



Report written and compiled by

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This publication is due for review in March 2020. To provide feedback on its contents or on your experience of using the publication, please email publications.feedback@rcn.org.uk

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1. Executive summary

Sexual and reproductive health (SRH) incorporates the epidemiology of sexually transmitted infections (STIs) and HIV/AIDS and sexual assault with the impact of these to society. It also includes contraception, teenage pregnancy and reproduction and male and female sterilisation and reproduction, together with wider services for gynaecology and menopause. The need for quality services for sexual and reproductive health are widely acknowledged as necessary to support reduction in the rates of STI and teenage pregnancy and to support wider health and wellbeing.

This report brings together the results of the RCN survey with nurses working in sexual and reproductive health. It was conducted to provide clarification and evidence following increasing concerns reported from those working in England on the impact of service provision following the changes to commissioning following the Health and Social Care Act (2012). This survey represents a small proportion of nurses who are working in SRH, but it offers some valuable insights to current working practices and the concerns of the nursing workforce. Nurses reported significant staffing pressures and workforce concerns with a lack of any clear planning for the future. This has been exacerbated by a lack of education and opportunities for staff development. The survey findings mirror the anecdotal concerns the RCN has been made aware of. The intelligence from the devolved countries across the UK did not reflect the same issues within SRH and therefore the report is focused on issues in England.

The survey data is presented alongside evidence from various other stakeholders, including the Faculty of Sexual and Reproductive Health (FSRH), British Association of Sexual Health and HIV (BASHH), the FPA (formally the Family Planning Association), the Royal College of General Practitioners (RCGP) and Public Health England (PHE).

The report also acknowledges that the current context of service provision is changing, with the move towards delivery of care via digital platforms and through online portals. Whilst these are broadly welcomed and seen as helping to improve accessibility of SRH, there is a need for these to have the same clearly identified safety and quality benchmarks as any other health care provision.

From a period of massive improvements in standards and quality for SRH, the significant funding pressures mean we are now in danger of reversing the trend for these improvements (BMA, 2018).

The RCN is recommending a focus on:

1. understanding where the education and training resources and provision are across England for SRH and to work with higher education institutions (HEIs) as well as Health Education England (HEE) to understand what is available and where the gaps are
2. work with other stakeholders to clarify the requirements and opportunities for nurses to specialise in sexual and reproductive health and help promote this to the profession
3. work with other stakeholders to develop quality standards for the development of online SRH in line with existing standards
4. continuing to lobby on the impact of budgetary cuts to sexual health provision and wider public health services.

2. Introduction

The concerns about sexual and reproductive health (SRH) service provision form part of the well-recognised challenges for the wider nursing workforce across the UK. The RCN continues to campaign to highlight the need for sufficient nursing staff across the system, with the right skills, knowledge and experience to deliver safe and effective patient care. Whilst the issue of staffing for safe and effective care is a UK wide issue, the focus of this report is the specific concerns about SRH service provision in England.

This report primarily focuses on the impact of public health spending decisions and the issues this has presented to SRH services, particularly in England. The intelligence from RCN regional teams and members has indicated significant challenges for the provision of sexual health, with services being decommissioned or significantly redesigned with wide variation in the accessibility and types of services available across the country.

There has been a growing move toward the development of online portals to provide sexual health services. These aim to improve accessibility and integrate various elements of sexual health services, from testing for HIV and other sexually transmitted infections (STIs) to wider sexual health and contraception advice. Whilst there is recognition that these services are very widely used and seen as beneficial by the public, there is increasing awareness of the need to make sure quality and safety is maintained, and this will depend on how the provision is set up. Alongside this are concerns from members about not being able to access appropriate education and training or adequate continuing professional development (CPD) to ensure they continue to provide safe and effective care.

This report presents information from the results of a recent RCN survey of members involved in the provision of sexual and reproductive health. The discussion is also informed through a review of the literature and from discussions with the key stakeholders including the; FSRH BASHH, the FPA and RCGP. It concludes by identifying recommended actions for the RCN and other stakeholders.

3. Background

Sexual health was defined by the World Health Organisation (WHO) in 2015 as:

“... a state of physical, mental and social wellbeing in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe experiences, free from coercion, discrimination and violence”
(WHO, 2015).

Sexual health is not simply the epidemiology of sexually transmitted infections (STIs) it is much wider, encompassing contraception, teenage pregnancy, HIV/AIDS, gynaecology, menopause, sexual assault, male and female sterilisation and reproduction.

The National Institute for Health and Clinical Excellence (NICE) guidance *Sexually transmitted infections and under-18 conceptions: prevention* (2007) indicates that rates of STIs and unplanned pregnancies are higher in the United Kingdom than in the rest of Western Europe (NICE, 2007). The recommendations within the guidance promote the need to reduce these and the unwarranted variation in services across the country to address these serious but preventable conditions.

Prior to the NICE guidance, concerns about rates of STI and underage pregnancy led to the publication of the first ever ‘Teenage Pregnancy Strategy’ in 1999 and the ‘Sexual Health Strategy’ in 2001 for England. The Welsh Assembly published their strategy in 2000; these were followed in Scotland and Northern Ireland with their vision for sexual health.

These strategies raised the awareness of sexual health within the four countries and funding became available for additional services in sexual health, a specialty traditionally ignored or neglected.

The aim of the 10 year Teenage Pregnancy Strategy was to address the historically high rates of teenage conception and reduce social exclusion. The very ambitious goal was to halve the under 18 year old conception rate. This was achieved by having national, regional and local structures working together. By 2014, the under 18 conception rates were 52% lower than the 1998 baseline and significant reductions were made in areas of high deprivation (Hadley et al., 2016). Additionally termination of pregnancy rates in England and Wales fell from 191,014 in 2015 to 185,596 in 2016 (PHE, 2017).

