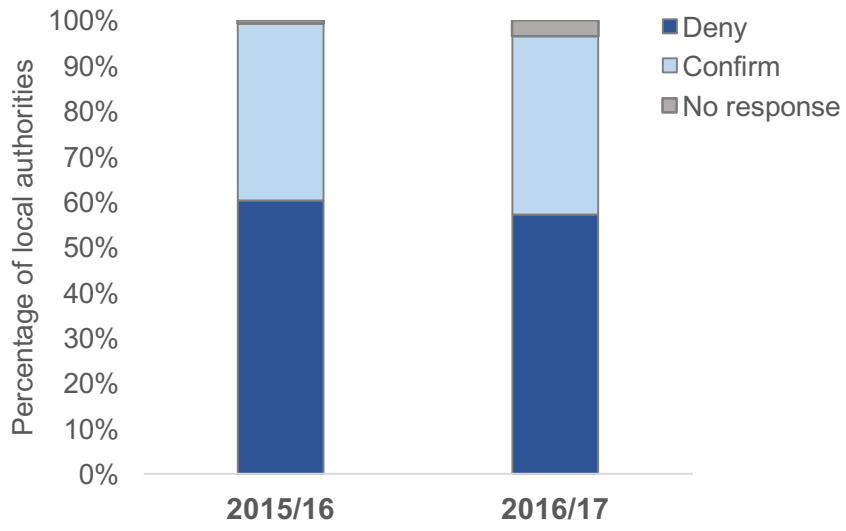
While we understand the financial pressures on commissioners of contraceptive services, the AGC has consistently made the case that commissioners should remove barriers that restrict women's access to contraceptive services. Guidance from the Department of Health is clear that:

> *"Highly visible, accessible contraception services that supply the full range of contraceptive methods can reduce unwanted pregnancy and better support people of all ages to have children when they are ready, and these will play a key role in improving outcomes."*[29]

As part of this audit, the AGC repeated the questions posed in *Sex, Lives and Commissioning I and II,* calling on local authorities to indicate whether they had any policy or contract in place that restricts access to services on the basis of age and/or place of residence. The audit found that age restrictions were most common, largely affecting women over the age of 25. In most cases they appeared to apply to EHC, a service commissioned by local authorities and delivered by community pharmacists.

When asked specifically about whether service specifications for community pharmacists providing EHC stipulated an upper age limit in 2015/16 and 2016/17, 57 councils, or 38 percent, stated that upper age limits are in place. Five fewer councils denied the existence of an upper age limit in 2016/17 compared to 2015/16.

Figure 10. Percentage of local authorities that confirm or deny putting in place age restrictions on the provision of free EHC from pharmacists providing, for the financial years 2015/16 and 2016/17



The audit showed that women over the age of 25 are most affected by these restrictions, meaning they cannot access free EHC from pharmacies. Further analysis of councils' responses revealed that more than half of councils with age restrictions on EHC in place

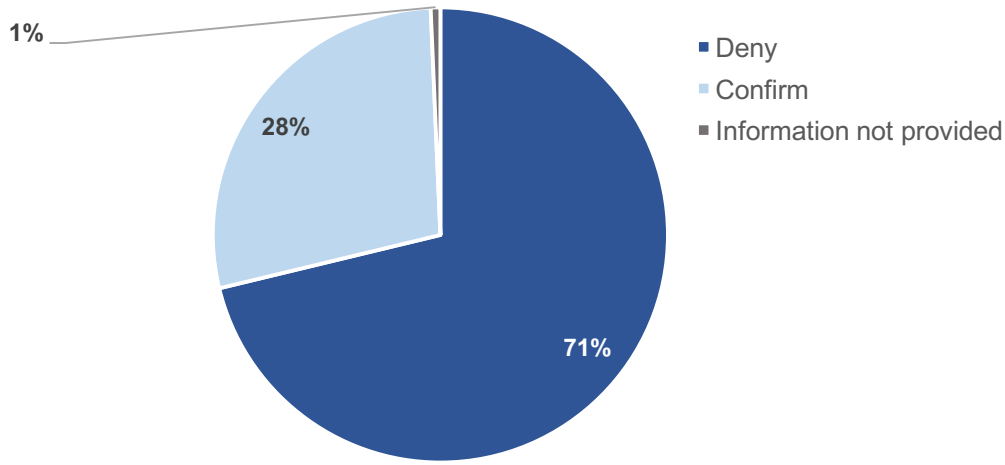
limited access to free EHC to women under the age of 25. Five councils indicated that only women under the age of 19 could access free EHC in their area. Two councils confirmed that age restrictions to free EHC were in place but did not specify the upper age limit.

