Informed, heard, empowered:

Placing women at the heart of reproductive health policy

A report from Bayer UK

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Forewords

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As a global leader in women's health, Bayer believes that access to high-quality reproductive healthcare, at every stage of the life course, is a fundamental right for every woman.* Empowering women to decide if – and when – they choose to start a family, to easily access the support they need for gynaecological health conditions, and to live well through the menopause and beyond, is paramount not just for women themselves, but for health systems and societies too.

In the UK, we are beginning to see a welcome recognition from policymakers that women's health has for too long been underprioritised. Governments in England,[1] Scotland,[2] and Wales[3] have all set out bold ambitions to reverse decades of neglect in women's healthcare, supporting women to live healthy lives and strengthen their contribution to society. It is now a year since England's Women's Health Strategy was launched by the UK Government in July 2022,[1] setting out an ambitious vision for women's health across the life course.

Set against this, it is disappointing that reproductive health, a pivotal foundation of women's broader health and wellbeing, remains a clear gap in policymaking in England. The commitment made in the Women's Health Strategy for England to set out plans for sexual and reproductive health, including "a focus on increasing access and choice for all women who want contraception",[1] remains undelivered – leaving reproductive health at risk of falling through the cracks. This is at a time when action to safeguard access to critical reproductive health interventions, such as contraception, is more urgently needed than ever: NHS data highlights that since 2014/15, there has been a 48% decline in contraception-related contacts with sexual and reproductive health services, and the number of clinics offering a service has fallen from more than 850 in 2015/16 to fewer than 400 in 2021/22.[4]

If the UK Government wishes to take a holistic approach to improving the health of women in England across the life course, it is important that reproductive healthcare plays a central role in this agenda. Through this report, Bayer's ambition is to help plug this current gap in the agenda by setting out our proposed gold standard in reproductive healthcare across the life course, from the education received in school, to improved access to contraception and menstrual health services, to managing the challenges that come with menopause. We are eager to see the Government build on its launch of the Women's Health Strategy, and ongoing work to roll out the Women's Health Hub model, to put in place concrete action to enhance women's access to reproductive health services – for example by removing barriers to the provision of the most effective methods of contraception. This report is one aspect of our broader commitment to partner with the system in co-creating these solutions.

In developing our recommendations, we have placed women's needs and experiences at the heart of our considerations. Only by ensuring women feel informed about their options, feel that their voice is heard by healthcare services, and feel empowered to make decisions about their reproductive health, can we put in place truly optimal reproductive health provision.

** Bayer recognises that access to reproductive healthcare is essential to anyone assigned female at birth, no matter how they identify. Bayer therefore supports and advocates for the right to access reproductive healthcare for trans, non-binary, and intersex people that need it. It is essential that there is an understanding of intersectionality to help minimise inequalities in care and the provision of essential services. We use the word women for simplicity but also in recognition that the majority of those requiring access to reproductive healthcare identify as women.*

Dr Janet Barter
President, Faculty of Sexual and Reproductive Healthcare (FSRH)

Maintaining good reproductive health and wellbeing across the life course has profound and positive long-term effects on individuals and society as a whole. Effective sexual and reproductive healthcare can empower women and other service users to have control over their lives and ambitions for the future. However, we know that many are still experiencing poor reproductive health.

Too many women are having to visit multiple services or sit on lengthy waiting lists to get their needs met. This should not be happening; access to contraception and other forms of reproductive healthcare is a human right.

As this report sets out, there are huge challenges facing the delivery of reproductive healthcare, from the fragmented commissioning of services to the workforce crisis, which heavily impacts this area of healthcare. However, we have an opportunity to maintain the momentum afforded by recent policy interventions such as the publication of the Government's Women's Health Strategy and the establishment of statutory Integrated Care Systems.[5]

It is with this in mind that we last year launched the FSRH Hatfield Vision,[6] *a blueprint for achieving our 2030 ambition to significantly improve reproductive health inequalities for all women and girls. The Vision, endorsed by over 40 organisations and leaders from across the breadth of the UK reproductive healthcare sector including the Academy of Medical Royal Colleges, the English HIV & Sexual Health National Commissioners Group, and the British Medical Association,*[7] *sets out 16 goals and 10 actions that are needed to create tangible and positive change – across the life course – for the healthcare of 51% of the population.*[6]

The FSRH Hatfield Vision also considers the steps needed to address varying outcomes experienced of different groups of women, such as the need to address poorer maternal health outcomes faced by black women and women of colour, as well as women and girls from Asian and minority ethnic groups.[8]

It is excellent to see the commitment from Bayer to improving outcomes for women, and the recommendations set out in this report to enhance provision at critical stages of the life course. On behalf of the FSRH, I welcome this report and hope the recommendations will support the delivery of the FSRH Hatfield Vision's 2030 goal.

Executive summary

The life course at a glance

Teenage years

Reproductive years

Today…

40%
of pupils rate quality of relationships and sex education (RSE) as 'good' or 'very good'[36]

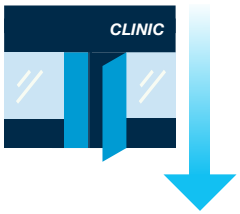
6%
of women learn about intimate health through school or university education[37]

Recommended action

Protect and enhance delivery of the RSE curriculum, embedding vulval anatomy and vaginal health as a core aspect of physical health education so that all women are empowered to look after their intimate health as they approach adulthood and beyond – supporting informed and sustainable engagement with health services throughout the life course.

Today…

Fewer than half
of the specialist clinics offering a service in 2015-16 were still doing so in 2021-22[4]



34%
of GP practices are only funded to provide LARC for contraceptive purposes, reducing women's access to highly effective treatments for heavy menstrual bleeding[49]

Prescribed LARC rates (excluding injection) vary from below 5 to over 85 per 1,000 women[44]

Recommended action

Seize the opportunity of the Women's Health Strategy and integrated care agenda to reverse a decade of fragmentation and growing inequality in women's reproductive health, through removing barriers to collaborative commissioning and workforce expansion. Replication of the Women's Health Hub model should serve to streamline and enhance women's access to LARC across contraceptive and gynaecological needs.

Action must be underpinned by a fair, long-term approach to funding of LARC provision through implementation of a nationally-set minimum fee for LARC fitting in primary care.

Menopause and beyond

Today…

10%

of women who worked during the menopause have left a job due to their symptoms[53]

52%

of GPs are not offered enough support to advise and treat women with menopausal symptoms[58]

Recommended action

A whole-system approach to support all women to maintain good health throughout menopause and beyond – in every aspect of their life, from family life to the workplace – with appropriate training for employers and healthcare professionals alike.

Unlike a disease-orientated approach, which focuses on interventions for a single condition often at a single life stage, a life course approach focuses on understanding the changing health and care needs of women and girls across their lives.

