

# Opportunities to embed sexual and reproductive healthcare services into new models of care

A practical guide for commissioners and  
service providers

## About us

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest UK professional membership organisation. It supports healthcare professionals to deliver high quality sexual and reproductive healthcare (SRH). The Faculty's 15,000-strong membership is comprised of doctors and nurses who work in various clinical settings in the community and GP practices. We offer our members and the public NICE-accredited evidence-based clinical guidance and service standards.

FSRH provides advisory services to aid service design and tendering processes. FSRH has a number of experienced SRH clinicians who act as advisors to commissioners or managers wanting to review or tender their SRH service. We also provide a range of training and qualifications in SRH, overseeing the Community Sexual and Reproductive Healthcare Specialty Training Programme. FSRH is a Faculty of the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK.

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## Executive summary

Constraints on NHS funding, workforce pressures and rising demand from a growing and ageing population demand that our health services do things differently.

New models of care are responding to these challenges, reshaping services around the needs of local populations. In line with the ambitions of the NHS Long Term Plan<sup>1</sup>, they seek to coordinate care between different providers and across commissioning boundaries. Their triple aim is to improve outcomes, enhance patients' experience and deliver financial savings.

**Sexual and reproductive health (SRH) care services are an ideal fit for areas building new models of care.**

They involve multi-disciplinary teams delivering high quality care across different settings. They provide convenient access to services, incorporating digital offers alongside face-to-face appointments. They take a patient-centred approach, giving people more control of their own health and care across their life-course. They seek not only to improve individual health and wellbeing, but also that of the population as a whole.

An audit for the FSRH in 2018 revealed that SRH services were rarely part of formal plans for emerging new models of care.<sup>2</sup> Yet a few local commissioners and providers had recognised the potential and were starting to reshape the way in which local SRH services were delivered. By redesigning and better integrating services, they have been able to:

- Provide contraceptive, sexual health and gynaecological services to a whole population
- Address the needs of vulnerable groups
- Enable patients to access holistic care across the health and social care system
- Incorporate digital services, driving convenient and user-centred access to care

**This report sets out case studies demonstrating the potential for new models of care to embed SRH services.**

These areas are trailblazers – breaking down barriers, encouraging different local providers and commissioners to collaborate and consolidate resources. We are grateful to each area for sharing their experiences. Already there are lessons to be learned from the changes they are making and the impact they are having for patients. Each case study sets out their recommendations for others.

**As leaders in this field, we are keen to partner with commissioners and providers to support them in improving SRH care across the country.**

**We urge local and national leaders to recognise the opportunities to embed SRH services in new models of care as they work together through Integrated Care Systems (ICs) and Primary Care Networks (PCNs).**

## Introduction

### The drive for new models of care

It is now widely recognised that the hospital-based model of care is often outdated<sup>3</sup>, with care in the community considered the solution to tackle increasing demand and resource limitations, where appropriate. Emerging new models of care are seeking to reshape services around the needs of local populations. These models encourage different local providers and commissioners to collaborate and consolidate resources, putting the patient at the heart of service design.

Despite being called 'new', the shift towards integrated models of care has been taking place in the NHS for the best part of a decade.<sup>4</sup> The concept was first introduced in 2008's *High Quality Care for All* report.<sup>5</sup> 2014's *NHS Five Year Forward View* committed to test different models, while the *NHS Long Term Plan and Implementation Framework* set out the blueprint for them to be rolled out nationally.

By 2021, Integrated Care Systems (ICSs)<sup>6</sup> will cover the whole country. Each ICS will aim to streamline commissioning arrangements to support providers to partner with local government and community organisations on population health, service redesign and Long Term Plan implementation. Meanwhile, Primary Care Networks (PCNs)<sup>7</sup>, based on neighbouring GP practices working together, are already being developed to serve populations of 30 to 50,000. The NHS App will provide citizens with access to NHS 111 online, their GP record and the ability to book appointments from their computer or smart phone. The ambition is the creation of fully integrated community-based digitally-enabled health care.

At the moment, new care models vary widely in size, shape and scope. However, they are underpinned by a set of common values. By and large, they are focussed on the triple aim of improving outcomes, enhancing patient experience and delivering financial savings. These are the same three aims that are driving change in SRH services.