The audit found evidence of restrictions based on income. For instance, Calderdale Council reported that access to free *'EHC is restricted by income for over 25's'*. There are also worrying signs that some councils are considering introducing age restrictions. For instance, South Gloucestershire Council indicated that they changed their policy such that in 2015/16, the council made payments to 25 and over, with no restrictions. In 2016/17, however, the council introduced new criteria whereby, "*we are asking pharmacists to give a reason where they make a provision to someone 25 or over, and we reserve the right to withdraw payment for any provisions that do not meet our 25 or over criteria."*

Not all councils have chosen to cap free EHC to those under 25. For instance, Kent County Council indicated that in 2015/16 they lifted the age limit '*to 30+ (from 20+)*'. Cambridgeshire County Council noted it provides free EHC to '*under 50s'.*

In the context of general practice, the audit revealed that age and/or residence restrictions are also in place. As shown in Figure 11, 28 percent of councils confirmed they have such policies in place for the prescribing of contraception. Of those councils that responded, six councils confirmed that they limit access to LARC methods by place of residence, stating that they only offered GP LARC services to residents of the area.

Figure 11. Percentage of local authorities that confirm or deny putting policies in place that restrict, due to a woman's age or place of residence, the prescribing or availability across general practice or community settings of contraception



Taking all of these restrictions into account the AGC estimates that 3.9 million women of reproductive age live in areas with some form of restriction on access to contraception.[30]

The AGC is deeply concerned about the existence of these restrictions and their potential effect on women's wellbeing and ability to access services. The AGC finds the restrictions on women over the age of 25, or even younger in some circumstances, especially worrisome particularly in light of recent abortion statistics, which show an increase in older women requiring abortion services.[31]

RECOMMENDATIONS

7. The Department of Health should commit to review and monitor commissioning arrangements for contraceptive services across England to identify any restrictions in access to contraceptive services, for example on the basis of age or demography

8. Commissioners should be supported to address restrictions on the provision of the full range of contraceptive options and to put in place appropriate funding and training arrangements to ensure that women's access to services is not restricted

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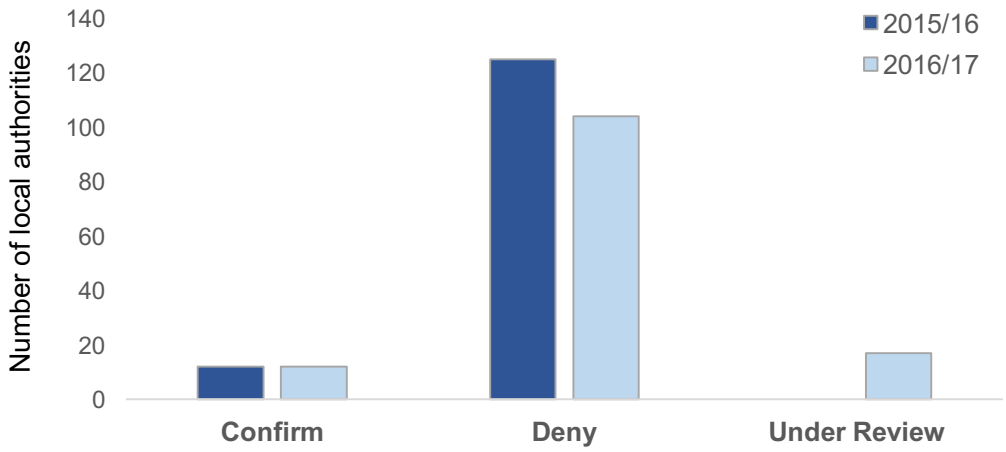
Delivery of contraceptive services – community, specialist and primary care

Women's ability to access contraceptive care is influenced by the number and location of contraceptive services available to them. The decommissioning of services, whether through site closures or the termination of contracts can make it more difficult for women to access contraception services. This may be because site closures force women to travel further to access a service or because restricted opening times make accessing the service more challenging.

