

Integrated sexual health: a better way of working?

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Background

In 2001, the Department of Health (DH) published the National Strategy for Sexual Health and HIV, which included a 10-year programme to improve sexual ill-health and modernise sexual health services in England.¹ Crucial to the implementation of the Strategy was the integration of the services treating sexually transmitted infections (STIs) and those providing contraceptive guidance. Services were to be planned around patient need, and were to include choice, open access, extended opening hours and seamless care.

Since 2001, commissioners within primary care trusts have therefore concentrated on seeking services, preferably integrated, that treat STIs and reduce teenage pregnancy. How this integration has been achieved varies; in some areas the hospital genitourinary medicine (GUM) department has expanded to include contraceptive provision, in others the contraceptive clinics provide a limited service for the testing and treatment of some STIs, whilst other areas have achieved a full merger resulting in a service that provides STI screening and contraceptive provision on one site. Theoretically this latter approach has many advantages: the disciplines of management of STIs, contraceptive provision and 'medical gynaecology' are closely related and it would certainly be in the patient's interest if they were located in one clinic.

However, the DH and commissioners do not appear to have considered that the main providers of treatment of STIs are physicians trained in general medicine who are members of the Royal College of Physicians, whilst those providing contraception services are members of the Faculty of Sexual and Reproductive Healthcare (FSRH) [formerly the Faculty of Family Planning and Reproductive Health Care (FFPRHC)], which is part of the Royal College of Obstetricians and Gynaecologists (RCOG). Consultants in either GUM or sexual and reproductive health (SRH) do not generally have specialist training in both disciplines. Integration to date has tended to result in one of the specialities dominating the other; my own perception is that GUM services have often overtaken the reproductive health services. This is perhaps inevitable given the government targets but it has focused service delivery on screening and testing for STIs with a corresponding loss of emphasis on conditions such as menorrhagia and other gynaecological conditions, which were often managed in contraceptive clinics.

Specialist training

GUM is a speciality within general medicine. SRH has had to fight for recognition and may only achieve specialist status later this year. The first birth control clinic in the UK opened in 1921, training for doctors and nurses in family

planning was only introduced in 1969 and family planning was finally incorporated into the National Health Service (NHS) in 1974. The medical and nursing staff working in these clinics were usually employed on a sessional basis, there being no career structure within family planning.

The FFPRHC (now the FSRH) was established in 1993 as a part of the RCOG. It developed its own higher qualification, the MFFP (now the MFSRH) but is only now in the process of applying for recognition of its own specialist training. Consultants in family planning nearly all have a basic training in obstetrics and gynaecology, have passed the MRCOG and/or the MFSRH, and some have completed subspecialist training in SRH; one of the subspecialist training programmes of the RCOG.

The training pathways reflect the needs and requirements of patient care as practised at least a decade ago. It is recognised that medical care needs to become more 'patient friendly' and community based. Sexual health in its broadest sense is an ideal speciality to move to a community setting. Community clinics, which were primarily sources of contraceptive provision, need to change and expand to meet all the sexual health needs of both the young and the older clients. However, the transition needs to be sensitively handled. Medical and nursing staff working in reproductive health clinics are trained in women's health. Many have had no training in men's health since qualification. Conversely, staff working in GUM clinics are familiar with infection in both men and women but many will have little, if any gynaecological, experience.

Integrated services

Many services have been integrated or contraceptive/medical gynaecology clinics have changed their remit and now provide testing and treatment for STIs in both men and women. The change has often been immediate, in response to demands from commissioners, and has resulted in a complete change in clinic profile. Clinics can be overwhelmed by clients requesting STI checks; not in itself a problem but the numbers involved have resulted in fewer people being seen for contraceptive provision. Many of the 'older clients' feel out of place in what has become a young people's service orientated towards different needs. In addition, many of the clinics now see both sexes whereas previously they were (almost) exclusively female. There is little clinic time now to pursue management of gynaecological conditions.

