NHS
Nottingham and Nottinghamshire

Female Sterilisation - policy alignment survey

Background

On 1 July 2022, the two clinical commissioning groups (CCGs) known as Bassetlaw CCG and Nottingham and Nottinghamshire CCG, which served the population of Nottingham and Nottinghamshire, were brought together and replaced by a new organisation called NHS Nottingham and Nottinghamshire Integrated Care Board (ICB).

Previously, the separate CCGs had different commissioning policies. Since the establishment of the ICB, efforts have been made to harmonise all internal and external policies for the new organisation. The goal is to ensure that people in Nottingham and Nottinghamshire have fair and equal access to healthcare within the same timeframe and based on the same clinical reasons.

Many of these policies have already been integrated into approved policy documents. In these cases, there have been no changes to the treatment, eligibility, or pathway. The only difference is that now the same policy applies to all residents of Nottingham and Nottinghamshire.

To ensure the policies align with strong clinical evidence and national guidance, NHS Nottingham and Nottinghamshire staff, including doctors and nurses, have reviewed them. This ensures that the policies apply equally to all patients in the area, with minimal impact in most cases.

However, one policy difference requires potential changes for patients: Access to Female Sterilisation. The former Bassetlaw CCG had no specific rules for approving this procedure, whereas the former Nottingham and Nottinghamshire CCG required patients to try an Intrauterine Device (IUD) (e.g., a Mirena coil) for one year before considering sterilisation. From April 2022 to March 2023 Nottingham and Nottinghamshire ICB received 287 applications for female sterilisation. Of this, 93 were rejected (32%) due to the requirement of the 12 month IUD trial.

Desktop research revealed that no other ICB has this requirement in their policies. A stance that is further supported by NICE (National Institute for Health and Care Excellence) guidance[1]. Instead, the NICE guidance encourages patients to consider all possibilities for long-acting reversible contraception (LARC) prior to being referred for permanent sterilisation. It also suggests providing patients with information about the risks, benefits, and success rates of sterilisation in contrast to alternative contraception methods such as LARC and male vasectomy.

[1] Scenario: Female sterilization (tubal occlusion) | Management | Contraception - sterilization | CKS | NICE

In addition to the clinical review the ICB could be at risk of legal challenge by not upholding equality standards if the requirement criteria were to continue as it misaligns with the ICB's statutory duties such as the NHS Act 2006[2] and the Equality Act 2010[3].

The removal of the mandatory IUD trial could potentially benefit patients in specific diverse communities who do not believe in, or hold reservations about, the use of IUDs. Moreover, survivors of sexual abuse and trauma (such as Female Genital Mutilation) might consider the utilisation of an IUD to be invasive and unsuitable. In addition, increasing the choice and accessibility of LARC and sterilisation services could play a role in reducing unwanted pregnancies or the need for terminations arising from unwanted pregnancies.

To address the disparity between the policies and align with national guidance, a recommendation has been made to remove the mandatory trial period and instead propose that patients "explore all suitable contraceptive options before considering sterilisation."

Methods

On 5 July 2023 the ICB launched an online survey to obtain feedback and comments around the proposed change to the female sterilisation policy. The survey comprised of two questions on the policy and demographic questions. Information was available on our website to promote the opportunity for people to be involved. Hard copies and other languages were available on request. The opportunity to participate was shared with the Mid Nottinghamshire Health Inequalities meeting, Citycare Partnership, Nottinghamshire Healthcare Trust, Community Voluntary Sector colleagues, the RAPID group (Chairs of all the Patient Participation Groups), Engagement Practitioners Forum and East Midlands Academic Health Science Network as well as being promoted on the ICB intranet and staff news.

