APPG for Sexual and Reproductive Health: Access to Contraception in England Inquiry – March 2019

Marie Stopes UK response

Marie Stopes UK is an independent provider of abortion care services throughout England, providing quality abortion care with post-abortion contraception services to more than 67,000 people, and vasectomy services to over 5,000 people every year. Our services in England are commissioned by Clinical Commissioning Groups (CCGs) to provide NHS abortion care and vasectomy services, and we also provide vasectomy and abortion care privately for those who are not eligible for funded treatment.

Marie Stopes UK provides abortion care and post-abortion contraception in 50 locations. We also offer vasectomy services at centres across England. We operate a 24-hour contact centre, One Call, where clients can make enquiries, book consultations, appointments and counselling, and speak to a nurse for aftercare advice.

Marie Stopes UK is a country programme within the global charity, Marie Stopes International. Our 36 sister country programmes around the world provide life-saving sexual and reproductive health (SRH) services in some of the world's poorest and hard-to-reach communities. Some operate in restricted environments and see first-hand the impact of lack of contraception provision and unsafe abortion, when women are forced to take matters into their own hands because healthcare providers cannot offer comprehensive, safe, legal services.

This submission will primarily focus on six points of the APPG's areas of interest:

- The extent to which the funding and commissioning of contraceptive services in England meets population need.
- The extent to which people can easily access the full range of contraceptive methods in a way that takes account of their holistic sexual and reproductive health needs.
- The extent to which people can access contraception, in a variety of settings and circumstances (including for post-pregnancy contraception in abortion services).
- Evidence relating to the quality of data for measuring; contraceptive outcomes, access to and uptake of different methods of contraception in a range of settings and staff skills, and how this could be improved.
- Examples of good practice, in all settings, which are improving or facilitating access to contraception.
- Recommendations for work which could be taken by bodies to improve access and standards of care and reduce variations.

We share the concerns of the APPG, that since 2013, fragmented and variable commissioning of SRH services, paired with cuts to local authority budgets, are making it increasingly difficult for individuals to access the full range of contraceptive methods, including emergency contraception, in a timely manner and in a way that suits their individual SRH needs.

We have spoken with team members from across Marie Stopes UK, from contraception and sexual health specialists, to commissioning and contracts specialists, to ask their views and experiences of the increasing difficulties our clients may face in accessing a full range of contraception both before they become in need of our abortion care services, and after they have left our care pathway.

Providing post-abortion contraception through CCG commissioning

Choice is fundamental to everything that we do and we respect the right of every person to decide whether and when to have children. It is vital that people have access to the full-range of contraception to be able to control their futures.

As abortion is classed as a clinical service, we are commissioned by CCGs as an independent abortion care provider, unlike contraceptive services which are commissioned by local authorities. As part of the abortion care pathway, we deliver most contraceptive methods post-abortion, including all long-acting reversible contraception (LARC). However, not all our contracts allow us to provide the contraceptive patch and Nuva Ring on behalf of the NHS. The variation in CCG contract does impact on what we can sustainably provide. We found that some clinical commissioning does not adequately fund contraception as an integral part of post-abortion care. Indeed, several years ago, we took a stance against continuing an abortion care contract which did not include post-abortion contraception. We feel that post-abortion contraception is a crucial service to allow our clients to try a contraceptive method that may better suit their bodies and lifestyles than the methods they had been using before accessing abortion care.

The abortion care option that our clients are eligible to proceed with does impact the type of contraceptive methods that we can provide on the day of her abortion treatment appointment. A client having surgical abortion treatment can, if they choose, have inter-uterine contraception (IUC) fitted at the time of their procedure. They also may have the option of other LARC methods, such as the sub-dermal implant, which can be fitted by a trained clinician during their consultation before their treatment. Other, more short-acting methods we can provide include condoms, the contraceptive pill (combined and progesterone only), and the contraceptive injection, which is often used as a bridging method if they would like more time to think about their ongoing method of contraception. After they have left our care, they will need to seek out further contraception services with their local authority commissioned provider.