Some clinicians who have been working for years in either GUM or contraceptive clinics have expressed feelings of doubt and inadequacy since the services have integrated. There has been no assessment or training to ensure that staff are competent to manage conditions outwith their recognised expertise. Ultimately this may lead to stress, illness and early retirement/leaving the speciality.

Sexual health, in its broadest sense, is a developing area of medicine that needs input from specialists in gynaecology, family planning, GUM and public health. The FSRH recently presented their new curriculum for specialist training in SRH at a Deanery Advisors meeting held in June 2009. Completion of this syllabus is said to equip an individual to work at consultant level in an integrated clinic. However, it is not clear how it fulfils GUM requirements and it is difficult to see how the two

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specialties can reconcile their differences about the STI component. This could be a major problem; until both specialties work together to produce a combined specialty training scheme that will accept trainees with a background in either general medicine or gynaecology, the old divisions between the specialties will remain to the detriment of patient care.

Career pathways

Whether or not one agrees with the government direction and emphasis on teenage pregnancy and STIs this remains DH policy; there is a requirement for an integrated sexual health service including STI and contraceptive provision and community gynaecology. Currently there is no single career pathway in either medicine or nursing that addresses this need. The Faculty and GUM should reconsider the current proposed curriculum for the Certificate of Completion of Specialist Training (CCST) in SRH.

Many of the doctors staffing the clinics providing contraception are specialty and associate specialist (SAS) doctors because historically there has been no career structure. Some of the younger doctors have stopped applying for permanent posts because they believe that the new FSRH CCST will provide them with a career pathway to consultant level; but this may be unrealistic. The RCOG has an excess of doctors in training and hopes that some will be encouraged to work in the community on a part-time basis having achieved the competencies of the advanced training module in sexual health.² In addition, the proposed new SRH specialist training will take entrants

from obstetrics and gynaecology after they have completed 18 months training. There does not appear to be a pathway for the specialty SAS doctors to achieve consultant status except by Article 14. We need to be honest with our specialty doctors about their future career prospects and not encourage false expectations.

Concluding remarks

Service provision and career structure in SRH is changing. For many the integration with GUM services has resulted in a different pattern of clinical work from that for which they trained and wanted to practise. Change is inevitable and the service must evolve to give best care to patients. However, staff must be given adequate training and clinic integrations carefully planned if the new holistic sexual health service is to flourish.

Statements on funding and competing interests

Funding None identified.

Competing interests None identified.

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VIEWPOINT

The move to integrated contraception and sexual health services: have we forgotten family 'planning'?

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Background

Recent reorganisation within primary care has seen community 'family planning' services become 'contraception and sexual health' (CASH) services, many integrating with genitourinary medicine clinics. With this we have seen a decrease in general community contraception clinics with women being asked to access general practitioner (GP) services for their basic contraceptive needs, and a corresponding increase in the development of clinics providing targeted services for specialised contraception and for young people in community settings.

Whilst this development has seen benefits in many ways, in contrast to the wide remit of 'family planning' clinics in reproductive health, it appears to have focused service delivery firmly on the prevention and treatment of sexually transmitted infections (STIs) and prevention of unintended pregnancies, in line with government guidelines and targets.¹ It could be argued that although these are key objectives for CASH services, one crucial aspect of care that now appears to have less emphasis is promotion of pregnancy planning and preconception care.

Importance of preconception care

The importance of preconception care, including lifestyle and dietary review before conception, has been highlighted in the government's quest to reduce perinatal morbidity and mortality.² Folic acid supplementation is recommended for all women planning pregnancy for 12 weeks prior to conception and for the first 12 weeks of pregnancy to prevent neural tube defects.³ Recent studies have affirmed additional benefits of folate supplementation in reducing both preterm birth⁴ and congenital heart defects.⁵ Women who are planning pregnancy are advised to eat a healthy diet containing plenty of fresh fruit and vegetables, and in order to prevent teratogenicity and infection the Food Standards Agency has made some recommendations regarding preparation

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