We specifically wanted to hear from patients who would have an interest in this policy change. Therefore, it was disseminated to the following groups:

- Maternity Voices Partnership and Local Maternity & Neonatal System contacts
- Nottinghamshire County Council Children and Womens contacts
- Miscarriage association
- Local baby and toddler groups
- JUNO Women's Aid
- She UK
- Heya
- Nottingham Women's Centre

The survey closed on 26 July 2023. 36 people responded to the survey. Of the 36 responses, 24 (67%) respondents confirmed they were members of the public, 8 (22%) respondents worked within the NHS, 2 (6%) respondents worked within the voluntary, community and social enterprise sector, 1 (6%) person selected that they work on behalf of an NHS organisation and 1 (6%) person preferred not to say.

[2] National Health Service Act 2006 (legislation.gov.uk)
[3] Equality Act 2010 (legislation.gov.uk)

Findings

80% of respondents support the recommendation, 61% (22) of respondents strongly support and 19% (7) somewhat support the recommendation. 8% (3) of respondents strongly oppose the recommendation and 11% (4) somewhat oppose as depicted in figure 1. No respondents selected a neutral response of 'neither support nor oppose'.

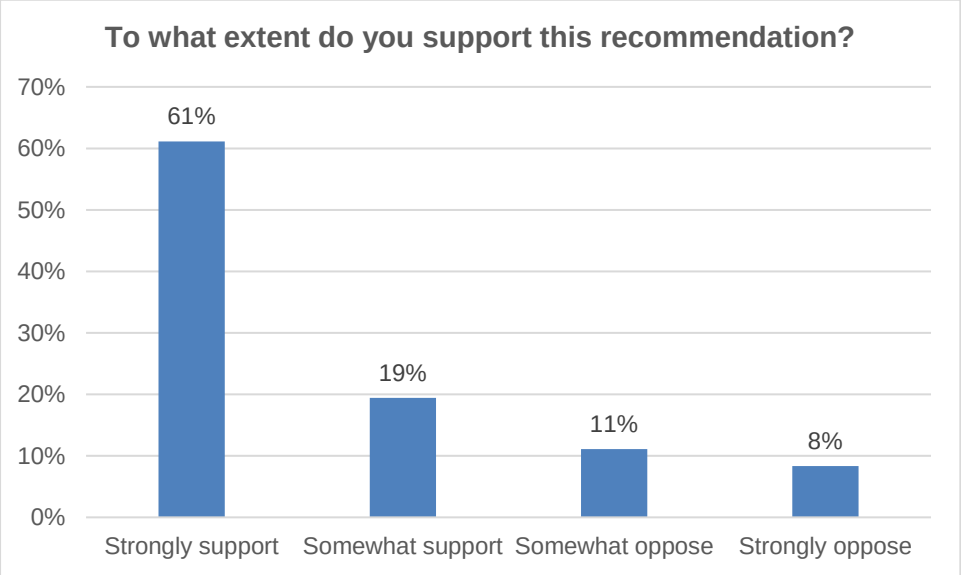

Figure 1. Support for recommendation (n=36)

"Women will have a very good reason for wanting sterilisation and will normally have already considered other options. They will not make this decision lightly. They should not be forced to do something that they already decided they do not want (i.e. have a coil)."

Bodily autonomy was the reason just over half (54%) of respondents 'strongly support' the recommendation, closely followed by patient choice (45%). Others also cited that the recommendation is a sensible and logical update to the current policy. Many also supported the policy change as it would decrease barriers to accessing female sterilisation.

One of the reasons put forward for somewhat opposing the change was the detrimental impact on resources:

"it will cause more sterilisation operations, which will cost more money and unnecessary General Anaesthetic when it is not as effective as something like the coil which is a 10 minute procedure"

The importance of accurate, timely information was emphasised with many who either supported or opposed the recommendation.

"I strongly support the recommendation with a caveat . As a clinician who has worked in the area of women's health, I am aware there are varying degrees of knowledge and expertise around intrauterine contraception. This is often a very suitable method with very low failure rates and LNG coils are excellent for heavy menstrual bleeding. Women who are properly counselled will sometimes choose this method over sterilisation, even if sterilisation was their initial preferred option. So the caveat would be around the requirement for high quality counselling as part of the pathway."

