October 2010

FPA response to Department of Health consultation on
Equity and Excellence: Liberating the NHS

About FPA

FPA is one of the UK’s leading sexual health charities, with an 80 year history of providing the UK public with accurate sexual health information, advice and support services.

FPA provides a comprehensive information service, including a national helpline and web enquiry service, which respond to 45,000 enquiries a year on all aspects of sex, relationships and sexual health, and a library and information service for professionals. We produce a range of publications for professionals and the public on sexually transmitted infections, contraception and pregnancy choices, including abortion, plus educational materials to support parents and schools in delivering age appropriate sex and relationships education. We distribute around 10 million pieces of literature a year. FPA offers a range of resources, including training courses, for those involved in delivering sexual health services. We also run a series of community based sex and relationships education programmes for young people, parents and people with learning disabilities. FPA represents a national voice on sexual health, working with and advocating for the public and professionals to ensure that high quality information and services are available for all who need them.

For more information, please contact:

Hayley Blackburn
Policy Manager
FPA
50 Featherstone Street
London EC1Y 8QU

Tel: 020 7608 5259
Email: hayleyb@fpa.org.uk
FPA welcomes the opportunity to comment on the White Paper, *Equity and Excellence: Liberating the NHS*. We have restricted the following comments to our areas of knowledge and expertise.

**Introduction**

FPA welcomes elements of the NHS White Paper, in particular moves to provide service users with more information, choice and control and that shared decision making will become the norm, with *no decision about me without me*. FPA also welcomes the commitment in paragraph 1.2 that the NHS is available to all free at the point of use, based on need not ability to pay and that health spending will increase in real terms in each year of this Parliament. FPA welcomes the commitment in paragraph 1.17 that the Department of Health will continue to work closely with the Department for Education as this will be crucial to ensuring that young people receive the education they need to protect their sexual health and to prevent unplanned pregnancies and sexually transmitted infections.

We have some concerns about the proposals. In particular, the absence of any reference to sexual health services\(^1\) and prevention in the White Paper raises questions about the future priority that will be attached to these issues within the NHS. We welcome the Government’s plans to publish a White Paper on Public Health in due course and we strongly recommend that sexual health services are an integral part of that White Paper. Improving sexual health services has been identified by the public as one of the top three public health issues\(^2\). Poor sexual health has significant cost implications for the state and for individuals, for example, research has shown that teenage parents and their children are at higher risk of poor health, social and economic outcomes than their peers, similarly the NHS cost of providing lifetime treatment for people with HIV is increasing by £1 billion a year. However, in the absence of the Public Health White Paper there remains a great deal of uncertainty around the provision of sexual health services.

**Putting patients and the public first**

FPA welcomes the proposals to ensure that service users and the public have greater choice and control over their health services and the treatment they receive. We know for example that it is vital that people are able to choose from the full range of 15 methods of contraception to find the one that suits them and their lifestyle best as this increases the likelihood that they will use it correctly and consistently. However, this only works if people have accurate, up to date

---
\(^1\) In this document FPA defines sexual health services as including the provision of the full range of methods of contraception, testing and treatment for all STIs and HIV, including partner notification, abortion service provision, and sexual dysfunction services, including psychosexual services.

and evidence based information on which to base their choices and can then access services which provide the full range of options. We welcome the Government’s aim, set out in paragraph 2.6, of giving people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family’s health and we would welcome more information about how this will be achieved. We also welcome the Government’s recognition that some people will require decision aids and support to be able to make their own choices, for example support for people with disabilities so that they can access information. Again, it would be helpful for the Government to set out in more detail how this might work in practice. FPA believes it is vital that everyone is able to access high quality information about their options, including all of their treatment options, to ensure that they can make a fully informed choice for themselves.

FPA also welcomes the emphasis within the White Paper on enabling people to accept more responsibility for their choices and their behaviour. The information and education services that FPA provides are specifically aimed at providing people with the knowledge and skills to make responsible choices and to ensure their behaviour does not harm them or someone else.

Patient records

Having control of their own records can give people greater control of their healthcare in many cases. However, FPA is concerned about how people will be supported to maintain the confidentiality of their records. It is not currently clear from the proposals what it will actually mean for people to control their own records, for example whether they will store them at home as they may not have anywhere to keep their information confidential. Whatever the mechanisms for enabling people to control their records, an appropriate system needs to be in place to ensure that people are made aware of and understand how they can maintain the confidentiality of their records.

