



All-Party Parliamentary Pro-Choice and Sexual Health Group

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Campaigning to raise awareness in parliament of the needs of women seeking abortion and the importance of improving all aspects of the sexual health of women and men in the UK.

A REPORT INTO THE DELIVERY OF SEXUAL HEALTH SERVICES IN GENERAL PRACTICE

A SURVEY BY THE ALL-PARTY PARLIAMENTARY PRO-CHOICE AND SEXUAL HEALTH GROUP

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INTRODUCTION

The purpose of the All-Party Parliamentary Pro-Choice and Sexual Health Group (APPG) is to raise awareness in Parliament of the needs of women seeking abortion and the importance of improving all aspects of the sexual health of women and men in the UK. The Group was formed in 2003, when the All-Party Parliamentary Pro-Choice Group expanded its remit following the publication of the National Strategy for Sexual Health and HIV.

Sexual health is one of the six key priorities for the NHS for 2007-8, an indication to PCTs that this issue remains important to the Government. Sexual health has been a stated priority for the NHS for several years and significant progress has been made in improving access to STI services, as well as reducing rates of under-18 conceptions. However, the APPG has consistently raised concerns that PCTs are interpreting the target to provide access to GUM services within 48 hours very narrowly and that joined up sexual health services are not being provided.

Sexual health is provided in many settings within a Primary Care Trust (PCT). Walk-in centres, community contraceptive (family planning) services, sexual health services, via school nurses and pharmacies, and general practices.

Approximately 80% of women in the UK obtain contraception from a general practice¹. It tends to be the first port of call for patients and as such is a key source of information and treatment. In addition, community contraceptive services have been reduced in recent years. Given the high volume of people who seek to obtain sexual health services from general practice, the APPG was keen to find out how this service was being provided and how PCTs were approaching this aspect of their services.

The APPG surveyed PCTs in March 2007 to discover what sexual health services were provided by general practices within their trusts.

¹ House of Commons Health Committee, Third Report of Session 2002-03, *Sexual Health*, 2003

SURVEY RESPONSES

The APPG posted the survey to all 152 PCT Chief Executives in March 2007. 122 PCTs (80%) responded to the APPG survey between March and June 2007. After the original timeframe of a month had passed, the survey was emailed to sexual health leads who had not responded. Despite the extended time given, many officials reported difficulties in obtaining the information within the survey, citing disruption due to re-organisation; staff turnover; and problems with data that was not compatible with the current geographic area covered by the PCT.

The survey was completed by a wide variety of health professionals working for the PCT – examples included: Sexual Health Promotion Manager; Public Health Consultant; Primary Care Programme Manager; Public Health Nurse; Teenage Pregnancy and Sexual Health Manager; Deputy Directors of Public Health; Health Promotion Strategy Manager; and other staff members completed the survey on behalf of the PCT.

The survey asked the following questions and the breakdown of findings is below.

1) How many general practices are in your Primary Care Trust?

The APPG asked this question to discover how widespread general practice provision of sexual health services was within PCTs. As the results below outline general practice provision varied in different areas.

CONTRACEPTION

2) How many of these general practices provide contraception as an additional service?

The APPG asked PCTs how many of the general practices within their trust provided contraception as an additional service. According to the responses received, 91% of general practices provide contraception as an additional service.

3) Have you completed an assessment of prescribing patterns for contraceptive services from general practice using prescribing data?

The APPG specifically asked PCTs about their provision of Long Acting Reversible Methods of Contraception (LARC), rather than all methods of contraception. LARC do not rely upon the user in order to work effectively, and as such are highly successful methods of contraception.

The National Institute of Health and Clinical Excellence (NICE) published guidance in 2005 which recommended that women requiring contraception should be given information about and offered a choice of all methods, including LARC. NICE also stated that contraceptive service providers should be aware that:

- all currently available LARC methods (intrauterine devices, the intrauterine system, injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use
- intrauterine devices, the intrauterine system and implants are more cost effective than the injectable contraceptives

- increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies.

