



Fieldwork for Draft Guidance on  
Contraceptive Services for Socially  
Disadvantaged Young People

FIELDWORK REPORT

29th June 2010

Fieldwork for Draft Guidance on Contraceptive Services for  
Socially Disadvantaged Young People  
National Institute for Health and Clinical Excellence

A report submitted by GHK

*Date: 29 June 2010*

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**Document Control**

<i>Document Title</i>	Fieldwork for Draft Guidance on Contraceptive Services for Socially Disadvantaged Young People
<i>Job No.</i>	J7751
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<i>Date</i>	29 June 2010

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## EXECUTIVE SUMMARY

### 1 Aims and Methodology

GHK Consulting Ltd were commissioned by the National Institute for Health and Clinical Excellence (NICE) to test the draft recommendations on ***NHS provision of contraceptive services for socially disadvantaged young people up to the age of 25.***

The purpose of the fieldwork was to test the thirteen recommendations in order to assess their relevance and usefulness to practitioners across a range of services inside and outside the NHS, as well as exploring the barriers and facilitators to implementation, and how any barriers might be overcome.

The fieldwork was carried out with **162 practitioners** consulted through focus groups, supplemented by additional interviews where required. A total of 15 focus groups were held - 12 of these were in local authority areas chosen for their location in each of the English regions, as well as their high deprivation and rates of teenage pregnancy. Two further focus groups were held with voluntary and community sector representatives; and one with practitioners in a local teenage pregnancy and sexual health network.

Participants in the fieldwork included contraceptive and sexual health (CASH) service staff, teenage pregnancy coordinators, NHS staff in related settings such as sexual health units in acute trusts and termination (TOP) services, GPs, public health specialists, commissioners, Connexions staff, voluntary sector workers and youth workers.

### 2 Key Findings

Overall the draft recommendations were welcomed by the practitioners taking part in the focus groups and individual interviews, where they were considered to be useful and relevant to their day to day practice. Furthermore, the vast majority of participants were pleased to see references throughout the recommendations to both young women and their partners, as well as to the involvement of young people.

- The practitioners found little to disagree with about the content and order of the recommendations themselves. The vast majority of practitioners welcomed the content of the draft recommendations, although some areas stimulated more discussion than others. These include the advanced provision of EHC, the coverage and definition of 'social disadvantage', and access to contraception and sexual health services in schools.
- The majority of participants felt the ordering of the draft recommendations was logical. However, some felt that the recommendation five (young peoples' services) could be condensed into recommendation 12 (communication) as there was some overlap in the content.
- Responses to the draft recommendations and actions varied between "something we aspire to" and "something we are doing already". Where practitioners felt the draft recommendations were something they could aspire to they were regarded as providing guidance on "gold standard" services for young people.
- The consultation highlighted that the practice and structuring of service provision for contraceptive services and sexual health services varies across the country. For example, one of the biggest variations acknowledged is the provision of emergency hormonal contraception (EHC). While such variation highlights different approaches to the provision of services to young people, it will also have potential implications for roll out and implementation of the recommendations and guidance.

- Participants discussed the provision of services for socially disadvantaged young people, and the provision of services for all young people. Many participants felt that 'socially disadvantaged' could be more clearly defined for the draft recommendations. However, there was debate as to whether the draft recommendations should be specific in relation to socially disadvantaged groups, or whether an overarching definition could be used. Where participants felt an overall 'catch all' description could be used, they often referred to the risk factors for teenage pregnancy.
- The vast majority of participants felt the recommendations were applicable to all young people, as opposed to those facing social disadvantage.
- Throughout the consultation practitioners reiterated that contraceptive services should not be seen separately from sexual health services. As a result, many practitioners felt that the recommendations should refer consistently to contraceptive and sexual health services. The vast majority of practitioners that work with young people tended to view contraception and sexual health as a holistic service, which in their daily practice is not separated. Therefore, the vast majority of practitioners felt the recommendations should include more explicit reference to STI testing, or where relevant, it should make references to other NICE guidance available.
- Many participants felt the draft recommendations are medically focused and do not take into account the additional services provided by other organisations. The vast majority of participants felt the content was aimed at clinical and health staff. Across the board, there was a strong view that a holistic approach (including support such as counselling and mentoring) with young people results in better outcomes.
- Many practitioners felt some of the wording used could be changed to strengthen the impact of the draft recommendations, particularly where schools are among those listed to take action.
- Many practitioners felt additional information on why the services are important would support the recommendations. Equally commonly, practitioners felt the draft recommendations could provide case examples of service delivery which is effective in engaging socially disadvantaged young people.
- The links in the recommendations to other key policies and documents could also be strengthened. Many practitioners felt the draft recommendations lacked links to other guidance documentation.

Across the whole consultation, several barriers to implementing the recommendations were identified, from a lack of funding to variations in local service provision, differing interpretations of confidentiality and safeguarding between agencies, practitioners' lack of knowledge in identifying and engaging with socially disadvantaged young people, and the position of some schools in relation to the provision of contraception and sexual health

While these potential barriers were reported, other practitioners described approaches implemented locally which had managed to negotiate, or at least reduce the impact of, many of the barriers mentioned. Examples of such approaches, or 'enablers', included:

- Commissioning specialist teenage pregnancy midwives; this service can deal with the needs of vulnerable young women and their partners in a holistic manner, by providing support and advice on contraception and relationships from the early stages of pregnancy, as well as tackling wider issues around risk-taking behaviour e.g. drugs and alcohol.

- Some fieldwork areas had started to offer contraception and sexual health services as part of a wider, general health and wellbeing drop-in service in schools and other community settings. This was felt to have the advantage of a more holistic approach (young people can receive advice about healthy relationships and other risk taking behaviours) and would reduce stigma and other concerns that young people have about accessing such services – as well as allaying schools' and colleges' concerns about whether such services fit with their 'ethos'.
- One local area had persuaded schools to provide health information on sex and contraception via the school intranet, getting around the problem of filters which blocked sites that might otherwise be informative.

Many of the participants also felt the draft recommendations could themselves be used to approach commissioners and other influencers to highlight the importance of sexual health and contraceptive services.

### **3 Summary of Changes**

A detailed summary of changes suggested by practitioners to enhance the draft recommendations – in terms of the target population for the recommendation, who should take action and what action should they take – can be found on page 76 of this report and is not reproduced here.

# 1 INTRODUCTION

## 1.1 Overview and Purpose of Fieldwork

GHK Consulting Ltd were commissioned by the National Institute for Health and Clinical Excellence (NICE) to test the draft recommendations on ***NHS provision of contraceptive services for socially disadvantaged young people up to the age of 25***. Fieldwork is an integral part of the development of NICE public health guidance, and this report presents the findings of a series of consultations on the draft recommendations, undertaken through a programme of focus groups and individual interviews.

The fieldwork took place between the 3<sup>rd</sup> and 24<sup>th</sup> June 2010, and collected views on the draft recommendations from 162 practitioners with an interest in contraceptive and sexual health across England. Participants included a range of professionals, commissioners, managers and staff within the NHS (such as contraceptive and sexual health services, primary care and young people's services), and staff within local authorities and the voluntary and community sector. The participants were asked questions on the relevance, utility and potential for implementation of the draft recommendations, in relation to the provision of contraceptive services to socially disadvantaged young people.

In keeping with the established practice in carrying out NICE fieldwork, the views contained in this report and the conclusions derived from them are entirely based on the evidence given by the commissioners, managers and frontline staff to whom we spoke.

GHK would like to thank all of the participants who committed their time to take part in the fieldwork, and particularly those who assisted with the focus group recruitment and organisation process in their areas.

## 1.2 Background and Scope

NICE were requested by the Department of Health to develop guidance on NHS provision of contraceptive services for vulnerable young people up to the age of 25. The scope of the guidance envisaged recommendations for good practice based on the best available evidence of effectiveness, including cost effectiveness.

The guidance is aimed at professionals, commissioners and managers working within the NHS, as well as staff working within local authorities with public health as part of their remit, and the wider public, private, voluntary and community sectors. The guidance is particularly aimed at: those providing contraceptive services or young people's sexual health services (e.g. specialists in sexual and reproductive healthcare, gynaecologists, nurses, pharmacists and GPs); youth workers, social workers, probation officers, teachers and others working with disadvantaged young people; and at parents, carers and other members of the public.

The guidance is intended to complement a range of existing NICE guidance on preventing sexually transmitted infections (STIs) and under 18 conceptions; looked after children; long acting reversible contraception (LARC); personal, social and health education focusing on sex and relationships; and alcohol education.

The full rationale and scope for this guidance is available at <http://guidance.nice.org.uk/PHG/Wave18/50>

## 1.3 Structure of this Report

This report is structured as follows:

- **Section 2 – Aims and Methodology:** setting out the aims for the fieldwork, the methodology followed and the characteristics of the individuals participating in it;



- **Section 3 – Responses to the Draft Recommendations Overall:** describing participants' responses to the draft recommendations overall, and the cross-cutting issues raised;
- **Section 4 – Responses to the Individual Draft Recommendations:** providing the participant responses to each of the thirteen draft recommendations, including suggestions for change in content and emphasis for each; and
- **Section 5 – Conclusions:** summarising the key findings, discussing the implications for NICE and the implementation of the final guidance, and consolidating the changes to the draft recommendations suggested by the fieldwork participants.

The report also features five annexes, providing:

- Annex A – the discussion guide used in the consultations;
- Annex B – the consent letter signed by the consultation;
- Annex C – the prior reading task set for participants;
- Annex D – the sign in sheets completed at the focus groups; and
- Annex E – the equalities monitoring form and data collected from the individuals participating in the fieldwork.

## 2 AIMS AND METHODOLOGY

This section describes the aims of the fieldwork, the key questions posed and the methodology followed, and presents the characteristics of the practitioners consulted during the fieldwork.

