

Would an exclusively contraceptive clinic help meet the needs of patients attending an integrated sexual health service?

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INTRODUCTION

Sexual health services have been subject to great change over the past few years. The move towards an 'integrated' service has seen the amalgamation of family planning and genitourinary medicine (GUM) services along with the development of specialist services. However, the number of individuals accessing contraception via services has decreased by 2.2% (49 844) from April 2013 to March 2014, when compared with 2012/2013, based on the Sexual and Reproductive Health Activity Dataset (SRHAD).¹ Oral contraceptives remain the most common form of contraception, used by 47% of women, while long-acting reversible contraception is used by 31%.¹

Within our own integrated sexual health service, we wondered if the increasingly specialised nature of the service has impacted on individuals already established on their chosen method of contraception. Are their needs being met?

CURRENT INTEGRATED SERVICE

Our service offers walk in 'queue and wait' morning sessions 5 days a week, plus appointments for contraception or GUM each afternoon and on three evenings a week (Tuesday, Wednesday and Thursday). In addition, there are specialist community gynaecology, complex GUM, erectile dysfunction, psychosexual medicine and HIV clinics. There is a triage service provided by the nursing staff for those attending, either when the 'queue and wait' session has reached capacity or in the afternoon. This role involves determining the urgency of an individual's problem or requirement and arranging appropriate review on the basis

of need. Following discussion with the nursing staff it became apparent that there was a significant number of women accessing triage because they had run out or were just about to run out of their contraception or were due their next contraceptive injection. Often they were unable to access an appointment at their general practitioner or, less commonly, with our service. Further, we noted that those attending the 'queue and wait' for a contraception-only consultation could wait for on average 1.5–2 hours for a 10-minute consultation.

NEW CONTRACEPTION-ONLY CLINIC

In view of this, we felt there was a contraceptive unmet need within our community. A small working group was convened to consider these issues. With the aim of redressing this unmet need we decided to pilot an open-access walk-in contraception-only clinic. The pilot started on 1 December 2014 and ran until 31 January 2015, from 2 to 4 pm, 5 days a week. It was staffed by experienced nursing staff. Those wishing to access the clinic were asked to complete a screening form to self-determine their suitability for the clinic. This document indicated that the clinic was only for those who required a repeat of their ongoing contraception, who had no problems with their chosen method, were not more than 14 weeks since their last contraceptive injection, did not experience any intermenstrual or postcoital bleeding or have any common medical or medication contraindications. If individuals were found to be unsuitable for the clinic the next available appointment for a contraception or GUM clinic was provided. Women were eligible even if they



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had not accessed contraceptive services from our clinic before, as long as they were content with their current method. This decision was made because the service is located in a large university city and we did not wish to alienate students and because we would prefer that the student population accessed these services rather than those targeted at under 19's, freeing up those services for potentially more vulnerable young people. The new clinic was advertised by poster within the clinic and nearby universities, by clinic reception staff taking telephone enquiries and on the service website.

Following their consultation, patients were asked to complete a short questionnaire detailing how long they had to wait to be seen, how convenient the service was, whether they would use the clinic again, whether they would recommend it to others, how they heard about it and finally the times they would like the clinic to be available. A total of 190 individuals attended the clinic during the pilot. Of those, 70 patients (37% of attendees) completed feedback forms. Analysis indicated that 40% of attendees had their consultation within 5 minutes of their arrival at clinic, 42% were seen within 10–15 minutes, 10% within 20–25 minutes, 4% within 40–45 minutes and 4% within 50–60 minutes. Sixty-seven of those responding found it very convenient and three found the service moderately convenient. All those who responded said they would recommend the clinic to their friends and 99% said they would use it again. The majority of those accessing the clinic had telephoned to make an appointment and were made aware of the service; others were informed by friends or via the website. The most common reason for attending was that they were running out of contraception and that they were unable to be seen in general practice.

Given that this was a new service, which ran over Christmas and New Year, we felt that the attendance rates and feedback from attendees supported continuation of the clinic. As a result of the pilot, alterations were introduced to improve the service. These included modifying the self-assessment form to more clearly indicate that the clinic is only suitable for those established on and happy with their current contraception. Questions which caused confusion were removed. Further, the option of attending a pre-existing walk-in, health care assistant-run, asymptomatic screening clinic was added, therefore allowing patients to retain access to a comprehensive service. We have increased the amount of information available for reception staff to provide when calls are received about the nature of the clinic, to reduce attendances by women who are not suitable. While we acknowledge that despite our best efforts this will still occur from time to time, the provision of more information at the outset will act to further reduce these occurrences.

EXPANDING THE SERVICE

Having decided to continue running the clinic, we sought to assess if there was scope for expansion. A random 2-week interval in January was selected and reasons for attendance for all those presenting to the morning walk-in 'queue and wait' clinic for solely contraception consultations were reviewed. The data were taken from SRHAD forms completed following an attendance for contraception. During the time frame, 96 individuals attended for contraception-only consultations; of these, 50 individuals met the criteria for our walk-in contraception clinic. This averaged five per clinic session, in spite of the new clinic. Clearly these data do not include those individuals who may have tried to access the service but were unable to be seen on their day of choice. To explore this further, a questionnaire was given to all those who attended for contraception only, over the course of 1 week. We received responses from 33 attendees, slightly more than half of those who attended for contraception. Of those, 26 would use a drop-in contraception clinic, two would not and four felt they might consider it. With regard to timing of drop-in clinic, a small majority (58%) selected multiple options. The most popular single time for the clinic was in the evening, followed by afternoons and then mornings. Of those who selected multiple options, one would prefer a clinic morning and afternoons, six would like afternoon and evening clinics, and eight would prefer clinics throughout the day (morning, afternoon and evening). While our sample is small, the responses indicate support to continue with the clinic, the need to increase advertising of the new service and support the expansion of the existing service. In addition, we considered whether more appointments would be of benefit to current service users. Seventy-two percent would like there to be more contraception appointments. The overall preference was for these appointments to be available in the evening, either in combination with an increase in afternoon appointments or solely in the evening.

Since the pilot, the number of women accessing the clinic has increased, perhaps as a result of word of mouth, as there has been no further advertising. Typically the clinic is accessed by 10–12 women each day. In addition to providing a service for women, it also provides a useful training opportunity for medical and nursing staff.

CONCLUSIONS

The introduction of a new, solely contraception, clinic within an integrated sexual health service may seem to some to be a backward step. However, it appears evident that it provides a service to those who are already established with a contraceptive method. In essence, it puts the patient back at the centre of our care pathways and addresses the concerns of those who felt that integration would lose some of the best

components of family planning services. Plans for the future of this clinic include greater advertising via general practices, pharmacies and within the student community, possible expansion of the service to mornings and early evenings in response to user consultation, along with ongoing review of the current service to ensure it remains fit for purpose.

Competing interests None declared.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCE

- 1 Health & Social Care Information Centre. *NHS Contraceptive Services: England, Community Contraceptive Clinics. Statistics for 2013–14*. 2014. <http://www.hscic.gov.uk/catalogue/PUB15746/nhs-cont-serv-comm-cont-clin-eng-13-14-rep.pdf> [accessed 3 March 2015].