Closures to community and specialist providers of contraceptive services

To investigate local authorities' plans for the delivery of services, the AGC's audit asked local authorities whether they had closed sites delivering contraceptive care in 2015/16 or planned to do so in 2016/17.

Figure 12. Number of local authorities that confirm or deny closing sites (not including GP clinics) delivering contraceptive care in 2015/16, or plans to close sites delivering contraceptive care in 2016/17

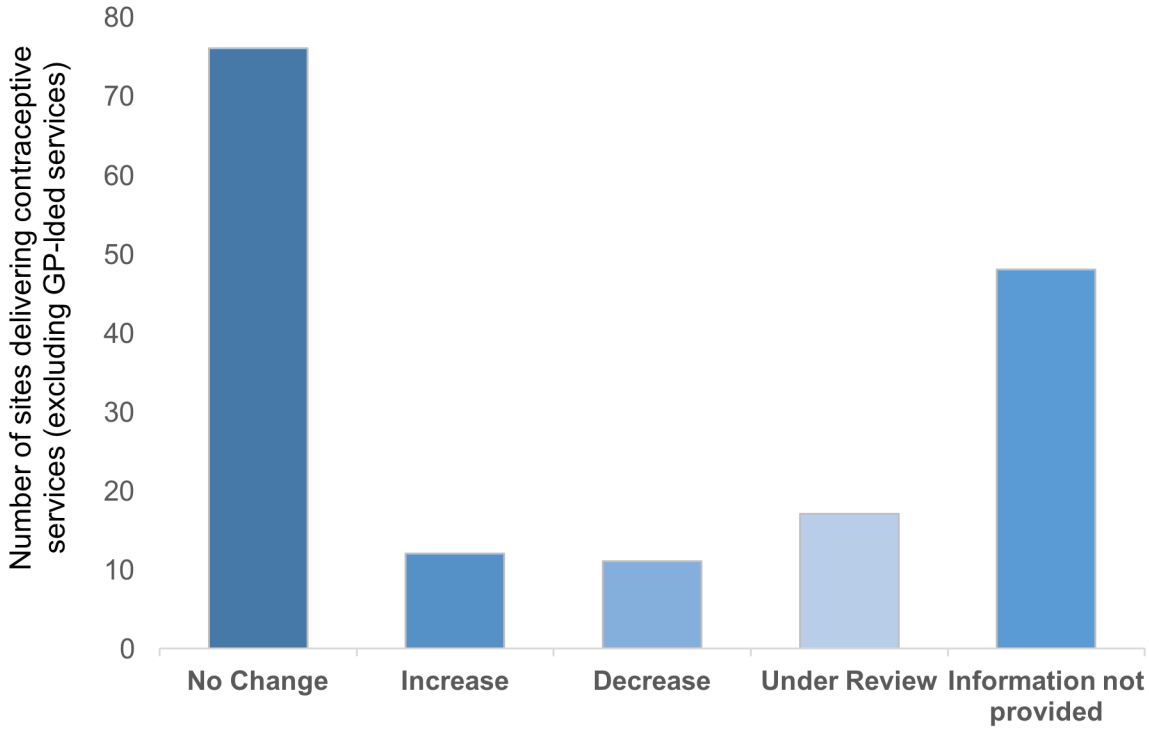


As shown in Figure 12, the AGC's audit revealed that sites delivering contraceptive services (not including GP clinics) are being closed. Of the 140 councils that responded to this question, one in seven (14 per cent) confirmed they had closed sites delivering contraception services in 2015/16 and/or have plans in place to close sites in 2016/17.

We estimate that this change will affect over 1.5 million women of, who may now find it more difficult to access the contraceptive care of their choice. Worryingly, a further 13 percent of councils who responded indicated they are considering site closures over 2016/17, suggesting that more services could be cut in 2016/17 and beyond.