### 2.1 Fieldwork Aims and Questions

The aims of the fieldwork were as follows:

*To examine the relevance, usability, acceptability, and implementability of the NICE public health guidance on NHS provision for socially disadvantaged young people with a variety of professionals, commissioners, managers and frontline staff.*

Consequently the key questions to be addressed by the fieldwork included:

- What are the views of professionals, commissioners, managers and practitioners on the relevance and usefulness of the draft recommendations to their current practice?
- What factors could help or hinder the effective implementation and delivery of the guidance, in particular the draft recommendations, as part of their current practice?
- What are the potential consequences of the guidance, in particular the draft recommendations for improving health and tackling health inequalities?
- What is the potential impact of the draft recommendations, and which are both feasible and likely to make a difference to practice?
- What would be the relative priority of each of the draft recommendations?

The questions informed the development of the discussion guide used in the fieldwork with practitioners, and can be seen in Annex A. In addition, practitioners were also asked to provide examples that illustrated current (and good) practice in the provision of contraceptive services to socially disadvantaged young people.

Our original proposal described how at least 112 practitioners would be consulted through 14 focus groups (including additional individual interviews as appropriate) across the consultation period. However, given the number of recommendations and the need to extend the duration of the focus groups, this target was reduced to nine focus groups with a minimum of 100 practitioners (including additional interviews).

An 'over sampling' recruitment approach was followed to ensure that the minimum participation target was reached. However, as interest in the topic was high, additional focus groups were held to ensure coverage by role/sector. A total of **15 focus groups were held and six interviews undertaken, with a total of 162 individuals taking part**. This total exceeded both the initial and revised participation targets for the fieldwork.

### 2.2 Methodology

The fieldwork methodology was developed by GHK in conjunction with the NICE project team, to ensure the approach conformed with CPHE fieldwork methods guidance. The methodology comprised three phases:

- An initial preparatory phase – including developing and populating a sampling frame, recruiting participants and arranging focus groups/interviews, and developing fieldwork guidance and materials;

- A fieldwork phase – comprising the delivery of the 15 focus groups and six interviews with a total of 162 individuals; and
- An analysis and reporting phase – including the analysis of the information from the focus groups and interviews, and the production of draft and final fieldwork reports.

The key elements of the methodology are summarised below.

### **2.2.1 Sample development**

A sampling frame was developed for the recruitment of fieldwork participants, and to ensure that a robust picture was provided of the views of a range of diverse professional groups, working in different settings and circumstances, on the draft recommendations.

The sample was structured around the nine English regions (which correspond with Strategic Health Authority boundaries), with at least one Local Authority being selected in each region. The Local Authority sample across within each region was selected by the following variables:

- Socioeconomic characteristics – as measured by the Index of Multiple Deprivation (2007);
- Teenage Pregnancy Rate;
- Rural and urban settings; and
- Local authority type (county council, unitary authority, metropolitan borough or London borough).

### **2.2.2 Participant recruitment**

Recruitment was undertaken using a purposive sampling process, designed to recruit a diverse group of participants to provide feedback on the draft recommendations. The recruitment process in local authorities was carried out as follows:

- Initial contact was made with the Teenage Pregnancy Coordinator in each local authority area, who was invited to participate and suggest other relevant contacts;
- A sample of staff working in the local authority, health services and voluntary and community sector organisations were then contacted and invited to attend focus groups or to take part in individual face to face or telephone interviews (where they were unavailable for their local focus group).
- A number of Sexual and Teenage Pregnancy Networks were approached to take part in the fieldwork, to supplement the local authority groups and ensure participation amongst health service based staff; and
- To ensure the participation of voluntary and community sector organisations, NICE provided a list of potential participants who were invited to attend two focus groups in GHK's London offices.

To ensure that a wide range of relevant practitioners were recruited to the 'local authority' focus groups, quotas were set for the recruitment and participation of individuals by job role/work area (attendance against quota being shown in Table 2.2 below). Each group, and the sample more broadly, was 'over recruited' to ensure that the targets were met.

Once recruited, informed consent was obtained from each participant (an example of the consent letter can be seen in Annex B). The draft recommendations were provided to each

individual shortly before the fieldwork took place, along with a short pre-read task designed to help structure their thoughts and feedback in advance (see Annex C).

Two days prior to each focus group, participants were sent a reminder email of the date, venue and time to maximise attendance. Participants not returning their consent forms could also complete them at their focus group events.

### **2.2.3 The focus groups**

A total of 15 focus groups were held:

- 12 by 'local authority area';
- 2 for voluntary and community sector representatives; and
- 1 for practitioners in a local teenage pregnancy and sexual health network.

Each focus group was around three hours in duration, attended by a lead researcher/facilitator and a scribe from GHK and recorded to allow quotes to be captured (although these were not transcribed). NICE and PDG representatives also attended eight focus groups, to experience the fieldwork process and hear practitioner views first hand.

A discussion guide, provided in Annex A, was used to structure the consultations. These were facilitated as opposed to led, as it was important that participants reached their own conclusions on the draft recommendations, where any gaps lay, and any potential barriers to implementation.

Participants were asked to complete a 'sign-in' sheet and an equalities monitoring form on arrival (see Annex D, with the data collected being shown as Annex E), with additional consent forms being available for any not returned in advance. Following each focus group a summary of the comments taken was circulated to all the attendees, to ensure any factual points and views had been recorded accurately. Ten participants commented on their summary sheets, with comments including examples of current practice and points they considered should be emphasised.

#### ***The 'local authority' focus groups***

Focus groups were undertaken in **12 local authority areas** (nine from the 'first choice' list and three from the 'reserve' list), with the authorities. Their characteristics and the number of practitioners attending are shown in Table 2.1 below. As suggested previously, attendance rates at all the focus groups were high, with a total of **133** individuals participating in the local authority groups alone.

#### ***The 'additional' focus groups***

Three additional groups were undertaken, two for representatives from voluntary and community sector organisations, and a third for practitioners in a local teenage pregnancy network:

- The voluntary and community sector focus groups were held in GHK's London offices, with a total of **12** individuals attending; and
- The North West London Teenage Pregnancy Network focus group was attended by **11** individuals/network members.

**Table 2.1: Achieved Sample for Local Authority Focus Groups**

Local Authority Area	Deprivation Ranking	Teenage Pregnancy Rate	LA Type	Focus Group Attendees
Manchester	4	71.3	MCD	13
Hull	10	70.3	UA	10
Bradford	28	47.2	MU	12
Southwark (and Lambeth)	24	76.7	LB	14
Staffordshire	50	42	County	8
Torbay	55	57.4	UA	10
Plymouth	58	51	Unitary	11
Portsmouth	67	57.66	UA	9
Leicester	19	50.3	UA	14
Peterborough	65	48.5	UA	9
Durham	50	50.7	County	14
Birmingham	9	52.9	MCD	9
<b>TOTAL</b>				<b>133</b>

#### 2.2.4 *The individual interviews*

Finally, individual interviews were undertaken with **six** practitioners, most commonly when they had shown an interest in the study but were unable to attend the focus groups in their areas. The majority of these interviews were undertaken by telephone, although **two** were undertaken on a face to face basis.

In each case the participation process reflected that followed in the focus groups, with each individual being provided with a copy of the draft recommendations and materials to secure consent. While the duration of the interviews was considerably less than the focus groups (between 45 minutes and one hour, compared to three hours for the focus groups), all the draft recommendations were covered, with interviewees being asked to prioritise the areas where they had the strongest opinions.

### 2.3 **Fieldwork Coverage – Types of Practitioners and Organisations**

Indicative quotas were set for involvement by practitioner and organisation 'type', with two main groups and a series of subgroups being identified:

- NHS Staff - staff employed by an NHS Trust, PCT Commissioning arm or community providers, including staff involved in commissioning or coordinating services for young people's sexual health, managing or planning service delivery and frontline staff (including doctors, nurses, non-clinical staff, midwives and health visitors, pharmacists, public health specialists and Teenage Pregnancy Coordinators).
- Non NHS staff - staff employed in the statutory (e.g local authorities or local authority led partnerships) or the voluntary and community sectors, working with NHS services and involved in the planning, coordination and delivery of local services. This group includes staff with a focus on advice and guidance, drugs and alcohol, homelessness, youth offending areas - and includes social workers, teenage pregnancy and youth workers.

Quotas were set for participation in the fieldwork by NHS and non-NHS staff, and by subgroups, with participation against quota being provided in Table 2.2.

**Table 2.2: Participation Target vs Achieved by Quota**

Type of Staff	Quota Target	Quota Achieved	Number of practitioners (subgroups)
Commissioners / coordinators of local services	25	24	
Service delivery managers or leads	25	60	
Front line staff	50	71	
Other (e.g. administrators, policy leads)	n/a	10	
<b>TOTAL</b>	<b>100</b>	<b>162</b>	
Contraceptive and sexual health services/professionals, including NHS funded Health Advisory Services and services based in schools	34	49	
<i>Doctors and nurses in GU departments</i>			6
<i>Nurses in community CASH services</i>			20
<i>Other community nurses (excl. school nurses)<sup>1</sup></i>			9
<i>Health advisors</i>			6
<i>Other sexual health professionals</i>			8
Teenage Pregnancy Co-ordinators <sup>2</sup>	10	15	
Family Nurse Partnerships staff	7	4	
Termination of pregnancy (TOP) Services	8	3	
Antenatal and postnatal care services <sup>3</sup>	8	2	
Other primary care or NHS professionals	13	41	
<i>GPs</i>			6
<i>School nurses</i>			8
<i>Pharmacists</i>			2
<i>NHS Commissioners including public health specialists</i>			13
<i>Others including service managers</i>			12
Other (non-NHS) groups including managers, professionals and advisors working with young people - youth services, social workers etc	20	48	
<i>Employed in the statutory sector (e.g. Connexions workers and commissioners)</i>			23
<i>Of which were: employed in the voluntary sector</i>			25
<b>TOTAL</b>	<b>100</b>	<b>162</b>	

<sup>1</sup> Including specialist nurses in chlamydia screening, youth offending, looked after children, & drugs and alcohol

<sup>2</sup> Including staff employed by the NHS and Local Authorities; however for the purposes of clarity all Teenage Pregnancy coordinators are counted in the 'NHS' part of the quota

<sup>3</sup> Health visitors and midwives

The table shows that of the achieved sample of **162** participants:

- **114** were from the NHS staff group - compared to a quota of **80**; and
- **48** were from the non-NHS staff group - compared to a quota of **20**.