Women's Health Strategy for England[1]

Introduction

Access to high-quality reproductive healthcare throughout the life course is a fundamental right. From teenage years, through reproductive years, to menopause and beyond, women must be supported to maintain their health, empowered to make an informed choice about the options available to them, enabled to access care easily and quickly, and – crucially – listened to when they do have concerns. For too many women in England, this is not the reality. Women are forced to wait for too long to access care, and when they do, the patient journey is often complicated, disjointed, and overlooks women's needs.

The landmark Women's Health Strategy for England presents a key lever in reversing this reality. Like many across the sector, Bayer welcomes the Strategy's ambitious vision to improve women's experiences of care, and health outcomes, as their needs change throughout the life course.[1] In the year since the Strategy's launch, commendable work has already been carried out to drive implementation. For example, in March 2023, the Department of Health and Social Care (DHSC) launched a £25 million fund to support the expansion of the Women's Health Hub model across England.[9] This presents a clear opportunity to secure holistic provision of healthcare for women, bringing essential services together to support women to maintain good health and ensure they can easily access the care they need at the right time and in the right place.

However, as the Strategy itself acknowledges, it is not the final step "on the journey to reset the dial on women's health".[1] Efforts to deliver the Strategy's ambition must take a cross-system approach, overcoming systemic barriers and fragmented commissioning arrangements – embedded over many years – while aligning with national priorities for backlog and primary care recovery. A more concrete focus on reproductive health – and the pervasive inequalities currently observed in reproductive health outcomes – will also be integral to supporting every woman to achieve optimal outcomes, no matter her background.

Effectively seizing – and building on – the foundations set by the Women's Health Strategy will require a collaborative approach that utilises expertise and insight from all parts of the system. At Bayer, we want to build on our heritage of working with NHS organisations to partner across the system, including Government and the wider community, to translate the vision of the Women's Health Strategy into concrete and long-term action, and replicate best practice to plug existing gaps – such as reproductive health – across England. As a first step, this report sets out a woman-centred approach in supporting women to achieve optimal reproductive health, from teenage years to menopause and beyond.

We need to make it as easy as possible for women to access the services they need, to keep girls in school and women in the workplace, ensuring every woman has the opportunity to live her life to her fullest potential.

Professor Dame Lesley Regan
Women's Health Ambassador for England, quoted while launching the Women's Health Strategy for England in July 2022[10]

What is the current landscape for women's reproductive health?

In its Women's Health Strategy, the Government acknowledges that, thanks to a disjointed and "male by default" health system, 51% of the population have for too long faced obstacles in getting the care they need.[1] Women feel their voices are not listened to, and services are not built around their needs or daily life.[1]

These obstacles are particularly clear in the case of reproductive healthcare, where fragmented commissioning arrangements mean that the system is difficult to navigate for both women and healthcare professionals, resulting in reduced access to vital services for women in many parts of the country. Contraceptive provision, for example, is split between three different commissioners: NHS Integrated Care Boards (ICBs), local authorities, and NHS England.[11] Compounded by underfunding – with sexual health services having taken the brunt of public health funding cuts since 2015–16[12] – and an under-resourced workforce facing high pressures and low morale,[13] too many women are unable to access the contraceptive and menstrual care they need, in a timely manner and in the way most appropriate for them.

As they reach menopause, many women report that poor understanding of the menopause by healthcare professionals and employers make it difficult to find the right support – despite being something experienced by almost every woman.[1]

EXPLAINER

Long-acting reversible contraception (LARC)

Long-acting reversible contraceptive (LARC) methods are widely accepted to be some of the most effective and cost-effective methods of contraception available and include intrauterine system (IUS)/intrauterine device (IUD), progesterone-only subdermal implants, and progesterone-only injectable contraceptives.[14] IUS methods are not only effective in preventing unplanned pregnancy, but are also the first-line recommended treatment for heavy menstrual bleeding (HMB) in women with no identified pathology or large fibroids or adenomyosis.[15]

LARC commissioning is particularly complex, however:

- *Local authority commissioners are responsible for LARC for contraceptive purposes, under Locally Commissioned Service (LCS) contracts[16]*
- *NHS commissioners are responsible for gynaecological LARC commissioning, for example to treat HMB, as a locally enhanced service (LES), which local commissioners can offer to local practices to supplement the nationally-agreed GP contract[17]*

The locally-determined nature of LCS and LES contracts means that there can be significant variation in scope and funding between different geographies, and GP practices can decide whether or not to sign up[17] – based on availability of the trained workforce, or decisions on financial viability. Without clear guidance for patients, providers, and commissioners, this variation and complexity risks creating avoidable misunderstanding that ultimately damages women's access to a critical service. Through the Fair Fees for Fitting campaign we stand with community stakeholders in calling for a new approach to collaborative commissioning of women's reproductive health.[6]

The fragmented sexual and reproductive healthcare system is notoriously difficult for women to navigate, and successive cuts to public health budgets have made it even harder for women to access the contraception they need.

Dr Asha Kasliwal

Past President of the FSRH, responding on FSRH's behalf in February 2021 to proposals to make it easier for women to obtain the progestogen-only contraceptive pill in pharmacies without the need for a prescription[18]

COVID-19 has only served to exacerbate many of these systemic challenges caused by fragmented commissioning, meaning that women's access to care is now at material risk.[1] This has a far-reaching and multi-faceted impact:

For women

In the public call for evidence designed to inform the Women's Health Strategy, just 40% of women reported being able to conveniently access the services they need in terms of location and 24% in terms of timing. Sexual and reproductive health services, such as contraceptive provision, were cited as areas with particular challenges, and women from marginalised communities were most likely to report difficulties.[19]

What is more, women too often find themselves 'bounced around' the system – for example when seeking a new method of contraception, or support for HMB[20] – as they are not able to easily access the care they need in primary or community care. In the case of HMB, women may be referred to secondary care gynaecology services – where, according to the latest NHS data, only 54% of patients referred are seen within the 18-week target[21] – when they could have their needs met more quickly, and more effectively, in primary care. While GP practices and community clinics are well placed to provide IUS for HMB in line with NICE guidance, currently only 6% of women are receiving IUS as a first line of treatment.[22] This is a poor outcome for women, while adding extra burden to secondary care services already facing significant backlogs. Providing evidence to the All Party Parliamentary Group (APPG) on Sexual and Reproductive Health in the UK's 2020 inquiry on access to contraception beyond the pandemic, Dr Jane Bush, a Clinical Lead in Exeter, spoke to the challenges in contraceptive provision in her area during the time of the inquiry:

People are travelling from London to access sexual healthcare from us as they have friends or relatives here and it is easier for them to come for a long weekend to Devon and have their needs met whilst here rather than find a service in London. One woman advised me she was unable to get her IUC [intrauterine contraception] changed in London as she was over 25 and therefore could not attend a sexual health service and her GP did not offer IUC fitting.[23]