These strategies resulted in the creation of greater opportunities for nurses to develop their roles within sexual health and HIV services. Nurses working in General Practice and school nursing particularly took on greater responsibilities for sexual health and expanded their role. Service provision increased and users had greater access to screening and testing for sexually transmitted infections and HIV and the profile and contribution of sexual health services was raised (PHE STIs annual data www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables).

4. Changes to commissioning of health services in England (2012)

The new commissioning arrangements followed the publication of the Health and Social Care Act (2012) in England led to major changes in the way the health service was organised. The changes intended to bring commissioning closer to communities and patients and ensure that provision of services was based on the local population's needs.

Table 1 below, shows how different elements of sexual health are commissioned in England, indicating the potential for confusion around service provision. For example, there are three different bodies commissioned to provide contraception; Local Authorities (LAs), Public Health teams via community clinics, NHS England via the GP contracts and Clinical Commissioning Groups (CCGs). The CCGs have responsibility for commissioning of termination of pregnancy services and yet, although the Royal College of Obstetrics and Gynaecology (RCOG) guidance (2011) recommends contraception is provided at the time of termination of pregnancy, there is no explicit requirement in the commissioning guidance for contraception to be included. This has led to confusion and variation in provision; in some areas women will be offered contraception as part of the termination of pregnancy pathway but it is not universal. Similarly, HIV testing is commissioned by all three bodies, which has also led to inconsistency in how the service is provided. These variances have the potential to increase the difficulty in accessing services and creating health inequalities between individuals who understand how to navigate the complex system and those who do not.

Table 1 Summary; commissioning arrangements for Sexual and Reproductive health care for England.

Clinical Commissioning Groups	NHS England	Local Authorities (LAs) (Public Health)
Termination of pregnancy services	Contraceptive services provided under the GP contract	Contraception primarily delivered in community clinics
Contraception for gynaecology purposes	HIV treatment and care	STI testing and treatment
Non-sexual health elements of psychosexual health services	HIV testing when required in other NHS England commissioned services	Cervical screening
Sterilisation	STI testing and treatment provided under the GP contract	HIV testing, prevention, sexual health promotion and social care
HIV testing when required in other CCG commissioned services	Cervical screening	Young people's sexual health services
	HPV immunisation programme	Services in schools
		Sexual health aspects of psychosexual counselling

The new commissioning arrangements were followed by the publication of a *Framework for sexual health improvement* by The Department of Health (England) in 2013 to support the new commissioning arrangements (DH 2013). The forward of the framework from the Parliamentary under Secretary for Public Health, acknowledged the excellent progress that had been made in sexual health over recent years.

“The Government wants to improve sexual health, and our ambition is to improve the sexual health and wellbeing of the whole population. To do this, we must: reduce inequalities and improve health outcomes.” (page 3)

The framework discussed the potential impact of sexual ill health on society and recognised that effective commissioning of interventions and services is key to improving

outcomes. It also acknowledged the need to work across the system to promote integration and inclusion as well as challenge stigma in relation to sexual health (DH, 2013). It also set out the commissioning arrangements and also stressed the importance for all agencies to work together to make sure progress in sexual health continues. Most sexual health services transferred to local authorities, with Clinical Commissioning Groups (CCGs) and NHS England also having a key role. This policy change aimed to enable better integration to local needs assessment, help raise the awareness of the importance of sexual health and support prevention. It is overseen by local health and wellbeing boards to ensure that the care people receive is comprehensive, high quality and seamless.

5. Background to nursing roles in sexual and reproductive health

The inter-disciplinary Independent Advisory Group (IAG) set up after the 2001 sexual health strategy to advise the Government on sexual health stated that:

“Good sexual health matters. It is a crucial ingredient in the overall good of the nation” (Gould, 2006).

The IAG advised on the importance for any government to ensure that sexual and reproductive health services, including HIV services are open access, of high quality and demonstrate good health outcomes. This gave greater emphasis for services to plan for the future and provide greater access to users. Nurses were integral to delivery of this and were encouraged to gain additional skills to meet the demands of the services. Nurses are now working in both specialist services and General Practice, with additional knowledge and skills, including insertion of subdermal contraceptive implants, fitting of intrauterine devices and skills in the detection of infections.

Nurses have a crucial role in helping individuals with sexual health matters, regardless of the health care setting, however, many student nurses have a ‘hit and miss’ experience of sexual health during their training programme and it has not been mandatory in the curriculum. Additionally many universities do not necessarily have staff with the expertise to teach SRH. This results in nurses lacking the confidence and competence to support individuals when they raise sexual health concerns. Nurses often

talk about holistic care but may not feel able to explore sexual health issues with individuals. The new Nursing and Midwifery Council (NMC) standards for nursing proficiency were ratified at the NMC Council meeting in March 2018. The new standards include the need for nursing staff to promote health as a core element and sexual health is included within this (NMC, 2018). However, these standards do not come into force until September 2018 and will need time to become embedded into the curriculum. Quality post registration education and training for nurses to develop specialist skills will still be required to meet service needs.

Recommended standards for all those working in SRH were published by the Medical Foundation for Sexual Health (MedFash) and HIV in 2005 and for the management of STIs in 2010. These standards helped to drive the quality of sexual health services nationally and across different areas of practice. Nurses in general practice, school nurses alongside general practitioners, sought training opportunities to gain knowledge and skills to help them discuss sexual health and provide screening and reduce the burden of infection amongst the population, through the Faculty of Sexual and Reproductive Healthcare (FSRH) and British Association for Sexual Health and HIV) BASHH. SRH courses are also available for nurses at a number of HEIs, however, there is still considerable variation in these with the skills and knowledge they provide and in their availability and accessibility across the country.

6. 2018 RCN Survey into sexual health and the role of nurses

Over recent years the Royal College of Nursing (RCN) has become increasingly aware of anecdotal evidence from nurses and the RCN regional teams about some of the issues in relation to sexual health services changing, insufficient funding, low morale, lack of opportunities and significant public health cuts in the specialty.