The table also shows that the quotas for participation by sub-group were mostly met, with the main exceptions being for Family Nurse Partnerships staff, Termination of pregnancy (TOP) Services, and Antenatal and postnatal care services. Part of the reason for this may be the way in which fieldwork participants identified themselves (for example, a specialist CASH nurse may also see many cases of terminations).

It can also be seen that among other groups, we spoke to 25 representatives of voluntary and community sector organisations, and both NHS and non-NHS practitioners across a wide range of settings that are the target groups for these recommendations.

## 2.4 Data Analysis

Once fieldwork notes were completed, data analysis followed a content analysis approach as outlined in Silverman (2005). This included the iterative use and immediate analysis of field notes throughout the fieldwork period. Using the main research questions, the researchers identified core themes emerging from the data, defining concepts, providing explanations and finding associations between the views of different participants. There were inserted into a grid.

Comprehensive briefing and debriefing sessions were held for the study team before and following the main fieldwork stage, to ensure that the fieldwork process and data analysis was carried out in a robust manner. This included a final de-briefing session where experiences across the group and individual consultations were detailed following the production of a series of 'headline' findings.

Throughout this report, we have used the following terms to give an indication of the weight of evidence given by practitioners:

- **'The vast majority of practitioners thought that...'** means that over 80% of the population referred to agreed with the particular view expressed, and constitutes very strong evidence in favour of a particular view;
- **'Many practitioners thought that...'** means that over 50% of the population referred to agreed with the particular view expressed, and constitutes strong evidence in favour of a particular view; and
- **'Some practitioners thought that...'** means that a significant minority (five or more people) of the total population across all the consultations referred to agreed with the particular view expressed. While this may constitute a minority view, such evidence could be taken into account when read alongside the other evidence provided by practitioners.

The findings of the fieldwork are illustrated by quotes from participants, as well as examples of the practice they described.

### 3 RESPONSES TO THE DRAFT RECOMMENDATIONS OVERALL

This section explores participants' responses to the NICE recommendations on the provision of contraceptive services to socially disadvantaged young people as a whole, and examines the cross-cutting aspects of the responses to the draft recommendations including specific barriers and facilitators to implementation. The subsequent Section 4 provides a summary of the key points raised in practitioners' responses to each of the 13 individual recommendations.

#### 3.1 Overall Views of the Draft Recommendations and Context

Overall, **the recommendations were welcomed widely by all participants in the consultation.** The vast majority of the practitioners felt the recommendations are useful and relevant to their day to day practice.

Throughout the discussions and consultation with practitioners a number of overarching, contextual issues were raised in relation to the draft recommendations and their potential for implementation, including:

- Public health commissioners have competing health priorities and services which require commissioning. Across the consultation, the vast majority of participants felt that sexual health and contraceptive services are not regarded as a priority within public health. However many participants felt the draft recommendations can be used to approach commissioners and other influencers to highlight the importance of such services.
- The change in government and cut backs in public spending were mentioned by the vast majority of participants as a potential barrier to implementation. Many participants also stated the changes in requirements for PSHE education as another potential barrier for service delivery within schools.
- Moreover, the move towards a commissioner / provider split has continued to bring about rapid changes in the configuration of contraception and sexual health services, placing providers that ought to be cooperating in competition with each other. Many participants were concerned about the challenge of integrating services that were already fragmented, and thought that these difficulties were likely to continue.
- Across service providers, variation occurred in service provision in relation to age groups. Many practitioners referred to specific provision for under 18's which those aged between 18-25 are unable to access. In addition, many service providers felt that the needs of those under 18 would be different. Throughout the consultation, practitioners often needed reminding the document was applicable for young people aged 18 and over.

*“There is not enough about adult services for 18-25 and there is a massive difference for this age group”*

*Clinical nurse lead*

- Contraceptive services and sexual health provision such as STI testing are viewed by many participants and frontline staff as joined up – therefore, the vast majority of participants felt that the provision of contraception should be offered with (where appropriate) STI information and testing. A smaller number of participants (in particular, those from voluntary sector organisations) also thought that delivery of sex and relationships education was also inseparable from this agenda.



**The practitioners found little to disagree with about the content and order of the recommendations themselves.** The vast majority of practitioners welcomed the content of the draft recommendations, and thought that they represented a high standard to aspire to. Furthermore, the vast majority of participants were pleased to see references throughout key recommendations to both young women and their partners, as well as references to the involvement of young people.

Some areas within the draft recommendations stimulated more discussion than others. These included:

- The advance provision of EHC;
- The coverage of ‘social disadvantage’ within the recommendations (many practitioners felt that the draft recommendations described best practice in relation to services for all young people, with the exception of recommendation 4) and how this linked to participants’ understanding of ‘at risk’ and vulnerable groups (see below);
- How best to ensure that all services that work with young people can maintain health service standards of confidentiality, when dealing with the subject of contraception; and
- How best to encourage schools and education settings to play a constructive role in contraception and sexual health.

The majority of participants felt the ordering of the draft recommendations was logical. However, some felt that the recommendation five (young peoples’ services) could be condensed into recommendation 12 (communication) as there was some overlap in the content.

**However many practitioners felt some of the wording used could be changed to strengthen the impact of the draft recommendations.** In addition to the specific suggestions for change in the individual draft recommendations listed in this report, many practitioners felt that they could be seen as submissive and could be changed to strengthen the actions to be taken, for example, using ‘should’ instead of ‘could’.

### 3.2 The Context for Implementation

The consultation highlighted that the **practice and structuring of service provision for contraceptive services and sexual health services varies across the country**, and showed the degree of variation in both the structures surrounding service delivery in practitioners’ respective areas and service provision between providers and different age groups. For example, one of the biggest variations acknowledged is the provision of emergency hormonal contraception (EHC). Here provision was found to vary between pharmacists, for example in many areas locum pharmacists are not able to prescribe EHC, in others free EHC is only available for under 18’s with the over 18’s having to pay, and in other areas advanced provision of EHC occurs but only within some service providers.

While the variation highlights different approaches to the provision of services to young people, it will also have potential implications for roll out and implementation of the recommendations and guidance. An example of variation within service delivery was given as practitioners feeling less confident to work with young people, and to broach and initiate a conversation about contraception.

*“There is an issue that if NICE say that young people should be able to obtain EHC and locally it wouldn’t be done”.*

*GP/Chair of Sexual Health Group*

Consequently **responses to the draft recommendations and actions varied between “something we aspire to” and “something we are doing already”.** Where practitioners

felt the draft recommendations were something they could aspire to they were regarded as providing guidance on “gold standard” services for young people. However, where practitioners felt they were already implementing the recommended actions, they were a useful tool to establish the extent to which their service delivery could be improved, as well to underline and vindicate their current approaches. For example, in some areas TOP and CASH services do not currently communicate, whereas other areas have explored collaborative service delivery, with ongoing communication between the two services. For example, some areas have established processes for family planning nurses to attend pre-assessment appointments to discuss contraceptive choices before an abortion.

*“These recommendations should set a high bar and gold standard of service”*

*Young People’s Contraceptive Nurse*

**The vast majority of participants were familiar with NICE and their role, and described them as being highly respected within public health.** Many felt that the draft recommendations endorsed by NICE could be used to provide leverage (in particular, with schools and commissioners), and as a facilitator to extending and improving current service provision. On the one hand, a number of commissioners thought that the draft recommendations could be used to approach current service providers to extend their service provision. One example given was a commissioner who currently has a contract for midwifery services, where they could approach the service provider and explain that NICE guidance states that contraceptive services should be provided. On the other hand, current service providers felt they could use the draft recommendations to approach and engage with commissioners of services.

*“Currently, it is very difficult to get on Facebook, or Twitter, or to use text messaging. Now we can take the guidance to say it’s a good idea”.*

*Chlamydia Screening Programme Manager*

*“Having this recommendation would aid school nurses in engaging with schools because it supports that work that is being done”.*

*School nurse*

However, some participants suggested NICE and NICE guidance/recommendations had a lower profile in non-clinical and non-health sectors such as education, which could influence the dissemination of the final guidance. Where this was mentioned, especially in relation to schools, participants suggested the information could be circulated by governing bodies and representative groups. Some participants were concerned that contraceptive services would not be provided in schools unless they were promoted by OFSTED.

### **3.3 Recommendation Focus and Coverage**

While the majority of practitioners consulted welcomed the recommendations and were happy with their content overall, a series of suggested amendments were made regarding their content and coverage, as described in subsequent sections of this report. However three main issues were raised consistently across the focus groups and interviews, as described below.

Throughout the consultation **practitioners reiterated that contraceptive services should not be seen separately from sexual health services.** As a result, many practitioners felt that the recommendations should refer consistently to contraceptive and sexual health services. The vast majority of practitioners that work with young people tended to view contraception and sexual health as a holistic service, which in their daily practice is not separated. Therefore, the vast majority of practitioners felt the recommendations should include more explicit reference to STI testing, or where relevant, it should make references to other NICE guidance available.

*“The guidance is for reducing teenage pregnancies and not sexual health – but the two go hand in hand”*

*Community Pharmacist*

*“The recommendation keeps swapping terminology – in this recommendation it talks about contraceptive services and then further on the guidance says sexual health. Does it mean contraception or sexual health or both? It should just say contraception and sexual health the whole way through”.*

*Chlamydia screening programme co-ordinator*

Many practitioners also felt that by providing a holistic service, some of the draft recommendations referring to service provision should not exclude reference to young people’s sexual orientation, and include provision for lesbian, gay, bisexual and transgender (LGBT) young people.

