Telephone counselling for subdermal implants and intrauterine contraceptives

Caitlin D Gorman,[1] Joanne Dennis,[2] Jennifer A Heathcote[2]

[1]Medicine and Health, School of Medicine, The University of Manchester Medical School, Manchester, UK
[2]East Cheshire Community Sexual Health Clinic, East Cheshire NHS Trust, Macclesfield, UK

Correspondence to
Miss Caitlin D Gorman, The University of Manchester Medical School, Manchester M13 9PL, UK; caitlindrewgorman@hotmail.com

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WHAT INITIATED THE CHANGE?

The rate of unintended pregnancies remains high in the UK, at an estimated 16%.[1] Long-acting reversible contraceptives (LARC) provide a highly effective alternative to the widely used contraceptive pills and condoms, which depend heavily on user reliability.[2 3] There is a clear need to increase the uptake of LARC by reducing barriers to access and removing obstacles in the process.

The requirement of a separate counselling appointment prior to insertion is a key factor in deterring women from LARC use.[4 5] Additionally, clinicians at East Cheshire Centre for Sexual Health have noted that women often comment that they do not require a counselling appointment as they feel they have already been given the information elsewhere. However, if a counselling appointment is not arranged, at insertion women are often found to be unsuitable for a variety of reasons, including the possibility of pregnancy, sexually transmitted infection (STI) risk or the need for further investigation.

WHAT CHANGES WERE PUT IN PLACE?

In an attempt to tackle this, in January 2017 we implemented a telephone counselling service for women requesting an intrauterine contraceptive (IUC) or subdermal implant. This aimed to increase the likelihood of procedures going ahead and minimise the need for patients to attend multiple appointments. Currently, there is one telephone clinic per week with six 20-min appointments, conducted by the clinical lead who pioneered this service.

If a patient opts for telephone counselling, their contact number is checked with electronic records and an appointment is issued. The patient is informed that they will receive their call within a 1-hour window, for example, 'between 2 and 3pm'. At the appointment, the clinician calls their number. The standard LARC counselling template is followed, as in a face-to-face consultation. If STI screening is required, the patient is sent a postal kit, or advised to access their local clinic or general practitioner for this. Following the consultation, the patient is offered an SMS link to the appropriate Family Planning Association (FPA) leaflet and is sent their insertion appointment details via SMS. In the case of a non-answer, the clinician makes a further attempt after 10 min, after which a failed attempt is recorded as a 'DNA' (Did Not Attend).

HOW WAS ITS SUCCESS MEASURED?

A service evaluation was carried out to gauge the success of the service. As a starting point, some broad questions were asked:

- Is the service meeting the needs of its patients?
- Is the organisation using its resources in the most effective way regarding time and skills?
- Is the service meeting standards set out by the Faculty of Sexual & Reproductive Healthcare (FSRH) guidelines concerning the provision of subdermal implants and IUC?[6 7]

Participants were recruited from patients, practitioners and booking staff who were chosen based on their perceived impact, influence and availability. Questionnaires focused on the role of each group, gathering opinions regarding their experience of the service.

Patients were asked to complete a questionnaire (box) at the end of their insertion appointment. This process proved to be a limitation, given the need for practitioners to remember to provide

Box Patient and practitioner questionnaire

- Patient questionnaire
  - Why did you choose a telephone consultation?
  - Did you receive your telephone call within the time advised?
  - Did you receive enough information during your telephone consultation?
  - Did you receive a leaflet prior to your procedure appointment?
  - Do you think that your telephone consultation prepared you adequately for the procedure?
  - Would you recommend a telephone consultation to a friend if she needed a similar procedure?
  - Any other comments?
- Practitioner questionnaire
  - What is your job role?
  - Do you insert subdermal implants or intrauterine contraceptives?
  - Which contraceptives do you insert?
  - As far as you are aware, have you fitted devices for women post-telephone counselling?
  - Have the patient's notes been adequately completed during the telephone consultation?
  - Do you carry out the counselling prior to subdermal implant or intrauterine contraceptive fitting?
  - Would you feel comfortable doing this over the phone?
  - What, if any, resources do you use when counselling a woman about the subdermal implant?
  - What, if any, resources do you use when counselling a woman about intrauterine contraceptives?
  - Do you have any concerns regarding the use of telephone consultations in this situation?
    - Doing the consultation yourself.
    - Fitting for a woman who has been counselled on the phone.
  - Do you have any additional comments about the future of the telephone counselling service?
  - Do you have any ideas of other clinical situations that the telephone service could be expanded to?

the questionnaire. Practitioners were approached throughout the evaluation period for their feedback regarding their current role in the provision of LARC, as well as their comments on the service at present and their desire or otherwise to take part in telephone counselling themselves. Although just one doctor is currently carrying out the telephone consultations, the insertion appointment can take place with any of the inserting practitioners within the service. Information required to assess demand was collected by accessing electronic records for the length and number of appointments undertaken so far and how many appointments had been booked for future clinics.