It is not clear from the proposals what the arrangements would be around parents and carers controlling their children’s records. FPA is concerned about the implications of parents having ownership of the health records of their children. In particular, there are occasions when young people may wish to access services without their parents’ knowledge, and they have a right to do so. This is a particular issue for young people’s access to sexual health services.

Concerns about their confidentiality being breached pose a major deterrent to young people accessing sexual health services. Research conducted by Brook with young people in 2005 showed that 74 per cent of under-16s said they would be less likely to seek sexual health advice if health workers could pass on details to social workers. If young people are denied access to confidential

---

3 Brook, *Wise Up!* survey of Brook clients, 2005
services, this will close off their opportunity to discuss sexual health and gain advice from trained professionals, as well as making them more vulnerable to unwanted pregnancies and sexually transmitted infections. Young people, including those under 16, have a right to access sexual health advice and services without their parents’ knowledge or consent. It is vital that any system enabling people to control their health records does not undermine this.

A system which enables people to control their personal health records must include provision for people who will need additional support to exercise their rights and to understand their records. For example, adults with learning disabilities may well have the capacity to access their records but need additional support to interpret and use them. A clear system of support should be in place to enable them to do this, recognising that their confidentiality must be respected and therefore there should not be an expectation that parents or carers will provide this support unless the person with learning disabilities specifically requests this. Adults with learning disabilities must be treated as adults.

HealthWatch

Through the sexual health direct service FPA often receives feedback from people about their experiences, positive and negative, of sexual health services. We strongly encourage people to provide this feedback directly to their local services and commissioners. However, many people who have accessed sexual health services are reluctant to provide feedback because of concerns that it would lead to their confidentiality being breached and we also play an advocacy role by providing the service user perspective through our networks and in our engagement with decision makers including government departments. This highlights the importance of independent scrutiny of commissioning and service provision and we welcome the intention for local HealthWatch to ensure that there is a service user voice at a local level. Given people’s concerns about confidentiality, we believe it is vital that HealthWatch makes particular efforts to ensure it is using varied and innovative means to secure feedback from service users. This might include anonymous feedback and liaising with organisations such as FPA which are able to provide a consumer perspective. It is important that HealthWatch also engages with people who do not or who no longer access services to identify any possible barriers to access. Seeking feedback from the people who are using services will only give part of the picture.

At a national level, FPA welcomes the creation of national HealthWatch as a strong champion for service users and the public. However, it will be important that it does not become seen as the only voice of service users. There are a variety of organisations in the voluntary sector which have significant expertise in advocating for and working with service users. This should be complemented by national HealthWatch in its advice to the NHS Commissioning Board, Monitor and the Secretary of State, not undermined by it.
Improving healthcare outcomes

FPA welcomes the focus on improving health outcomes. We would like to see investment in services that ensure improved sexual health outcomes, with fewer people experiencing unplanned pregnancies and sexually transmitted infections. We understand the intention to have a greater focus on outcomes rather than on how services are delivered and to remove unnecessary bureaucracy and perverse incentives. We believe there is a case for retaining some national targets, for example, many sexual health services are extremely time-sensitive and swift access to services can have a significant impact on outcomes. FPA is, therefore, concerned that the loss of performance measures such as securing 48 hour access to sexual health services and the number of abortions carried out before ten weeks could have an adverse impact on people’s health and wellbeing. For example, people who think they may have a sexually transmitted infection but cannot get an appointment at a sexual health service do not necessarily stop having sex, which can mean that they pass the infection on to their partner(s) while they wait to see someone. Similarly, if women have to wait a long time to access an abortion service they will have a later abortion than would otherwise be the case with the additional relative risks that this can pose to their health and wellbeing, as well being more costly for the NHS. It is unclear in the White Paper proposals how performance will be managed to ensure that progress to date on improving sexual health, for example on reducing teenage pregnancy rates, will not be lost. FPA believes that some of the current performance measures should be retained to ensure that people can access services swiftly that will improve sexual health outcomes.

To ensure continuity of service provision, it will be crucial that sexual health outcomes feature in the NHS Outcomes Framework and that these very clearly link across to the outcomes set for the Public Health Service and also for social care services. There are a variety of factors that affect people’s sexual health and wellbeing, including the availability and accessibility of high quality sexual health services, and it will important for the Outcomes Framework to reflect the range of roles the NHS is involved in.