In response, the RCN undertook a survey from 9 January to 11 February 2018 to support our understanding of the issues around provision of sexual health following the changes to commissioning arrangements from the 2012 Health and Social Care Act.

The survey was conducted to ascertain and gather evidence on:

- how and where nurses are working in SRH
- the availability of education and training and Continuing Professional Development (CPD) opportunities for sexual health and the ability of nurses to access these
- the impact of changes on the nursing workforce.

Methodology

The survey questions were designed by the RCN Professional Lead for Public Health and colleagues from the RCN Policy Team, in conjunction with RCN sexual health nurses and members of the RCN Public Health Forum. We also consulted with colleagues FSRH and BASHH.

The survey ran for four weeks and the survey link was promoted to the RCN members via email, to the members of the Public Health, Women's Health, Midwifery, General Practice Nursing, Community Nursing and Children and Young People's forums. It was also promoted via Facebook and twitter. The FSRH and BASHH also helped to disseminate the link.

640 individuals responded to the survey, with 256 partial responses and 384 complete responses. All the responses have been included in the analysis.

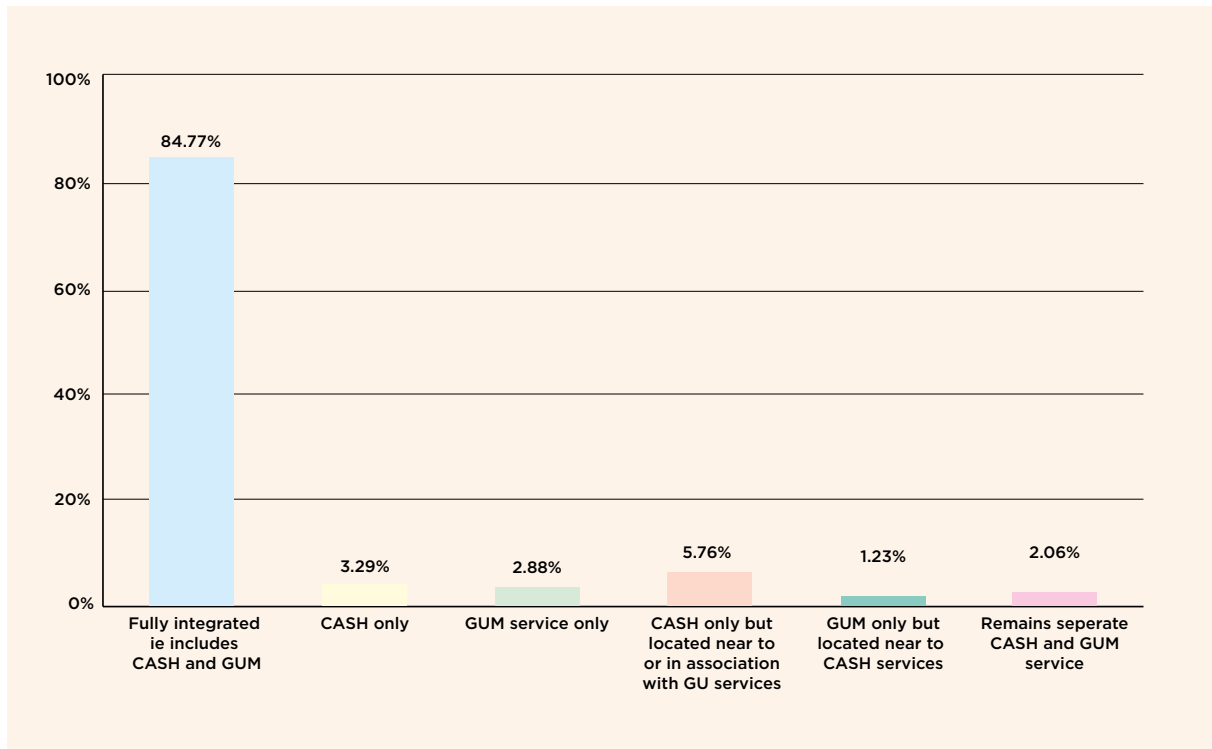
Analysis and discussion of data

Just under 65% of the respondents were from people working in specific sexual health services. These were from a variety of SRH settings; the majority were in fully integrated services (contraception and genitourinary medicine (GUM), others worked in contraception and sexual health (CASH), others in GUM only, others in contraception but located near a GUM service (see figure 1 below for detail).

There has been a move over the past eight to ten years to have fully integrated services where both nurses and doctors are dually trained. The intention behind this approach was to help make sure service users can have all their needs met in one place.

The data showing where nurses are working suggests that there has been some success in integration of services, although there is variability across England.

Fig 1: Showing percentage of nurses working in different types of specialised sexual and reproductive health services.



The survey also asked for nurses to comment on where they were providing SRH services outside of specialist provision. This accounted for 35% (131) of the total responses:

- 70.23% (92) of these were nurses working in primary care
- 7% were school nurses and a further 1.5% from other community nursing children and young people's services
- 20% were from other areas including; prison services, occupational health, out of hour's services or practice nurses.

The nurses indicated that they were involved in providing a range of care, including; HIV, genitourinary medicine, pregnancy, contraception and wider women's health issues which would include menopause and cervical screening.

The survey was primarily targeted to attract responses from nurses who identify themselves as particularly working in SRH care. The numbers of respondents and this methodology mean that these numbers do not necessarily reflect the split between the specialist sexual and reproductive nursing workforce and nurses providing this care as part of other services. They do however provide an indication of the issues and that these are seen in various parts of the system.

Themes identified from qualitative data

A brief analysis of the qualitative data, using a thematic approach, highlighted some specific themes (further detail is provided in Appendix 1):

- education and training in sexual and reproductive health which included:
- Availability and accessibility of appropriate level courses
- Funding for training and support from employers
- complexity with the commissioning arrangements
- workforce planning and skill mix between support staff and registered qualified sexual health nurses
- impact on staff and service users.

i. Education and training for nurses in sexual and reproductive health.

