

INTRA-UTERINE CONTRACEPTIVE DEVICE FITTINGS

A National Enhanced Service under the New contractual arrangements

Proposal to offer services from {surgery name} based on the national specification and benchmarking

Proposal date:

Introduction

1. All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

Background

2. Evidence shows that:

(i) IUCDs make up approximately 5 per cent of contraceptive usage in the UK Anonymous. Trends in contraceptive use. Living in Britain. London: HMSO, 1998. This is much lower than in many other European countries. In Scandinavia, IUDs make up 20% of contraceptive usage United Nations Department for Economic and Social Information and Policy Analysis. World Contraceptive Use (Wall Chart). New York: United Nations, 1994

(ii) clinical effectiveness is excellent, with a recognised failure rate for all devices of 0.2-2.0 per 100 woman-years. For the levonorgestrel-releasing intrauterine system (LNG-IUS) the failure rate is 0.16/100 woman-years which is comparable to female sterilisation Guillebaud J. Contraception: Your questions answered. London: Churchill Livingstone, 1999

(iii) it is one of two areas of contraceptive provision with relatively high levels of litigation Goodwin H. Family planning - medico-legal trends. Journal of the MDU 2000; 16: 23-24 and the most important factor influencing failure rate and problems is the competence of the professional inserting the device. Guillebaud J. Contraception: Your questions answered London: Churchill Livingstone, 1999

(iv) the risk of pelvic inflammatory disease attributable to IUCD usage is low at 1.5. Shelton JD. Risk of clinical pelvic inflammatory disease attributable to an IUD. Lancet 2001; 357: 443 If 1000 women have an IUCD inserted, then 1.5 of them will develop pelvic inflammatory disease

(v) the World Health Organisation (WHO) supports the use of the IUCD in young women including those under 20 years provided they are at low risk of sexually transmitted infections (STI) Wildemeersch D. Taking up the challenge: can effective long-term intra-uterine contraceptive methods radically reduce the number of unintended pregnancies? Journal of Family Planning and Reproductive Health Care 2001; 27: 121-123

(vi) the LNG-IUS has additional non-contraceptive benefits of decreasing menstrual loss and is part of the management of menorrhagia recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) RCOG. Guidelines for the initial management of menorrhagia. London: RCOG, 1998

(vii) insertion of a copper IUCD up to 5 days after presumed ovulation acts as a very efficient emergency post-coital contraception. Because of its increased post-coital time frame and non-hormonal constituents, it is complementary to the emergency use of the progesterone-only contraceptive pill

(viii) IUCD fitting is not undertaken by all general medical practitioners and maintaining expertise in IUCD fitting can be difficult. Gupta S, Miller J. A survey of GP views on intra-uterine contraception. Br J Family Planning 2000; 26: 81-84

Local factors

2a Include any special local factors to support your case eg {surgery name} cover very rural population with a widely dispersed population over **sq km. patients have to travel over **miles to reach their nearest hospital outpatients or laboratory. Within this setting, one of the PCT priorities is equity of provision and we would submit that our patients should not need to travel large distances to hospital care if the service can be provided efficiently and safely within primary care. Patients living close to hospital laboratory have the advantage of easier access to services compared to our very rural population some of whom might need ambulance transport to get to hospital care.

Aims

3. The aims of this service are to:

- (i) ensure that the full range of contraceptive options is provided by practices to patients
- (ii) ensure that the availability of post-coital IUCD fitting for emergency contraception should be more adequately provided as another means of reducing unwanted pregnancies
- (iii) increase the availability of LNG-IUS in the management of menorrhagia within primary care.

Service outline

4. This national enhanced service will PROVIDE:

- (i) fitting, monitoring, checking and removal of IUCDs as appropriate
- (ii) production of an up-to-date register of patients fitted with an IUCD. This will include all patients fitted with an IUCD and the device fitted. This is to be used for audit purposes, and to enable the primary care team to target these patients for health care checks
- (iii) practices to undertake regular continual professional development (CPD)
- (iv) provision of adequate equipment. Certain special equipment is required for IUCD fitting. This includes an appropriate room fitted with a couch and with adequate space and equipment for resuscitation. A variety of vaginal specula, cervical dilators, and equipment for cervical anaesthesia also need to be available. An appropriately trained nurse also needs to be present to support the patient and assist the doctor during the procedure
- (v) chlamydia screening before insertion of the IUCD and, if positive, refer for screening for other STIs. This should be in accordance with national policy, or with PCO policy if there is no relevant national policy
- (vi) the use of condoms to prevent infection
- (vii) regular assessment. A check of the IUCD after fitting is suggested at six weeks and thereafter annually. In addition any problems such as abnormal bleeding or pain should be assessed urgently
- (viii) provision of information. Written information should be provided at the time of counselling and reinforced after fitting with information on follow-up and those symptoms that require urgent assessment
- (ix) production of an appropriate GP record. Adequate recording should be made regarding the patient's clinical history, the counselling process, the results of any chlamydia screening, the pelvic examination, problems with insertion, the type and batch number of the IUCD, and follow-up arrangements. If the patient is not registered with the practice providing the NES, the providing-practice must ensure that the patient's registered practice is given all appropriate clinical details for inclusion into the patient's notes

(x) the use of LNG-IUS for the management of menorrhagia in primary care as part of a care pathway agreed and developed with local gynaecology departments. To ensure these devices are used for the correct patients and the approved indications

(xi) an annual review, which can include audits of the following areas:

- (a) the register of patients fitted with an IUCD
- (b) continuous usage rates
- (c) reasons for removal
- (d) complications.

Accreditation

5. Practitioners undertaking this procedure will have undertaken appropriate training. This will be based on modern, authoritative medical opinion, for example, the current requirements set down by the Faculty of Family Planning and Reproductive Health Care (FFPRHC) for the letter of competence in intrauterine techniques (LoC IUT). This involves a demonstration of gynaecological skills in assessing the pelvic organs, a minimum number of ten observed insertions in conscious patients, and appropriate knowledge of issues relevant to IUCD use, including counselling.

6. Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

Costs

7. The proposed costing is £75 insertion fee per patient and a £20 annual review fee per patient