For the health and care system and wider society

Many women with HMB could be treated in primary or community care, in line with the NHS's ambitions to reduce pressure on secondary care and Getting It Right First Time (GIRFT) recommendations for gynaecology.[24] However, commissioning barriers mean that many primary and community services cannot provide treatments such as IUS for women living with HMB.[24] As a result, menstrual disorders continue to make up 12% of all referrals to gynaecology services, making it one of the most common reasons for referral:[24,25] with gynaecology waiting lists facing the biggest increase of all medical specialties,[26] this is not a sustainable situation. At secondary care, there remains significant variation in the use of hysterectomy for HMB: while national guidelines state that hysterectomy should only be considered in specific circumstances, GIRFT identified in 2021 that in 23 providers, at least 90% of hysterectomies were for "benign indications" such as HMB.[24]

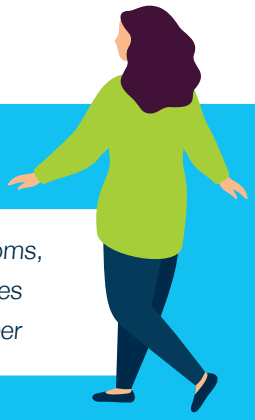
PATIENT SPOTLIGHT

Insights from RCOG

In 2022, the Royal College of Obstetricians and Gynaecologists (RCOG) published a report, Left for too long: understanding the scale and impact of gynaecology waiting lists, which explores the impact of long gynaecology waiting lists on patients. Women living with HMB reported the severe impact that HMB has on their daily lives, particularly when waiting for care and treatment. This included finding it difficult to get out of bed, struggling with low mood and mental health issues, and even requiring admission to hospital for iron infusions or blood transfusions due to anaemia.[26]

Looking at pregnancy choices, unplanned pregnancies have far-reaching personal and societal implications. Currently in England, 45% of pregnancies and one third of births are unplanned or associated with feelings of ambivalence,[27] with the cost of an unplanned pregnancy estimated at £1,663 in direct healthcare costs, rising to £2,922 with the inclusion of social costs.[28] Increasing access to LARC is a critical strategy in decreasing the rate of unplanned pregnancies, ultimately reducing costs on the health and care system and society.

Too many women with HMB are 'bounced around' the system



Woman suffers HMB symptoms, hampering everyday activities including family life and career

Woman visits GP as first port of call, who may not feel confident diagnosing or treating HMB, not be aware that IUS is the first-line treatment option, or not be commissioned to offer IUS for gynaecological purposes[48,49]

Many community sexual health services – where nurses regularly insert LARC for contraceptive purposes – are not commissioned to insert LARC for HMB[24]

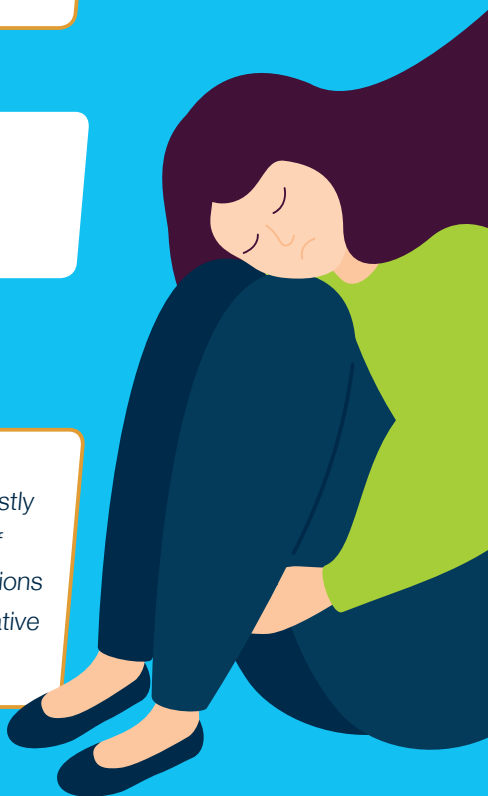
Woman continues to live with pain and disruption

GP refers woman to secondary gynaecology services without any treatment in primary or community care

Almost half of women wait over 18 weeks from referral to treatment with gynaecology service[21]

Whilst waiting, woman continues to struggle with HMB symptoms – which may worsen – potentially creating mental health issues or severe anaemia requiring acute intervention[26]

At secondary care, woman may receive a costly and invasive hysterectomy: around 75% of hysterectomies nationally are for benign indications such as HMB[24] *despite the availability of alternative NICE-recommended options including IUS*[15]



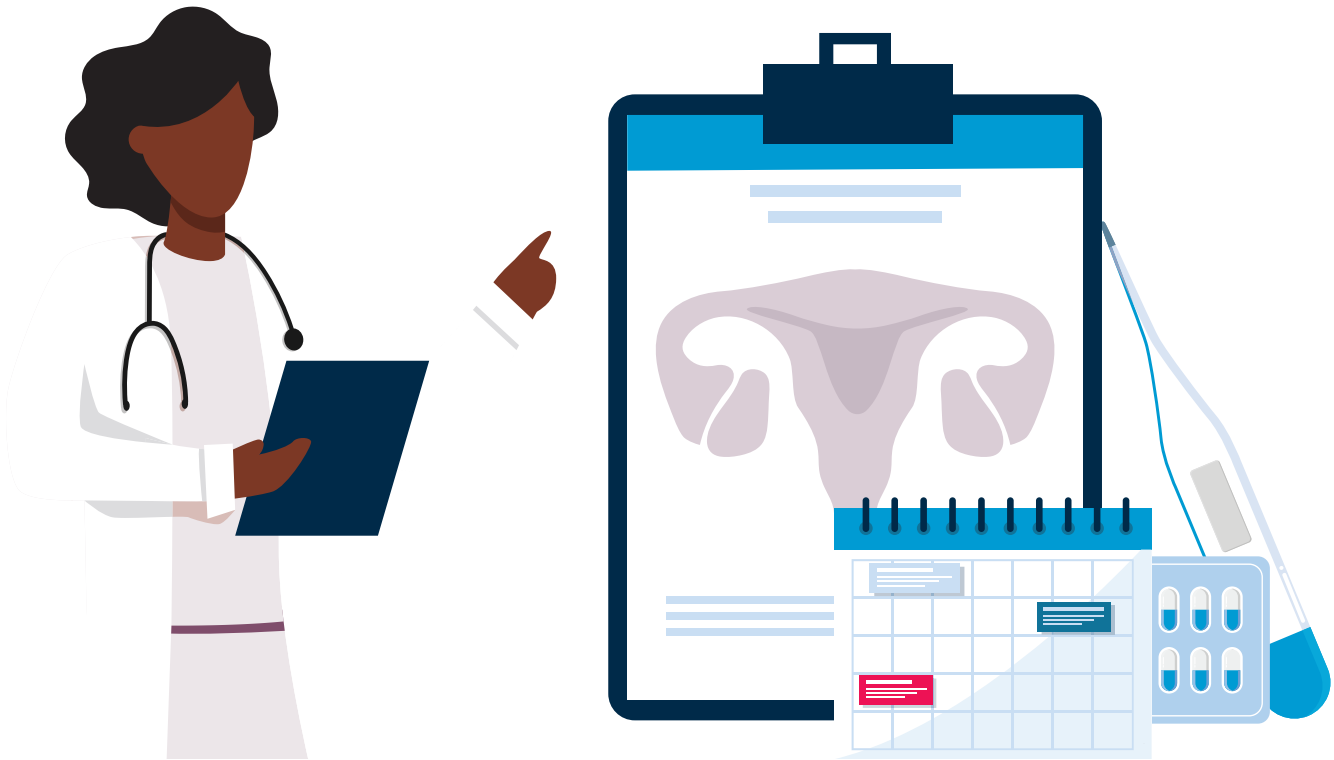
What needs to happen next?