"It seems more vague. If a person knows they want to be sterilised, are we expecting them to try all other options first? Will there be a timeframe? Whose discretion is it at? This seems like it might be making the process harder for women to access the treatment they want."

"I have been sterilised and I would not have wanted intrauterine contraception or any other contraception in case it failed. I made this informed decision with support from my GP. It is my body and I do not wish to be forced into having options around my health. I feel it is more about practitioners educating women on the choices of contraception rather than stipulating that we have to trial intrauterine contraception for one year before considering sterilisation. I question the equality in such decision making when male counterparts health is becoming more readily available yet women's are becoming more restrictive: mensuration [sic], abortion, menopause and now contraception."

The above response is also an example of a few respondents' sentiments querying whether equivalent mandatory service criteria was replicated for policies relating to male services.

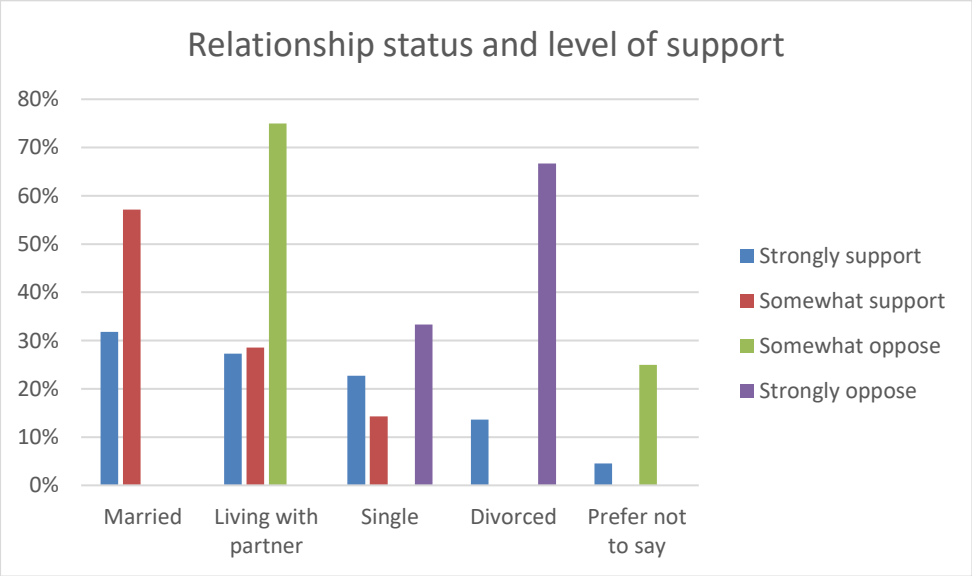

Figure 2. Relationship status and level of support (n=36)

Figure 2 shows that for those who strongly support the recommendation there was a mix of relationship status. There is a correlation is for those who are married and support the recommendation either strongly or somewhat and those who are divorced selected strongly oppose the most.

Conclusion 1: 32% of people wanting female sterilisation were not able to access the service because of the IUD requirement in Nottingham and Nottinghamshire. Clinical review indicated that the current Nottingham and Nottinghamshire criteria differs from national guidance. The majority of survey respondents supported the change to the sterilisation policy, mostly citing support due to bodily autonomy and patient choice.

Recommendation 1: To remove the requirement for patients to trial the IUD for 12 months.

Conclusion 2: Many noted that it is vital there is sufficient high-quality and timely information regarding contraception and sterilisation so that patients and clinicians can be confident they are making an informed choice.

Recommendation 2: To ensure that there is appropriate information and advice for patients exploring this treatment.

Appendix: Demographic profile of survey respondents

35 of the 36 people who completed the survey were women and 1 was a man (figure 3).