If a client is following the medical abortion pathway, their post-abortion options will differ due to the nature of the treatment. The implant can be offered and fitted by a trained nurse during their consultation before they are issued the abortion medication. Short-acting contraception options are also available at their appointment. However, any medical abortion client requesting an IUC as their ongoing contraception will not be able to leave their abortion treatment appointment with their method of choice, as the abortion must be completed before the IUC is positioned. This makes it necessary for the client to return to our clinic for fitting, once the abortion is complete. We can offer bridging methods such as the contraceptive injection to make sure they are protected against unplanned pregnancy in the short term.

To increase access to LARC for clients who cannot have their LARC of choice at the time of abortion, we have created and established a number of nurse-led LARC lists. These lists are distinct from abortion treatment, and require clients to return to a Marie Stopes UK service post procedure. The LARC lists are proving to be extremely popular. We have found that the most popular nurse-led LARC appointment is for the implant (47%), the next popular being the IUD (34%) followed by the IUS (19%) (Appendix A).

However, one challenge that we face is that we can't be assured that if a client does not wish to have a post-abortion contraception appointment with us, that she will be able to access the full range of contraception outside our service. Our CaSH Nurse Specialist, Julia Hogan, described that 'when an appointment for LARC fitting post-abortion is offered, clients often say "It's ok – I'll go to see my GP" – not knowing that their GP might not be trained to fit the IUC, or that their local Family Planning Clinic has a massive waiting list.'

Where we invite clients to return to the clinic for post-abortion LARC, our contracts allow that we can charge the commissioning CCG for the cost of the contraceptive device, but not for the cost of consultation, which

we must cover ourselves. This is not particularly sustainable for independent providers, but we continue to work in this way to improve access to contraception. We know anecdotally that it's not always easy for women to get access to contraception appointments at local CaSH or Family Planning Clinics at a time that suits them, often due to the services being reduced or closed as local authorities cut budgets to SRH services.

Cuts to contraception services and an increasing abortion rate

The Advisory Group on Contraception (AGC) recently published their paper on the cuts to local authority (LA) spending on contraception, reporting that of the councils which fall into the quartile of highest social deprivation, 61% of these councils cut or froze their SRH budget between 2016/17 and 2017/18. Of these councils, it was also found that there was a 53% increase in the number of abortions.[i] Cuts to LA budgets have been drastic, which has made it difficult for LAs to meet commissioning commitments for SRH services. The proposed change in funding model away from ring-fenced funding is clearly a threat to LA public health services, and disproportionately so in poorer LA areas. Cuts to contraception services mean women are vulnerable to unplanned pregnancies. These statistics are hard to ignore, and it does suggest that unmet need for contraception services may have contributed to the increased abortion rate in England and Wales for women aged 30-34, and for women aged 35 and older. [ii] Though our organisation does not have any hard data to say that women need abortions because of lack of access to contraceptive services, we do have anecdotal evidence. Many clients will tell us that they have tried, and failed, to access local contraception services due to increasing wait times, or that there is no local service at all. Variations in LA commissioning is causing inequity that significantly affects reproductive health.

The FPA has also reported survey results which found that only 2% of GPs offered the full range of contraceptive methods, with the contraceptive pill (combined hormonal and progestogen-only) being the only method of contraception that all GPs said they prescribe.[iii] Anecdotally, we know this to be true, as many of our clients reveal to our nursing teams during their abortion consultation that they did not know that other, more effective methods are available. This illustrates how crucial it is that comprehensive contraception options are available as part of general practice.

LARCs are the most reliable method of contraception for women who may still wish to have children in the future. In 2017/18, 41% of women in England chose a LARC, with 42% choosing the most common method - the user-dependent oral contraception. The proportion of LARC use has been rising steadily over the last 10 years, however the number of women using an SRH service to access contraception has fallen for three consecutive years.[iv]

While abortion care services should not be relied upon to provide the most comprehensive contraception service, post-abortion contraception is vital, particularly in promoting the efficiency of LARC to clients who may not have known that these options are available.

Improving access to post-abortion contraception

We are actively looking at ways to improve uptake of LARC post-abortion. There are two main areas of focus – reporting systems and training. Our approaches to removing barriers to LARC access post-abortion and to produce quality data include:

- Commissioning a major update of our client record system for more accurate data reporting and outcomes on contraception use and uptake among our clients.

