HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM FACULTY OF SEXUAL AND REPRODUCTIVE HEALTHCARE (SCOTLAND COMMITTEE)

1. Considering the Health and Sport Committee's report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities.

The Faculty of Sexual and Reproductive Health (FSRH) is the largest UK professional membership organisation working at the heart of sexual and reproductive health (SRH), supporting healthcare professionals to deliver high quality care. FSRH has early 1200 members in Scotland – over half work in primary care and many are GPs.

The Health and Sport Committee's report set out a range of priorities, and SRH-related interventions and services are mentioned at various points. The first Sexual Health Strategy in Scotland in 2005\(^1\) recognised the need to improve sexual health and set out new arrangements for SRH services across the NHS in Scotland. The intention (set out in the diagram below) was that SRH services provided by GPs and other primary care staff would operate at Tier 4 - with specialist SRH staff providing training if required, alongside the development of community-based SRH services. Specialist SRH services (within integrated centres providing specialist family planning and genitourinary medicine services that became a major outcome of Respect and Responsibility) were Tier 5 with referrals coming from primary care in most instances.

These new structures, underpinned by local and regional planning including managed clinical networks and national clinical leadership groups, have overall been successful but since the early 1990s when the new accessible and non-judgemental integrated specialist sexual and reproductive health services first developed, there have been major technological and pharmaceutical advances, as well as behavioural changes facilitated through digital media. Sexual health priorities have rightly targeted those most at risk of poor sexual health such as men who have sex with men, young people, and black and minority ethnic communities, and all of these factors have contributed to increased attendances at Tier 5 clinics. Many specialist sexual health services are dealing with an ongoing cycle of reduced budgets that in some cases is leading to a reduction in opening hours and to some services.


This complex set of circumstances is informing current discussions concerning a refreshed Scottish Government sexual health and blood-borne virus strategy for 2020. It is really important that thinking about a different future for primary care in Scotland dovetails with these debates to ensure that the sexual and reproductive health of the whole population is addressed at a community as well as population level, and that the critical role of primary care is fully recognised. Current efforts to create Public Health Scotland are also relevant here, as access to a range of sexual and reproductive health services is a key component of health and wellbeing, as set out in the response FSRH’s Scotland Committee made to the PHS Consultation.

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<thead>
<tr>
<th>Tier One</th>
<th>Self Management</th>
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<td>Tier Two</td>
<td>Individualised Information with some intervention</td>
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<td>Tier Three</td>
<td>Services located in the community</td>
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<td>Tier Four</td>
<td>Enhanced Sexual &amp; Reproductive Health Services</td>
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<td>Tier Five</td>
<td>Specialist Sexual &amp; Reproductive Services</td>
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Public information and knowledge is very important to positive health outcomes, and FSRH recognises that the public may misconstrue and misunderstand the services offered by the NHS and independent contractors like GPs. For example, those who contributed to the Health and Sports Committee’s Report listed a range of healthcare professionals that they would like to see based in primary care said (page 15 of the Report) and sexual health workers were noted as one such group. This suggests that GPs and primary care staff are not regarded as delivering sexual health care; maybe because individuals have not accessed SRH via primary care, and see Tier 5 services as the only provider. FSRH’s Scotland Committee sees this as a retrograde step and feels that the tiered delivery model for sexual health needs to be supported and resourced to meet population need, and that all healthcare professionals providing it need appropriate training and support.

The Report also included comments from the Scottish Youth Parliament that they wanted to be able to access sexual health staff without going through their GP, and again this may be a misunderstanding that the gatekeeper role of the GP into secondary care does not always apply for specialist sexual health. Young people are welcomed within specialist sexual health services, as a key target group, and do not need a GP referral. FSRH’s GP members think that there needs to be more patient education about GPs’ role in providing SRH and in when specialist services should be accessed. It is recommended that, whatever the outcome of this review, there needs to be a clear and comprehensive public information
campaign about how to access health services, and what to expect within each setting, and from each healthcare professional.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

The key to avoiding unintended pregnancy is timely access to SRH support for women and many women wish to obtain contraceptive services via their local GP practice as they do not want or need to access specialist Tier 5 SRH services. It is also true that in some parts of Scotland, because of geography, resources and funding, specialist sexual health services have not developed to the necessary level and primary care is an essential provider. FSRH GP members tell us that they are happy to deliver routine contraception, supported by accessible patient information leaflets, clinical information for healthcare professionals on the websites of specialist sexual health services, and the ability to engage with FSRH’s Clinical Effectiveness Unit.

Whatever the context, it is sometimes the case that GPs and others in primary care respond to women requesting contraception by referring them to sexual health clinics, sometimes because they feel that they do not have the skills and knowledge required, and perhaps because they see this as the recommended pathway. FSRH believes that this is an unnecessary referral as contraception should not be seen as being specialist, and this approach re-stigmatises an already stigmatised health area and may put women under unnecessary stress – and at risk of an unintended pregnancy. Primary care needs to continue to respond to this demand and to support women in their own community. FSRH provides qualifications, and ongoing support, to GPs and practice nurses to do this and does not wish to see this essential service depleted.

Access to contraception is embedded in a range of global frameworks and aspirations. For example, the following statements appear in the United Nations Sustainable Development Goals2 (FSRH annotation in italics):

**Sustainable development goal 3** (Ensure healthy lives and promote well-being for all at all ages) states the aims:

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births – *access to contraception and appropriate pregnancy planning contributes to this*
- By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

**Sustainable development goal 5** (Gender equality) states the aims to:

2 https://sustainabledevelopment.un.org/?menu=1300
- End all forms of discrimination against all women and girls everywhere
- Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

**Sustainable development goal 10 (Reduce inequalities)** states

- Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard

Scotland is committed to the United Nation’s Sustainable Development Goals, and it is stated that the Scottish Government’s *National Performance Framework* and the Goals share the same aims. However, there is no mention of sexual and reproductive health within the recent document *Scotland’s Wellbeing: Delivering the National Outcomes*³ and FSRH in Scotland are concerned that an opportunity is being missed for understanding the centrality of SRH to gender equality, and the pivotal role that primary care has in helping to achieve that.

**3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?**

FRSH’s Scotland Committee values multi-disciplinary teams and the contributions of all members. We recognise the importance of GP clusters and hubs, and see there being huge opportunities to deliver improved SRH outcomes through developing GP clusters around complex contraception for example, allowing women to access services close to home and to avoid attending Tier 5 specialist clinics. This could include the involvement of local pharmacists who have already taken on emergency contraception as part of their contract. GPs could operate within a locality, perhaps sharing LARC provision - taking patients from other practices to sustain numbers for competency or to ensure access for women in a timely manner. We would also suggest that there are arguments to be made for SRH-qualified nurses to be employed within primary care as part of the multidisciplinary team to support access to contraception, not as a separate service (as touched on earlier) but as an integrated team member.