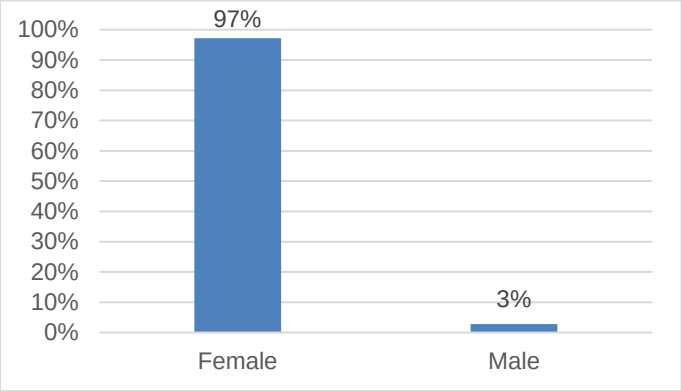

Figure 3. Gender of respondents (n=36)

Of the 36 who completed the survey, 2 (6%) were aged between 25-34, 15 (42%) were aged between 35-44, 12 (33%) were aged between 45-54, 4 (11%) were aged between 55-64, 2 (6%) were aged between 65-74, 1 (3%) person was aged over 85 (figure 4).

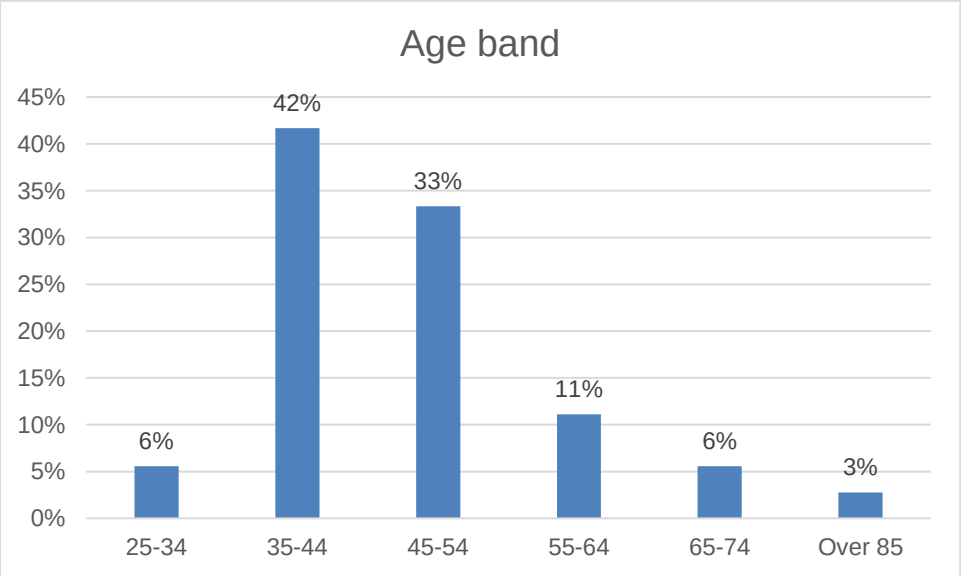

Figure 4. Age of survey respondents (n=36)

The majority of survey respondents were White (English, Welsh, Scottish, Northern Irish or British) (86%), %). 1 person selected two categories and also indicated that they were White and Black African (3%), 1 person indicated they were White – Irish (3%) and 2 people said they were White – Other (5%) and 1 person indicated they were Indian (3%) (figure 5).