(Long Acting Reversible Contraception : Nice Guideline, October 2005)

47% of PCTs reported that they had not completed an assessment of prescribing patterns for contraceptive services from general practice using prescribing data. Whether LARC are provided by general practices in those PCTs is simply “unknown”.

THE FOLLOWING STATISTICS ARE BASED ON THE RESPONSES FROM THE 53% OF PCTS WHICH HAD ANALYSED THE PRESCRIBING DATA.

4) How many general practices currently provide IUDs / IUSs?

An Intrauterine Device (IUD) is a small plastic and copper device that is placed in a woman’s womb. This method was previously known as a ‘coil’, and depending on the type of IUD, can stay in place and effectively prevent pregnancy for between three and ten years. An Intrauterine System (IUS) is a similar T-shaped plastic device, which additionally releases a progestogen hormone and which can stay in place for up to five years.

Both methods are over 99% effective in preventing pregnancy. IUDs / IUSs may only be fitted by a trained medical practitioner, and these practitioners must fit a certain number each year in order to maintain their skills and continue to provide this service.

According to responses of those PCTs which have analysed prescribing data, **65.7%** of general practices within these PCTs provide IUDs / IUSs – just under two-thirds.

5) How many general practices currently provide contraceptive implants?

A contraceptive implant is a small flexible rod that is placed just under the skin in a woman’s upper arm. It releases a progestogen hormone similar to the natural progesterone that women produce in their ovaries. The implant is over 99% effective and works for up to three years. Only a doctor or nurse who has been trained to fit the implant may insert one, and they must also maintain their skill by fitting a certain number of implants each year to remain qualified.

According to responses of those PCTs which have analysed prescribing data, **30.5%** of general practices within these PCTs provide Implants. This means that many women will not be able to access the full range of contraception if they attend one of the **69.5%** of general practices which do not provide this service.

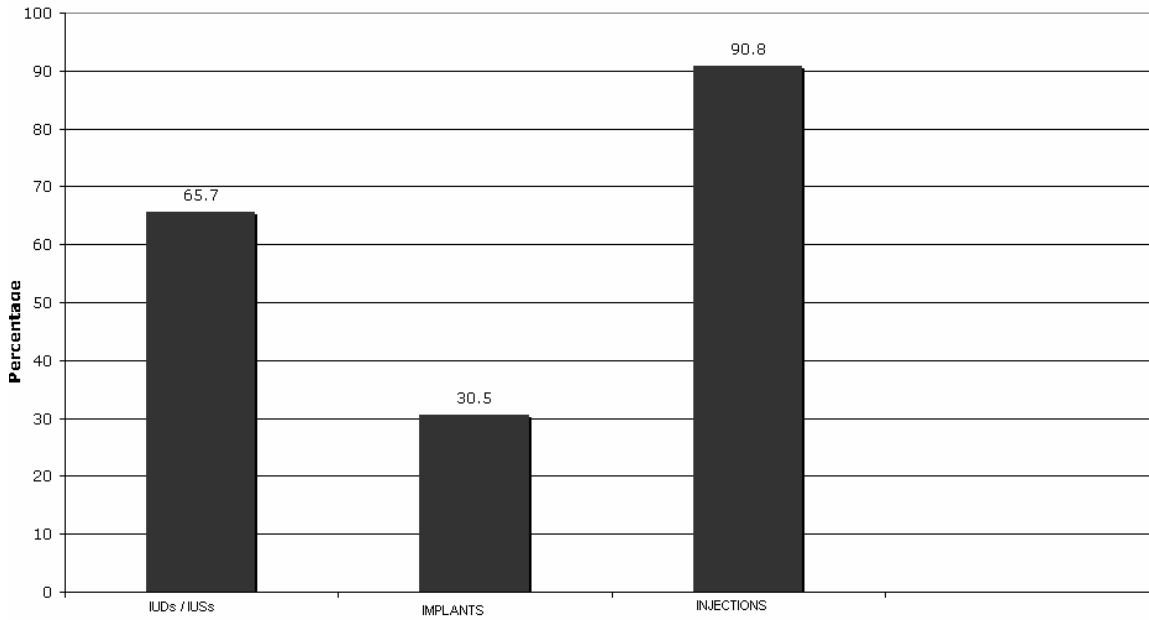
6) How many general practices currently provide contraceptive injections?