### The opportunity for SRH services in new models of care

SRH services are well placed to be embedded in new models of care because they exemplify many of the qualities looked for in new models:

- **Multidisciplinary working to deliver high-quality care across different settings.** SRH medical Consultants deliver specialist and complex clinical care. However, they are also highly-skilled system leaders who can design and support SRH services provided by other healthcare professionals including GPs, nurses and healthcare assistants.

- **A patient-centred approach.** SRH services seek to give people more control of their own health, care and wellbeing across their life-course. Good SRH begins with education and supports sexual and reproductive wellbeing throughout people's lives. It covers the provision of contraception and the prevention and treatment of sexually transmitted infections. It includes family planning and abortion services and encourages post-reproductive health. It is offered without judgement and regardless of an individual's background, circumstances or sexual orientation.
- **Convenient access to services.** SRH services are offered in multiple settings, from hospital to community settings, to general practice, to pharmacy. Increasingly services are working to incorporate digital offers alongside face-to-face appointments and home-testing (e.g. for STIs).
- **A whole population approach.** SRH services not only seek to improve individual health and wellbeing, but also that of the population as a whole. SRH Consultants receive extensive training in public health, ensuring services are rooted in prevention and health promotion, and aligning with national ambitions set out in the NHS Long Term Plan to promote wellness and tackle health inequalities.

## Untapped potential

In 2018, the FSRH conducted an audit to assess the extent to which SRH was being factored into new models of care.<sup>8</sup> 51 strategies and operational plans were reviewed from Sustainability and Transformation Partnerships, NHS England Vanguards and large-scale general practice organisations.

The results showed that few areas had explicitly recognised the opportunity to embed SRH services and there was huge, untapped potential.

Of the 51 new models reviewed, only 36 mentioned some aspect of SRH care (excluding maternity services). Of these, most were general references, often in the context of collaboration, transformation or integration, and almost always in relation to sexual rather than reproductive health. They were broad in nature and lacking in detail. In terms of specific mentions for services:

- 21 models mentioned STI diagnosis and management and/ or HIV testing
- 15 models mentioned community gynaecology and/ or contraceptive services

All other aspects of SRH care were mentioned by fewer than five new models. Psychosexual services and menopause services each received just a single mention in the review.

## Trailblazers

The audit also incorporated interviews with experts in SRH, including service commissioners, healthcare professionals and academics. All interviewees commented on the potential for SRH services to be more widely incorporated into new models of care. Drawing on their knowledge and networks, the FSRH was able to identify case studies of areas working to deliver SRH services in innovative ways.

## Case studies

The case studies that follow demonstrate different new models of care for SRH services and complement the work of Public Health England's Sexual and Reproductive Health Commissioning Pilots. We are grateful to them for sharing their experiences and lessons learned.

### Case study 1: Improving provision of long-acting reversible contraception (LARC)

#### Name

Modality Partnership

#### Type of model

The Modality Partnership is a single GP 'super partnership' delivering primary care and out-of-hospital/community services to more than 400,000 patients across eight regions and at more than 40 sites nationwide. It is one of the largest super partnerships in the UK.

#### Overview of activity

Building on its successful vanguard which focused on gynaecology, Modality Partnership set out to improve long-acting reversible contraception (LARC) provision by organising a direct contract with the local hospital. To improve services, it centralised administrative functions and provided a direct telephone line for consultations and bookings. The improved service was then promoted to women in the area who had previously turned away from accessing LARC in primary care.

#### Need identified

Women had stopped accessing LARC through their GPs because it was difficult to get appointments. When women were able to get appointments, these were often cancelled at the last minute because sexual and reproductive health was not prioritised by local teams.

#### Actions taken

The Modality Partnership has improved services by:

- **Providing a direct telephone line for women.** Women are able to call a single number to get advice and information on LARC. If they would like to book an appointment, they can do so directly. This saves them time and avoids frustration.
- **Centralising administrative functions and diary systems across all practices.** The Modality Partnership has also developed a central diary for LARC appointments. To set this up, they carried out an audit of practitioners' time across practices. A portion of each practitioner's time was taken from the local diary and added to a central digitalised LARC diary. This is managed by a centralised administrative team of three. The diary system means women have a greater choice in appointment times and no longer face the frustration of repeated cancellations.