Concerted and fully-funded action is now required to put in place high-quality and holistic reproductive healthcare for every woman in England, building on the foundations of the Women's Health Strategy.

The pioneering Women's Health Hub model – which sees essential women's services coming together to provide a more streamlined and holistic model of care delivery – has real potential to improve access and quality of care, reduce pressure on secondary care, and tackle fragmentation in care provision.[1] This, rightly so, has been recognised by the Government,[6] and as demonstrated by trailblazer models such as Liverpool's,[29] could drive a step-change in the way women are able to engage with and access the health and care system. However, a joined-up approach to expanding the use of the model is critical to ensure that no aspect of reproductive healthcare falls through the cracks, especially given the continued absence of a dedicated Sexual and Reproductive Health Action Plan.[30] Having supported the initial development of the Women's Health Hub approach, Bayer is keen to see one of the founding ambitions of the model – to support access to provision of LARC for both contraceptive and gynaecological purposes, including HMB[31] – be embedded as a central priority, as well as integrating a wider range of tailored services, such as menopause care, throughout the life course.

Alongside national action, the Government must ensure it is working with Integrated Care System (ICS) leaders to translate the momentum from the first year of the Women's Health Strategy to the ICS level – leveraging the wider opportunity offered by the integrated care agenda – while facilitating collaboration between NHS, local authority, and voluntary sector organisations to overcome systemic barriers in the delivery of women's reproductive healthcare.

To help shape this work, in the following pages we set out the case for change for enhancing reproductive health provision at critical stages of the life course, before summarising our recommendations throughout these stages. While this is not an exhaustive approach covering every element of women's reproductive needs, it is informed by our own heritage and key areas of expertise in women's health.



CASE STUDY

Achieving success with the Women's Health Hub model

Case study provided by the Faculty of Sexual and Reproductive Healthcare, Royal College of Obstetricians and Gynaecologists, Royal College of General Practitioners, and British Menopause Society

The Women's Health Hub model of care, which the Government committed to encouraging the expansion of as part of the Women's Health Strategy, presents a key opportunity to improve women's health outcomes and reduce inequalities across the country. In particular, ICSs could enable significant improvements in the way care pathways work for women living in their footprint, determining priorities based on local need.

With this in mind, the Royal College of Obstetricians and Gynaecologists, Royal College of General Practitioners, the Faculty of Sexual and Reproductive Healthcare, and the British Menopause Society produced a joint position statement providing a consensus view on how this opportunity can be harnessed by ICSs and supported nationally by Government and the NHS. It also considers key enablers and barriers to success, and outlines considerations for women's health services that systems provide and how they can be brought into Hub models.[32]

The joint position sets out that Hub models should ensure women are seen 'in the right setting, by the right professional, at the right time' by better integration of women's health services across primary, secondary, and sexual and reproductive health.[32] *It contains a series of key aims for the Hub model to improve women's experience and access to care – through improving access to prevention and early intervention services, improved education and information provision, and building a Hub workforce based on the skills and competencies required to provide high-quality holistic care.*

To read the full joint position statement, visit: https://www.rcog.org.uk/about-us/campaigning-and-opinions/position-statements/achieving-success-with-the-womens-health-hub-model/

Teenage years
Building the foundations for optimal reproductive health

Why does it matter?

Teenage years are a pivotal stage in women's lives, as they begin to understand more about their bodies and how they can look after their reproductive health, with most girls beginning menstruation during this period.[33] Accurate and easily accessible information and education is critical during this time, shaping how women engage with their health, and health services, throughout the course of their lives – during reproductive years and beyond. The value of good quality, comprehensive sexual and reproductive health education for young people is widely recognised in the UK and across the world, and protected as a fundamental human right by international standards including the UN Convention on the Rights of the Child and the UN Convention on the Elimination of all Forms of Discrimination against Women.[34]

What is happening now?

The introduction of statutory relationships and sex education (RSE) in England in September 2020 was a landmark moment, setting out the requirement that all pupils are taught about issues including menstrual cycles and contraception.[35] For young women, this knowledge is critical as they enter puberty and begin to negotiate the challenges that come with this phase of life.

However, gaps do remain:

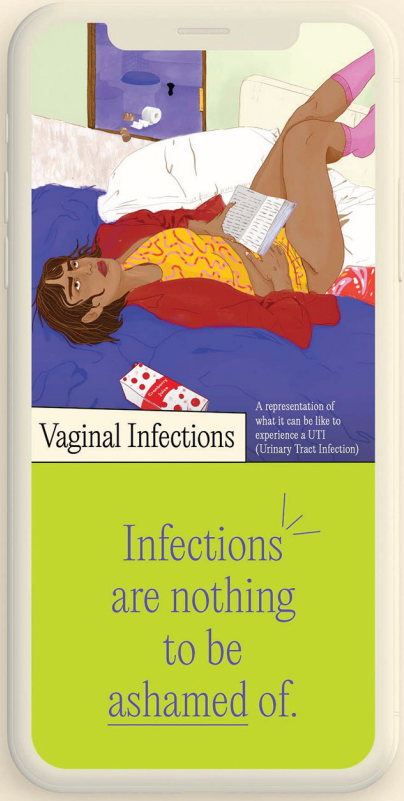
- *In a poll by the Sex Education Forum in 2022, only 40% rated the quality of their RSE as 'good' or 'very good'[36]*
- *56% of pupils reported learning not enough, or nothing, about how to access local sexual health services[36]*
- *In separate research, only 6% of women reported having learned about their intimate health through school and university education, leading to avoidable shame and distress. Almost half of UK women are worried about the appearance of their vulva[37]*

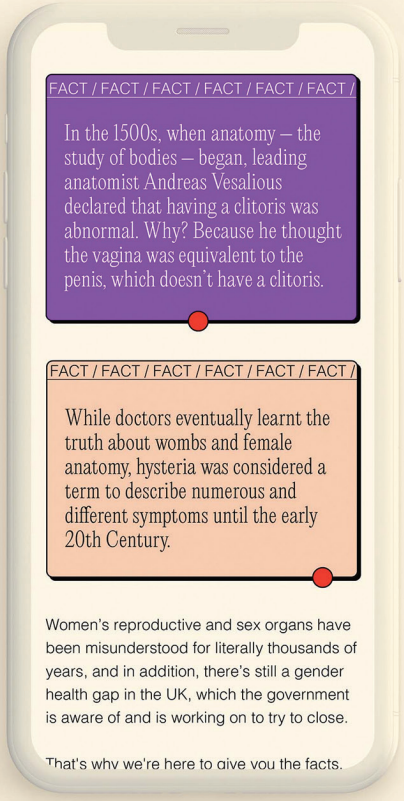
The upcoming RSE guidance review provides an important opportunity to consolidate the strengths of the RSE curriculum already in place, while ensuring that the curriculum is working as effectively as possible to support women to have healthy and productive relationships with their own health, and to empower them to make informed decisions.[38] In doing so, women will be able to access the right services for their needs at the right time, ultimately reducing long-term burden and costs on the health and care system.