This finding was reinforced by evidence that, as shown in Figure 13, a number of councils have decreased the number of sites contracted to deliver specialist and/or community contraceptive services across 2015/16 and 2016/17. Around eight percent of councils reported there would be fewer sites delivering non-GP contraceptive services in 2016/17 than the previous year.

Figure 13. Change in number of sites delivering non-GP contraceptive services between 2015/16 and 2016/17



Moreover, 18 councils (over 10 percent) indicated they are 'reviewing' the number of sites they support, suggesting that more closures may be set to happen. Councils stated that sites providing contraceptive services were closed in some cases due to "*low usage"* or were reconfigured as part of new integrated sexual health contracts. Nearly a third of local authorities did not provide any information.

In some areas, however, local commissioners have increased the number of sites providing contraceptive services, which is welcome.

Although there may be good reasons for reviewing where services are delivered, it is often the case that reducing sites can make it harder for women to access contraception, particularly LARC methods that require longer or more than one appointment. It is essential that any decision to decommission or close a service should be made only after a full impact assessment, including consultation with service users.

Impact of cuts on the provision of contraception services in general practice

The AGC has long argued that, as services delivered through community and specialist providers are downscaled or decommissioned, more women will be directed towards general practice to access contraception.

A survey of members of the Primary Care Women's Health Forum (PCWHF) highlighted the knock-on effect of site closures, where the lack of family planning services in an area can lead to general practice being '*completely overwhelmed with demand, particularly for coils'.*[32] The joint Faculty of Sexual and Reproductive Health (FSRH) / British Association for Sexual Health and HIV (BASHH) Rolling Survey and Questionnaire to members highlighted that in

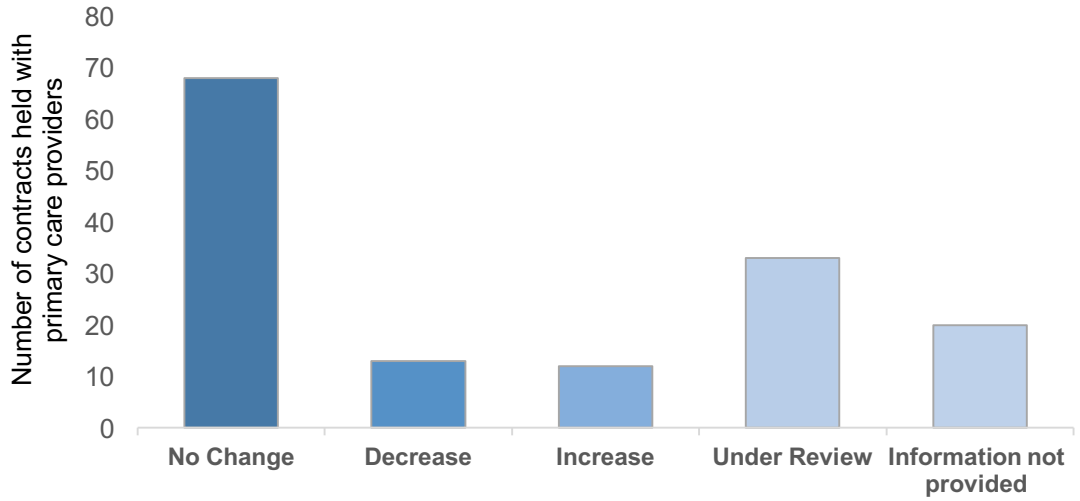
one South West locality, 14 contraception and sexual health clinics were cancelled, resulting in patients waiting up to three months for an appointment to obtain LARC.

In theory, general practice is well equipped to provide women access to a full range of contraceptive services, including LARC. However, general practice is currently facing well-documented resource and workforce constraints, and is struggling to provide a fully open access contraceptive service.

General practice delivers around 80 percent of contraceptive care[33], under the remit of core general practice. This covers general advice and prescriptions for user dependent methods such as oral contraceptives, condoms and contraceptive injections and is funded by NHS England through the GMS contract. It does not include the fitting and removal of LARC methods such as IUD, IUS or subdermal implants, which is funded as an 'enhanced service' through local authorities. This means that, unless specific funding through the local authority is in place, GPs are unlikely to offer women access to LARC methods.

