Restoration of SRH Services during Covid-19 and Beyond

FSRH Statement

June 2020

The Faculty of Sexual and Reproductive Healthcare (FSRH) is committed to maintaining high standards in Sexual and Reproductive Healthcare (SRH) throughout the COVID-19 pandemic and beyond.

Changes to the Covid-19 lockdown are being introduced across the four UK countries. As such, the focus is beginning to shift from accommodating the surge in demand for Covid-19 care to restoring services so that they meet the needs of the population.

Different forms of social distancing will remain in place for a number of months to come. Hence, the need for restoring SRH services should be balanced with the continuing need to protect patients and the NHS from risk of Covid-19 infection. Albeit challenging, balancing infection risk will be essential to ensure that vulnerable groups are able to access the care they need. It is also vital to recognise that different approaches will be needed across the UK nations.

This guidance on restoration of SRH services is aimed at decision-makers, commissioners, service managers and healthcare professionals. It was developed in consultation with FSRH's Scotland, Wales and Northern Ireland Committees. It provides recommendations on which services should be prioritised during restoration. It also outlines what has worked well during strict lockdown and should remain in place beyond the pandemic; for instance, the need for a variety of modalities of consultation to meet the SRH care needs of all, including the most vulnerable.

We believe the post-pandemic landscape offers significant opportunities to tackle the SRH commissioning challenge that has hindered the delivery of effective person-centred SRH care in England. To enable positive change to last once the health and social care system is stabilised, we will need to go further than restoration, effectively rehabilitating the fractured commissioning of SRH services.

1) Restoring SRH services while Covid-19 is endemic and social distancing remains

1.1 Evidence of impact

In order to better understand the impact of lockdown measures on SRH services, we have released a rolling members survey. Around 66% of respondents stated that they had been forced to end or limit the provision of SRH services. Of those stating that they had been forced to end or limit the provision of SRH services, 55% were not confident that their patients would be able to access this care elsewhere, in primary care and the community.

A recent study by Imperial College London has found that restrictions on non-urgent clinical services such as gynaecology and sexual health coupled with a decline in A&E attendances disproportionately affect marginalised and vulnerable groups, such as those from disadvantaged socio-economic backgrounds and migrants. They argue that the decision to suspend non-urgent services at NHS hospitals in response to the Covid-19 pandemic will lead to worsening health inequalities. Therefore, the gradual and safe re-introduction of routine SRH care is crucial to ensure everyone can access the SRH care they need.

1.2 Restoring SRH services

General principles

The Academy of Medical Royal Colleges has published general principles for re-introducing healthcare services, which FSRH supports. Broadly, there needs to be a phased, realistic approach to restoration according to local need and service capacity, as a spike in demand is likely once services resume. This might lead to rising pressure in specialist and primary care SRH services, which were already under-resourced and under-funded pre-pandemic.

Further, adherence to general preventive measures such as handwashing, physical distancing, environmental cleaning of surfaces, testing and isolation policies as well as correct use of PPE should continue. Testing and isolating procedures could reduce staff availability, whilst some are still redeployed. This could prove challenging to restoration of SRH services, and consideration of local capacity is essential.

While social distancing remains in place, it is recommended that initial consultations continue to be done remotely, with safeguarding measures in place during all consultations. Local protocols should be followed to minimise the risk of transmission of Covid-19 at the time of any procedure.

Priority groups and vulnerable populations

Local services should consider how best to ensure that those individuals at highest risk of unplanned pregnancy have access to the most effective contraceptive method that is acceptable to them. This should include individuals attending abortion and maternity services; under 18s; those with language barriers; those with drug and alcohol problems; homeless; women involved in prostitution; victims of sexual assault; learning disability; serious mental illness; those who are shielded and/or shielding members of their family.

Local pathways for referral for vulnerable groups including via social services, sexual assault referral centres (SARCs), BAME groups and young peoples' outreach should be maintained and/or restored wherever possible. Examples of continuing outreach services include proactive telephone calls to vulnerable populations; clinic-in-a-box support to homeless temporarily housed in hotels; inclusion Health Outreach Team (IHOT) composed of harm reduction, BBV and SRH.

Restoring SRH services - suggested approach

Essential services should continue to be prioritised as per FSRH guidance on essential SRH services during Covid-19 (March 2020). Below is a suggested approach to restoring other SRH services:

Suggested Approach - Recovery Phase 1
Long-acting reversible contraception (LARC) • Prioritise where possible when considered benefit outweighs risk of Covid-19 and capacity exists • Progestogen-only injectable: initial phone/video consultation; face-to-face Depo injection and first self-injection of Sayana Press • LARCs for vulnerable groups Refer to FSRH guidance on contraceptive provision after changes to lockdown for extended use of LARCs and replacement
Combined hormonal contraception • Combined hormonal contraception for both contraception and managing bleeding problems - phone/video consultation; face-to-face consultation if blood pressure and BMI not known

Menopause care

- Easy access to repeat prescriptions of HRT via remote consultation, especially women experiencing no problems

Postpartum contraception

- Contraception provided prior to discharge where postpartum contraception programmes exist
- 6-month supply of the progestogen-only pill offered to all women after giving birth (unless they have a medical contraindication)
- IUD/ IUS can be inserted at a caesarean section provided the surgeon feels competent to do so
- Provide women with clear information on how to use their chosen method and when to seek medical advice