Delivering high quality SRH and HIV services depends upon a well-educated skilled workforce, providing services in the right place and time to meet local needs. An All Party Parliamentary Group (APPG) published *Breaking down the barriers* (2015), which highlighted the need for sufficient health care professionals with skills and knowledge in sexual health, reproductive health and HIV services to enable delivery of a high quality service.

There are no national standards for nurse education in England around SRH since the demise of the National Boards in the early 2002, nor is there consistency in provision.

In contrast, the Faculty of Sexual and Reproductive Healthcare (FSRH) set a range of education standards for doctors to practice in this area <https://www.fsrh.org/education-and-training> and these are increasingly mandated and built in to contracts for doctors to work in SRH.

The lack of agreed standards for nurses means that nurses currently access education and training from a variety of sources:

- higher educational institutions (HEIs) offer a range of options and these vary in content, clinical placements, cost and credits

awarded to students on completion. Nurses in some areas have to pay extra to get clinical placements on top of the university fees

- the FSRH provide a range of opportunities for nurses around SRH. Alongside medical professionals, nurses can study for the FSRH diploma, essential skills (foundation level) insertion of subdermal implants and intrauterine contraception. Courses offering this diploma seek accreditation from the FSRH every five years. This approach streamlines the training of doctors and nurses, ensuring they are trained to the same national standard
- BASHH provide courses for nurses on sexually transmitted infection and HIV.

Some providers have looked at new ways for nurses to gain the knowledge and skills needed to become competent nurses. Examples include combining a blended approach, where staff are employed and then follow a programme of study using the FSRH e-Learning programme, in conjunction with e-Learning for Healthcare, the FSRH course of 5 structured clinical training modules, visits to other relevant services and clinical supervision and mentoring. Assessment is conducted by a portfolio of evidence, signed competencies, reflections from clinical sessions and outcomes of visits. These programmes have proved to be positive with staff and they ensure parity between professionals providing the service. They have been adopted in a number of areas (Shawe et al., 2013). No formal evaluation has been done to compare the different programmes and the impact on patient care.

The FSRH and BASHH also provide conferences on sexual and reproductive health which are open to nurses, for a fee, which can support their CPD. Both the FSRH and BASHH publish guidelines and standards for sexual and reproductive health and these are updated in light of new evidence.

Some of the nurses in the survey commented that they welcomed the wider range of courses available to them and the parity of education alongside medical colleagues:

'Excellent for nurses to be able to get the same qualification as doctors (FSRH).'

'The standard has improved and provided equality between doctors and nurses.'

Some nurses went on to say they would appreciate more integrated training

opportunities:

'BASHH need to work with the FSRH to offer integrated training which caters for all levels of clinical staff.'

However, many also commented on the lack of available courses in their areas indicating that there was not parity across the country and that some courses offered didn't meet the necessary standards:

'There is no training within my trust.'

"Dumbing" down of training due to budget cuts, cheaper options and lack of understanding of standards required.'

Some nurses also expressed frustration that previous nursing courses are no longer recognised in the same way:

'FSRH has the monopoly on accreditation and does not recognise ENB R71. Very disappointing.'

'Goalposts keep moving. I completed a degree and now the FSRH/BASHH is the gold standard'

Nurses, as with other practitioners, must be familiar with the most recent guidelines and make sure they are able to adhere to them if they have a role in the provision of care. The reality is that there is no definitive standard apart from the FSRH. Many universities offer diploma and degrees. As services experience greater difficulty with recruitment of nurses in the specialty, different education models using blended learning and portfolios could be increasingly attractive to nurses and help address the workforce issues.

There was also many comments on the accessibility of appropriate courses and a sense that training was in some places too skilled and task-based rather than really enabling nurses to acquire advanced and specialist knowledge:

'More focus on just acquiring physical skills e.g. implants rather than longer courses to promote knowledge'

'In-house training and competency based documents rather than accredited learning and not transferable between Trusts.'

There were also a number of comments indicating that lack of funding was the main cause for many of the issues.

'Funding is a big issue and is not available.'

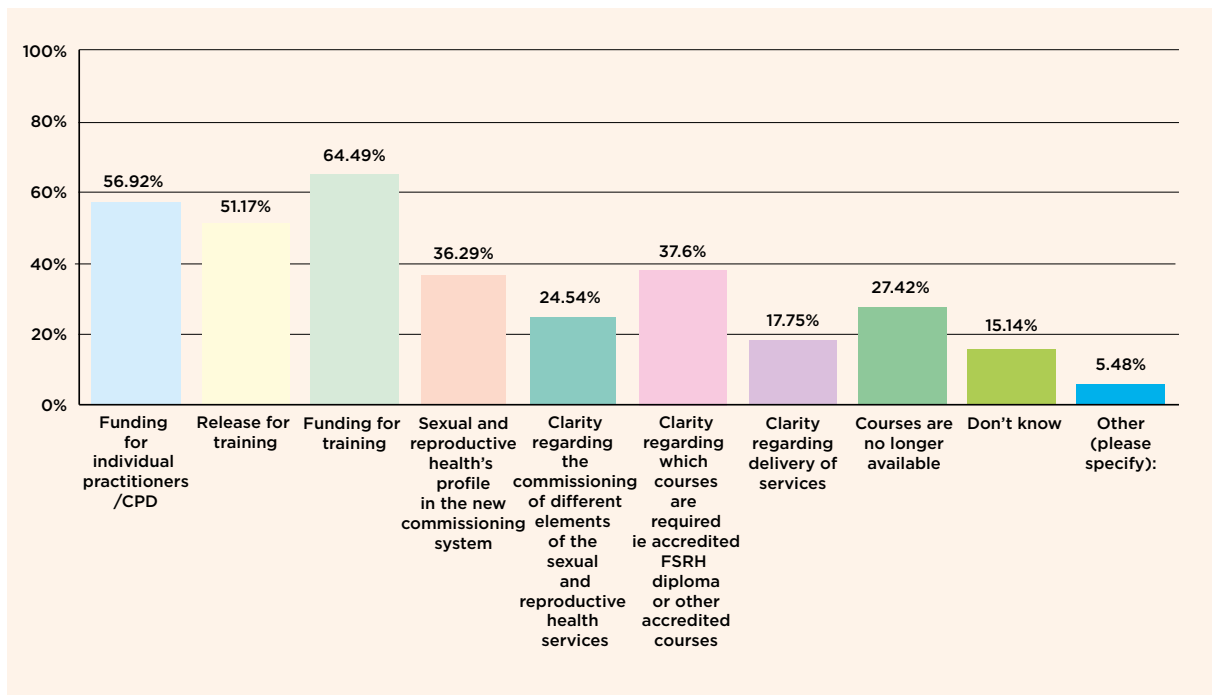
Public health funding has drastically decreased.'