As shown in Figure 14, the AGC audit revealed that 'enhanced service' contracts for the fitting and removal of LARC in general practice are being scaled back or decommissioned in some areas, with around 7.5 percent of councils reporting they will have fewer contracts in place in 2016/17 than the previous year.

Figure 14. Overview of the number of contracts held with primary care service providers for the fitting and/or removal of IUD and IUS between 2015/16 and 2016/17



Of further concern, nearly a quarter (24 percent) of those local authorities that responded to the survey were unable to provide the specific details for the number of contracts in 2016/17, but indicated that these services were under review. This may indicate that further cuts can be expected.

These findings add to existing evidence of GP-run contraceptive services either being decommissioned or downgraded.[34] The PCWHF survey of members found that enhanced services funding for LARC to general practices was being withdrawn by some local authorities, resulting in LARC services no longer being offered, or practices having to cut down on the number of appointments offered.[35] A GP survey undertaken by *GPonline* soon after the new arrangements were introduced found that one in eight GP partners whose practice provided LARC services in 2013 said they had since had to stop providing the service following the changes to commissioning.[36]

GP practices are increasingly reluctant to take on LARC contracts due to insufficient funding, the administrative burden and the additional appointment time needed for counselling, fitting and follow up. One GP quoted by the PCWHF stated that as the practice is "*continuing to make a loss on each [LARC] procedure performed it is very likely that we will stop offering the service when the time comes to renew the contract.*"[37]

In addition, GPs are also struggling to access the required professional and ongoing training to fit and remove IUD and IUS. This becomes a vicious cycle – the FSRH survey found that a dwindling supply of GPs trained to fit LARC is an increasing barrier to the delivery.[38] The AGC has long argued that having a well-trained workforce to fit and remove LARC is essential in ensuring that women are able to access the contraceptive method of their choice.

The AGC would welcome broader investigation into the impact of challenges facing general practice on the delivery of contraceptive care. The AGC notes that the development of new models of care for general practice, including GP networks and federations that encourage GP practices to come together to deliver services at scale, may offer new opportunities for the provision of contraceptive care. Although these approaches may act as a something of a solution, they must be matched by funding and offer women a full range of services.

RECOMMENDATIONS

9. Prior to decommissioning any contraceptive and reproductive health services, commissioners should conduct and publish an impact assessment of how service changes will impact on women's access to contraceptive services and potential health outcomes, including consulting with local service users

11. The Department of Health and Health Education England should publish guidelines that make it clear where the lines of responsibility lie for the funding (or commissioning of) the training of health providers across key areas such as the fitting and removal of LARC methods, consultation skills and clinical leadership

Conclusion

Three years have passed since the devolution of public health functions to local authorities. This report has sought to provide a clear picture of how local authorities are delivering contraceptive services across England. There are examples of good practice, but the AGC is concerned by evidence of variations and restrictions on access to high quality open access contraceptive services.

Access to and choice from the full range of contraception methods is a fundamental right for all women, regardless of age. It is mandated in legislation and is essential to delivering the sustainability of the NHS in the long-term. The AGC is gravely concerned that this fundamental right is now being eroded across England due to fragmented (or ignored) commissioning responsibilities and unsustainable financial pressures.

Progress has been made over the past decade in reducing abortion rates and teenage pregnancy rates. The Department of Health, Public Health England, local authorities and the NHS must work together to ensure that this progress continues, ensuring better outcomes for women of all ages. If we go backwards, women, their families and society will pay a high price.

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Appendix 1 – Members of the Advisory Group on Contraception

Sue Burchill, Head of Nursing, Brook

Dr Amanda Britton, GP Principal, Basingstoke; Medical Director North Hampshire Alliance

Dr Anne Connolly, GP, Clinical Lead for Maternity, Women's and Sexual Health, NHS Bradford and Airedale

Robbie Currie, Sexual Health Programme Lead, Public Health, London Borough of Bexley

Genevieve Edwards, UK Communications Director, Marie Stopes International

Abigail Fitzgibbon, Head of Advocacy and Campaigns, British Pregnancy Advisory Service