I would be very uneducated if I didn't research a lot myself.

They try too much not to talk about 'taboo' topics but that's exactly the issue, the less we speak on issues then the less educated everyone is on these topics.

Anonymised responses from two secondary school students regarding RSE[39]

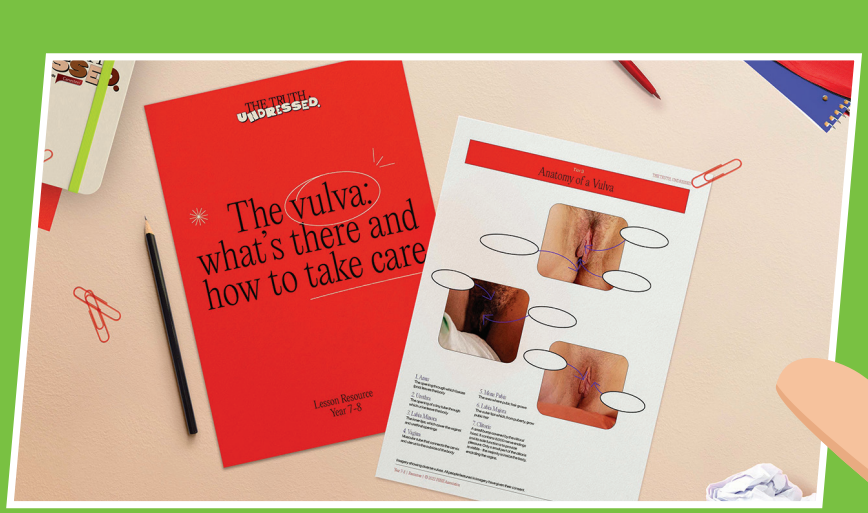




CASE STUDY

The Truth, Undressed

Bayer's award winning The Truth, Undressed education programme – developed in collaboration with the PSHE Association – aims to tackle the stigma and confusion around women's intimate health by providing evidence-based digital and social media content and school-based lesson plans on vulval anatomy and vaginal health – without metaphors, euphemisms, oversimplification, or sexualisation. Tiered lesson plans ensure pupils aged 11-18 fully understand their intimate health, growing their confidence in talking about it and empowering them to look after their vaginal health and wellbeing, including seeking medical care when required. Lesson plans have already been delivered to nearly 150,000 students, receiving a positive response from pupils, parents, and teachers alike.[40]



Reproductive years

Maintaining good reproductive health to live a full life

Why does it matter?

Women of reproductive age make up almost 20% of England's population.[41] Most women will menstruate for nearly 40 years,[42] and throughout these years, will require support to prevent unplanned pregnancies. At the heart of this, women should have a full choice of contraceptive methods, delivered in their preferred setting – an ambition set out in the Women's Health Strategy, but not yet expanded upon or fulfilled.[1]

Women should also be supported to maintain good menstrual health, ensuring that periods do not get in the way of their everyday lives.

What is happening now?

LARC is a cornerstone of supporting women through their reproductive years, while also contributing to a sustainable health system. Within primary care, the provision of LARC is an incredibly valuable investment: every £1 invested in primary care LARC provision saves £48 in direct public sector healthcare and non-healthcare costs over ten years.[14] LARC is also a highly effective treatment for HMB,[15] and when administered in primary and community settings, can reduce costly and invasive referrals to secondary care in line with Government priorities for the NHS to reduce the post-pandemic backlog.[24]

While the value of LARC, both to individuals and the wider system, is clear, systemic commissioning and funding challenges, and a shortage of highly-trained fitting professionals,[43] mean that LARC is inaccessible for too many women. This challenge has only been exacerbated by the disruption created by the COVID-19 pandemic:

- *Fewer than half of the specialist clinics offering a service in 2015-16 were still doing so in 2021-22[4]*
- *Across primary and specialist care, around 500 clinics are yet to re-open following the COVID-19 pandemic[44]*
- *LARC uptake is yet to recover to pre-pandemic levels, with the latest data for LARC prescriptions (excluding injections) showing an average of 41.8 per 1,000 women in England in 2021 – an 18% drop from 2019, just two years earlier[45]*

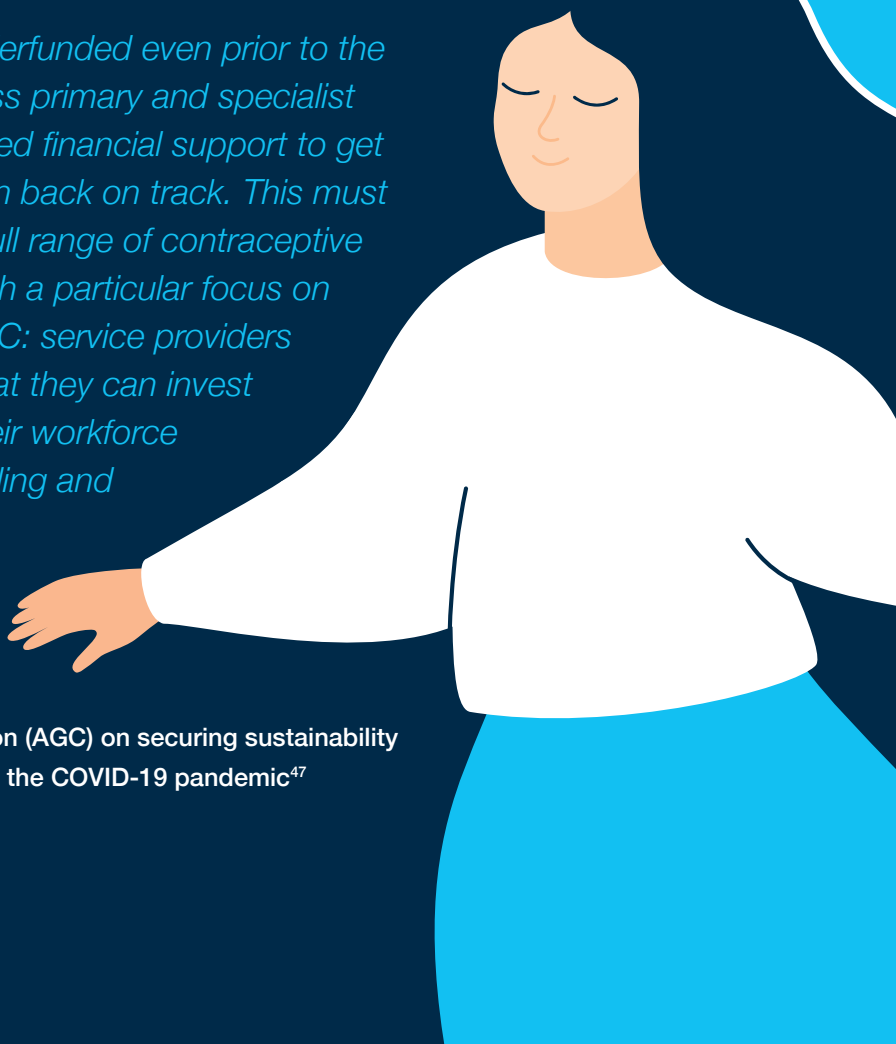
Access to LARC in also an issue of vast inequalities, subject to a severe postcode lottery that means in some areas uptake exceeds 85 per 1,000 women, while in other areas the same rate falls below 5 per 1,000 women.[45]