- Training to increase our teams' confidence in promoting the effectiveness of LARC during the abortion consultation. This includes webinars and face-to-face training focusing on all contraceptive methods.

- Working in collaboration with the Faculty for Sexual and Reproductive Health (FSRH) on post-abortion LARC fitting. We now only train to FSRH standards for the implant and IUD, and are part of an FSRH pilot to increase the number of abortion practitioners who are implant fitters (Appendix A).

- Working in collaboration with contraceptive implant brand, Nexplanon, for training and competencies assessments.

- Our recently updated training portal can generate reports on which team members are trained in which contraception fitting techniques, when competencies need to be reassessed, and when training expires, to ensure our teams' skills are enabling access.

Our aim is for every centre to have at least one Nurse / Midwife IUD fitter, for clients returning post-medical abortion, and 70% of core Nurse/ Midwife team members to be trained in implant fitting. We have a CaSH Nurse Specialist team member, and have recently recruited another, along with CaSH Nurse Champions for our Centres.

Providing vasectomy through CCG commissioning

In some areas of England, we are also commissioned by CCGs to provide independent vasectomy services. Vasectomy services are commissioned by CCGs and not local authorities as with female contraceptive options. This creates a disconnect between male and female contraceptive methods.

In 2016, it was reported that the number of vasectomies in England has dropped by 64% over the previous decade.[v] To an extent, the decline may be explained by couples choosing to have children at a later age. However, over the past few years we have seen many CCGs have reduced the number of vasectomy procedures they will fund, or withdrawn funding altogether, meaning clients must self-fund to access private services. We find that if local CCGs are putting forward cost improvement plans, vasectomy often comes up as a service that they are planning to cut or reduce. NHS waiting lists for vasectomies are already several months' long in some areas of the country and any further restrictions to access will result in a significant health inequality. It is unclear if the CCGs are speaking to their local authority about the availability of contraception services when making the decisions to cut NHS vasectomy services. The fragmented commissioning means that vasectomy and all other contraception may not be considered as a joint needs assessment.

It is crucial to ensure everyone has access to contraceptive services. For men who decide they do not want any / more children, vasectomy should be a readily available choice.

Fragmentation of commissioning for Sexual and Reproductive Health services

It is clear that fragmented commissioning for contraception provision has had a negative effect on SRH services.

Local authority cuts to contraception services, and CCG cuts to vasectomy services have created a post-code lottery whereby in some areas of the country people are better protected against unplanned pregnancy than others. Improved funding is needed to target areas of greatest inequalities and needs.

Our services are commissioned by CCGs, not local authorities, to provide abortion care and vasectomy. As part of the abortion pathway we can provide post-abortion contraception, but once a client has left our post-abortion care pathway, we are unable to provider further contraceptive services to her in the future. This not only creates a gap in data, to know if the contraception our client left us with is working well for her or if she wanted to try a different method, it also creates a lack of continuum of care.

If commissioning is to remain separated between LAs and CCGs, they should work collaboratively to ensure the commissioning and provision of local SRH services allows for the full range of contraception, including LARC and emergency contraception, to be offered and accessible in their area. We need assurances that funding decisions take the whole area of sexual health into account, even if funded by different bodies. Support from Public Health England and NHS England will be vital to eradicate inconsistencies and damaging variations based on cost saving exercises across the services.

At a local government level, there are some areas where Councils are already collaborating to improve and maintain SRH services by implementing SRH strategies. Further opportunities are needed for shared learning and collaboration between local government, commissioning bodies, providers, and training bodies.

We call for the defragmentation of the current SRH commissioning arrangements, which are detrimental to sexual health and wellbeing. A completely revised approach to SRH commissioning is needed, one that addresses the entire reproductive pathway from female, male and trans perspectives. There may be some health services in which it's right for different commissioning bodies to fund different areas of healthcare, but where services overlap, as in the case of abortion, sexual health and contraception, we need to be able to integrate the whole specialist healthcare area and bridge the existing gap.