FPA welcomes the involvement of NICE in the development of quality standards to support the Outcomes Framework. Their evidence based approach gives significant credibility to the guidance they produce. It would be helpful if there were more detail available about how NICE will develop the capacity to deliver this significant workload alongside its existing programmes of guidance development.
Autonomy accountability and democratic legitimacy

GP-led commissioning consortia

FPA understands the intention to bring decision-making within the NHS much closer to service users and to increase the clinical input into commissioning decisions. However, it is unclear from the proposals set out in the White Paper where the commissioning of sexual health services would take place. We are concerned that devolving commissioning of sexual health services to GP-led commissioning consortia may have adverse consequences for people’s sexual health and wellbeing.

Sexual health is not something many people are willing to talk openly about, even if they have accessed sexual health services. Consequently it can be difficult to assess accurately the need for sexual health services in a local area, compared to the demand for services. FPA is concerned that GP-led commissioning consortia may not have the expertise or capacity to undertake the in-depth needs assessments required to commission appropriate sexual health services.

There are some elements of sexual health service provision, for example public information and prevention work, which will benefit from economies of scale and where national commissioning would be of significant benefit. For example, FPA currently provides the sexual health direct service on behalf of the Department of Health. This includes the provision of expert information services including: a telephone helpline; a web enquiry service; a sexual health clinic finder search facility; a library service for professionals; and a comprehensive specialist website as well as the development and review of over 30 different booklets on all aspects of sexual health which are disseminated to every general practice and sexual health clinic in England and which are considered to be the gold standard in sexual health information. It would not be possible for GP-led commissioning consortia to develop and deliver these services individually to the same standard or as cost-effectively given the levels of quality assurance and consumer testing that is required.

Similarly, some elements of sexual health services are only required for a relatively small number of people and consequently would also benefit from a national approach to commissioning. For example, very few abortions take place at later gestations and the GP-led commissioning consortia are therefore unlikely to have significant experience of commissioning them. However, for women who need these services, swift access is paramount and clear pathways have to be in place to ensure that this is the case. FPA anticipates that all sexual and reproductive health and HIV services, including the provision of information, will be commissioned through the proposed Public Health Service. However, if this is not the case, we recommend that these services are commissioned nationally because the stigma that continues to surround these services risks deterring
people from being open about the services they need and consequently there is a danger that services will not be commissioned and people's sexual health and wellbeing will be adversely affected.

As has been noted above, many people are reluctant to talk about sexual health and they often have significant fears about their confidentiality being breached when they access sexual health services. This means that many people actively choose not to approach their own GP about sexual health. FPA is concerned that the creation of GP-led commissioning may lead to confusion about GPs' involvement in sexual health services and therefore deter people seeking the advice and help they need. FPA understands that not all GPs will be personally involved in the commissioning process. However, many people may believe that GP-led commissioning means their own GP will individually commission services on their behalf. If they do not want their GP to know about them accessing sexual health services this could deter them from coming forward. Similarly, some people will travel significant distances even going out of their area to seek advice and treatment because of concerns about their confidentiality being breached. It is crucial that people’s ability to travel to access services is maintained under the new commissioning system and that the commissioning consortia put arrangements in place to enable this to happen.

FPA is concerned that some GPs have a conscientious objection to some sexual health services and this may affect commissioning decisions, resulting in people in a particular area being unable to access services. A survey conducted by Marie Stopes International in 2007 found that 20 per cent of GPs described themselves as anti-abortion and some of these doctors exercise a conscientious objection and refuse to refer women for abortion services. If GPs were to exercise their conscientious objection by refusing to commission abortion services, women would be denied access to a service they need to maintain their health and wellbeing. It is vital that there are clear directions from the National Commissioning Board to ensure that the personal views of GPs cannot restrict access to services.

FPA welcomes the proposal that GP-led commissioning consortia will be held to account for their stewardship of NHS resources. As investment in contraception is cost-saving we would anticipate that this would lead to an improvement in the provision of contraception services. However, it is vital that this accountability does not deter long-term decision making or lead to services being restricted inappropriately. Previous experience has shown that commissioners can be concerned about the upfront costs of treatment without considering the longer-term cost-effectiveness of them, for example, in the past, services have avoided providing long-acting reversible methods of contraception (LARC) because they were more expensive initially without recognising that LARC methods have been shown to be more cost effective than other methods of contraception even after

---

one year of use. Similarly, there is a risk that commissioning consortia would seek to restrict access to procedures such as abortion on cost grounds which would inappropriately deny women access to services they need. It is vital that services are commissioned to meet identified local need and that services are commissioned cost-effectively rather than access simply being restricted or denied.

