Purchasing for Quality: the Providers’ View

Family planning services

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Beyond the somewhat quaint label of family planning lie the health gain opportunities of contraceptive and preventive sexual health care.

This article will concentrate on contraceptive services provided for women by general practitioners (GPs) and their teams and in community clinics. Although all those involved in heterosexual activity will at some time in their lives need to consider the relation between sexuality and fertility, current contraceptive methods that require clinical procedures and prescription only medicines are those for women. The needs of men would obviously need to be addressed in a quality service.

Contraception provides one of the basic building blocks of health care. It is strikingly cost effective¹ and is an area in which effort in understanding and being responsive to the needs of clients and potential clients will reap benefit.² Politically, the necessity of maximising uptake of contraception in the developing world rather than in the NHS sometimes seems easier to see, and over recent years there has been a largely unplanned reduction in family planning clinic services.³

Contraception enables people to exert a degree of choice over whether to have children or when, or both. It is by its nature inextricably linked with emotional and sexual wellbeing, and it is impossible to talk about contraception without addressing sexuality – the two are inseparable.⁴ This has led to various complementary services such as psychosexual counselling, well woman clinics, and specialist young peoples’ and menopause services being provided with contraceptive care in many family planning services provided by district health authorities (DHAs) or trusts.

A definition of quality for family planning services might usefully be that of their fitness for their purposes: the prevention of unwanted pregnancy and sexually transmitted diseases, including those caused by HIV, and the promotion of sexual health. Purchasing for quality will necessitate understanding the needs and constraints of both potential clients of the services and current clients and also those of the providers: it will seek to optimise outcomes through proactive and ongoing education and the convergent development of attitudes and practice in all these groups. The particular mix and emphasis of services will need to reflect the local situation: this depends on the availability of good information about, and understanding of, demographic, cultural, and socioeconomic epidemiological data, as well as feedback from statistics of service uptake and client opinion.

Service users’ perspectives

Women’s ability to recognise their individual needs for contraception and to act to seek any necessary professional help is influenced by many factors, including their individual experience and relationships, their sexual behaviour,⁵ their societies’ attitudes to sexuality and fertility, their education, and their feelings of personal self determination and self worth.⁶ Very little of this is determined primarily by the provision of health services.

However, recognising these complexities and providing client-centred services in a context that helps overcome the embarrassment and stigmatisation of addressing sexual issues enables and encourages attendance for contraceptive care.*

The requirements for service providers to be sensitive to the needs of their clients is paramount in this type of health care. If service providers are perceived to break confidentiality or to have attitudes of carelessness or contempt in these very personal interviews women will not take up the services. Potentially excellent clinical care may be useless if women are dissuaded from seeking help by the attitudes of reception and administrative staff or if the service organisation does not allow for “emergency” consultations.⁷ This is particularly important in providing postcoital contraception.

Individuals may change their contraceptive method and their providers of contraceptive care throughout their reproductive life, with decisions typically being made at specific times, as follows.

- At the beginning of sexual experience
  - After an accidental pregnancy or fear of one
  - At life changes – for example, a career change
  - After a planned birth

* Accepted good practice unsupported by published evidence
• When the family is complete
• At the end of a relationship or the beginning of a new one
• When fertility is perceived to be low (for example, perimenopausally)
• When there are problems with a particular method
• When there are other health problems.

**Information for service users**

The services available should be advertised widely, with thought given to ways in which marketing can inform and encourage current non-attenders to use the services. Reliable information about the confidentiality of the service will be important for many women, as will the knowledge that they can choose to consult female staff.

Once women have reached the service of their choice they have further information needs. Information about the range of contraceptive methods available, including their effectiveness, suitability, risks and benefits, and mode of action, will help each woman to make the best choice for herself. When the choice has been made further detailed information about the use of the method, when to return for routine checks, what to do if something goes wrong, and encouragement to return for further information will help women use contraception with confidence. The time needed to raise and discuss all these issues makes the initial contraceptive consultations some of the most time consuming in primary care.

Information given orally should be reinforced by well designed, clear, and well organised written material. A selection of consumer researched leaflets (which carry the Plain English Campaign’s crystal mark) are produced by the Family Planning Association (FPA).

In a recent study of women undergoing termination of pregnancy over a quarter were using a prescribed contraceptive method at the time they conceived. Although all methods have expected failure rates, the overall rate of unwanted pregnancy points to the importance of strategies to improve compliance and encourage women to report expeditiously their queries about, or problems with, their chosen method. Readily available telephone information will allow women to check quickly any problems with their method.

The quality of clinical communication is related to positive health outcomes. Participation by the client in the encounter improves satisfaction and compliance. Many professionals make assumptions and often underestimate a person’s level of information, motivation, and ability or needs and may “censor” or “limit information.” Various ways may be used to pressure women to use certain methods, although such behaviours in health care professionals are very often counter productive and must be avoided.