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Appendix A

Embedding high quality LARC provision in a non-NHS post-abortion setting

This poster[1] describes the success and barriers encountered in the journey towards this quality improvement initiative in the provision of post abortion LARC.

Authors: Caroline Gazet & Julia Hogan (corresponding author julia.hogan@mariestopes.org.uk), Marie Stopes UK. May 2018

Introduction: Abortion services are commissioned to provide all methods of contraception, including long acting methods, immediately after abortion or as soon as possible. National guidance from NICE[2], RCOG[3] and FSRH[4] recommend that women should be advised about the superior effectiveness of the long acting reversible contraceptive (LARC) methods. The uptake of LARC should be actively encouraged as women leaving abortion services with a LARC have a reduced risk of an unplanned pregnancy in the near future[5]. LARC include intrauterine contraception, implants and injectable contraception.

The barriers faced in setting up high quality LARC provision included:

- The organisation was not registered as a training provider for the Faculty of Sexual and Reproductive Health (FSRH).
- Previous requirement in Letter of Competence (LoC) to fit and remove implants.
- Some team members have difficulty in passing the Electronic Knowledge Assessment (eKA).
- No nurses were trained to fit intrauterine contraception.
- LARC provision was generally doctor led, which is costly and does not utilise team members' skills effectively (except for surgical abortion LARC).
- With the increase in women choosing medical abortion, access to LARC was reduced as appropriately trained team members and clinic lists were not available, and women who complete their abortion at home could be 'lost' to future LARC provision.

The solutions have included:

- Employing experienced faculty registered trainers (FRT) as nurse specialist and clinical director.
- Canvassing the FSRH to create a bespoke LoC SDI for abortion providers.
- Creating a team of faculty registered trainers (FRTs) who can train team members to fit implants and intrauterine contraception (IUC).
- Establishing Marie Stopes UK as a FSRH training provider.
- Ratifying a LARC strategy with support for nurse training.
- Creating policies to support nurses to fit IUC post medical abortion.

[1] Original poster displayed as part of the Faculty of Sexual and Reproductive Health Annual Scientific Meeting 2018.

[2] National Institute of Clinical Excellence. (2014). Long Acting Reversible Contraception. Clinical Guidance 30. https://www.nice.org.uk/guidance/CG30

[3] Royal College of Obstetricians and Gynaecologists. (2015) Best practice in comprehensive abortion care. https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf

[4] Faculty of Sexual and Reproductive Health (2017a) Contraception After Pregnancy. https://www.fsrh.org/standards-and-guidance/documents/contraception-after-pregnancy-guideline-january-2017/

[5] ibid.

Quality assurance & governance: Moving to the nationally recognised Faculty of Sexual and Reproductive Health (FSRH) qualifications

The organisation has a firm commitment to provide high quality training to equip the nursing and midwifery team members to deliver contraception care. To this end, in 2016 the decision was made to cease the 'in house' training of team members to fit implants and to adopt the Faculty of Sexual and Reproductive Health (FSRH) Letters of Competence (LoC) in implant fitting and intrauterine contraception. The Letter of Competence in implant fitting is,

"…a training programme that has been designed to equip the learner with the evidence based knowledge, attitude and skills required to consult with a woman requesting contraception, and to appropriately provide a subdermal implant, manage complications and side effects." - FSRH[6]

New letter of competence for implant fitting only

In July 2017, the Faculty of Sexual and Reproductive Health (FSRH) launched a new qualification for clinicians working in maternity and abortion services to provide subdermal implants (SDI) for contraception. The LoC SDI Insertion Only (LoC SDI-IO) aims to meet the needs of professionals who routinely perform SDI insertions, but not removals. Marie Stopes UK is very proud that one of our nurses, Alexandra Murphy, was the first person ever to receive this award.[7]

"The new LoC SDI Insertion Only is good because now as abortion nurses we can do the training quicker. This means we can offer the complete service - the abortion and the LARC for more women, which is great…when you have trained to fit implants you can promote them more thoroughly." - Alexandra Murphy, Nurse at Marie Stopes UK