'No funding opportunity to attend anything other than in-house training'

'Due to funding less money available for nurse training'

The current system does not appear to support robust workforce planning or facilitate training needs analysis. The report *Breaking down the barriers* by the All Party Parliamentary Group (APPG, 2015) recognised this, warning that there is no systematic analysis of the workforce in terms of numbers or training to meet the system needs. The lack of a planned approach to developing this workforce, together with lack of investment in CPD funding, makes it problematic for nurses to transfer into sexual health services. Nurses without the knowledge and skills are often unable to get employment and unable to fund courses themselves to gain the transferable knowledge and skills required.

Funding for courses and problems with being released from work for training were cited as issues for the majority of respondents. When asked how easy it has been to access appropriate and accredited post registration sexual and reproductive health qualification, 63% of respondents stated that being able to devote time to their study was their concern. See Figure 2 below, for the breakdown of the reasons given for ease of access and availability of education and training. Many of these concerns highlighted the morale issues within the workforce and frustration about expectations and opportunities for development.

Fig 2: Reasons given for access and availability of training opportunities

ii. Complexity with the current commissioning arrangements

Locally commissioned providers are responsible for ensuring that there are sufficient staff numbers to deliver the services and the outcomes that have been commissioned. This should be detailed in service contracts and specifications. Commissioners have a responsibility to ensure that the service specification supports ongoing training and education and should be a mandatory inclusion in provider contracts.

The survey qualitative feedback indicated variation in this, with a level of confusion in the current system and frustration with the perceived importance of sexual and reproductive health to the wider system.

In terms of education, the perception is that it is not seen as important by some commissioners.

'Just not there for nurses to access due to the challenges in the health economy as well as commissioners perceptions of what is good.'

The nurses commented on the lack of importance placed on contraception care and support in relation to other areas:

'We really don't care about contraception courses for nurses and we don't take students anymore'

'Contraception seems the poor relation to GUM'.

The respondents also indicated that there has been a decline in service provision over the last few years:

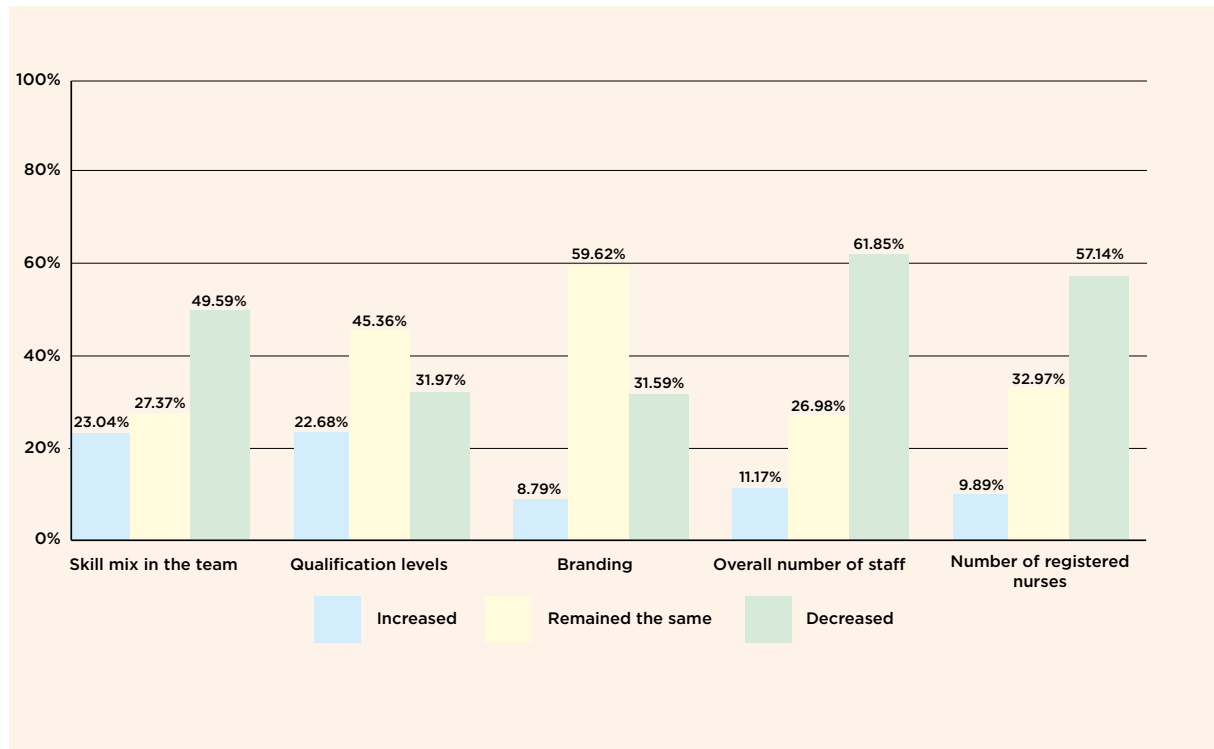
'There has been a noticeable deterioration in the past three years'.