*“it stands out that there is nothing about LGBT throughout”*

*Youth worker*

*“I don’t feel enough emphasis has been made with regard to holistic care i.e. contraception/STIs/alcohol and substance use/delay”*

*Health Advisor*

**Participants discussed the provision of services for socially disadvantaged young people, and the provision of services for all young people.** Many participants felt that ‘socially disadvantaged’ could be more clearly defined for the draft recommendations. However, there was debate across the consultation whether the draft recommendations should be specific in relation to socially disadvantaged groups, or whether an overarching definition could be used to prevent some groups from being stigmatised or omitted from potentially targeted services. Where practitioners felt the draft recommendations should be more prescriptive about the types of young people to be targeted, they felt some socially disadvantaged groups were omitted, including travellers, migrant workers, asylum seekers and refugees, young people with drug and alcohol addictions, and young offenders. Where participants felt an overall ‘catch all’ description could be used, they often referred to the risk factors for teenage pregnancy.

**Many participants felt the draft recommendations are medically focused and do not take into account the additional services provided by other organisations.** The vast majority of participants felt the content was aimed at clinical and health staff. Across the board, there was a strong view that a holistic approach (including support such as counselling and mentoring) with young people results in better outcomes. Overall, the vast majority of practitioners felt that contraceptive and sexual health for young people was ‘everyone’s business’ as opposed to being within the remit of health services. As a result, the vast majority of participants felt the remit and ‘who should take action’ lists could and should be expanded. In addition, the vast majority of participants felt the recommendations were applicable to all young people, as opposed to those facing social disadvantage. Finally, some participants suggested the recommendations should also include parents.

*“More clarity is needed throughout the document, they are trying to get everything into one document, it either needs to refer specifically to the socially disadvantaged or be completely generic – is this targeted or universal?”*

*Manager, community sector provider*

### 3.4 Adding Value to the Recommendations

In addition to specific points around content and coverage, the practitioners also described a series of areas for consideration to help ‘add value’ to the final recommendations and so help with their implementation.

Many practitioners felt **additional information on why the services are important would support the recommendations**. Practitioners felt information to add context to the draft recommendations would add value in two ways. Firstly, information and statistics regarding prevalence of unintended pregnancies in young people (and providing some rationale) would create better 'buy in' from key strategic and funding players. Secondly the recommendations highlight the future needs of young people, including for example, the importance of preventing pregnancy following an abortion, the potential risks associated with repeat terminations and fertility, and the provision of information which challenges existing myths.

Equally commonly, practitioners felt the draft recommendations **could provide examples of service delivery which is effective in engaging socially disadvantaged young people**. This point was made in relation to working with groups of young people that are often more difficult to engage, or when working with young people which requires subtle changes due to cultural differences. This point was reiterated in a number of areas.

*"What I really wanted to see in this – and I haven't seen much about really, is stuff around cultural issues"*

*Teenage pregnancy prevention team manager*

The issue of including practical case examples extended across the draft recommendations, including on data collection for assessing local need and capacity, effective data sharing between agencies and examples of effective communication methods.

**The links in the recommendations to other key policies and documents could also be strengthened**. Many practitioners felt the draft recommendations lacked links to other guidance documentation. This includes for example, making explicit links to other related NICE Guidance and to other relevant guidance such as the Department for Children, Schools and Families (now Department for Education) guidance on contraceptive provision in schools. Some practitioners felt the link between alcohol and risk taking sexual behaviour was missing from the recommendations.

*"We need to strengthen the links between alcohol abuse and sexual health. That's been strongly highlighted in other documents and it just seems strange it's missed out of here"*

*Public health manager*

However, practitioner views were mixed on the specific references to You're Welcome across the draft recommendations, and while many welcomed its inclusion others felt the standard it set may be challenging to achieve.

*"You're Welcome is great but will be a huge effort for a practice with a massive interest in sexual health and the vast number of GP's will not have the time but would be happy to do something that didn't involve 20 pages of tick boxes. A hurdle that is less high would be more beneficial"*

*General practitioner*

## 4 RESPONSES TO THE INDIVIDUAL DRAFT RECOMMENDATIONS

This section explores participants' responses to the 13 draft recommendations individually, setting out the most relevant points raised by practitioners in relation to each, and including comments on potential barriers to implementation as well as any gaps identified.

The review of the draft recommendations follows a common structure, and in order to summarise participants' feedback clearly, the key points are set out as bullet points with descriptive text. The structure provides a copy of the draft recommendation, followed by the overall findings from the focus groups and interviews, and a description of any potential barriers to implementation and perceived gaps in the recommendation cited. Each section concludes with a table setting out suggested changes to the content of each recommendation, which are also consolidated across all 13 draft recommendations in Section 5.

## 4.1 Recommendation One - Assessing Local Need and Capacity to Target Services

### **Recommendation 1: assessing local need and capacity to target services**

#### **Who is the target population?**

- All young women and men.

#### **Who should take action?**

- Strategic health authorities (SHAs), public health observatories, those responsible for data collection and analysis in SHAs and primary care trusts (PCTs), directors of public health, local authorities, local strategic partnerships, PCT commissioners and practice-based commissioners, directors of children's services, children's trusts.
- Managers of contraceptive and sexual health services in PCTs and acute trusts, voluntary sector and private sector providers of contraception, sexual and reproductive health services for young people, public health practitioners with responsibility for contraception and sexual health, teenage pregnancy coordinators and those responsible for Connexions services and other services for young people.

#### **What action should be taken?**

- Involve young women and men, including socially disadvantaged young women and men, both in assessing their need for services (including their preferred configuration, such as type of services offered and opening hours and location of services) and in the planning, monitoring and evaluation of those services by working collaboratively across organisational and geographical boundaries.

#### **Assess local need:**

- Public health observatories should gather anonymised regional and local demographic data and information on contraception and sexual health inequalities. In conjunction with teenage pregnancy coordinators and sexual health leads, they should disseminate the data to inform needs assessments and target resources and services to those with the greatest need, while maintaining universal access.
- With support from public health observatories and local public health networks, commissioners should make full use of anonymised regional and local health intelligence and routinely collected surveillance data (for example, conceptions, births and contraceptive prescribing data, numbers of young people visiting contraceptive services and sexually transmitted infection [STI] data) to identify areas of local need (both geographically and in terms of specific population groups, for example, black and minority ethnic communities and people with physical or learning disabilities).
- Regional public health leads, public health observatories and SHAs, working with PCTs, local authorities and local strategic partnerships, should develop and publish comprehensive joint strategic needs assessments for contraceptive and sexual health services for young people, including socially disadvantaged young people, across the local area.

#### **Audit capacity:**

- Map the current range of services, service activity levels, and capacity for the local population across all contraceptive service providers, including GP, pharmacy-based, school and college-based, and voluntary sector services, and 'out of hours' (evening and weekend) and outreach services. Staffing levels and range of professional skills (including GP practices) for the locality, including size of premises, location, opening hours and accessibility, should be included.

#### **Target services:**

- Use these data to develop an action plan setting out organisational responsibilities for the delivery of local services for young people, including socially disadvantaged young people at times and in locations to meet their needs.
- Regularly evaluate these services in the context of this guidance, and in the context of changing local needs use local accountability mechanisms (for example, local authority overview and scrutiny committee reports) to examine specific issues.

### 4.1.1 Findings

The vast majority of practitioners considered that this recommendation was both important and topical, with reference being made to existing needs assessment activities by the groups. In some cases the draft recommendation was considered helpful in making the case for resourcing data collection activities, and the emphasis on involving young people

in the process of assessing need and formulating appropriate responses was also viewed positively.

- **The vast majority of practitioners thought that a recommendation about assessing local need and capacity was important.** Most practitioners said that they were currently working towards the standard set in this draft recommendation (for instance, pointing to local contraceptive and sexual health needs assessments that they had carried out), and they recognised the importance of collecting data. In a minority of fieldwork areas, assessing need was an ongoing exercise, although many PCT / LA areas treated needs assessment as a one-off activity. Some practitioners pointed out that good quality needs assessment was costly, and were glad to see this draft recommendation included. However, some practitioners wanted to know more about best practice in conducting needs assessments; while others wanted the recommendation to make a stronger case for reviewing and updating needs assessments regularly.

*“This recommendation is a good starting point, and will help [us] head in the right direction.”*

*PCT Commissioner*

- **Across most of the fieldwork areas, participants pointed out the challenges to gathering good quality data about local needs and services.** Data is often held by many different organisations and equally, mapping services can be difficult (see below). There are many gaps in knowledge about the groups most at risk of poor sexual health and not accessing services; for example, young people leaving prison, or fathers of teenage mothers. Some practitioners pointed out that data is often held paper form. Finally, there are also practical considerations to sharing data; for example, one commissioner said that sharing the figures for teenage conceptions with schools was difficult because if the cases were few, this could lead to young people being identified and confidentiality being breached.

*“Different agencies working with young people do not share information as well as they should. This is because they collect different information in different formats. In addition, data collection is often paper based which acts as a barrier to sharing”.*

*Commissioner, maternity services*

- **The vast majority of the fieldwork participants were pleased that the draft recommendation stated clearly that involving young people was an important part of the needs assessment process.** Some practitioners said that they already take account of the views of young people, although current practice varied and there were different views on how this could best be done. Practitioners were also keen to emphasise that listening to young people had to be done in meaningful way, with services being changed as a result of their input. However, some practitioners also said that capturing the views of those young people that are most at risk was challenging; in general, participation tends to favour the most articulate and least disadvantaged, unless care is taken to design appropriate mechanisms for this.
- **Many practitioners (particularly the voluntary sector and other providers based in the community) were keen to see recommendation 1 place a greater emphasis on ‘qualitative’ feedback when needs were being assessed,** and were concerned that an overemphasis on numerical data could lead to the good work that some services do with small numbers of young people with high levels of need being overlooked.

- **Some practitioners also felt that the draft recommendation supported them in making a case for the collection of data and for the commissioning of contraceptive and sexual health services.** This was a point made by commissioners in a number of groups; they thought that the recommendations would help them engage with other agencies in order to fill the gaps in data.