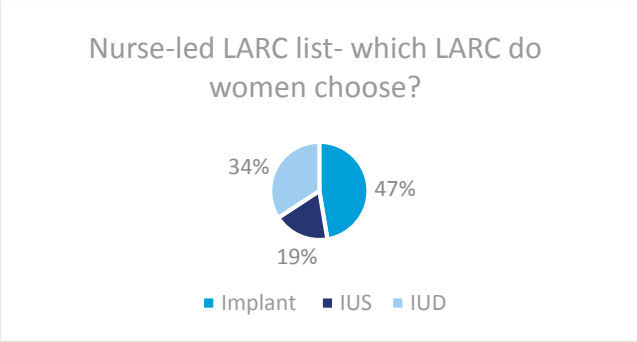
Supporting team members to pass their eKA using webinars

Before undertaking the practical aspect of fitting implants, team members must pass an online exam, the eKA. The eKA was introduced by the FSRH in 2013 to make sure that healthcare professionals studying Faculty qualifications have the knowledge needed to progress to the clinical aspects of these qualifications. The eKA is part of a learning journey to support healthcare professionals to deliver contraceptive and non-specialist sexual and reproductive health care (SRH).

Some team members have found the learning required to pass the exam challenging, so a suite of webinars have been written by our team of Faculty Registered Trainers to guide team members through the knowledge required to pass the exam.

Changes in abortion provision

With increasing numbers of women choosing to have a medical abortion, access to intrauterine contraception has been reduced as it is necessary for the products of pregnancy to be passed prior to the fitting of the intrauterine contraception. To increase access to LARC for these women who cannot have their LARC of choice at the time of abortion, we have created and established a number of nurse-led LARC lists. These lists are proving to be extremely popular and fully booked.

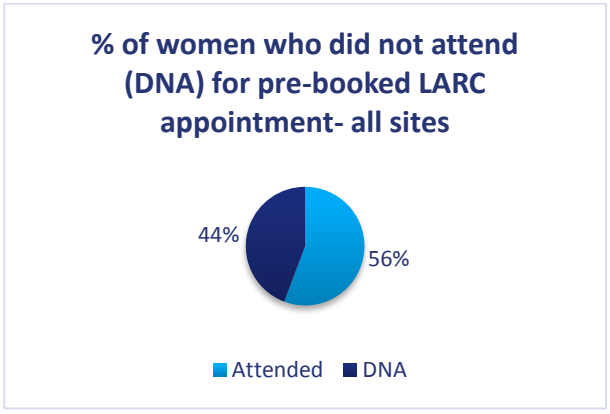


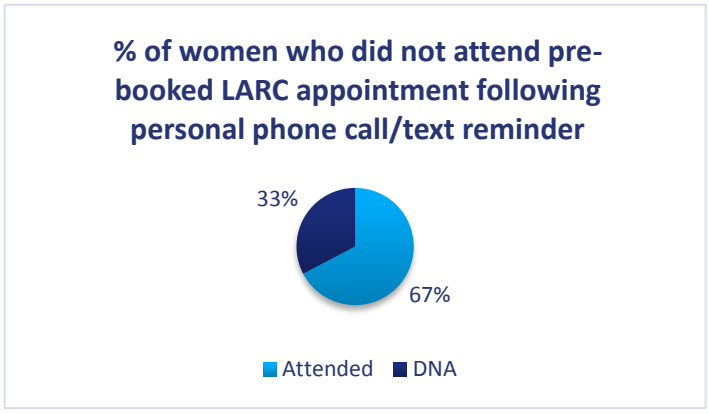
[6] Faculty of Sexual and Reproductive Health. (2018) Letter of Competence Subdermal Contraceptive Implants Techniques Insertion Only (LoC SDI-IO) https://www.fsrh.org/education-and-training/letter-of-competence-subdermal-implants-loc-sdi-insertion-only/

[7] Faculty of Sexual and Reproductive Health. (2018) Providing access to contraception for post-abortion women by Aly Murphy from Marie Stopes. https://www.fsrh.org/blogs/providing-access-to-contraception-for-post-abortion-women-by/

Attendance uptake at post-abortion LARC lists

Attendance rates at post-abortion services LARC clinics can be low. We have found that a personal phone call or text can increase attendance rates.