There are two types of contraceptive injection available in the UK. The most commonly used injection, Depo-provera, protects a woman from pregnancy for 12 weeks. Another injection, Noristerat, is effective for 8 weeks. Both use a progestogen hormone as the contraceptive, and are over 99% effective.

The APPG found that contraceptive injections are widely offered by General Practice. Within PCTs where prescribing data had been assessed, 90.8% of general practices offer this method of contraception. Other PCTs, which had not assessed the data, also

stated that the contraceptive injection was offered by the majority of their general practices.

Breakdown of Assessed GP Provision of LARC Methods



SEXUALLY TRANSMITTED INFECTIONS

7) Do you have a locally enhanced service (LES) with general practice to provide diagnosis and treatment of sexually transmitted infections?

8) If so - how many general practices are providing it?

Enhanced services are services that the PCT has decided to commission from general practice in accordance with a specification which has been developed by the PCT. Therefore, sexual health as an advanced service may vary from PCT to PCT

Their main purposes are to expand the range of local services to meet local need; improve convenience and choice; and ensure value for money. They were designed to provide a major opportunity to expand and develop primary care, and give practices greater flexibility and the ability to control their workload. These are locally developed services designed to meet local health needs². The APPG was keen to learn what proportion of PCTs offered this service for sexually transmitted infections.

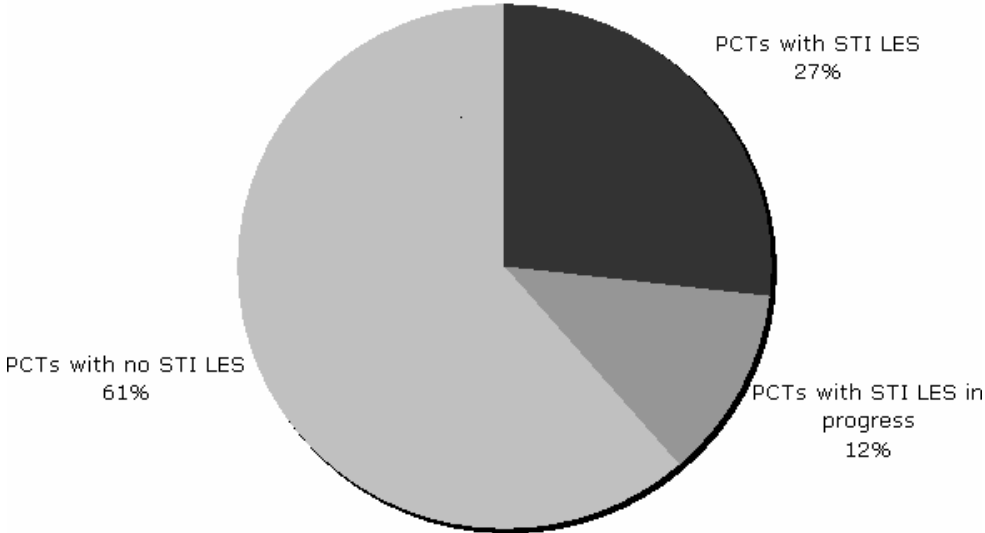
Only 33 of the 122 PCTs (**27%**) which responded to the survey provide a locally enhanced service for STIs.

This percentage hides the relatively low number of general practices involved in providing these enhanced services. In many cases, only one or two General Practices within the PCT provide a locally enhanced service to their communities. There are 334 general practices which are providing this service, out of 1,939 possible general practices represented by the participating PCTs. In a London PCT 44 out of 48 general practices provide such a service. In contrast, in a PCT in Buckinghamshire only one out of 28 general practices offers the service. There is a wide disparity in availability of this service at local and regional level.