Ann Furedi, Chief Executive, British Pregnancy Advisory Service

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

Natika Halil, Chief Executive, Family Planning Association

Jane Hatfield, Chief Executive, Faculty of Sexual and Reproductive Healthcare

Ruth Lowbury, Chief Executive, MEDFASH (Medical Foundation for HIV & Sexual Health)

Dr Diana Mansour, Consultant in Community Gynaecology and Reproductive Healthcare, Newcastle upon Tyne Hospitals NHS Foundation Trust

Councillor Jonathan McShane, Cabinet Member for Health, Social Care and Culture, London Borough of Hackney and Lead Member for Sexual Health, Local Government Association

Karen Pitney, Public Health Outcome Manager, Gloucestershire County Council

Laura Russell, Senior Policy and Parliamentary Affairs Officer, Family Planning Association

Deborah Shaw, Lead for Sexual Health, Public Health England

Professor Jill Shawe, Specialist sexual and reproductive health research nurse

Dr Connie Smith, Chair, HealthWatch Camden

Harry Walker, Policy Manager, Faculty of Sexual and Reproductive Healthcare

Jason Warriner, Chair of Public Health Forum, Royal College of Nursing

Dr Chris Wilkinson, Lead Consultant, Margaret Pyke Centre

Observers to the Advisory Group on Contraception:

Mark Scott, Government Affairs and Advocacy Manager, Bayer

Lesley Wylde, Partnership Development Manager, Bayer

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Appendix 2 – FOI requests submitted to local authorities

Request 1: Please state the budget allocated by your local authority for each financial year (a) 2014/15, (b) 2015/16 and (c) 2016/17 for (i) contraception, (ii) HIV prevention, (iii) GUM services and (iv) all sexual and reproductive health services

Request 2: Please confirm or deny whether cuts were made to your local authority's budget in-year during the financial year 2015/16 for (i) contraception and (ii) all sexual and reproductive health services

a) If confirmed, please disclose how much money was cut from your local authority's budget in-year during the financial year 2015/16 for (i) contraception and (ii) all sexual and reproductive health services

Request 3: Please confirm or deny whether your local authority has a policy or contract in place for providers of contraceptive services that does not include a requirement to treat non-residents of your local authority

a) If confirmed please supply details, including restrictions in provision, prescribing or access to services for non-residents of your local authority

Request 4: Please confirm or deny if you have received invoices for contraceptive services provided to residents of your local authority that have been undertaken out of your local area in the past 12 months

a) If confirmed, please indicate if you pay invoices received for contraceptive services undertaken out of your local area (a) always, (b) after further investigation, or (c) never.

Request 5: Please confirm or deny whether your local authority has any policy or contract in place that restricts access to specialist and/or community contraceptive services (not supplied by general practice) to women on the basis of age

a) If confirmed please supply the local authority's policy or contract on restricting access to contraceptive services

Request 6: Please confirm or deny whether your local authority has put in place, or plans to put in place, any restrictions (due to a woman's age or place of residence) on the prescribing or availability a

general practitioners and community settings of (i) any methods of emergency contraception, (ii) long-acting reversible contraceptive methods or (iii) other contraceptive methods during the financial year in (1) 2015/16 and (2) 2016/17

a) If confirmed please supply the details, including restrictions in provision, prescribing or availability of formulations for individual methods

Request 7: Please confirm or deny whether, for the financial years (i) 2015/16 and (ii) 2016/17, service specifications for community pharmacists providing emergency contraception stipulated an upper age limit for those able to receive emergency contraception free of charge

Request 8: Please state the number of contracts you held with primary care service providers in your area to provide the fitting and removal of intra-uterine devices (IUD) and systems (IUS) for the financial years (i) 2015/16 and (ii) 2016/17

Request 9: Please confirm or deny if your local authority has commissioned a free condom distribution scheme in the financial year (a) 2015/6 and (b) 2016/17

Request 10: Please confirm or deny if your local authority has closed any sites delivering contraceptive care in the financial year 2015/16, or will be closing any sites delivering contraceptive care in the financial year 2016/17

Request 11: Please state the number of sites in your local authority contracted to deliver specialist and/or community contraceptive services (not supplied by general practice) in the financial years (i) 2015/16 and (ii) 2016/17