**Provider considerations**

Nationally, about two thirds of women seeking contraception from the NHS attend their own GP, and most of the rest attend DHA or trust clinics. Currently there are few providers of contraceptive care in the private sector in the United Kingdom. This dual provision is currently managed and paid for from two separate purchaser budgets, that of the Family Health Services Authorities (FHSAs) and the DHAs. Although this has made it difficult to gain an overview of service provision across populations, it is clear that a choice of providers is necessary to maximise uptake. Though women will vary in their preference, the trend has been for GPs to provide a service for women currently spacing pregnancies whereas clinics have a larger proportion of women who are delaying their first pregnancy or who have decided to have no more children.

All clinicians providing contraceptive care (both nurses and doctors) have similar basic needs for knowledge and training. The purely “medical” content of contraceptive care is relatively circumscribed and can be taught in traditional ways. This knowledge can be encapsulated in guidelines for taking histories and physical examination and procedures and forms about prescribing.

Supporting the clinicians and their administrative staff to feel comfortable and hence be effective working in a client centred way may entail exploring their attitudes to their own sexuality and their client’s sexuality in the context of the work. This is difficult, and resources for this have not been available to most in the NHS. The developed interpersonal skills often necessary to take a sexual history and to give the information that allows for informed choice have unfortunately not been part of most clinical undergraduate or postgraduate training.

**Contraceptive care in general practice**

GPs are paid a nationally negotiated item of service fee for contraceptive services. This is claimed from the FHSAs and paid in fixed quarterly amounts against a form signed by the client which covers care for a year. Although there is a specific fee for fitting an intrauterine device, all other contraceptive transactions attract the same fee irrespective of how many consultations an individual woman might need during each year.

There are currently no training or updating requirements for undertaking this work, although some GPs have a certificate of the Joint Committee on Contraception or the earlier equivalent FPA family planning certificate of competence in family planning; nurses working in family planning clinics and some nurses working in general practice hold a qualification of the English National Board or the earlier equivalent Joint Board of Clinical Nursing Studies or a FPA family planning certificate.

Most women attending GPs for contraception will be prescribed oral contraceptives, indeed many GPs provide no other contraceptive methods.

There are provisions for women to attend a GP other than the one with whom they are
registered for general medical care in order to increase the choice of providers available. This is especially important for women who live in areas poorly supplied by DHA or trust clinics. As far as can be ascertained few women know of this possibility, and very few use it. A degree of cooperation and negotiation between GP practices as well as better advertising would allow this option for women to become more useful. Practice leaflets must make clear which services are available.

The time necessary for the initial contraceptive interview and when changing contraceptive methods, added to that necessary for vaginal examination (which is one of the most intimate and time consuming routine examinations performed in general practice), puts extra strain on busy practices. Unfortunately, segregating women requiring contraceptive care into special sessions with extra available time risks losing the chance for “opportunistic” consultations during general surgery times, which some women prefer for accessibility, and which some will feel is less embarrassing than attending at a time that will signal to others their need for contraceptive care.

Attention must be given to making emergency appointments available for those in need of hormonal methods of postcoital contraception (which must be administered within 72 hours) and ensuring that practice receptionists understand and can facilitate the difficulties of negotiating an early appointment because of a contraceptive “accident.”

If fittings of intrauterine devices are to be offered, supplies of sterile instruments will be needed, as will facilities for resuscitation. Otherwise, a limited range of clinically clean instruments for vaginal examination and the equipment for general physical examinations and appropriate facilities (couch, lamp, sink, etc) are all that is required.

Information and continuing education and training for GPs and their teams

Further development of training and updating of current medical knowledge and practical skills in contraception, together with support to develop guidelines for rational prescribing, is a central component of service development. Formalising communication pathways between GPs and the related sexual health services that might be needed by their clients (for example, genitourinary medicine services,18 NHS termination of pregnancy counselling and surgery, psychosexual counselling, and DHA or trust family planning) should also be considered.

It would be constructive to clarify the widespread misunderstandings of the legal position on giving contraceptive advice to those under the age of consent. The current confusion prevents some doctors from feeling that they can help those under 16, and many young people at risk do not feel confident to seek professional care as they do not realise that the present General Medical Council’s rulings require that doctors must justify any breach of confidentiality.19 18 A doctor or other health professional can provide contraceptive advice or treatment, or both, to those under 16 without parental consent, providing they believe the young person has sufficient understanding and maturity to enable them to understand fully what is proposed.

Medical and clinical audit can be of great help in providing information on current practice, drawing up practice guidelines, and showing directions for further service development.*

Contraceptive care in DHA or trust family planning services

Despite the depredations of the past few years of clinic closures and the very uneven levels of provision across the United Kingdom DHA or trust (largely clinic based) services still provide most of the specialist care, offer a service for those women who do not choose oral contraceptives and whose GPs do not provide alternatives,12 17 and undertake most of the practical training of both doctors and nurses for postgraduate certification in contraception.18

Most remaining clinic services are still able to offer more time to each client than in the typical GP interview and a choice of the full range of contraceptive methods. They are perceived by their clients as offering a greater degree of anonymity and thus for some, especially the young, less embarrassment; a specialised service; more time to discuss problems; and greater accessibility, especially the opportunity of attending evening sessions.12 17 19

Women can (or should be able to) refer themselves to DHA or trust clinics regardless of catchment area.20 A full range of methods can be made available at various times of the day from local clinics and health centres.