While we welcome the proposal in paragraph 2.10 of the White Paper that assessments of commissioners’ performance will be published so that they can be held to account for their use of public money, we are concerned that this may not be meaningful for many people. It is unclear as yet how the information will be published to enable people to make accurate comparisons and judgements about the value for money achieved, as opposed to simply which commissioner appears to have spent the most or the least. FPA therefore recommends that clear processes are put in place at national level for independent scrutiny of commissioners’ performance in meeting the needs of local populations and achieving value for money.

The National Public Health Service

FPA welcomes the creation of a national Public Health Service and the Government’s commitment to provide ring-fenced local public health budgets. FPA strongly recommends that all sexual health services are included in the Public Health Service because of both the financial benefits that can accrue from investment in sexual health services and the social benefits. Investment in sexual health services in cost-effective; by helping to prevent unplanned pregnancies and sexually transmitted infections, sexual health services and prevention can save the NHS, and other Government Departments, significant amounts of money. In 2005, NICE calculated that fully implementing its guidance on access to long-acting reversible methods of contraception would save the NHS in England more than £100 million a year. In addition, sexual health services and prevention work have significant social benefits, for example, by helping to reduce high levels of teenage pregnancy and therefore having a positive impact on young people’s life chances. For example, FPA has calculated that our information services, based on 33,000 calls to our helpline, 13,000 enquiries to our web enquiry service and dissemination of 7,900,000 information leaflets, delivers a saving to the state, in a twelve month period, of £3,882,198. This is a very conservative estimate and the real savings are likely to be higher.

---

5 NICE, National cost impact report: implementing the NICE clinical guideline on long-acting reversible contraception (London: NICE, 2005)
6 Savings were estimated to be made through: avoided GP appointments; avoided unplanned pregnancies; avoided onward transmission of STIs as a result of early treatment; avoided medical complications of untreated STIs; and avoided need for later stage abortions as women were referred more swiftly to abortion services.
FPA welcomes the role of local authorities in the proposed Public Health Service. Many factors can affect people’s health and wellbeing not simply access to health services. Rates of teenage pregnancies are strongly associated with rates of deprivation but are also affected by educational attainment, good quality sex and relationships education and access to sexual health services. Local authorities should be well placed to provide leadership and co-ordination on all of these elements. However, it is important that there are sufficient resources for local authorities to invest in services and to develop the necessary expertise to assess local needs accurately. Public health can be complex precisely because so many factors can play a role; this requires a sophisticated response which it is not clear local authorities are currently in a position to deliver for sexual health.

There is a risk that the devolution of powers over public health to local authorities could lead to a separation between public health and delivering health services to people who are ill. Health services play a significant role in both primary and secondary prevention and it is therefore vital that they continue to be involved in public health. FPA strongly recommends that this is set out in the responsibilities of both the GP-led commissioning consortia and local authorities to provide greater clarity. In addition, we recommend that there is a statutory duty created for GP-led commissioning consortia to engage and work in partnership with the health and wellbeing boards within local authorities. This will be vital to ensure that health and wellbeing boards can confirm that local sexual health needs are being assessed and addressed appropriately and tackle local health inequalities.

Changes to training and education

FPA has concerns about the proposals to devolve greater power over education and training to a local level. It is not clear how general oversight of the workforce will be maintained without national involvement. There is an aging workforce delivering sexual health services and there is a significant risk that there will not be sufficient numbers of healthcare professionals with appropriate training and qualifications to replace them as they retire over the next few years. This situation could be exacerbated if decisions on education and training are taken only at a local level.

Currently, although around 80 per cent of contraception provision takes place in general practice or primary care compared to 20 per cent in community services, 80 per cent of contraception training takes place in community services. FPA is extremely concerned that the GP-led commissioning consortia will not have sufficient capacity or expertise to plan and co-ordinate the necessary training in future and this will have a detrimental effect on people’s ability to access the sexual health services they need.

There have been significant problems in sexual health training for some time, particularly around training for nurses. Training budgets have often been seen as a soft target for cuts in recent years and currently there is not a clear system for
managing and co-ordinating nurse training in contraception and sexual health across the country which has led to wide variations in quality and consistency. Removing the national oversight of training and education could lead to greater variability in the quality of all medical training and education, with no system of quality control and qualifications from different places having the same name but not having the same content.

FPA recommends that the arrangements for paying providers according to outcomes are clarified. We understand the principle that paying according to outcomes should lead to an increase in quality. However, it is not clear how investment in training and education for staff will be reflected in these payments, particularly in situations where the majority of training takes place in a different sector to the majority of service provision, as has been set out above.