- **Harnessing digital to promote greater awareness of services.** After establishing new ways of working, Modality Partnership needed to let women know about the changes. They used text messaging to contact women of reproductive age on GP lists and advertised the new services

### Lessons learned

- **Good local relationships are key.** One of the main reasons that the Modality Partnership was able to redesign services was because the local hospital was unable to meet demand. This forced them to re-evaluate how they ran their gynaecology service.
- **Patient centred planning is essential.** When redesigning services, leaders at Modality Partnership recommend starting by asking whether women are happy with existing services. They recommend identifying needs; e.g., women want to be seen (a) soon, (b) locally and (c) in a place with parking. Anonymity is often important for women. If services are integrated, anonymity can be ensured by letting patients approach practices other than the one they live closest to.
- **Get the practical things right.** Look at the whole patient pathway and how it can be simplified. Often very simple changes can make a difference. Ensuring services can be effectively and practically redesigned depends on trusted relationships between NHS organisations.



## Case study 2: Extending access to sexual and reproductive health services

### Name

Royal Borough of Greenwich

### Type of model

A consultant-led community SRH service providing open access, integrated sexual and reproductive health care to people of all ages. Community gynaecology is provided in the main clinical hub at Market Street, with satellite clinics throughout the borough.

### Overview of activity

Most London Boroughs were part of the London Sexual Health Services Transformation project in 2017, which aims to deliver a collaborative sexual health commissioning model. Service reconfiguration led by an SRH Consultant in the Royal Borough of Greenwich has created a one-stop-shop model of service, so that patients can access basic and specialist SRH services on site and close to home. By effective reorganisation, Greenwich has shifted from over-reliance on expensive secondary care to highly effective community-based services. The savings delivered can be reinvested into community-based services to improve overall access to sexual and reproductive care for the local population.

### Need identified

The borough faces significant challenges in relation to the health of the local population, linked to high levels of deprivation amongst significant proportions of the population, especially in the north of the borough. Women in Greenwich were struggling to access SRH services or gynaecology at the right place at the right time, with an inconvenient and expensive care pathway based on in-hospital care. Fragmented commissioning arrangements meant that services were working in silos.

### Actions taken

Greenwich has worked to deliver a collaborative model by:

- **Creating a one-stop-shop model of care.** Bringing together commissioners, providers and the local authority to devise a community-based model, extending access to SRH and gynaecology services in the community, away from the hospital setting.
- **Implementing an integrated pathway.** This was split into separately contracted services – self-managed care via digital access (GSH), community service and hospital genitourinary medicine (a specialist sexual health clinic, by referral only).
- **Increasing capacity in community settings.** The services have developed an effective interface with GPs as well as achieving a reduction in hospital-based genitourinary medicine activity to approximately 75%, by making it easier for patients to access a wider range of sexual and reproductive healthcare in the community.

- **Digital self-managed care via online access to improve accessibility.** Patients can access information on services, order home STI kits and watch videos providing information on symptoms.

### Lessons learned

- **Fostering collaboration with other healthcare professionals is crucial.** Working across community care settings can help to prevent unnecessary hospital admissions, increase overall capacity and access and provide an effective interface with local GPs. However, an integrated pathway needs good local relationships, which take time to build.
- **A less fragmented pathway is efficient for services and better for patients.** By implementing a new integrated pathway, Greenwich has created a less fragmented and more convenient care pathway for women. For example, if a woman has been referred to the service for heavy menstrual bleeding, the service can provide an ultrasound, consultation and insertion of an IUS. By contrast, the same woman referred to secondary care may need three appointments, resulting in costs in transport and time off work. These pathways for patients are crucial but require smooth links to local hospitals.
- **Don't be afraid to be a trailblazer.** The model in Greenwich has been at the forefront of innovation in SRH services. Their digitally-enabled service was the first of its kind. It has now been rolled out and adopted by different providers across the whole of London.