*“Data collection is needed to inform the commissioning process”*

*Clinical nurse lead*

#### **4.1.2 Barriers to implementation**

While the idea of supporting data collection was welcomed, not all the practitioners were found the draft recommendation to be clear about what data should be collected and in what format. References were also made to the inherent challenges in collecting such data, including the inherent sensitivities surrounding the subject area with young people, a lack of consistency in the data collection tools and approaches currently being used, and issues around sharing the resulting data, between different organisations.

- **Practitioners were not clear about what type of data to collect.** Some thought that the recommendations needed to be clearer on the type of data to collect and what format should be followed. This was especially important when organisations deliver many different services to meet varied targets; and practitioners felt that different data collection tools and IT infrastructure across different services and agencies can also make data collection more difficult and can act as a barrier.

*“The recommendation could go further to suggest a broader set of data could be used for targeting and that other agencies (particularly outside health e.g. education) should be included to encourage the sharing of data”.*

- **There are inherent difficulties in collecting service user data.** Some practitioners thought that socially disadvantaged young people were reluctant to provide much personal information, for fear of others finding out; other practitioners wanted to emphasise that anonymity was important for some young people to feel confident in using a service (see responses to recommendation 6) and that too much data collection at a consultation could deter those most at need from accessing contraception.

*“Young people sometimes don’t like to register or provide information, they are resistant to that, often having had so much information about themselves shared about already. The most disadvantaged young people don’t want to give their name or date of birth”*

*Youth Offending Service Manager*

- **Auditing capacity and mapping activity can be difficult.** Some practitioners felt that mapping activity can be difficult for a number of reasons: firstly, that information varies according to whatever funding stream is paying for a service (which means that provision offered through the voluntary sector can be missed); and secondly, arrangements for service provision can change frequently, so the results of such exercises quickly go out of date. There are many providers involved in the delivery of sexual health and contraceptive services – from GPs to CASH services, specific services for young people, GU clinics in acute settings, and other specialist services - and practitioners in many of the fieldwork areas pointed out how local services have changed frequently from year to year.

*“there’s so many different strands of provision on a topic like this and so mapping that provision against data on local need can be very difficult”*

*Community pharmacist*



- **Weak partnerships may also influence the sharing of information.** In some places, services such as teenage pregnancy and public health sit in different organisations with different priorities, and practitioners said that this caused difficulties in working together.

*“There’s an over reliance on health data. Different organisations have different protocols around sharing data and so it makes obtaining data outside of health difficult. To get healthy schools data is difficult to get”.*

*Commissioning manager for young people’s sexual health and teenage pregnancy*

#### 4.1.3 **Gaps in the Draft Recommendation**

To address these concerns, some practitioners suggested that the draft recommendations include reference to, and examples of, the type of data they should collect, and include illustrative examples of effective cross-agency data collection approaches. Some practitioners also wanted to see the recommendation give greater clarity about which agency might lead on producing a local action plan; participants in the voluntary sector focus group suggested that this should sit under the local Children and Young People’s Plan (CYPP) as this would help to get contraception and sexual health on the agenda for all agencies working with young people.

#### 4.1.4 **Suggested Changes to Text**

Finally, Table 4.1 below summarises the changes suggested to the content of Draft Recommendation 1 by the study participants.

<b>Table 4.1: Suggested Changes to Draft Recommendation 1</b>	
<b>Section of Draft Text</b>	<b>Suggested Changes</b>
<b><i>Who is the target population?</i></b>	None
<b><i>Who should take action?</i></b>	The list was thought to be comprehensive, but some practitioners suggested that one agency should be responsible for leading on implementing the recommendation.
<b><i>What action should they take?</i></b>	Practitioners suggested that the draft recommendation could describe / give examples of how common difficulties could be overcome.  The fieldwork suggested the draft recommendation could give greater clarity about what type of data to collect to inform needs assessment and auditing capacity.  Practitioners suggested that Children and Young People’s Plans could be a useful vehicle for action plans.

## 4.2 Recommendation Two – Commission Integrated and Comprehensive Services

### **Recommendation 2: commission integrated and comprehensive services**

#### **Who is the target population?**

- All young women and men.

#### **Who should take action?**

- Commissioners in PCTs, local authorities and GP practices with responsibility for hospital, community and education-based contraception and sexual health services, primary care services and young people's services, pharmacies, and services provided by voluntary and independent sector organisations.

#### **What action should be taken?**

- Identify local priorities and targets based on local need, using appropriate tools, such as health equity audit and equality impact assessment, making use of NHS commissioning and local area agreement processes, as appropriate.
- Establish collaborative evidence-based commissioning arrangements between PCTs to provide contraception and sexual health services for young people at convenient, accessible locations such as city centres, colleges and schools so that no young person is denied services because of where they live.
- Ensure that all contraception and sexual health services (including those provided in general practice) meet the 'You're welcome' quality criteria (DH 2007) as a minimum requirement and the draft revised standards for sexual and reproductive health services as specified by the Faculty of Sexual and Reproductive Healthcare (2010a) and the Department of Health/Medical Foundation for AIDS and Sexual Health (Medical Foundation for AIDS and Sexual Health/DH 2005).
- Develop joint commissioning of needs-led contraceptive services for young people:
  - Ensure that there are integrated and managed service networks and comprehensive referral pathways for all young women and men both into and out of contraceptive services; and
  - Ensure these referral pathways cover abortion services, maternity services and all other relevant health, social care and children's services, youth and community services, education, and the voluntary and private sectors. When commissioning provision of contraceptive services, including emergency contraception, ensure that pharmacies, walk-in centres and all services that are commissioned to provide contraceptive services (including emergency hormonal contraception) do so consistently, rather than variably depending who is on duty.

### 4.2.1 Findings

Again the practitioners interviewed and attending the focus groups welcomed the draft recommendation, particularly around the provision of consistent advice on a consistent basis. However there was some confusion over what was meant by 'integrated services', (with additional clarity on this point being considered helpful), and while reference to quality standards was useful, the specific inclusion of the You're Welcome standard caused concern among many practitioners.

- **Overall, participants welcomed that the statement that services should be delivered “consistently, rather than variably depending on who is on duty”.** This was seen as a point that should be made more strongly throughout the document. In some focus groups, participants discussed the provision of EHC and the variation in young people's experiences, for example, whether a locum pharmacist will provide EHC to a young person (see recommendation 10). However, some participants also wanted to see the recommendation state that young people need to have a choice of different contraceptive services within whatever pathways are created, as a single approach does not work for all young people.
- **The references in the draft recommendation to “evidence-based commissioning”, “joint commissioning”, and “integrated and managed service networks” were also thought to be helpful** in overcoming silo working which was

thought to be a common problem in this field. (For example, some practitioners discussed the National Chlamydia Screening Programme and how chlamydia screening ought to be part of all services – yet they also pointed out that it is usually managed separately from other sexual health services).

*“An integrated approach is essential, if someone has to travel for sexual health services and then again for contraceptive services this is not practical and it should be integrated”*

*General Practitioner*

- **Practitioners welcomed the inclusion of ‘You’re Welcome’ in the draft recommendation, but had concerns about how realistic it would be to implement.** Most practitioners considered that ‘You’re Welcome’ was best practice, and that the principles underpinning it were essential to high quality services for young people. However, setting it as a minimum requirement (rather than an aspiration) was felt by some to be unrealistic, and the process itself was thought to be thorough but bureaucratic. Some local areas have developed their own variants of the standards; one area described how a local ‘badge’ has been created based on the principles of ‘You’re Welcome’, which has been achieved by a high proportion of GP practices within the area.

*“naming ‘You’re Welcome’ and expecting every provider to achieve the ‘You’re Welcome’ criteria is massively unrealistic and unpractical...although I wouldn’t like to see detracting from setting a series of minimum standards that young people should expect”*

*Commissioner*

#### **4.2.2 Barriers to Implementation**

Barriers to implementation raised in the consultations included the variation in practice by locality, and the particular challenges in engaging with schools (the latter is discussed in greater detail under the findings for recommendation 9).

- **Current contracting arrangements are a barrier.** In particular, some participants felt that no matter what commissioners did, GPs would always have a choice not to deliver many contraceptive services (especially for young people) leading to inconsistency across practices. While GPs have to offer basic contraceptive services and signposting under their contract, contraceptive services such as fitting IUS / LARC fall under enhanced services, which GPs can choose to deliver for an additional payment. Some participants were concerned that this could lead to young people having less choice of contraceptive methods, as not all the methods would be available (and some GPs might be less inclined to discuss the options available elsewhere).
- **It is difficult to engage schools in the provision of contraceptive and sexual health services.** Most participants felt that it was difficult to engage schools (especially faith schools) and persuade them to host a service for young people. There were a number of factors mentioned for poor links with some schools, including competing priorities such as educational attainment, a fear of parents’ reactions, a perception that the school is promoting risk taking behaviour and a belief within Senior Management Teams and Governing bodies that their school does not need the services.

#### **4.2.3 Gaps in the Draft Recommendation**

A series of gaps in the draft recommendation were identified by the practitioners, and listed below.

- **There was confusion about the meaning of 'integrated'.** Some felt it was unclear what was meant by the term 'integrated' services, and participants had different interpretations about what was meant by the term and felt that this should be clarified.

*"I am not sure what this means.....does it mean one stop shops or integrated GU, contraceptive services and sexual health or contraceptive services and sexual health?"*

*GU Consultant*

- **Equally, practitioners often had differing views of what was meant by 'joint commissioning'** as this could be used to refer to varying arrangements, from pooled budgets to 'involving' partner agencies in decision making. In addition, some participants suggested that 'referral pathways' should be clearly defined, as understanding of this varies among different agencies and areas. Others thought that referring to 'World Class Commissioning' might help to give greater clarity, as well as to broader strategies for commissioning effective services for children and young people.

*"for some services, simply signposting to another service is considered to be a 'referral' while for others the term signifies a more formal process".*

*Sexual Health Commissioner*

*"A robust referral/appointment system could also be mentioned. At present we are often selective about where we refer young people due to the problems we experience trying to communicate with clinics/CASH staff"*

*Health Advisor*

- **Some practitioners thought it would be helpful if the recommendations gave examples of good practice.** While they felt that the drafts were useful, practitioners also wanted to read more examples of good practice, which could support practitioners to design services and effective referral pathways for young people, or to compare existing arrangements.