WHAT WAS THE OUTCOME?

The telephone counselling appointments have provided a time-effective alternative for patients and staff, while continuing to deliver the same high level of patient care. Of the 120 women who have been through the telephone counselling process so far, 20 took part in the post-insertion questionnaire. Fourteen of these women reported that their reason for choosing a telephone appointment was based on convenience and time benefits. All four booking staff provided responses, reporting that they felt the appointments have been in demand. This is supported by electronic records showing that telephone clinics have been fully booked for the next month. Availability is certainly an element for improvement, but it should be emphasised that this was implemented as a trial, and its success so far has provided adequate support for expansion. To begin with, appointments were for 30 min. However, the mean consultation and documentation time was calculated to be 19 min, which allowed for a reduction to 20 min, thus increasing capacity.

All the patients felt adequately equipped with knowledge, prepared for their procedure, and would recommend the service to others. This was supported by their additional comments, highlighted in table 1, alongside those of the practitioners. The overall process is in line with the FSRH clinical guidance,[6 7] and there were no concerns regarding confidentiality or insertion safety.

All the practitioners (n=7) involved in the evaluation currently counsel for and insert either subdermal implants, IUC or both. All reported that they would feel comfortable doing this over the telephone, but some added that this would require appropriate support and training. Ordinarily, practitioners use a variety of resources during counselling, including FPA leaflets, FPA website, models and manufacturers' information. However, there was no mention that not being able to use these resources over the telephone was a concern for them.

WHAT WERE THE CHALLENGES?

A few concerns were raised by practitioners, all of which are useful to consider when striving to improve patient care and experience. For example, situations involving a more complicated STI risk or an abusive relationship are more difficult to discuss over the telephone. This is something that should be addressed on a patient-by-patient basis, and indicates that an in-clinic appointment may be more appropriate. It is a possibility that STI screening rates could decrease, given the remote nature of the consultation. However, its importance should be emphasised and strongly encouraged for those who are deemed higher risk. In addition, there must be an emphasis on checking contact details and confirming consent for contact.

Table 1 Comments and concerns raised by patients and practitioners

Patients	Practitioners
► Worked really well for me as I work and have children. ► Great service. Quick and friendly. ► I feel my request was dealt with adequately and efficiently by the clinic and doctor. ► Quick, efficient service. ► It was very quick and easy over the phone and the doctor was friendly and informative. ► Really appreciated the convenience of the telephone consultation – highly recommended. ► Really good not to have to come in just for a conversation that could be handled by phone. ► Sometimes if it's questions, appointments aren't required, so was quicker by telephone. ► The phone line was a little crackly and sometimes had to ask her to repeat herself. ► Fantastic service – much appreciated. ► Poor line on telephone – difficult to hear consultation. ► Fab service and lovely staff.	► Continue and to be made the norm in most patients. ► Can use it more. Needs to be someone suitably qualified. ► Can see body mass index (BMI) and get a gut feeling if suitable. ► Body language is important. Can explain why asking questions and emphasise the importance. ► Implant counselling easier over the phone as sexually transmitted infection (STI) risk not as much of an issue. Guidelines say that lack of results shouldn't stop insertion of intrauterine device (IUD). Need to look at who else can do them. ► Only (clinical lead) doing them at the moment. Could be rolled out with appropriate support and training. ► Unsure as not seen a patient previously counselled over the phone. ► One occasion patient did not disclose about abusive relationship. Another occasion the patient declined the IUD at the fitting appointment. ► Good idea, however, it is important to update medical history and document that this has been done. ► Paves the way for using telephone as a consultation medium elsewhere.

WHAT IS THE FUTURE OF THE TELEPHONE SERVICE?

In response to the feedback received and data gathered, the telephone service will continue and the number of appointments will be increased in line with patient needs. Both doctors and nurses within the service are eager to take on these consultations themselves, with the appropriate support and training. This will consist of information about the logistics of telephone consultations, as well as confidentiality, identifying appropriate patients, and an update to our clinic guidelines for the provision of LARC, which will serve as a readily accessible point of reference. It should also be noted that the provision of additional insertion appointments is likely to be necessary if an increase in LARC uptake occurs, the need for which will be monitored closely.

The positive feedback from our patients and staff has provided support for this service, which serves as an example of how we can move towards remotely accessible sexual health services, suiting the lives of our modern-day patients. Practitioners suggested the exploration of other clinical situations in which this framework could be implemented, including re-issuing of contraceptive pills, asymptomatic screening and results reviews for stable HIV-positive patients. These recommendations will be discussed and further assessment of their feasibility will be carried out in due course.

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