Staff are employed in these clinics on a salaried basis, many working part time, under nationally negotiated terms and conditions of service for the community health services. Management arrangements for the services vary widely, with most services in some form of community unit and some with gynaecology in acute units. All clinicians must have the relevant postgraduate or postbasic certification, although in many districts reception staff are not given any training; the quality of service would be improved if they were.21

The facilities required for the clinical work are the same as those in general practice, but a significant difference is that the clinics hold and dispense their own supplies of prescription only medicines and barrier contraceptives. As well as the price for the supplies this dispensing service also incurs the costs of community pharmacy and logistical support such as transport, as well as staff training in dispensing. The substantially better prices that can be negotiated with direct suppliers mean that despite this the service is usually cheaper than FP 10 prescription from GPs.1

* Accepted good practice unsupported by published evidence
The family planning team that offers these contraceptive services can also form a part of sexual health promotion work in wider contexts. Examples of joint working include the following.

- Working with schools to support the teaching of the biology of sex and the wider aspects of responsible and fulfilling sexuality and personal relationships, including visits to clinics
- Working with other health service staff (for example, midwives, gynaecology staff in acute units, staff at genitourinary medicine clinics, health visitors and other community nurses, and staff of services for drug users) who can help to inform their clients of the contraceptive services and help with promoting sexual health
- Working with health promotion staff to develop information sensitive to local needs and taking part in sexual health promotion initiatives with the general public
- Working on clinical audit with GPs
- Facilitating provision of information on post-coital contraception and appropriate prescription from accident and emergency departments.

**Information for family planning teams**

Many family planning staff working in a single service have separate managerial and professional lines of accountability and no overall leadership with defined and agreed service objectives. There is little sense of how their individual commitment to the service is mirrored within the units in which they are employed. Clarifying the required purpose and roles of each DHA or trust family planning service and facilitating the flow of information and feedback between the “frontline” staff and their managers can improve the effectiveness of their working.*

Family planning staff have the advantage of having chosen to specialise in sexual health and are therefore generally prepared to acknowledge the special difficulties of their work and the importance of developing client-centred working. Because so many of them work part time in clinics at different sites regular meetings are necessary to allow them to audit their work, discuss and develop their procedures and guidelines, and identify themselves as part of a coordinated team* – and this has resource implications.

Family planning staff share with GPs the need for updating on medical developments, good communication with others providing sexual health care, and medical and clinical audit.

**Purchasing quality in family planning services**

The need for the service delivery to be tailored to local conditions, complicated by the two sources of provision, makes it difficult to draw up a single blueprint for purchasing that makes sense in rural, suburban, and inner city areas. What clearly has to be established by each purchaser is the current provision of service, the range of services that it wishes to develop for its population, and which services should be most usefully developed in each geographical area.

Joint working between the FHSA and DHA purchasers using the expertise of their information departments, public health specialists, and community health councils and of informed providers can greatly improve the overview of the provision across populations and the attainment of the goals of each purchaser. In fact, neither purchaser can work properly without information about the local activity of both types of provider. Tools have been developed to help purchasers with these processes. The NHS Management Executive’s guidelines for the review of family planning services usefully spans both GP and DHA or trust provision. The FPA has produced a model contract which provides a comprehensive list of all the varied functions of DHA or trust family planning services. Special difficulties in understanding the patterns of provision in general practice are that the current forms used to claim the item of service fees are often used simply as a measure of how much is to be paid and that there has been little development of basic, anonymised data to help inform purchasers and providers.

Setting targets which aim at reducing the level of unwanted pregnancy in women of age \( x \), by amount \( y \), in the next \( z \) years is only a first step. Preventing unwanted pregnancy and promoting sexual health also demand attention as to how the services are offered if purchasing is to encourage better provision and these targets are to be achieved.

The box outlines some of the important considerations which purchasers should use to inform their specifications.

**Conclusions**

An essential first step is to clarify the purposes and commitment of both DHA and FHSA

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purchasers in purchasing for improvement in the quality and effectiveness of family planning care across their catchment populations. The detailed work that is then needed to develop specifications for the service and to negotiate them with the providers can escape attention at a time when DHAs and FHSAs are already so busy. However, appropriate provision and uptake of contraceptive care and promotion of sexual health are the fundamental building blocks of a physically and psychologically healthy society. Successfully preventing unwanted pregnancy is probably the most cost effective activity that DHAs and FHSAs engage in, and it releases resources for other aspects of health care.

19 Tameside Family Health Services Authority, Tameside and Glossop Health Authority, Derbyshire Family Health Services Authority. *Health needs assessment - primary care family planning services*. Tameside and Glossop, Tameside FHS, Tameside and Glossop Health Authority, Derbyshire PHS, 1992.