The Health Promoting Health Service (HPHS) aims to support the development of a health promoting culture and embed effective health improvement practice as part of quality healthcare delivery. This contributes to the delivery of NHSScotland’s Healthcare Quality Strategy which puts people at the centre of quality delivery and encourages NHS Boards to share and spread their exemplars of high quality healthcare, pursue their local commitments, take new action to improve quality and consider different ways of working.

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hphs case study number 8

NHS Ayrshire & Arran share an example of successfully mainstreaming a pilot to provide access to long-acting reversible contraception (LARC) for postnatal women.

The outcomes

This was a clear and innovative pilot study that has been mainstreamed to provide women with the opportunity to access effective postnatal reliable contraception. The service was well received and, in the pilot period, 139 implants were inserted.

Although the pilot aimed to particularly target vulnerable women, an appetite amongst the general postnatal population for such a service was identified following information on the intervention from healthcare workers. It was anticipated that this timely contraceptive provision would reduce the rate of future unplanned pregnancies and thereby also the rate of induced abortions.

To date 488 sub-dermal contraceptive implants have been inserted within 27 months (which includes the pilot period).

Following a successful review of the pilot project, the directorate agreed to mainstream the service and it has now been part of business as usual for 18 months.

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Drivers

Ayrshire has one of the highest teenage pregnancy rates in Scotland. It is recognised that accessing and prioritising reliable contraception can be challenging, and even more so in the postnatal period, which is a busy and often stressful time for women.

Through consultation with relevant staff and patients in the maternity setting, a gap in the provision of postnatal contraception in Ayrshire Maternity Unit was identified. Midwives recognised the need to offer this service to postnatal women. It was, therefore, felt appropriate to use the existing skills of staff and to offer the service to postnatal women as part of routine care in the maternity setting.

The service was neatly aligned with the NHSScotland Healthcare Quality Strategy 2010 by taking a patient-centred approach, as well as providing a timely service. Although the Chief Executive’s Letter (CEL) 01 (2012) was issued after this pilot was completed, the work of this project fell within its health improvement concept.

What we did

A gap in service provision was recognised for women requiring prompt access to reliable postnatal contraception. In order to meet these needs, a nine-month pilot was launched in May 2010 offering contraceptive implant insertion in the immediate postnatal period. This method provides effective contraception for up to three years. Although the pilot aimed to meet the needs of vulnerable postnatal women (young women, women with addictions or those with child protection issues), the service was also made available to any postnatal woman who requested it. It was hoped that this project would provide timely contraception, thereby reducing the risk of a future unplanned pregnancy. In turn, it was hoped that this would affect local teenage pregnancy and abortion rates.

The project offered sub-dermal (under the skin) progestogen-only contraceptive implants to postnatal women. This service was provided within a few days of their baby’s delivery, and before the women were discharged from hospital. The procedures took place in the day ward, which is located within the maternity unit.

The termination of pregnancy services for NHS Ayrshire & Arran are located in the day ward and therefore the staff in this department were already trained to provide this contraceptive service. Additional training and support was provided to staff as required.

The project to extend this service to postnatal women was led by an experienced clinician in sexual health. In order to use the existing skills and resources, the management approved funding from the Women’s, Children’s and Sexual Health Directorate. A targeted marketing strategy was developed which included promoting the service to nurses and midwives in hospital and in the community who were looking after antenatal and postnatal women.

The promotion also included the production of leaflets and small posters which were displayed in waiting areas and on toilet doors. Dr Catriona Melville, Consultant in Sexual and Reproductive Health said, ‘promoting this service was quite effortless because it was based on an expressed need’.

This project was a partnership of a multidisciplinary team including clinical, nursing and non-clinical health professionals as well as the patients themselves. GPs were informed of the treatment provided to their patients and any issues relating to individual patients were discussed and addressed.
What we found difficult
The initial challenge was to engage key staff members but there was such enthusiasm and cooperation from staff that, once funding had been agreed, the project ran smoothly.

Due to the availability of staffing, it was initially difficult to provide this service over weekends (although demand was much less than on weekdays). Some women also decided to opt for the implant once they had been discharged home. To overcome these challenges, a number of midwifery staff were identified who could offer the service out-of-hours if required. Additionally, now that the service has been mainstreamed, some woman return to the day ward to access this service in the postnatal period. The staff are happy to accommodate this.

There is no information available on the numbers of women who may have had their implant removed somewhere other than NHS Ayrshire & Arran’s sexual health services. It was, therefore, difficult to accurately predict how many women continued with the contraceptive method. This was reviewed in the pilot in an attempt to identify the proportion of women who returned to have their implants removed. It was noted that only 11 women from the pilot returned to have a removal procedure in Ayrshire & Arran sexual health services.

Myths concerning the contraceptive implant such as it affecting breastfeeding had to be overcome by education of other healthcare professionals and the women themselves.

What worked well
• Provision of access to a reliable form of contraception.
• The staff who provided this service offered flexibility, were enthusiastic and skilled/knowledgeable without additional training.
• The project provided women, particularly vulnerable women who may otherwise have found it challenging to access their GP or another service for contraception, with the choice to take control of their reproductive health.
• It also gave women time to enjoy their baby and the postnatal period without worrying about contraception.
• A widespread range of women of all ages used this service.
• Women were enabled to take control of their reproductive health and plan future pregnancies.
• The anticipated benefits of this included a reduction in unplanned pregnancies in the early part of the postnatal period, and also encouragement for pregnancy spacing.
• Some staff members learned new skills as part of their KSF development.

Evaluation
• It is vital to overcome the thought process that antenatal and postnatal care solely concerns the immediate care for the mother, the baby and breastfeeding. The findings suggest that it is wider than that; it is about improving the health of both mother and baby by addressing the all-health issues that would have an impact on both, for example, looking after the mother’s future reproductive health.
• Funding, and other barriers, may present difficulties in providing this targeted service, however, the main resource are the skills of staff. If existing skills are utilised to their potential, there would always be a way to improve health while patients are under maternity care.
• It is a very simple and straightforward method that can be replicated in other maternity wards.
• There was initial investment in terms of time, organisation and training. However, this was a valuable activity to benefit patients and contributed towards the health improvement agenda, including the reduction of health inequalities.
• The project would recommend a specific piece of research in order to quantify actual impact.
Future steps

Future activities to support mainstreaming the services include:

- Offering full provision of the service over the weekends.
- If demand increases, offering more staff reproductive health training to be skilled to insert implants.
- Monitoring how many women return to have their implants removed.
- Continuing the promotion of the service amongst primary care and educating fellow professionals to dispel existing myths about offering postnatal implants for contraception.
- Discussing contraception, and particularly LARC, in the antenatal and postnatal period. A key target of sexual health service providers is a reduction in teenage pregnancies.
- Commissioning research to assess the impact of this service in all women, particularly amongst vulnerable groups who received an implant. It would look at whether the implant increased the gap between pregnancies or reduced the number of unplanned pregnancies in all women who received the implant, but particularly vulnerable women.
- It is recognised that sub-dermal implants are one of the more expensive methods of contraception, however, cumulative costs of abortions, teenage pregnancies, unplanned births and care for women with addictions (and their babies) would suggest that this is a cost effective method.

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