Overcoming this stark variation will require reform to commissioning of LARC provision, so that this highly clinically- and cost-effective option[14] is more widely available, and long-term costs created by poor access[28] are reduced. While the new NHS Pharmacy Contraception Service will not provide IUS/IUD, it could provide a useful lever to further embed a cross-system approach, whereby general practice capacity is freed up for more complex services such as LARC fittings, and women are more effectively counselled about, and signposted towards, the available options.[46]

I am pleased to see this report highlight the challenges women face when accessing care for HMB. As Co-Chair of the Menstrual Health Coalition (MHC), I believe collaborative working between the Government, NHS organisations, and stakeholders is essential to improving the way in which women receive support, advice, and appropriate treatment for their symptoms. I am pleased to see this report highlight the barriers fragmented commissioning and funding arrangements place on women's access to treatment, something which the MHC has campaigned for since the publication of the group's report into Heavy Menstrual Bleeding in 2020. Most importantly, this report will help to increase patient and clinician awareness of HMB, which the MHC believes has contributed to the delay in diagnosis and treatment of those affected by the condition.

Dr Anne Connolly MBE
General Practitioner with a special interest in women's health
and Co-Chair of the Menstrual Health Coalition

Highly stretched and underfunded even prior to the pandemic, services across primary and specialist settings now need targeted financial support to get provision of contraception back on track. This must enhance delivery of the full range of contraceptive options in all settings, with a particular focus on improving access to LARC: service providers must have confidence that they can invest in the development of their workforce to provide LARC counselling and fittings to all women who prefer these methods.



Advisory Group on Contraception (AGC) on securing sustainability for contraceptive provision after the COVID-19 pandemic[47]

Improving access to LARC in primary care

The critical need for Fair Fees for Fitting

Women's health services like cancer screening, contraception, abortion and maternity services have been in three silos of commissioning... None of those three funding pots picks up the pieces when they don't get it right; the people that don't give you contraception aren't the ones to pick up the maternity bills or the abortion bills.

Professor Dame Lesley Regan
now Women's Health Ambassador for England, speaking in her capacity as Professor of Obstetrics and Gynaecology at Imperial College London on the importance of a joined-up, equitable approach to women's health[48]

There is clear impetus – driven by women's health experts from Professor Dame Lesley Regan to the FSRH, advocating for improved reproductive health outcomes through its FSRH Hatfield Vision[6] – in ensuring women can access LARC in the way that is most convenient for them. For the majority of women, this is their GP practice;[49] however, LARC provision in primary care is uniquely impacted by the issue of fragmented commissioning in women's healthcare, which has led to deeply embedded funding issues.

- ***Given variation in local commissioning arrangements,[16,17] around a third of GP practices are not funded to provide LARC for gynaecological purposes such as HMB,[50] forcing women to seek care from secondary or community services, which can lead to longer waits for treatment and support***
- ***Only 20% of practices have developed a service to accept referrals from local GP practices – this gap creates further barriers along the patient pathway[50]***
- ***There is significant variation in the fee paid to GPs by local authorities to provide LARC fittings – in many areas the fee is simply not sufficient to cover the cost of providing the service or train staff to fit LARC, forcing GP practices to reduce or even stop LARC provision[50]***

The disparity among regions is stark. In my city, the rate for GPs prescribing LARC is only 2.1 women per 100,000; whereas in other parts of the country it is 51.5 women per 100,000. Access issues have particularly hit marginalised groups with services reporting a drop in the number of young, black, Asian, and minority ethic people requesting the services. As we continue to emerge from the pandemic, we have the unique opportunity to reshape contraceptive services according to the needs of women.

Dame Diana R Johnson

MP for Kingston upon Hull North and Chair, APPG for Sexual and Reproductive Health in the UK, contributing to a House of Commons Debate on International Women's Day on Thursday 10 March 2022, and speaking to the levels of disparity in access to LARC at the time of the debate[51]

The findings from the most recent Primary Care Women's Health Forum's survey of LARC fitters shine a light on the vast variation in the fees paid, ranging between £25 – £100+.[52] This variation is fostering significant geographic inequality in women's access to LARC.

As GP surgeries reduce the LARC services they offer, clinicians are not accessing the training they need or performing the number of LARC fits needed to maintain their skills, risking a precious part of the workforce becoming deskilled. This leaves a critical workforce gap: in some areas, there may be only one trained fitter for over 10,000 women,[13] leaving local women with severely reduced choice and no service at all if these GPs are away or approaching retirement. Our experience suggests that this is being identified at the system level as a long-term pipeline issue that will struggle to recover, unless action is taken now.

Successful replication of the Women's Health Hub model must have full consideration of these issues, and take steps to ensure a minimum viable fee for LARC fitting in primary care, in every part of the country. This should ensure equitable funding for both contraceptive and gynaecological LARC provision, while ensuring providers are fairly reimbursed for wider aspects including workforce training and the complexities associated with inter-referral.

Menopause and beyond

Empowering women to take control

Why does it matter?

The menopause is a universal experience that almost all women will go through. However, the way women experience the menopause and their symptoms can vary considerably, and it can have a very real impact on the quality of women's day-to-day lives.[53] It is therefore critical that all women have ready access to personalised support, counselling, and information, helping them to make informed choices on the treatment options available at each stage of menopause.

What is happening now?

Too many women are not properly informed on or supported through the menopause. In the public call for evidence designed to inform the Women's Health Strategy, only 9% of respondents said they have enough information about the menopause, and many women reported that managing menopause in the workplace had a severe personal impact.[1] In fact, 10% of women who worked during the menopause have left a job due to their symptoms, and this figure rises to 22% for disabled women.[54]

A range of effective treatment options are available to help women manage their symptoms and carry on with their daily lives. Rising demand points to a growing awareness of these options[55] and we welcome the Government's prioritisation of menopause in its first year of implementing the Women's Health Strategy. This work has involved removing barriers to hormone replacement therapy (HRT) and making cheaper and more accessible options available through the prescription prepayment certificate.[56] However, supply issues continue to be reported despite action by the Government to minimise disruption,[57] and access to the full range of treatment options can still be challenging for many women.