## Case study 3: A population health approach to system planning and development

### Name

Tower Hamlets Together

### Type of model

Tower Hamlets Together was one of NHS England's Multi-speciality Community Provider (MCP) Vanguard sites. The vanguard programme finished in 2018. Since then, the work has been absorbed by a partnership of local health and social care organisations. Tower Hamlets is split into four localities, each with two mature GP networks (established 2009-2010), with each network serving a population of around 30 to 50,000 patients.

### Overview of activity

Tower Hamlets Together has taken a population health approach to system planning, segmenting their local population across the life-course. With the unique advantage of joined-up local datasets, they identified female reproductive health as a priority area and launched a quality improvement programme to improve reproductive health in the borough.

### Need identified

Using datasets, Tower Hamlets Together was able to match hospital activity data to GP records and identify areas of high outpatient and inpatient spend per head. This highlighted significant cost arising from female reproductive healthcare and a huge discrepancy in IUD fitting rates across GP practices in the area.

### Actions taken

Tower Hamlets Together established workstreams – Born Well, Growing Well, Living Well, and Promoting Independence, which segment the local community across the life-course. Under the Living Well workstream, Tower Hamlets Together has improved services by:

- **Implementing a life-course approach to improve reproductive health.** The partners focus on pre-conception, conception, contraception (including access to LARC), psychosexual services and community gynaecology.
- **Launching a quality improvement programme.** Tower Hamlets Together uses the Institute for Healthcare Improvement's Triple Aim measurement of improving population health, improving patient satisfaction and decreasing cost. This included, for example, setting up a LARC fitting clinic in a pharmacy with unusually high levels of emergency contraceptive use.
- **Aspiring to care that is patient-centred.** The partners seek to put the patient at the centre of the service, rather than it being transactional and/or condition-focussed. For example, innovative services have been developed for women and men who have experienced sexual violence.

### Lessons learned

- **Data is important.** Tower Hamlets have identified that there is more to do around system data. They are keen to develop data flows needed to support the use of the 'small tests of change' quality improvement methodology as well as effective methods to capture and use women's perspectives to shape service development.
- **Don't underestimate the emotional impact of fragmented commissioning.** Local leaders knew that their commissioning was fragmented. What became clear was that this translates into a fragmented and often poor value offer for women, especially in understanding and supporting their emotional journeys through their reproductive health issues.
- **Engagement is an evolving process.** So far, the partners have engaged public health and CCG commissioners, general practice and networks as well as community women's health including abortion care services and genitourinary medicine. Hospital-based gynaecology is not yet engaged, and there is still more work to do.

## Case study 4: Bridging the gap between primary and secondary care

### Name

Manchester Community Gynaecology Service

### Type of model

The Manchester Community Gynaecology model is a consultant-led community-based gynaecology service. The service was set up in 2006 and led by a General Practitioner with a Special Interest (GPwSI). In 2008, it became a Consultant-led service. This has enabled robust clinical governance with a doubling of attendances and expansion of range of services provided. It is commissioned by CCG commissioners and provided by Manchester's Sexual and Reproductive Health Service.

### Overview of activity

The Manchester Community Gynaecology service was set up to provide an intermediate level of gynaecological care closer to home. The service sees over 1,400 attendances annually within four to six weeks of referral. The aim of the service is to provide investigation and treatment at the first visit which has enabled a New to Follow Up ratio of >2:1. Careful triaging means that the secondary care referral rates are less than 10%.

### Need identified

Patients had expressed a preference for services closer to home in a community setting. Pressures on secondary waiting lists were also a driver for this change.

### Actions taken

Manchester has set up community-based medical gynaecology services providing convenient access and safe services for women, by:

- **Being consultant-led.** Providing a consultant led service has enabled an expansion of the range of services and delivery by a multidisciplinary team. This has also ensured that robust governance and training are in place.
- **Ensuring women are directed to the most appropriate service.** Access to the service is via GP referral. All referrals are triaged to ensure the clinic only sees women with conditions that can be safely managed in the community. As a result, the service's secondary care referral rates are under 10% and patient satisfaction is consistently high.
- **Bridging the gap between primary and secondary care.** Close links and two-way communication between GPs and consultants have reduced the need for patients to travel to repeat appointments. There are also robust pathways into secondary and tertiary care.