*"It would be good if it was possible to put some examples of best practice in. This is what everyone tries to do – some examples of best practice would be useful. We want the recommendations to be more directive"*

*Community pharmacist*

- **Gaps in the 'who should take action' list mentioned by participants included the voluntary and community sector, and practice based commissioning / GP consortia.**

*"It would be useful if commissioners looked at the entire service network and recognised that the voluntary sector is an important part of that"*

*Voluntary Sector representative*

- **Finally, some participants suggested that this recommendation should make reference to commissioners ensuring that all practitioners working with children have up to date CRB clearance.**

#### **4.2.4 Suggested Changes to Text**

Finally, a series of suggestions for change in the content of Draft Recommendation 2 were suggested during the fieldwork, as summarised in Table 4.2 below.

<b>Table 4.2: Suggested Changes to Draft Recommendation 2</b>	
<b>Section of Draft Text</b>	<b>Suggested Changes</b>
<b><i>Who is the target population?</i></b>	None
<b><i>Who should take action?</i></b>	The voluntary and community sector, and practice based commissioning / GP consortia could be mentioned.
<b><i>What action should they take?</i></b>	<p>Participants felt greater clarity might help to ensure better understanding of the terms 'integrated', 'referral pathways' and 'joint commissioning'.</p> <p>The draft recommendation could give examples of good practice in designing referral pathways and commissioning services, particularly where schools are involved.</p> <p>The draft recommendation could add references to other strategies and guidance.</p> <p>Some participants felt the draft recommendation could mention CRB clearance.</p>

### 4.3 Recommendation Three - Contraceptive Services for Young People

#### **Recommendation 3: contraceptive services for young people**

##### **Who is the target population?**

- All young women and men.

##### **Who should take action?**

- Managers, doctors, nurses, pharmacists, receptionists and other staff of NHS and NHS-funded contraception and sexual health services, including GP services, pharmacies, walk-in centres, acute and emergency care, the voluntary and independent sector.

##### **What action should be taken?**

- Ensure that young people have access, without delay, to dedicated confidential contraception and sexual health services for young people which, as a minimum requirement, meet quality criteria such as 'You're welcome' (DH 2007) and local and national standards for contraceptive services, such as those specified by the Faculty of Sexual and Reproductive Healthcare (2010a) and the Department of Health/Medical Foundation for AIDS and Sexual Health (Medical Foundation for AIDS and Sexual Health/DH 2005) and clinical guidance on contraceptive choices for young people (Faculty of Sexual and Reproductive Healthcare 2010b).
- Doctors, nurses and pharmacists should:
  - Where possible, provide the full range of contraceptive methods, especially long-acting reversible contraception (LARC) condoms to prevent transmission of STIs and emergency contraception (both hormonal and timely insertion of an intrauterine device). Services that cannot offer the full range of contraceptive methods should provide accessible and timely routes into services that can;
  - Provide information about the full range of contraceptive methods, including emergency contraception (both hormonal and intrauterine) and LARC, and offer advice on the most effective methods and how to use them effectively and consistently;
  - Offer culturally sensitive, confidential, non-judgmental, empathic advice and guidance according to the needs of the young woman and/or man involved; and
  - Set aside adequate consultation time to encourage and support informed decision-making.
- Service managers, with the support of other staff, should offer services that:
  - Are flexible, for example, out-of-hours services at weekends and in the late afternoon and evening;
  - Are available both without prior appointment (drop-in) and by appointment in any given area. Appointments should be available within 2 working days. Services should advertise clearly whether they operate on a drop-in, appointment or mixed basis;
  - Strive to ensure that scheduled appointments run on time and that the waiting time in the clinic is less than 60 minutes;
  - Provide accurate information about availability and opening times; and
  - Are open to young people under 16 who present for any service without a parent or carer.
- Service managers, doctors, nurses, receptionists and other staff should:
  - Promote contraception and sexual health services to young men, and encourage young men to use them.
  - Ensure clear information is available about all local services, in the form of leaflets and posters. Services should be advertised through local media, including the internet, for example social networking media.
  - Disseminate accurate and up-to-date information about the availability of local contraception and sexual health services, including those that provide emergency contraception, using local and community networks for example, youth services and youth inclusion projects. Publicise this information in schools and education settings working with personal, social, health and economic (PSHE) education, and sex and relationships education lead teachers and coordinators and teenage pregnancy coordinators
  - Produce this information in formats that appeal to young people and that can be distributed widely across the local area.

### 4.3.1 Findings

This draft recommendation was widely welcomed by the vast majority of focus group participants and interviewees, particularly regarding flexible and out of hours provision for young people given the variations in practice described across the country. However more clarity was required regarding the term ‘without delay’ in the context of service provision, and the waiting time of up to 60 minutes suggested was widely considered as being too long for young people.

- **The vast majority of practitioners welcomed the draft recommendation, especially the emphasis on providing flexible and out of hours services.** Practitioners were pleased that this was mentioned, as flexibility was considered to be an important enabler for young people being able to access services.

*“Discretion is paramount and therefore having the flexibility to access services at different times is essential”.*

Nurse

- **Most practitioners also welcomed the emphasis on providing a full range of services wherever possible,** given that in some areas socially disadvantaged young people are less likely to travel outside of their local area to access service provision. However, other practitioners (often in urban areas) also thought this was important because young people are prepared to travel in order to access services where they are likely to be more anonymous – hence the importance of commissioning flexible services and multiple choices for young people.

*“Young people won’t travel to access services. Especially if they are socially deprived”*

CASH Service Team Leader

- **The draft recommendation was thought by the vast majority of practitioners to represent good practice in providing contraceptive services for all young people, not just the ‘socially disadvantaged’.** Practitioners thought that it set a good practice standard for all services (much like the other recommendations), and thought that the recommendations as a whole should make this clearer.

*“You’re almost setting Gold standards for socially disadvantaged young people, but the same should apply to the rest of the population as well”.*

GP

- **Many practitioners felt the recommendation is a useful tool in the provision and development of contraceptive services for young people.** Throughout the consultation local service provision was reported to be variable. However, participants felt the draft recommendations were useful to gauge current service delivery (for example, some participants felt draft recommendations were unlikely to have an impact as they currently deliver services to the minimum points suggested), while other groups felt the recommendation was useful for setting a benchmark for service delivery,

*“This is what we aspire to”.*

Commissioner

- **Many practitioners also thought that the emphasis on clear information, and all services being able to ‘signpost’, was important.** As discussed in the response to draft recommendation 12, it was thought that young people receive many contradictory messages about sexual health, contraception and healthy relationships

and services they can access for help. It was thought that all services working with young people could do more to deliver on contraceptive and sexual health – as well as wider education on sex and healthy relationships – in a holistic manner, and through as many means as possible, including accurate signposting from teachers, youth workers and other frontline professionals. Some practitioners thought the recommendation should be stronger and compel schools and education settings in particular to do more to publicise services and provide consistent messages. Many focus groups welcomed the mention of using social networking and the media, and many practitioners referred to locally based websites which provide information about contraception services for young people.

*“There is enough information that professionals hold that professionals can signpost young people to services that they are unable to provide. All professionals have that information”.*

*Advanced nurse practitioner*

*‘It would be better if we were able to say, you can’t be seen here today, but we could see you here, here and here, so as long as it wasn’t too far out of the locality, that would be a better service wouldn’t it?’*

*PCT commissioning manager for sexual health*

- **The recommendation on setting targets for waiting times (“appointments should be available within 2 working days... and that the waiting time in the clinic is less than 60 minutes”) was broadly welcomed by the vast majority of practitioners.** However, it was also thought that if services were to be flexible and responsive, these waiting times were too long and most young people (at least those in their teens and younger) would not (or could not) wait that long, particularly where services such as emergency contraception were needed. Practitioners reiterated the importance of seeing young people quickly, as they may be accessing the services during their lunch break or after school.

*“It depends what the definition of an appointment within two days means, it it’s first point of contact, that’s reasonable, but equally the timing has to be appropriate relevant to the actual need”.*

*GP lead for sexual health services*

- **On the other hand, the waiting times were thought to be more ‘aspirational’ in some areas.** Very few practitioners in the local areas where we carried out fieldwork were able to state that they were already meeting the standards set out in the draft recommendation in full. In other words, while they were welcomed, they were not felt to be realistic to achieve, given the pressures on services and the way that services are currently designed (in spite of 48 hour access to GUM clinics being an important NHS target for many years).

*“60 minutes waiting time is too long for young people – this would not be workable”*

*CASH nurse*

*“The presence of specific targets in this recommendation (2 days, 60 minutes) is helpful ammunition to take to the commissioners”*

*Sexual health commissioner*

- **Therefore there was some ambiguity in the term ‘without delay’, and the expectation of the recommendation.** Some participants felt the term could be clarified in order to differentiate between what waiting times / access targets were appropriate for different types of service.



*“giving appointments within less than two working days as well as flexible services gives contradictory messages...do they mean appointments should be available in specific young person’s clinics? If that’s the case it’ll have a tremendous impact on PCTs, since that’s not what they are working towards at the moment”.*

*Clinical lead for sexual health*

- **There were local variations in practice in relation to the provision of appointments.** Some areas have withdrawn appointments as an option and have focused on drop ins (or ‘walk ins’) due to the high rates of ‘did not attend’ (DNA). Some practitioners discussed how DNAs could be reduced; one GP said that their service used text messaging to remind young people about their appointment, which had reduced the DNA rate.

#### 4.3.2 **Barriers to implementation**

Several potential barriers to implementation were suggested, including the skills and knowledge of existing staff to extend their remits, the availability of funding to support any training required, and the challenges of delivering increasingly flexible provision.