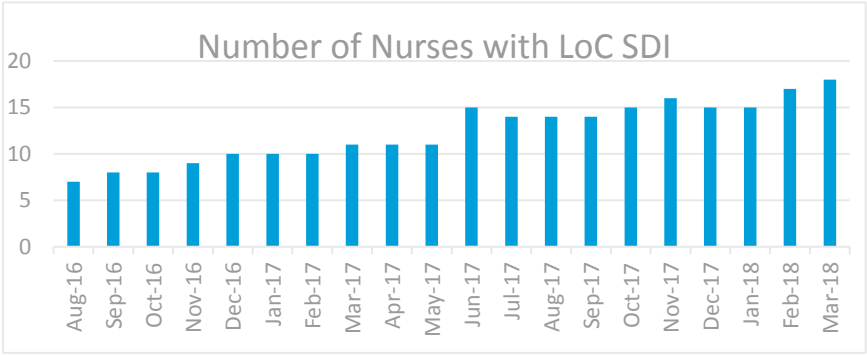




Results

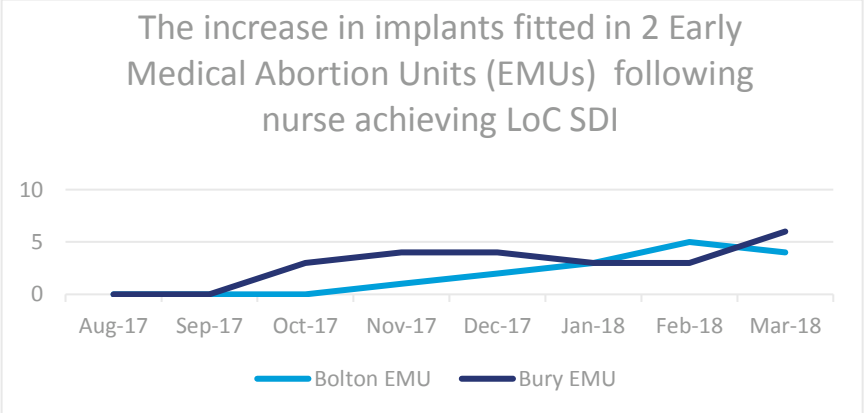
The successes so far include:

- We currently have 18 nurses with a LoC SDI & 3 nurses with LoC IUT, with more being training imminently.
- We are running 5 post-abortion LARC clinics nationally.
- We are running the training webinars with a cohort of enthusiastic nurses and midwives.



Future plans:

- Introduction of more LARC clinics.
- Continue to proactively encourage women to return for their LARC appointment.
- Evaluate the webinar programme and embed in training calendar if successful.
- Training of more nurses to fit post medical abortion IUC.



Conclusion: Implementing quality improvements reduces risk and provides assurance to the board and to women. It demands commitment to manage the process and team members value having a nationally recognised accredited qualification and feel empowered to provide high quality service for the women that we see.

End Notes

[i] The Advisory Group on Contraception, At tipping point: An audit of cuts to contraceptive services and their consequences for women, November 2018, available at http://theagc.org.uk/wp-content/uploads/2018/11/At_tipping_point_AGC_Nov_18.pdf

[ii] The abortion rate in England and Wales for women aged 30-34 increased from 15.1 per 1,000 women in 2007 to 18.2 in 2017, while the abortion rate for women aged 35 and older also increased from 6.9 per 1,000 women in 2007 to 8.5 in 2017. Department of Health and Social Care, Abortion Statistics, England and Wales: 2017, September 2018, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/714183/2017_Abortion_Statistics_Commentary.pdf

[iii] The Advisory Group on Contraception, At tipping point: An audit of cuts to contraceptive services and their consequences for women, November 2018, available at http://theagc.org.uk/wp-content/uploads/2018/11/At_tipping_point_AGC_Nov_18.pdf

[iv] NHS Digital, Statistics on sexual and reproductive health services England 2017/18, September 2018, available at: https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2017-18

[v] Boseley, S. (2016), Number of vasectomies in England falls 64% in 10 years, *The Guardian*, available at: https://www.theguardian.com/society/2016/oct/21/number-of-vasectomies-in-england-falls-64-in-10-years