Although it was not an option on the survey question, 14 PCTs which do not currently have a locally enhanced STI service stated that they were developing this service. An example of one of the PCT Locally Enhanced Services is included in the appendix.

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PCTs - STI LES



ABORTION

9) What percentage of conceptions end in abortion in your Primary Care Trust area? (According to most recent ONS data)

This question caused the most difficulty for PCTs, and the data received was insufficient for analysis. Because of the priority attached to reducing under-18 conceptions with the Teenage Pregnancy Strategy and the resulting measurement of rates through PCT Local Delivery Plans, all PCTs were aware of the under-18s conception data within their locality. However, this survey asked for the percentage of conceptions which end in abortion for all women. Many PCTs struggled to get the data, as they had not previously used it, while several others could only give an estimate.

Because of the scant figures that were provided, it is not possible to draw any conclusions. What is more concerning is that PCTs do not seem to be accessing or assessing this information – which is available from the ONS - outside the context of reducing rates of teenage pregnancy.

The APPG endorses the evidence that to become a parent before the age of 18 will severely affect the life chances of both the parent and the child, and it supports the work of the Teenage Pregnancy Unit in their work to reduce the teenage conception rate. Abortion data for 2006 showed that women within the 20-24 age group had the highest rates of abortion, and the rate for women aged 25-29 was also high. Across England, the percentage of conceptions which end in abortion ranges from 38.2% to 15.6% (2004 figures). Much more needs to be done to reduce unintended pregnancies for women of all ages, by improving provision of contraception as well as education about fertility and sexual health for both women and men.

The APPG is concerned that abortion services (placed within the acute sector) and contraceptive services (situated within primary care) do not seem to link up strategically or economically. This could mean that there is a lack of knowledge about the demands upon contraceptive services, and that PCTs are not using all the available data to assess gaps in services. If budgets were more closely linked, there might be more progress in improving contraceptive services.

Ultimately, women are bearing the brunt for this lack of planning. More needs to be done to ensure that fewer women are faced with an unintended pregnancy.

Improving sexual health services will have a huge benefit for the women and men accessing these services, in both the short and long term. It is also more cost-effective for the NHS, helping to prevent both unintended pregnancies and sexually transmitted infections³.

³ Armstrong, N. and Donaldson, C., The Economics of Sexual Health, fpa, 2005

SUMMARY

In assessing this data, we also need to look at how health professionals are enabled to provide sexual health services. Training in the fitting of implants and intrauterine devices / systems is provided by community contraceptive (family planning) clinics. Recent surveys by the Faculty of Sexual and Reproductive Healthcare (formerly the Faculty of Family Planning and Reproductive Healthcare) show that these services have been reduced by PCTs due to financial constraints.

What will also be lost are the specialist knowledge and the capacity to train doctors and nurses within general practice who will be attempting to fill this gap. The APPG is extremely concerned that women, as a consequence, will not benefit from a full range of contraceptive service provision; this means that they may not be offered the best method for their personal circumstances, and the risk of method failure and unintended pregnancy is increased.

Similarly with the detection and treatment of STIs by general practice, more encouragement and resources should be provided to help those practices which would like to offer this enhanced service. The APPG understands the Quality and Outcomes Framework (QOF) is currently under negotiation and hopes that the findings of this survey help to demonstrate that more must be done to promote sexual health care at general practice level.

Greater efforts are needed to ensure that sexual health care may be effectively provided in the community by general practice. Enhanced services for sexual health are by no means a 'ticked box'.

KEY FINDINGS AND RECOMMENDATIONS

Finding: Lack of assessment by almost half of surveyed PCTs about what long acting contraceptive methods are being provided by General Practices.

The All-Party Parliamentary Pro-Choice and Sexual Health Group recommends that all PCTs should undertake regular audits of the provision of all methods of contraception, taking into account NICE guidelines and DH recommendations.