- **Limited funding and existing staff skill levels can be a potential barrier.** Many participants felt that implementing the section of the draft recommendation referring to the fitting of LARC would require much more additional training (instances were given where school nurses or GPs did not see *providing* contraception to young people to be part of their role, let alone the fitting of LARC, although this was an extreme). While it was seen that the draft recommendation would be useful for young people, funding the training for staff to do this was expected to be difficult.

*“If staff are going to take on fitting LARC’s – then they need training and who would fund that?”*

*Health Development Worker (Voluntary Sector)*

- **Providing out of hours and flexible provision can be challenging** – and may be dependent on the willingness of staff, as well the availability and number of staff and funding.

*“There is a significant need to have some kind of mobile provision e.g. clinic in a box to go alongside the core services. But there should be staff that are able to take that core offer out to people”.*

*Sexual health and specialist services lead*

- **At this point in many of the focus groups (participants were asked for their responses to each of the recommendations in the order they were written), many practitioners discussed further barriers to implementing this draft recommendation such as access to schools, problems with the use of social media by public sector organisations, and training gaps.** These issues are discussed further in recommendations 9, 12 and 13 respectively.

#### 4.3.3 **Gaps in the Draft Recommendation**

A series of gaps were suggested in the draft recommendation, namely:

- **Many practitioners felt there were gaps in the ‘who should take action’ list.** Suggested additions included: commissioners – who are responsible for ensuring that these services are properly funded and designed; schools, colleges and other education settings; youth workers and young people’s services; learning disabilities teams working with young people; children’s centres; outreach workers and support

groups working with young people, in particular voluntary sector agencies that may also provide contraceptive and sexual health services, or sex and relationship education (SRE). Many practitioners wanted to see greater emphasis on all services that work with young people being able to provide basic advice and signposting in a sensitive and confidential manner (i.e. provide 'Level 1' services).

*"It should be everyone's responsibility and it isn't just health"*

*Lead for risk and resilience agenda*

- **Many practitioners wanted to see more guidance given on the importance of training within this recommendation**, as many professionals may feel uncomfortable working with young people because they lack training; there is no national standard in training for working with young people.
- **Some practitioners thought that the draft recommendation was focused only on young people choosing contraceptives for the first time**, and that it should also make reference to young people who are switching their choice of contraceptive.
- **Some practitioners wanted this recommendation to make explicit reference to the Fraser guidelines and that under 13s are entitled to service provision.**
- **Some practitioners expressed surprise that other pieces of NICE guidance such as guidance on fitting LARC, or forthcoming recommendations on PSHE, were not referenced in this draft recommendation.**

#### 4.3.4 Suggested Changes to Text

Finally, a series of suggestions for change in the content of Draft Recommendation 3 were suggested during the fieldwork, as summarised in Table 4.3 below.

Table 4.3: Suggested Changes to Draft Recommendation 3	
Section of Draft Text	Suggested Changes
<b><i>Who is the target population?</i></b>	None, but many practitioners believed the recommendation should make it clear that this is the standard expected of services that work with all young people (and not only the 'socially disadvantaged').
<b><i>Who should take action?</i></b>	In general, practitioners wanted to see a wider range of target professionals included (not only clinical ones) including: <ul style="list-style-type: none"> <li>▪ Commissioners;</li> <li>▪ Staff in schools, colleges and other education settings;</li> <li>▪ Youth workers and young people's services;</li> <li>▪ Learning disabilities teams working with young people;</li> <li>▪ Children's centres; and</li> <li>▪ Outreach workers and support groups working with young people, in particular voluntary sector agencies.</li> </ul>

<p><b><i>What action should they take?</i></b></p>	<p>The fieldwork indicated that terms such as ‘without delay’ and access time targets for appointments and drop in services could be clarified further.</p> <p>The recommendation could refer to training, communication and access to schools.</p> <p>Participants suggested the recommendation could refer to how some of the barriers to delivering flexible services can be overcome.</p> <p>The recommendation could make reference to young people wishing to change their choice of contraceptive, and the Fraser guidelines.</p> <p>The fieldwork indicated that practitioners would welcome signposting practitioners to other relevant NICE guidance.</p>
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#### 4.4 Recommendation Four - Socially Disadvantaged Young People

##### **Recommendation 4: socially disadvantaged young people**

###### **Who is the target population?**

- *Socially disadvantaged young people, including those not in education, employment or training, and those with special needs, disabilities or health problems.*
- *Young people from minority cultural or ethnic communities.*

###### **Who should take action?**

- *Service managers and staff in contraception, sexual and reproductive health services in the NHS and in NHS-funded voluntary and independent sector organisations.*
- *Doctors, nurses and pharmacists providing contraception, sexual and reproductive health services for young people.*

###### **What action should be taken?**

- *Provide additional support for disadvantaged young people to enable them to gain access to contraceptive services without delay and to support them as necessary in using the service (for example, access to interpreters, one-to-one support, facilities for people with physical and sensory disabilities, and assistance for those with learning disabilities).*
- *Encourage and enable teenage and young mothers to attend services, for example by working with family nurse partnerships or children's centres.*
- *Offer support and referral to specialist services, for example for young people who misuse drugs and/or alcohol and those who may have been sexually exploited, trafficked, or are the victims of sexual violence.*
- *Provide outreach services that offer the full range of treatment options, information and tailored advice and support for socially disadvantaged young women and men and those in rural areas who cannot reach existing clinics and contraception and sexual health services.*
- *Offer culturally sensitive, confidential, non-judgmental, empathic advice and support. Tailor this to the needs of the young person involved, for example, providing relevant information in small manageable amounts, checking whether it has been understood, and being prepared to reiterate and revise information if required.*

#### 4.4.1 Findings

A key point raised throughout the consultations related to the definition of 'socially disadvantaged young people', the breadth and nature of the specific groups mentioned (including the overlap with those young people / young adults deemed to be vulnerable or at risk in relation to their sexual behaviour), and whether the draft recommendations should refer to good practice in identifying such groups.

- **The recommendation was welcomed, but was thought by many practitioners to be less useful than they expected.** Some expressed surprise that there was only one recommendation among 13 relating specifically to 'social disadvantage'<sup>4</sup>. Some practitioners commented that the recommendation assumed that the socially disadvantaged were already engaging in contraceptive services – and that there was little reference in this recommendation to how such young people could be identified, encouraged to access (and return to) services, and best practice in engaging with them. Some other practitioners also wanted to see greater reference to a holistic approach to sexual health and relationships – notably, the importance of high quality PHSE for vulnerable young people (who are most likely to be victims / perpetrators of partner violence, drug and alcohol misuse, etc.)

<sup>4</sup> See section 3 for the wider context to this kind of feedback; many practitioners thought that the recommendations as a whole were presenting good practice in contraceptive and sexual health services for all young people (which they generally felt be a better approach than focusing on social disadvantage in isolation).

- **There was debate in most of the focus groups about whether the draft recommendation was sufficiently inclusive.** Many gaps in the coverage of the recommendation were highlighted, in particular looked after children and children in care (this was mentioned by practitioners in every fieldwork area – see below for more information about perceived gaps in the target population). On the other hand, some practitioners that felt if the recommendation was seen to refer too much to specific groups of socially disadvantaged young people, there was a danger other groups may be missed or not targeted for service provision. They also expressed concern that referring to young people in such groups could label and stigmatise.

*“[the recommendation could be] more specific about who they’re talking about”.*

*Looked after children nurse*

- Some participants also felt that the specific inclusion of young people from minority and ethnic groups was not welcomed, as not all young people from these groups are socially disadvantaged.

*“The message from this document is that all young people from ethnic or minority communities are disadvantaged and I feel very uncomfortable with that. I would imagine that young people from these communities would also feel uncomfortable with this.”*

*Sexual Health Service Manager*

- **Linked to these issues described above, many practitioners were also confused as to whether this recommendation referred to those young people deemed to be ‘vulnerable’ or ‘at risk’ in relation to their sexual behaviour.** The majority of participants felt a young person did not have to be socially disadvantaged to be vulnerable or at risk; but there is an overlap between these groups, and moreover young people at risk will need the same additional support, specialist services and outreach services described in the recommendation. Most practitioners said that all young people can be vulnerable or at risk of teenage pregnancy and engaging in risk taking behaviour (with some saying that this is not possible to identify until a sexual history is taken by a professional). The vast majority of practitioners thought the recommendation could be clearer about what groups are being referred to.

*“young people don’t have to be socially disadvantaged in order to be vulnerable, although services have to find a way to prioritise those with greatest need”.*

*Project Manager – Youth Charity*

- **Some practitioners disagreed with the reference in the draft recommendation to “small manageable amounts” of information,** stating that it was not the amount of information but the quality / effectiveness of delivery that mattered most.

#### **4.4.2 Barriers to Implementation**

The main potential barriers to implementation for Draft Recommendation 4 were linked to issues around targeting ‘socially disadvantaged’ young people and the funding of services to engage them.

- **It can be difficult to identify socially disadvantaged young people and many practitioners wanted more guidance on how to identify and engage with young people with particular disadvantages or risk factors.** Practitioners thought this was particularly difficult when young people access services only for a short time, access services through a pharmacist, or want to withhold personal details because they wish to remain more anonymous. Many practitioners discussed the difficulties in engaging and maintaining contact with socially disadvantaged young people, and

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while they understood how services should be provided for the groups of young people, they would like additional guidance on how to engage them and support them to attend services.