- **Implementing patient-initiated follow up.** On completion of treatment, patients are advised to initiate follow up if the symptoms are not resolved in 3 months. They are able to call directly rather than wait for a new referral. This has streamlined the process, reduced the follow up ratio dramatically and works well for GPs. This follow up is also available via telephone consultation, which further frees up capacity.
- **Investigations and treatment at single visit.** Most patients can be managed at a single visit with the facility of onsite ultrasound scanning.

### Lessons learned

- **Collaboration is crucial.** The strong relationship between the service and their CCG commissioners has developed an excellent service. The service is monitored regularly against KPIs set out in the service specification. A collaborative, flexible approach means innovation is promoted and service developments implemented quickly.
- **Relationship with GPs.** Building this relationship has helped the service to run smoothly and effectively. Two way communication has enabled GPs to develop a good understanding of what the service provides and also supports them to develop their skills in primary care. Telephone and email advice service to GPs has been made available.
- **Keeping a patient-centred approach.** This has enabled delivery of a service with excellent levels of patient satisfaction and very low level of complaints. A popular example is 'patient initiated follow up' where the patient is advised to initiate follow up if the symptoms are not resolved in three months. Patients appreciate the easy access, shorter waiting times and minimum visits.
- **Multidisciplinary team working.** Having the right skill mix, empowering all staff to develop and fostering a sense of ownership through close team working has been crucial. Staff feel valued and take pride in the service which is reflected in the quality of care provided and excellent patient experience.

## Recommendations for commissioners and providers of SRH services

1. **All areas should consider the potential to embed SRH services in new models of care.** Local and national leaders need to recognise the opportunities to embed SRH services in new models of care as they work together through ICSs and PCNs.
2. **Start with a needs assessment of the local population.** This should include asking whether patients are happy with services and how they can be improved.
3. **Join up local datasets where feasible.** This will enable all parties to develop a shared understanding of local needs, trends in accessing services, spend on SRH and patient outcomes.
4. **Take a life-course approach.** Consider all the elements of SRH that patients will need from education to pre-conception, conception, contraception, community gynaecology and psychosexual services.
5. **Co-create a vision for what local SRH services will look like and deliver.** This should be based on the local needs assessment, be agreed by all local commissioners and providers and informed by patients.
6. **Consider the potential for one-stop-shop models of care.** Evidence suggests that more services can be effectively delivered in community settings, freeing up capacity for complex care and reducing multiple appointments for patients.
7. **Make it as easy as possible for patients to get appointments.** Provide direct phone line or email booking options for patients and centralise diary and booking systems.
8. **Examine whether digital technologies can enable more services to be provided online.** These might include, for example, information provision, service booking and STI-testing kit ordering. However, some patients will prefer – and need – written information or access to advice via telephone or face-to-face. Online services are a complement, not a substitute, to face-to-face consultations and best practice and guidelines must be adhered to at every user contact to ensure safety and quality of care.
9. **Collect and report outcomes.** It is essential that commissioners and providers are able to determine what impact the changes are having on patient outcomes, patient experience and financial efficiency.
10. **Keep engaging with local partners.** Trusted relationships will not develop overnight, so continued engagement is needed to co-create the vision, determine the plan of action, course-correct where needed and share success.
11. **SRH services must be delivered in accordance with nationally recognised standards in SRH.** This requires mainstreaming standards of care at the local level. FSRH's Service Standards on Sexual and Reproductive Health<sup>9</sup> have been developed specifically to support providers and commissioners in providing safe, high-quality SRH services, ensuring patient safety.
12. **Ensure a multi-disciplinary team with the right skill-mix is supported by a SRH Consultant.** A SRH consultant-led service enables the provision of a range of services delivered by a multidisciplinary team. A consultant-led service also ensures robust governance and staff training are in place.