Finding: LARC provision is patchy. Contraceptive implants in particular are only available from a minority of general practices, and as assessment has not been carried out by all PCTs, it would also appear that IUDs and IUSs are not universally available from general practice. Despite the NICE guidance and DH recommendations, women do not tend to be provided with the full range of information and contraception.

The All-Party Parliamentary Pro-Choice and Sexual Health Group recommends that a contraceptive consultation must include information on all current methods available, and PCTs must ensure that there is an adequate number of general practices providing these methods.

Finding: Provision of an enhanced service for the detection and treatment of STIs has so far been taken up by a minority of PCTs. Only a small percentage (5%) of general practices in England are delivering this service.

The All-Party Parliamentary Pro-Choice and Sexual Health Group recommends that a greater incentive than is currently offered is given to PCTs to provide this service. A greater number of QOF points should be offered for sexual health services, including contraception, STIs and abortion referral.

Finding: The percentage of conceptions ending in abortions has not generally been scrutinised by PCTs, except for the Under-18 figures.

The All-Party Parliamentary Pro-Choice and Sexual Health Group recommends that PCTs should use all evidence available to them in as they work towards improving sexual health of all people and reducing unintended pregnancy for all women. Furthermore, budgets for abortion and contraceptive services should be linked to ensure communication and strategic planning, in order to reduce unintended pregnancies and repeat abortions.

APPENDIX 1 –

EXAMPLE OF LOCALLY ENHANCED SERVICE FOR SEXUAL HEALTH (anonymised)

Local Enhanced Service for Primary Care Sexual Health Clinics

Service Level Agreement

Contents:

1. Finance Details
2. Signature Sheet
3. Service Aims
4. Criteria
5. Accreditation
6. Ongoing Measurement & Evaluation

Financial Details

This agreement is to cover the 15 months commencing 1 January 2006.

On agreeing a service plan with the PCT for the 15 months commencing 1 January 2006 practices will receive:-

In 2005/06 each practice contracted to provide this service will receive a rate of payment as detailed below:

2 Hour stand alone clinic – £272.36/clinic

Appointment based service – 20 minute appointment - £45.40/appointment

These payments will be reviewed on an annual basis and will be subject to recommended inflationary increases in future years as appropriate.

PAYMENT WILL ONLY BE MADE UPON RECEIPT OF PRACTICE SIGNATURE SHEET

Signature Sheet

This document constitutes the agreement between the practice and the PCT in regards to this local enhanced service.

Signature on behalf of the Practice:

| Signature | Name | Date |
|-----------|------|------|
| | | |

Signature on behalf of the PCT:

| Signature | Name | Date |
|-----------|------|------|
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Service Aims

The importance of primary care in a sexual health strategy is demonstrated by the facts that:

- (i) about 75-80 per cent of contraception is provided in primary care
- (ii) more than a third of women found to have chlamydia (the most common bacterial STI in the UK) were diagnosed in primary care
- (iii) primary care is highly accessible to all people including young women, and primary care is well accessed by many who may be at risk of HIV.

Service delivery should be informed by relevant national strategies, such as (in England) the Social Exclusion Unit Teenage Pregnancy Report (June 1999), the *Best Practice Guidance on the Provision of Effective Contraception and Advice Services for Young People*, published as part of the Teenage Pregnancy Strategy in 2000, and the National Strategy for Sexual Health and HIV (July 2001) and the Strategy Implementation Action Plan (June 2002).

Each PCT should consult with all relevant stakeholders, to determine the service models and standards of care appropriate to its local population with respect to minimum standards of prescribing (formulation, dose, drugs of limited value etc), attendance and follow-up rates, hepatitis B testing and immunisation rates, partner notification etc. Care pathways should be agreed with stakeholders, and all should be made aware of these pathways. The pathways should include guidance with respect to other relevant services. These should be used as part of the audit and monitoring criteria for the national enhanced service.

Criteria

The Local Enhanced Service Specification details the following criteria.