'Definite decrease in past five years and is dependent on the employer'

iii. Workforce planning and skill mix between support staff and registered qualified sexual health nurses

When asked about the changes to skill mix within the teams nurses were working in, 57.1% said that there has been a reduction in the numbers of registered nurses and 61% on the reduction to the overall workforce (as shown in Fig 3).

Fig 3: Changes to nursing staff working in sexual and reproductive health care teams



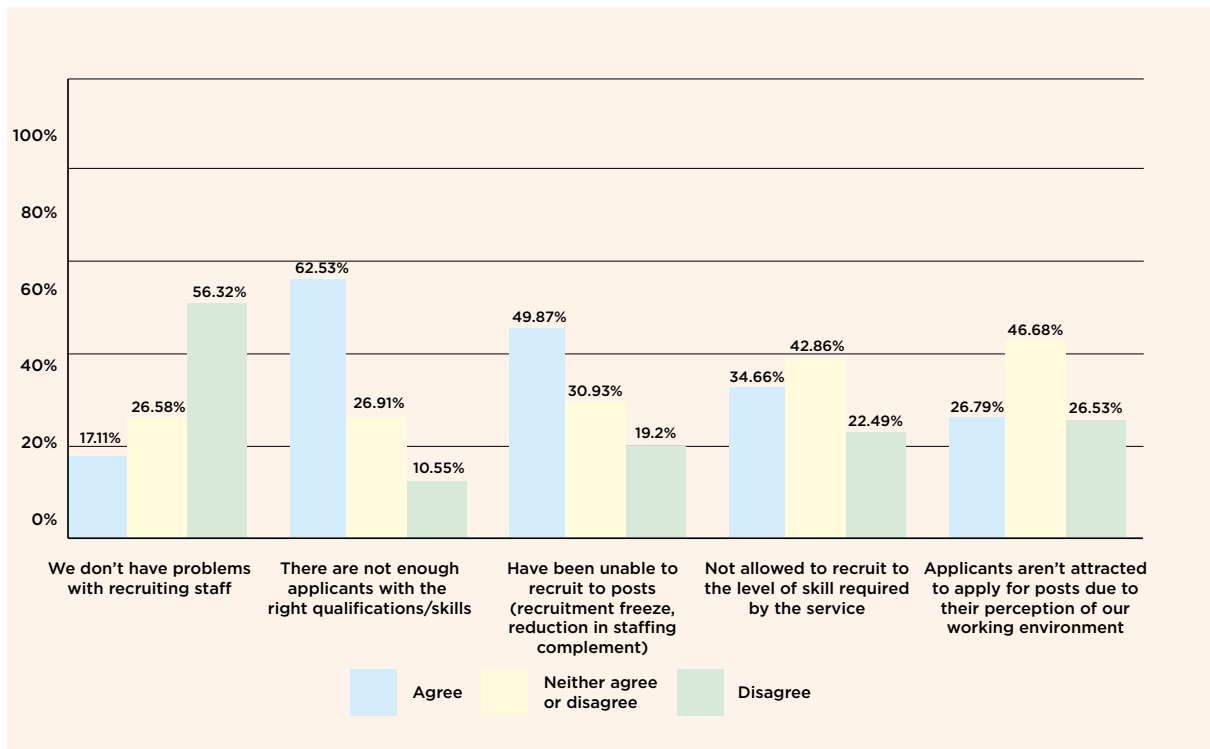
Several respondents highlighted the lack of workforce planning for the future. When asked about the staff with the right qualifications, 62.5% said they did not have the right staffing levels:

‘It’s gone down and down - no experienced instructing nurses soon. there is nobody with serious experience coming up behind us. ‘

‘The service has been run down massively. Had two nurses and a doctor plus a support worker and now it is me as the only qualified member and one support worker.’

The survey respondents indicated that staff recruitment and retention were significant problems; more detailed presentation of responses can be seen in Fig. 4.

Fig 4: Perceived staff recruitment issues.



62.5% stated there was not enough staff with the right skills. Recruitment freezes/ blocks were given as reasons for lack of adequate staff recruitment in over 83% of cases. The respondents also indicated concern that the service is just not seen as attractive to new staff.

iv. Impact on staff and service users

Respondents expressed their concerns about the pressure on services and how they are not able to provide good quality care which in turn means turning individuals away from the services:

'Our services are very stretched but sadly due to commissioning changes many clinics have closed and we had to turn people away'

Some nurses are leaving because they feel unable to provide the level of care they want to:

'Staff are leaving because they are no longer able to provide the service they signed up to. Constant tendering, uncertainty leads to instability. The holistic care of client focused nursing has disappeared into a tick box system to achieve only what the commissioners want without looking at the overall holistic care of the patient'

The system and ways of working was also cited as a reason for poor staff morale and why staff are leaving:

'Many highly trained and skilled staff are leaving due to low morale and changes to working patterns.'

'Many of my colleagues have taken periods of sickness due to work related stress.'

This all suggests very real quality issues for some SRH services and some significant potential workforce issues for the future.

7. Evidence from across the system on the current situation for sexual health

From Public Health England (PHE) data, it is estimated that year-on-year, there will be an increase in the number of STIs diagnosed. However, in 2017 PHE reported that in 2016, there were approximately 420,000 diagnoses of STIs in England, a decline of 4% compared to 2015. The most common infection was chlamydia with over 1.4 million tests being carried out and over 128,000 diagnoses made. The introduction of the human papilloma virus (HPV) vaccination in adolescent females has contributed to a reduction of 74% of first episode genital warts in 15-17 year old girls, however, the access to screening for HPV has been affected by the diversity of service provision and commissioning across the country. The report also showed an increase of 12% in syphilis diagnoses. It also indicated that the impact of STIs remains greatest in young heterosexuals 15-24 years, black ethnic minorities and gay, bisexual and other men who have sex with men (MSM). New diagnoses of, chlamydia, syphilis, genital herpes and warts have increased amongst gay, bisexual and other men who have sex with men from 2007-2016 in England. So despite anticipated increases, there has been a reported decrease overall in the number of infections reported in 2016. However, there is concern that the drop is as a result of fewer tests being carried out and not a real drop in infection rates.