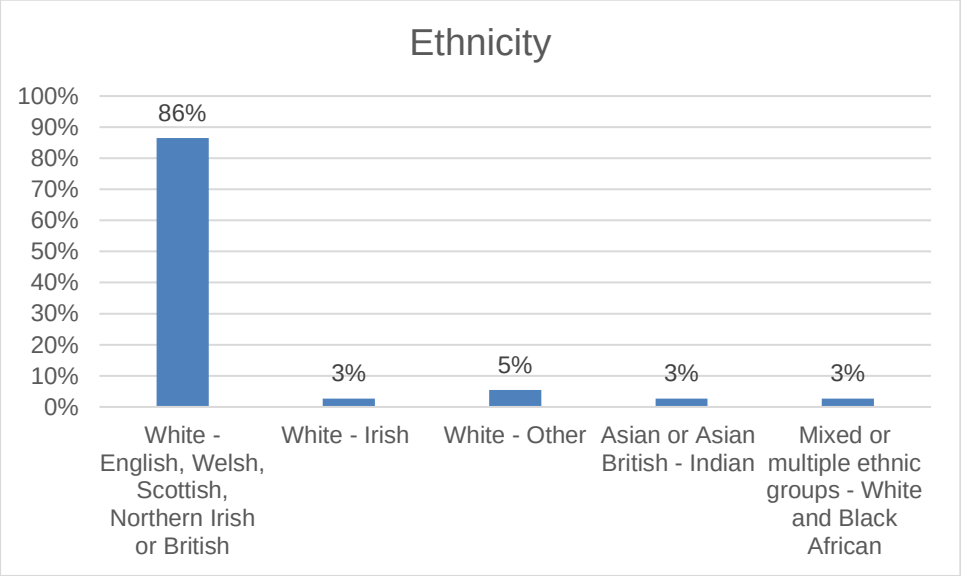

Figure 5. Ethnicity of survey respondents (n=37)

Of the 36 who completed the survey, 34 (94%) were not pregnant, on maternity leave or returning from maternity leave, 1 (3%) indicated that they fitted into this category and 1 (3%) preferred not to say (figure 6).

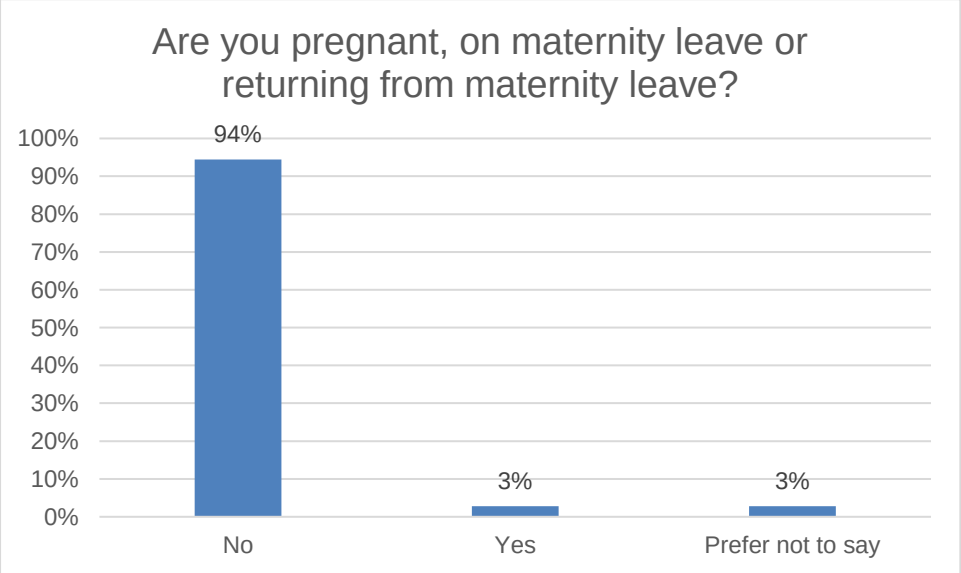

Figure 6. Survey respondents pregnant or on/returning from maternity leave (n=36)

The majority of respondents told us that they were either living with a partner (11) or married (11) (both 31%), 7 (19%) respondents were single, 5 (14%) divorced and 2 (6%) preferred not to say (figure 7).