Refer to FSRH guidance on provision of contraception by maternity services after childbirth during the Covid-19 pandemic April 2020

Abortion care

- Telemedicine for early medical abortions should continue, with home use of mifepristone and misoprostol

Refer to RCOG, FSRH, RCM & BSACP guidance on Covid-19 and abortion care

Suggested Approach - Recovery Phase 2

Contraceptive choice

- Easing of lockdown restrictions can be an opportunity for individuals on bridging contraception to access their contraceptive of choice when it is safe to do so

Long-acting reversible contraception (LARC)

- Routine LARC: phone/video consultations; restore procedure clinics
- Face-to-face management of all LARC problems as appropriate
- Complex LARC procedures

Other specialist clinics

- Psychosexual counselling

2) Positive changes that should remain during and post-Covid-19

2.1 Regulatory change

Abortion care

Most women are opting for medical abortion during lockdown in England. Remote telemedical abortions now account for 78% of total early medical abortions (EMAs) and around two thirds of total abortion procedures. The average waiting time for patients has dropped from 9.6 days to 4.6 days since the approval order permitting the use of mifepristone at home, and the average gestation at the time of procedure has dropped by over a week, from 8 to 6.8 weeks in England.

In Scotland, abortion provision is undertaken largely via sexual and reproductive healthcare services. Early data shows that the majority of women have opted for telemedicine consultation and home administration of medications. In April 2020, there was an increase in requests for termination of pregnancy of around 30% compared to previous years.

This suggests the temporary measures have had a positive impact on timely access to early abortion care. FSRH has welcomed such measures, and now urges Governments across the UK as well as the Department of Health and Social Care (DHSC) and its counterparts across the country to allow home use of mifepristone and telemedicine for early medical abortion permanently, ensuring women have easy and timely access to this essential healthcare service.

In Northern Ireland, women are unable to access telemedical abortion services due to regulations whereby mifepristone cannot be taken at home. SRH services are providing an interim service for early medical abortion during the COVID-19 outbreak. However, for these services to continue, they must be adequately funded and facilitated in Northern Ireland.

Reclassification of the progestogen-only pill

FSRH endorses work being undertaken by the Medicines and Healthcare Products Regulatory Agency (MHRA) to reclassify the progestogen-only pill (POP) from 'prescription-only' to 'pharmacy product', thereby making it easily accessible in pharmacies, while reducing unnecessary pressures on GPs.

POP is a reliable bridging method if it is not possible for women to access their preferred method while the requirement for social distancing remains, making reclassification of POP even more urgent. We urge MHRA to work closely with DHSC to expedite the reclassification of POP. This will make it easier for women to avoid unplanned pregnancies and access contraception in the heart of communities during and post-Covid-19.

Postpartum contraception

With GP practices and SRH clinics reducing or shutting down services due to Covid-19, it is more important than ever for the NHS to ensure consistent and effective provision of post-partum contraception. Maternity services are well-placed to provide effective contraception after birth, reducing the need for women to seek further care once they have left the maternity unit. There is consensus across professions for postpartum contraception programmes to be rolled out in maternity services. We call on the NHS and the relevant health departments in each nation to have regard for FSRH guidance on the provision of contraception by maternity services after childbirth during the Covid-19 pandemic and to introduce contraceptive care in maternity services consistently across the UK.

Scaling up digital infrastructure

Increased investment into digital infrastructure is required across the UK. We recommend that a national digital service platform be developed for SRH in England, Wales and Northern Ireland*, which will serve as a one-stop point of access for the general public and will support the maintenance of access to essential SRH care. This service should operate seamlessly with regional and local face-to-face services, providing effective triage and a streamlined care pathway for those patients referred for face-to-face treatment.

**A national SRH IT system (NaSH) is already in place in Scotland allowing online booking for services.*

3) Beyond the pandemic

3.1 Tackling SRH commissioning in England

We believe the post-pandemic landscape offers significant opportunities to tackle the commissioning challenge once the health and social care system is stabilised. The pandemic has exposed further the inherent faults in the SRH commissioning system. Fragmented SRH commissioning has hindered the delivery of effective person-centred care post Health and Social Care Act 2012, whereby delivery of services is fractured between NHS England, Local Authorities and Clinical Commissioning Groups (CCGs) in England.

There is consensus across the medical profession that current commissioning structures are not fit for purpose, with calls for an end to fragmentation of services, endorsed by the AoMRC. To enable positive change to last, we will need to go further than restoration, effectively rehabilitating the fractured commissioning of SRH services.

3.2 Ensuring access to a mix of consultation modalities

The lack of face-to-face consultations is having detrimental impacts on the SRH care of vulnerable groups. Without face-to-face consultations, picking up on safeguarding issues, domestic abuse and teenage pregnancy is more difficult. Remote consultations do, however, have advantages for women in remote and rural areas or those who struggle to travel to a central clinic due to childcare responsibilities, amongst others.

The availability of different modalities of consultation – face-to-face, remote and online – is vital to provide comprehensive SRH care for all women and girls, and to deal with the increased demand for SRH care after services normalise. Therefore, we call for the restoration of SRH services that include all such modalities of consultation, including face-to-face, in a manner that is safe for both patients and healthcare professionals when moving beyond the pandemic.

Remote and online services are a complement, not a substitute, to face-to-face consultations and, irrespective of consultation modality, best practice and guidelines must be observed to ensure safety and quality of care.