The FPA warned that the overall reduction was possibly related to fewer diagnoses.

“A decrease of 4% in rates of sexually transmitted infections might look like success, but unfortunately this may well be more the result of fewer tests being carried out, rather than fewer STIs being transmitted. (Chief Executive, FPA)

Following the 2015 announcement of a £200m reduction to the public health budget, devolved to local authorities (PHE), the FPA, published the *Unprotected Nation* report (2015). The report assumed that sexual health services accounted for 10% of the overall public health spending. The FPA warned that a 10% reduction in spending on contraception and sexual health services would result in an extra 72,299 sexually transmitted infection diagnoses by 2020, at a cost of £363m and urged for priority to be given to investment

into sexual health services (FPA, 2015). The report also warned that the current level of cuts to public health spending over the next five years, by 2020, could result in an extra 72,299 STI diagnosis at a cost of £363m.

The Royal College of General Practitioners (RCGP) highlighted that any cuts made to the public health funded elements of sexual health provision is often felt by other parts of the system which are paid for by different commissioners. Local authority driven reductions to specialist services increases the workload on general practice and other core contraceptive services (RCGP, 2016). The Advisory Group on Contraception (AGC) conducted a Freedom of Information (FoI) request audit in 2017 examining the impact of public health cuts on local authorities provision of contraceptive services and half of local authorities reduced spending on contraceptive services in 2017/18 and nearly two thirds of local authorities made cuts to their overall SRH services between 2016/2017 (AGC, 2017).

The Primary Care Woman's Health Forum reports that 37% of their GP members had experienced a recent increase in women seeking appointments for contraception as specialist services appointments became harder to obtain (RCPG, 2017). It is estimated that 80% of contraception provision is provided by general practice and practice nurses are often at the forefront of the delivery. The RCGP also reported reduced access for women in general practice to the most effective methods of contraception, namely long acting reversible of contraception (LARC) with 9% of GPs in England stating that these services had closed in the past five year (RCGP, 2017). LARC methods of contraception are subdermal implants, intrauterine devices (IUCD) and intrauterine systems (IUS) (RCGP, 2017). In order to provide LARC, doctors and nurses must undergo additional training provided by FSRH trained doctors and nurses and they need to maintain competency levels. Doctors and nurses in any setting must seek accreditation from the FSRH every five years in order to practise.

It must be noted that training in LARC is costly and time consuming and competencies must be

maintained, therefore any large-scale reduction in the commissioning of LARC could affect the number of competent practitioners in the future.

The AGC have reported that since 2015/16 some 45% of local authorities have reduced the number of intrauterine systems fitted and removed in general practice and 29% have reduced the numbers fitted and removed in community services (AGC, 2017). Additionally, 13% of local authorities reduced the number of contracts with general practice for 2017/18 (AGC, 2017). This could potentially reduce access for women and the skills gained could be lost for some doctors and nurses forever. Training is generally provided by the specialist services and any reduction in such training opportunities could have drastic effects for the future workforce both in specialist services and well as in general practice.

The FPA 2015 report *Unprotected Nation* warned that if current level of cuts to public health continue over the next five years, every £1 lost to sexual and reproductive health could cost the public purse up to £86 overall (FPA, 2015). In contrast, the estimates are that for every £1 spent on contraception saves over £11 to costs elsewhere in the NHS. Around half of all pregnancies in England are unplanned, and termination of pregnancy rates amongst women over 30 years are rising, resulting in an estimated direct cost to the NHS of £240m; (DH, 2017).

8. New ways of working/ online services

With the increased demand year-on-year by service users, services are increasingly being redesigned to take into account the changing way individuals access services but equally in consideration of financial constraints within public health.

There has been a growing move towards the development of online portals. These online services aim to improve accessibility and integrate various elements of sexual health services for HIV and other sexually transmitted infections and wider sexual health and contraceptive advice, which prompt individuals to seek additional support from local services if needed. These initiatives have been largely developed alongside sexual health experts including sexual health nurses and have been broadly welcomed and seen as a way to help integrate health care, increase access and promote digital technology.

There is evidence to suggest a demand for these services with 50,000 online tests for genital chlamydia infection delivered annually within the English National Chlamydia Screening Programme (NCSP) (Baraitser et al., 2015),

Limited resources and new screening tests that use non-invasive sampling have driven investment into online sexual health. These new approaches allow service users to register on a website and request tests to be sent to

their home. There are various pathways and models but essentially individuals provide self-taken samples which are then sent by post to the laboratory and the results are sent back via text message to the individual's mobile phone. Treatment is then sent to the individual after a consultation, ensuring there are no contraindications to the medication.

Whilst this new approach does offer a way to improve accessibility and provides alternative mechanisms for service delivery and public engagement with services there needs to be careful consideration to ensure quality and safety is maintained and this will depend on how the provision is set up. There needs to be consideration on how transition from online to clinic services occurs and how safeguarding issues are protected (Spencer-Hughes et al., 2017). It is vital that online provision is not just driven by a need to reduce costs, and online services should not be commissioned in isolation from, or instead of, existing services. Online services need to be developed in a complimentary way to current face-to-face provision and providers need to adhere to the same guidance and standards as all other services and follow best practice for prescribing and the safeguarding of children and vulnerable adults. Education and training for staff providing online services should equate to that expected from sexual health professionals in clinics.

9. Recommendations

1. Workforce, education and training.

1.1 The RCN recognises the importance of parity between doctors' and nurses', education and training. However, given the issues cited on access and availability of courses, alongside the confusion on what training is required and the lack of visibility for education and training provision within the commissioning and tendering process, the RCN will work with members and wider stakeholders; FSRH, BASHH, HEI's and others to review and map the current training provision and accessibility of courses with the aim of improving accessibility of educational training and increasing awareness of the importance of maintaining a skilled workforce.