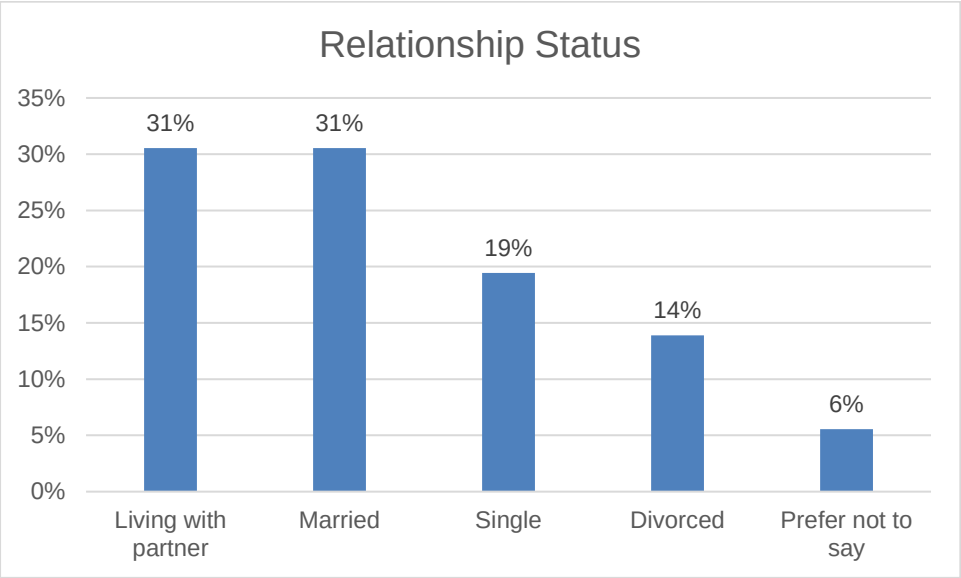

Figure 7. Relationship status of survey respondents (n=36)

Of the 36 respondents 31 told us which district/borough they resided in. 11 (31%) resided in Nottingham City, 5 (14%) in Gedling, Mansfield and Rushcliffe respectively, 2 (6%) in Ashfield and Newark and Sherwood respectively, and 1 (3%) Broxtowe (figure 8).

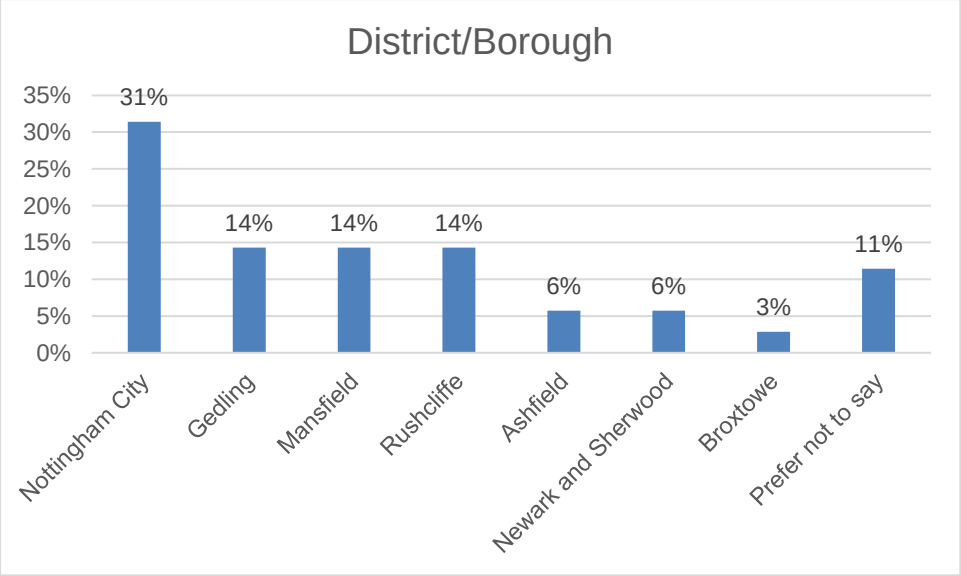

Figure 8. District/borough of survey respondents (n=36)