The following pages contain some further guidance from the PCT on expected processes, outcomes and deliverables based on this process. On aspiring to this service practices are required to submit plans under each of these items to the PCT.

1. Direct Service Delivery
2. Data Collection
3. Staffing
4. Liaison/Shared Care
5. Review/Audit

Criteria One : Direct Service Delivery

Details

- Undertake a comprehensive sexual health assessment with a holistic approach to assessment of risk of STI, HIV and/or unplanned pregnancy, including consideration of other relevant health problems such as drug misuse or mental health problems
- a service for HIV testing, including pre and post test counselling.
- screening and treatment for Chlamydia and Genital Warts using the most reliable testing methods available
- treatment of Chlamydia and Genital Warts without prescription charge
- effective communication with all potential patients of the service particularly the following; young people including young men, gay and lesbian people, and ethnic minorities
- the provision of information on, testing and treatment for all STIs (excluding in the case of testing and treatment HIV infection, syphilis, Hepatitis B and C or treatment-resistant infections)
- the assurance of partner notification of relevant infections by adherence to agreed guidance
- fitting, monitoring, checking and removal of IUCDs as specified within the NES for IUCD
- fitting, monitoring, checking and removal of Implanon as specified within the LES for Contraceptive Implants.

Practice Plans for Year 05/06

(please detail below your practice's plans for this criteria)

Practice Evaluation at end of Year / results

(at the end of the year please detail below the practice's results for this criteria)

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| Criteria Two: Data Collection |
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| Details <ul style="list-style-type: none">• records kept on the advice, counselling and treatment received by patients. It is the clinician's responsibility in conjunction with the patient to agree what to enter in the lifelong patient notes• a register of all patients being treated under the enhanced service |
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| <i>Practice Plans for Year 05/06</i> <i>(please detail below your practice's plans for this criteria)</i> |
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| <i>Practice Evaluation at end of Year / results</i> <i>(at the end of the year please detail below the practice's results for this criteria)</i> |
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| Criteria Three: Staffing |
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Details

- Training programmes to be developed for GPs and GP registrars, practice nurses and other relevant staff (such as health advisors)
- Additional training and continuing professional development for clinicians commensurate with the level of service provision expected of a clinician in line with any national or local guidance to meet the requirements of revalidation
- Suitable training for all staff involved with patients seen for sexual health and HIV-related conditions
- Accreditation - Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

Practice Plans for Year 05/06

(please detail below your practice's plans for this criteria)

Practice Evaluation at end of Year / results

(at the end of the year please detail below the practice's results for this criteria)

Criteria Four : Liaison/Shared Care

Details

- the practice to act as a resource to colleagues in sexual health care in primary care
- effective liaison with local sexual health services and cytology and microbiology laboratory support and other statutory or non-statutory services where relevant (such as young people's services)
- a sound understanding of the role of different professional groups in the shared care of HIV positive patients, and those at risk of HIV

Practice Plans for Year 05/06

(please detail below your practice's plans for this criteria)

Practice Evaluation at end of Year / results

(at the end of the year please detail below the practice's results for this criteria)

Criteria Five : Review/Audit

Details

All practices undertaking this service will be subject to an annual review which could include an audit of:

- the number of patients seen for specific interventions.
- the number of people screened and treated effectively
- attendance rates for each service offered
- gestation at abortion and follow-up contraception rates
- the number of at-risk individuals tested and immunised according to local guidance for blood-borne viruses
- age, gender, sexuality and ethnicity of patients to ensure that those most at risk from unplanned pregnancy and poor sexual health are accessing the practice.

Practice Plans for Year 05/06

(please detail below your practice's plans for this criteria)

Practice Evaluation at end of Year / results

(at the end of the year please detail below the practice's results for this criteria)

Accreditation

Those health care professionals who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

Ongoing Measurement & Evaluation

The ongoing measurement is outlined in the various criteria in the previous section.

In addition the practice is required to agree with the PCT this service specification/plan at the start of the year and to submit the completed document at the end of the year for evaluation purpos