Access challenges have been attributed in part to a lack of recognition of menopause symptoms by women and healthcare professionals, a reluctance among some healthcare professionals to prescribe treatments, and significant variation in access to specialist menopause services between different parts of the country.[1,58] In fact, according to the British Menopause Society, only 62 GPs in England and Scotland, out of 54,024, are recognised menopause specialists.[59] Furthermore, in a recent survey of 173 UK-based GPs, 52% indicated that they were not offered enough support to advise and treat women with menopausal symptoms, and 77.5% expressed the need to improve training on menopause in medical school.[59] The absence of a Quality and Outcomes Framework (QOF) indicator on menopause may be hindering the adoption – and prioritisation of – good practice across England.[60]

While the majority of menopause care takes place in primary care, women with more complex symptoms can be referred to a menopause specialist in secondary care. Growing waiting lists mean that many women are not being seen – and provided with support – in an appropriate timeframe,[26] following serious disruption during the COVID-19 pandemic, which saw many services adversely impacted by the suspension of non-urgent planned care and redeployment of staff.[61]

Awareness and attitudes towards menopause, and women's access to care and support, have seen a marked transformation in recent years. We cannot, however, see menopause as a "job done", as both primary and secondary care care services remain highly stretched, and access to support is still restricted for many women. Work to enhance and expand the role of primary care in reproductive health services – for example through Women's Health Hubs – should recognise the potential to integrate menopause services, easing pressure across the system.

PATIENT SPOTLIGHT

Insights from RCOG

RCOG's 2022 report, Left for too long: understanding the scale and impact of gynaecology waiting lists, highlights the significant impact that menopause can have on daily life, particularly for those women waiting for care for more severe symptoms. Women reported having to give up work, struggling with sex and personal relationships, and grappling with worsening anxiety and lower self-confidence.[26]

CASE STUDY

Creating a primary care network women's health offer at Sutton's 'Sunflower Clinic'

In Sutton, clinical leaders identified a range of gaps in women's health provision, including limited availability of intrauterine options for menopause in primary care. As a result, women were being pushed to secondary care and experiencing long waiting times to access community gynaecology services, with menopause services particularly difficult to access for more underserved groups. A clear need was identified in expanding the provision of menopause care closer to home.

Capitalising on the existing momentum towards integrated care that was being driven by primary care networks (PCNs) across Sutton, the new 'Sunflower Clinic' was established, aiming to act as a 'one-stop shop' for menopause diagnosis and treatment plan design – aiming to sit alongside, rather than replace, the care delivered by general practices. The impact to date has been very positive:

- *High rates of clinic utilisation, with 94% of appointments booked and 75% attended*
- *All patients rate their experience as 'good' or 'very good'*
- *The majority of GPs report that the clinic helps them to avoid referring into secondary care*

Moving forward, the Sunflower Clinic aims to play a key role in women's health provision and deliver a range of reproductive services – including and beyond menopause. To deliver on this ambition, the team is currently engaging across the system to unlock existing commissioning barriers, as well as working on demonstrating the clinic's financial and operational viability.[62]

While donations were provided by Bayer to the Sunflower Clinic to support this initiative, Bayer had no input in to the setup, content, or delivery of the service.

Our recommendations across the life course

What needs to change?

Teenage years

Success looks like…

The UK Government's focus on improving education and information through implementation of the Women's Health Strategy should work in tandem with the upcoming review of RSE to protect and enhance delivery of the RSE curriculum, in full consultation with pupils, teachers, and expert stakeholders

Our recommendations

- *All pupils should receive high-quality, evidence-based education on vulval anatomy and vaginal health through the national RSE curriculum, with full support for teachers to ensure they have the knowledge, confidence, and tools to deliver effective intimate health education*
- *Work of the Women's Health Strategy to improve information provision on women's health should harness and align with innovative examples already available, to ensure accessible content is in place for all women – from the teenage years and into adulthood – and support informed and sustainable engagement with the health and care system: Bayer would be happy to share insights from the Your Contraception, Your Choice app[63] to help shape and direct this content*

Reproductive years

Success looks like…

The UK Government must seize the opportunity of the Women's Health Strategy and integrated care agenda in England to reverse a decade of fragmentation in women's health. Primary care should be recognised as the front door to delivering women's reproductive health, and the ideal foundation of the Women's Health Hub model, with current barriers to collaborative commissioning and provision removed as a matter of urgency

Our recommendations

- *The Women's Health Strategy's commitment to set out plans for sexual and reproductive health – including 'a focus on increasing access and choice for all women who want contraception'[1] – must be acted upon by DHSC. This should closely align with work to safeguard LARC financial viability and must:*
  - *Sit alongside upcoming guidance for systems on rolling out Women's Health Hubs to ensure no aspect of reproductive health falls through the cracks, in any part of the country*
  - *Be underpinned by a review of commissioning pathways to understand the barriers to collaborative commissioning, and how these might be tackled*
  - *Include action to train and incentivise a new generation of LARC fitters, helping systems to avoid a significant skills gap*
- *All ICSs should be asked to assign a 'Women's Health Lead' with responsibility for delivering national ambitions for women's health services across their sexual and reproductive health needs, including LARC commissioning*
- *Actions to tackle the COVID-19 elective care backlog[63] must be harnessed, alongside collaborative commissioning and integrated working, to enable more women with HMB to more easily and quickly access the care and support they need from primary care. This will help to reduce and streamline referrals to secondary care and ensure more costly, specialised interventions such as hysterectomy are only a last resort, in line with the ambitions of Getting It Right First Time[24]*

Menopause and beyond

Success looks like…

A whole-system approach must be taken to support all women to maintain good health throughout menopause and beyond – in every aspect of their life – with primary care at the forefront

Our recommendations

- *All women must be able to access proactive and personalised menopause support in primary care, with digital options made available wherever preferred and clinically appropriate to support providers in managing demand. Menopause support should form a key service of Women's Health Hubs, with the increasing role of community pharmacy in women's health leveraged to provide an additional source of support and signposting across the wider system*
- *Underpinning this, training and education bodies should review the current menopause training offer for GPs and practice nurses, ensuring that the general practice workforce has full awareness of the range of treatment options available for menopause symptoms*
- *Through Women's Health Strategy activity across menopause and education and information, the UK Government should develop high-quality and accessible education and training resources on the menopause for employers and employees, ensuring broad understanding of how menopause affects working women and what adjustments may be necessary to support them*
- *As recommended by the APPG on Menopause,[59] menopause indicators should be included in the GP QOF, incentivising and upskilling GPs on menopause diagnosis and treatment options so that they are better able to counsel women during this time*

Fair fees for fitting

Success looks like…

Effective replication of the Women's Health Hub will depend on the UK Government taking urgent action to ensure financial viability and appropriate commissioning arrangements for LARC provision in primary care – across contraceptive and gynaecological purposes – tackling the existing and pervasive variation currently in place