## Additional reading

The following sources are relevant to discussions around new models of care:

- Bayer, *Improved practice for women's reproductive health – local progress case studies*, 2019
- Bayer, [Bayer Women's Health. Collaborative commissioning to provide an integrated women's reproductive health service](#), 2019 (interactive online toolkit)
- Faculty of Sexual and Reproductive Healthcare, [Better care, a better future: a new vision for sexual and reproductive health care in the UK](#), 2015
- Faculty of Sexual and Reproductive Healthcare, [Do sexual and reproductive health services feature in new models of care? Findings from an audit](#), 2018
- Faculty of Sexual and Reproductive Healthcare, [Service Standards for Sexual and Reproductive Healthcare](#), 2016
- Faculty of Sexual and Reproductive Healthcare & British Association for Sexual Health and HIV, [Standards for Online and Remote Providers of Sexual and Reproductive Health Services](#), 2019
- Department of Health, [High quality care for all: NHS next stage review final report](#), 2008
- Health Foundation, [Some assembly required: implementing new models of care](#), 2017
- Local Government Association, [Collaboration and cooperation: Sexual and reproductive health commissioning in local government](#), July 2019
- National Audit Office, [Developing new care models through NHS vanguards](#), 2018
- NHS England, [NHS Long Term Plan](#), 2019
- NHS England, [NHS Long Term Plan Implementation Framework](#), 2019
- NHS England, [Integrated Care Systems](#), 2018
- NHS England, [The NHS Five Year Forward View](#), 2014
- NHS Providers, [New care models: harnessing technology](#), 2017
- Public Health England, [Contraceptive services: estimating the return on investment](#), 2018
- Public Health England, [Commissioning local HIV sexual and reproductive health services: tools and resources for commissioners to help plan and commission regional and local services](#), last updated 2018
- Public Health England, [Sexual and Reproductive Health Profiles: Total prescribed LARC excluding injections rate per 1000](#), 2017
- Public Health England, [Sexual health, reproductive health and HIV: a review of commissioning](#), 2017

You can also find more on our [dedicated page for commissioning and policy resources](#) on the FSRH website<sup>10</sup>.



## Get in touch

The FSRH is keen to partner with national and local policymakers, commissioners and providers to consider how SRH services could be better incorporated into new models of care going forward.

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## References

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<sup>1</sup> NHS England (2019), *NHS Long Term Plan*, available at: <https://www.england.nhs.uk/long-term-plan/>

<sup>2</sup> Faculty of Sexual and Reproductive Health (2018), *Do sexual and reproductive health services feature in new models of care? Findings from an audit*, available at: <https://www.fsrh.org/documents/briefing-audit-sexual-reproductive-healthcare-new-models-care/>

<sup>3</sup> The British Medical Journal (2018), *NHS outpatient model is no longer fit for purpose, says RCP*, available at: <https://www.bmj.com/content/363/bmj.k4759>

<sup>4</sup> National Audit Office (2018), *Developing new care models through NHS vanguards*, available at: <https://www.nao.org.uk/wp-content/uploads/2018/06/Developing-new-care-models-through-NHS-Vanguards.pdf>

<sup>5</sup> Department of Health (2008), *High quality care for all: NHS next stage review final report*, available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/228836/7432.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf)

<sup>6</sup> NHS England (2018), *Integrated care systems*, available at: <https://www.england.nhs.uk/integratedcare/integrated-care-systems/>

<sup>7</sup> NHS England (2019), *Primary Care Networks*, available at: <https://www.england.nhs.uk/gp/gp/v/primary-care-networks/>

<sup>8</sup> Faculty of Sexual and Reproductive Health (2018), *Do sexual and reproductive health services feature in new models of care? Findings from an audit*, available at: <https://www.fsrh.org/documents/briefing-audit-sexual-reproductive-healthcare-new-models-care/>

<sup>9</sup> Faculty of Sexual and Reproductive Healthcare (2016), *Service Standards for Sexual and Reproductive Healthcare*, available at: <https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-sexual-and-reproductive-healthcare/>

<sup>10</sup> Faculty of Sexual and Reproductive Healthcare, *Information for Commissioners and Policymakers*, available at: <https://www.fsrh.org/policy-and-media/information-for-commissioners-and-policymakers/>

This report is available online at: <https://www.fsrh.org/documents/fsrh-report-2019-new-models-of-care-sexual-reproductive-health/>