1.2 RCN to promote the FSRH and BASHH educational training resources and standards from foundation through to advanced level practice to support practitioners with career development and ensure consistency in approaches to drive up standards.

1.3 There does not appear to be the same need in the devolved countries at the current time so this work should focus on England only for the time being, however, it can be expanded to include the opportunities and availability of courses across the UK in time.

2. National website resource for nurses

2.1 It is clear that the opportunities for SRH training and development need to be clearer and the routes into the specialty more clearly defined. Nurses wishing to gain knowledge and skills around sexual and reproductive health need to be able to see what provision is available, what is most suitable to their needs and understand how to access courses. The RCN will develop a resource detailing the courses available and how to access these.

3. New ways of working and online service provision

3.1 Given the ongoing need for quality SRH care we need to look at different ways to meet the demand. It is imperative that standards for online services are comparable to any other service and quality and safety not compromised. The RCN will work with the FSRH, BASHH and others to develop national best practice standards for online services applicable to all providers of SRH services, in line with existing standards.

4. Public Health Spending

4.1 This report links to wider concerns the RCN has expressed on the impact of the cuts to public health budgets in England. The RCN will continue to lobby on the impact of these cuts to sexual health services; the need for continued ring-fencing of public health funding and the need to mandate on the provision of SRH services. This should be alongside the wider cuts to public health spending and how this impacts on the wider health and social care provision and the health outcomes for the population.

Limitations of the survey

Whilst the response rate to the survey offers relatively small numbers, the findings from this small scale survey support the previous intelligence that SRH services are under threat and it has provided a valuable insight into the current landscape of service provision, commissioning and reduction in staffing levels in some parts of SRH services.

10. Conclusions

The concerns reported by nurses and others, such as, access to appropriate education and training and pressures to the workforce are of significant concern and that the current funding pressures and commissioning arrangements are perceived to have compounded the problems. The survey also highlighted wider issues with recruitment and retention of staff, as significantly impacting on staff morale.

The evidence from the RCN survey adds to wider concerns reported by the RCGP, FPA and Primary Care Woman's Health Forum highlighting the negative impact since the creation of the Health and Social Care Act (2012) and specifically the reduction in Public Health spending on SRH in England over the last few years.

If the ambitions since the publication of the sexual health strategy and the Framework for sexual health are to be realised, a greater focus must be given to allocation of funds and less fragmentation of commissioning.

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Appendix

Further detail of comments and qualitative themes:

Positive aspects	Less positive aspects
<p><i>Lots more courses available to nurses.</i></p> <p><i>Excellent for nurses to be able to get the same qualification as doctors (FSRH).</i></p> <p><i>Standard has improved and provided equality between doctors and nurses.</i></p> <p><i>FSRH excellent courses and recourses.</i></p> <p><i>BASHH need to work with the FSRH to offer integrated training which caters for all levels of clinical staff.</i></p> <p><i>I am lucky to work in an establishment which believes in staff development.</i></p> <p><i>I was lucky but there is no funding or backfill for new nurses coming in now.</i></p> <p><i>On line studying.</i></p> <p><i>I have been fortunate to be involved in a pilot and in house training.</i></p> <p><i>I lead on sexual health within our Practice therefore GP employer supports my training.</i></p> <p><i>The e Learning resources are a really good source for updates but face to face is harder to come by.</i></p> <p><i>Good that nurses are associate members of the FSRH and can study for the diploma.</i></p>	<p><i>Lack of funding despite appraisal promises. Have to do in my own time.</i></p> <p><i>There is less opportunity to attend training/study days due to CCGs allocation of funds.</i></p> <p><i>Lack of protected time. Lack of funding means many courses have been withdrawn.</i></p> <p><i>No funding opportunity to attend anything other than in- house training</i></p> <p><i>Due to funding less money available for nurse training.</i></p> <p><i>Absolutely none at all in our service since integration.</i></p> <p><i>Local training is no longer available on the area to train in LARC.</i></p> <p><i>Limited and expensive sometimes you have just learnt and have updates without accreditation.</i></p> <p><i>FSRH has the monopoly on accreditation and does not recognise ENB R71. Very disappointing.</i></p> <p><i>Less time to go on courses.</i></p> <p><i>I am aware that for many courses there is no funding.</i></p> <p><i>Courses are too generic.</i></p> <p><i>Just not there for nurses due to challenges in the health economy.</i></p> <p><i>“Dumbing” down of training due to budget cuts, cheaper options and lack of understanding of standards required.</i></p> <p><i>One needs to search as not easily available</i></p> <p><i>More in house training and competency based documents rather than accredited learning and not transferable between Trusts.</i></p> <p><i>Funding is a big issue and is not available. Public health funding has drastically decreased.</i></p> <p><i>Goalposts keep moving. I completed a degree and now the FSRH/ BASHH is the gold standard.</i></p> <p><i>More focus on just acquiring physical skills e.g. implants rather than longer courses to promote knowledge.</i></p> <p><i>‘Less available courses.’ Or ‘No training within my Trust’ and ‘Lack of courses in my location’ and ‘Not being offered at local university.’</i></p>

Glossary

AGC	Advisory Group on Contraception
APPG	All Party Parliamentary Group
APG	All Party Group
BASHH	British Association for Sexual health and HIV
CCG	Clinical commissioning group
CPD	Continuing Professional Development
FPA	Family Planning Association
FoI	Freedom of Information
FSRH	Faculty of Sexual and Reproductive Healthcare
HEI	Higher Education Institution
IAG	Independent Advisory Group
LARC	Long Acting Reversible Contraceptives
MEDFASH	Medical foundation for aids and sexual health
NCSP	National Chlamydia Screening Programme
NICE	National Institute for health and clinical excellence
PHE	Public Health England
RCN	Royal College of Nursing
RCOG	Royal College of Obstetrics and Gynaecology
RCGP	Royal College of General Practitioners
SRH	Sexual and Reproductive Health
WHO	World Health Organisation

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