Our recommendations

- *The Government should set a nationally-determined, minimum viable fee for LARC, across gynaecological and contraceptive purposes. Bayer recognises this undertaking will require input from a range of stakeholders, and has recently formed a strategy group to move forward efforts to shape the future of sustainable primary care LARC provision*
- *LARC access should be recognised as a central aspect of Women's Health Hubs. Government guidance to support ICSs as they establish local Women's Health Hubs should make clear national expectations on fair and equitable funding for primary care LARC provision, in recognition of the cost-savings that can be harnessed across the system*
- *The Government should publish a plan for how the £25 million funding allocated towards Women's Health Hubs[9] will help to safeguard LARC access through implementation of the model. This could leverage existing work to support sustainable delivery of primary care, for example use of the Additional Roles Reimbursement Scheme (ARRS) to grow additional capacity in general practice[65]*

Spearheading a digital-first menopause support offer

A partnership between Bayer and women's mental health start-up Lumino

As well as physical effects, we know that menopause can have a huge impact on our mental health. At Lumino, our mission is to improve mental health for everyone – starting with everyone going through the menopause transition. We know Cognitive Behavioural Therapy (CBT) can help. We're excited about technology helping us democratise access to high-quality clinical interventions. By providing healthcare professionals and patients with a digital solution to manage menopause we will be able to make CBT, adapted for menopause-related symptoms, available at low-cost and at scale, while offering patients minimal waiting times and greater choice. We are excited to be working with Bayer on this important challenge through the company's G4A Digital Health Partnerships, to innovate across the reproductive health landscape and create greater access to digital solutions, to better support everyone going through menopause.

Becky Cotton
Co-founder and CEO, Lumino

How do we measure success?

Taken and driven forward together, the recommendations set out in this report can make a tangible difference to women's reproductive health at key stages of the life course, in line with the vision set out in the Women's Health Strategy. While a range of datasets must be evaluated to measure success, for example LARC uptake rates, and secondary care admissions for gynaecological conditions such as HMB, the outcomes reported by women themselves are key to ensuring they feel informed, heard, and empowered in their experiences of reproductive healthcare.

The Women's Health Strategy's commitment to commission a reproductive health experiences survey every two years[1] provides an important opportunity to monitor and track progress against these recommendations, and identify areas for improvement in line with the views and experiences of women themselves. We are eager to see the Government fulfil this commitment, and it will be critical that the survey seeks out the perspectives of women from all backgrounds – including women from underserved and marginalised communities – and looks to measure the following areas:

- *How far women feel informed – and supported – to look after their reproductive health, and how comfortable they feel seeking care*
- *The extent to which women feel empowered to make a full choice between the range of contraceptive methods, with shared decision-making being a fundamental principle of contraceptive care*
- *Women's experiences in accessing LARC – for contraceptive and gynaecological purposes – in the setting of their choice, and how long they need to wait*
- *Women's experiences of accessing care for menstrual conditions such HMB, including timeliness and ease of access*

- *How far women feel able to live well through the menopause, in their personal lives and in the workplace*

Combining these insights with quantitative data on access – including workforce availability, waiting times, and service provision – will help to develop a complete picture of reproductive healthcare, and identify opportunities for improvement as they arise. Bayer actively monitors a range of datasets at the national and local levels, and would be eager to explore how we can share our work to support the DHSC.

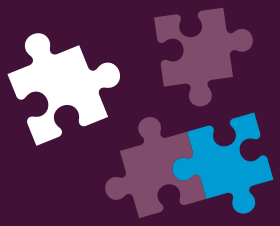
Putting our vision into practice
How can Bayer help?

As a global leader in women's health, Bayer is committed to improving women's lives in countries across the world, through groundbreaking research – including a collaboration with the University of Oxford to explore new treatments for endometriosis, uterine fibroids, and polycystic ovary syndrome,[66] and ongoing clinical trials in the menopause – and through partnering with health systems to upskill the workforce and tackle capacity challenges. This includes access initiatives, education, and training for healthcare professionals.

At the policy level, we aim to work with experts from across the system to tackle the most pressing challenges in women's reproductive healthcare. For example, through the formation of a campaign strategy group and engagement across the community, we are bringing together a range of stakeholders to facilitate discussions on the optimal route to secure a fair fee and equitable funding model for primary care LARC provision, across contraceptive and gynaecological purposes. We hope that this work will support the health and care system to tackle the existing postcode lottery in access to LARC, ensure a successful roll-out of Women's Health Hubs, with LARC as a fundamental building block, and ultimately realise the clear benefits of improved LARC access for women and the wider system.

Looking to the future, Bayer recognises that partnership working is critical to success, and believe that our work in the UK is aligned to the priorities set out in the Women's Health Strategy. To that end, we would be eager to explore the following opportunities:

- **Harnessing Bayer's expertise in education and information,** *illustrated through tools such as the Your Contraception, Your Choice app[62] to support the work of the Women's Health Strategy to create a dedicated area on the NHS website for women's health*



- **Continuing and expanding our work with ICSs** *– building on existing collaborative projects led by our Healthcare Partnerships Managers – to help local leaders translate national guidance on women's health to their local context, and support them to use our tools as they look to establish successful and cost-effective Women's Health Hubs*

- **Extending our current training offer** *– coordinating it with national guidelines/NHS England – and create a wider programme to support fitting in Women's Health Hubs as they are established, and to share the data and insights we have collected, through our HMB tool, on the system-wide benefits of treating HMB in primary care wherever possible*

We would be delighted to discuss any aspect of this report, or our offer to the system, in further detail. Please contact, Aahad Ali, Government Affairs Manager: **Aahad.ali@bayer.com**

The value of working in collaboration

Demonstrating the return on investment of service redesign

I have worked with Bayer and other industry partners to support access to contraception, including LARC in Liverpool. We have been devising more innovative ways to improve care and access to sexual health services amongst a backdrop of rising demand, post-pandemic. A Women's Health Hub model in Liverpool saw the implementation of an inter-practice referral service offer for LARC via the nine PCNs, using a 'hub and spoke' approach. This work has led to a fast-growing service that sees budgets more effectively combined and clinicians not restrained by the commissioning body.

Bayer already has a tool – the HMB budget tool – that allows us to accurately estimate the savings generated by appropriately managing HMB in primary care. We currently use this to plan our delivery of services. The Bayer team recently worked with me to model additional services that could potentially be provided by primary care practitioners and Women's Health Hubs in Liverpool, going beyond HMB.

Having this information allowed us to make a business case that has led to an investment from the ICB in a ring pessary fitting and removal service, widening the suite of support services we offer. We are now working together to explore how this modelling might be scaled up to support other areas to do the same. Bayer's tool means that we can estimate savings in sexual and reproductive health services, and allocate budgets in a more efficient way. Using this tool could help other areas map out services and make similar savings.

James Woolgar
Sexual Health Commissioning Lead at Liverpool City Council and Chair of the English HIV and Sexual Health Commissioners' Group

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