Appendix 3. Local authorities that responded to the FOI request

Barnsley Borough Council
Bath & North East Somerset Council
Bedford Borough Council (joint response with Central Bedfordshire Council)
Birmingham City Council
Blackburn with Darwen Borough Council
Blackpool Council
Bolton Metropolitan Borough Council
Bracknell Forest Council
Bradford Metropolitan Council
Brighton and Hove City Council
Bristol City Council
Buckinghamshire County Council
Bury Metropolitan Borough Council
Calderdale
Cambridgeshire County Council
Cheshire East
Cheshire West and Chester
City of London Corporation
City of Westminster
City of York
Cornwall Council
Council of the Isles of Scilly
Coventry City Council
Cumbria County Council
Darlington Borough Council
Derby City Council
Derbyshire County Council
Devon County Council
Doncaster Metropolitan Borough Council
Dorset County Council (joint response with Bournemouth Borough Council and Poole Borough Council)
Dudley Metropolitan Borough
Durham County Council
East Riding of Yorkshire Council
East Sussex County Council
Essex County Council
Gateshead Metropolitan Borough Council
Gloucestershire County Council
Halton Borough Council
Hampshire County Council
Hartlepool Borough Council
Herefordshire Council
Hertfordshire County Council
Hull City Council
Isle of Wight Council
Kent County Council
Kirklees Metropolitan Borough Council
Knowsley Metropolitan Borough
Lancashire County Council
Leeds City Council
Leicester City Council
Leicestershire County Council
Lincolnshire County Council
Liverpool City Council
London Borough of Barking & Dagenham
London Borough of Bexley
London Borough of Brent
London Borough of Bromley
London Borough of Camden
London Borough of Croydon
London Borough of Ealing
London Borough of Greenwich
London Borough of Hackney
London Borough of Hammersmith & Fulham
London Borough of Haringey
London Borough of Harrow (joint response with London Borough of Barnet)
London Borough of Havering
London Borough of Hillingdon
London Borough of Hounslow
London Borough of Islington
London Borough of Lambeth
London Borough of Lewisham
London Borough of Merton
London Borough of Newham
London Borough of Redbridge
London Borough of Richmond upon Thames
London Borough of Southwark
London Borough of Sutton
London Borough of Tower Hamlets
London Borough of Waltham Forest
London Borough of Wandsworth
Luton Borough Council
Manchester City Council
Medway Council
Middlesbrough Borough Council
Milton Keynes Council
Newcastle upon Tyne City Council
Norfolk County Council
Northamptonshire County Council
North East Lincolnshire Council
North Lincolnshire Council
North Somerset Council
North Tyneside Council
Northumberland County Council
North Yorkshire County Council
Nottingham City Council
Nottinghamshire County Council
Oldham Metropolitan Borough Council
Oxfordshire County Council
Peterborough City Council
Plymouth City Council

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Portsmouth City Council
Reading Borough Council
Redcar and Cleveland
Rochdale Metropolitan Borough Council
Rotherham Metropolitan Borough Council
Royal Borough of Kensington and Chelsea
Royal Borough of Kingston upon Thames
Royal Borough of Windsor and Maidenhead
Rutland County Council
Salford City Council
Sandwell Metropolitan Borough Council
Sefton Metropolitan Borough Council
Sheffield City Council
Shropshire Council
Slough Borough Council
Solihull Metropolitan Borough Council
Somerset County Council
Southampton City Council
Southend-on-Sea Council
South Gloucestershire District Council
South Tyneside Metropolitan Borough Council
Staffordshire County Council
St Helens Borough Council
Stockport Metropolitan Borough Council
Stockton-on-Tees Borough Council
Stoke-on-Trent City Council
Suffolk County Council
Sunderland City Council
Surrey County Council
Swindon Borough Council
Tameside Metropolitan Borough Council
Telford & Wrekin Council
Thurrock Council
Torbay Council
Trafford Council
Wakefield City Metropolitan District Council
Walsall Metropolitan Borough Council
Warrington Council
Warwickshire County Council
West Berkshire Council
West Sussex County Council
Wigan Metropolitan Borough
Wiltshire Council
Wirral Metropolitan Borough
Wokingham Council
Wolverhampton City Council
Worcestershire County Council

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