*“Reaching vulnerable young people is very difficult as many of them are not in education or training and therefore how can they be accessed or encouraged to use contraceptive services?”*

*Lead Nurse*

*“You don’t know you have a socially disadvantaged person until you sit down with them”*

*Sexual health practitioner*

- **Funding and staffing for outreach services was mentioned by many participants as a barrier to implementing the recommendation.**

*“Funding for outreach services is generally inadequate”*

*Project manager, voluntary and community sector*

#### **4.4.3 Gaps in the Draft Recommendation**

Changes suggested by the practitioners to Draft Recommendation 4 included:

- **Many participants thought the list of ‘who should take action’ in the recommendation should be broader than health services – it should include other services such as Children’s Centres, Connexions, social services, youth offending services and other services where NEET young people and other vulnerable groups are likely to be engaged with.** Practitioners said that many young people from disadvantaged backgrounds will not be in any educational setting; in addition, some practitioners said that children’s centres may not want to be seen as a base for the provision of contraception and sexual health advice. On the other hand, services such as Connexions have lists of individual young people at risk and more could be done to make services work together effectively for the benefit of young people’s health.
- **Many practitioners felt that the voluntary and community sector should be included,** as they have skills in communicating with young people and building ongoing relationships with socially disadvantaged young people that can make the difference to them engaging with health services. This includes Children’s Centres, integrated youth support services and Police, which should be included in the ‘who should take action’ list.
- **The vast majority of participants all mentioned groups that they thought were missing from the target population.** Young people in care/looked after children, and young people leaving care were the most commonly noted omissions. In addition the Traveller community, homeless young people, drug and alcohol users, asylum seekers and refugees, young people in socially deprived areas, young carers, youth offenders, young people in rural locations, young people who are physically abused, sexually exploited young people, young people with mental health issues were all mentioned by practitioners.

*“the recommendation needs to be more specific about who they’re talking about”*

*Looked after children nurse*

*“There are other groups that should be included in the target community, travelling community, homeless, alcohol and drug users, those leaving care, asylum seekers and refugees. It is important for this to be specific”.*

*Education manager, Brook*

- **Some practitioners also noted that the definition of social disadvantage and the agencies involved in supporting people change with age:** by age 25, young people may be using adult services such as the Jobcentre, or may be involved with services such as probation, prison or adult social services. These latter services were therefore also important to include in the list of ‘who should take action’.

*“I hadn’t picked up the point that we were looking up to under 25’s. The pharmacy service is only for those under 19 – If you get someone who is 20 then you have to charge them and they walk away. I think I really welcome the idea that it’s going up to 25”*

*Community pharmacist*

- **Some participants felt the recommendation could include references to other relevant guidance on vulnerable groups and their health.** For instance, the recommendation could refer to NICE guidance on looked after children, or to the ‘high risk’ factors for teenage pregnancy.

*“it would be helpful if the recommendation could cross reference to other strategies”*

*PCT commissioning manager for sexual health*

#### 4.4.4 Suggested Changes to Text

Finally, a series of suggestions for change in the content of Draft Recommendation 4 were suggested during the fieldwork, as summarised in Table 4.4 below.

Table 4.4: Suggested Changes to Draft Recommendation 4	
Section of Draft Text	Suggested Changes
<b><i>Who is the target population?</i></b>	<p>The vast majority of participants thought that the list could be more inclusive.</p> <p>Participants felt ‘young people in care/looked after children’ and ‘young people leaving care’ could be added.</p> <p>Other suggested omissions included the Traveller community, homeless young people, drug and alcohol users, asylum seekers and refugees, young people in socially deprived areas, young carers, youth offenders, young people in rural locations, young people who are physically abused, sexually exploited young people, and young people with mental health issues.</p> <p>The participants highlighted that the language should be careful not to stigmatise.</p> <p>Consider whether more clarity is needed in relation to ‘social disadvantage’ and ‘vulnerable / at risk’ (as suggested).</p>
<b><i>Who should take action?</i></b>	<p>Participants suggested widening the group for who should take action to a range of</p>

	<p>services that are relevant to socially disadvantaged young people and adults – with suggestions including:</p> <ul style="list-style-type: none"> <li>▪ Children’s Centres;</li> <li>▪ Connexions;</li> <li>▪ Social services;</li> <li>▪ Integrated youth support services;</li> <li>▪ The Police;</li> <li>▪ Youth offending services;</li> <li>▪ Other services where NEET young people and other vulnerable groups are likely to be engaged with; and</li> <li>▪ The voluntary and community sector.</li> </ul> <p>Reflecting the age range for the draft recommendation, also include Jobcentres, and the probation, prison or adult social services.</p>
<p><b><i>What action should they take?</i></b></p>	<p>The fieldwork indicated that more advice and guidance could be included on how best to identify, engage and maintain contact with vulnerable young people.</p> <p>Participants suggested considering replacing “small manageable amounts” of information with a reference to the quality / effectiveness of delivery.</p> <p>Throughout the fieldwork, participants felt the recommendation could include references to other relevant guidance on vulnerable groups and their health (e.g. NICE guidance on looked after children).</p>



## 4.5 Recommendation Five - Young People's Services

<p><b><u>Recommendation 5: young people's services</u></b></p> <p><b>Who is the target population?</b></p> <ul style="list-style-type: none"> <li>▪ All young women and men</li> </ul> <p><b>Who should take action?</b></p> <ul style="list-style-type: none"> <li>▪ Professionals with a responsibility for the health and wellbeing of young women and men in social care, children's services, and voluntary and independent sector organisations, including youth workers, probation officers, education welfare officers, youth counsellors, and Connexions personal advisers.</li> <li>▪ Doctors and nurses specialising in genitourinary medicine, child and adolescent mental health services, drug and alcohol services, emergency and acute care and community care, including GPs, practice nurses, school nurses, and midwives.</li> </ul> <p><b>What action should be taken?</b></p> <ul style="list-style-type: none"> <li>▪ Provide information to young men and women about the location and opening times of local contraception and sexual health services, including GP and pharmacy services.</li> <li>▪ Use every appropriate opportunity to offer sensitive, non-judgemental information and advice about contraception and sexual health.</li> <li>▪ Routinely provide printed, quality assured information, to support verbal information and information about local contraceptive services when providing a related intervention, such as:             <ul style="list-style-type: none"> <li>- screening for Chlamydia or other STIs;</li> <li>- pregnancy testing;</li> <li>- emergency hormonal contraception;</li> <li>- postnatal care;</li> <li>- post-abortion care; and</li> <li>- treatment for STIs.</li> </ul> </li> </ul>
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### 4.5.1 Findings

Draft Recommendation 5 was considered by most practitioners to be both important and useful, although the titling and fit with recommendation 12 (communication) was confusing for some practitioners. In addition, reference was made in the focus groups and interviews to novel approaches to providing information to young people, which were felt to offer useful examples for inclusion either in this recommendation or in recommendation 12.

- **The vast majority of fieldwork participants recognised the importance of the recommendation, and many clinical professionals thought that it would be useful to take to services outside of health which work with young people** (such as schools, although schools staff are not explicitly mentioned in the list of 'who should take action').
- **The vast majority of practitioners also found the mention of providing information to both young men and women to be a useful emphasis** within the draft recommendation, as young men are often overlooked.
- **Many practitioners felt the content of the draft recommendation was useful, but felt the title was unclear**, and does not relate to the content of the recommendation. Among the comments made by practitioners were that they felt it to be 'generic', 'ambiguous' or 'repetitive' (alongside the other recommendations). Some participants felt the recommendation referred more to Information, Advice and Guidance or signposting for young people, as well as publicity. Some participants

suggested the content of this draft recommendation was better combined with recommendation 12.

- **Many participants referred to innovative and effective methods they have used to provide information to young people.** This included providing information to young people using methods such as CDs and USB sticks, or using cartoons on publicity. In one area, a number of different media have been used to target young people aged between 18 and 25, including advertising on buses, on beer mats and in the railway station.
- **Likewise, some practitioners thought that the recommendation could go further in encouraging not only the production of printed information, but other means of promoting services** (see also the responses to recommendation 12). Some practitioners felt strongly that for socially disadvantaged young people, outreach and word of mouth / campaign using peers played a more important role.
- **Some practitioners thought that the recommendation could be worded more strongly** so that all frontline professionals working with young people are more actively encouraged to provide signposting and good quality information at all times.

#### 4.5.2 **Barriers to Implementation**

The potential barriers to implementing the draft recommendation related to inconsistent practice within local areas and nationally (which highlighted the need for training) and the importance of ensuring that any materials produced are kept up to date.

- **Practitioners said that advice from different sources is inconsistent.** Many practitioners referred to local examples where advice from non-specialist professionals such as teachers and youth workers can be inconsistent and poor quality, with some feeling that more training for these groups was important. In addition, some practitioners said that they and other frontline workers can feel embarrassed talking about contraception and sexual health to young people, which also reflected a training need.
- **Many fieldwork participants mentioned that information, especially in relation to services, can go out of date;** it requires time and funding to ensure that information is kept up to date so the correct information about service provision and opening times is given to young people. Some practitioners pointed out that services, funding streams, providers, referral pathways and 'brands' change frequently in sexual health, so keeping up with developments is more difficult and confusing for young people. In some areas, services check their own information to ensure it is up to date and clinic times are accurate.

*"There is currently an issue locally where it is the local authority's duty to distribute information, but where this does not take place, it is important that there is something in the recommendation about ensuring the distribution of up to date information takes place and where that responsibility lies".*

*Commissioning manager for young people's sexual health and teenage pregnancy*

*"it needs to include reference to updated and relevant information which accurately reflects services available across sectors in different localities".*

*Young Person's Sexual Health Team Leader*

*"we have loads of leaflets – I am forever throwing them away because they go out of date".*

*Project Manager – Voluntary and Community Sector*

### 4.5.3 **Gaps in the Draft Recommendation**

Here the perceived gaps in the draft recommendation related to the comprehensiveness of the individuals listed under the ‘who should take action’ heading, the printed information for young people included, and suggestions on presenting materials for young people.

- **Many participants felt there were a number of practitioners and professionals missing from the ‘who should take action’ list.** Participants felt the list should also include school staff, specialist services such as those dealing with drug and alcohol misuse, paediatricians, social workers, care professionals, education psychologists, CAMHS, health visitors and terminations (TOP) staff. Some felt that Local Authorities and PCTs should also be included, as they should have a responsibility for collating the information about services in their local area. Many participants felt that A&E staff should also be included, as young people often present at accident and emergency departments for EHC. Some suggested that the list currently includes agencies more likely to be engaged with younger age ranges and therefore the ‘who should take action’ list risks overlooking the 18-25 age group.
- **The majority of participants felt the recommendation should explicitly mention the use of different formats and media to provide information to young people.** This included the use of different colours, typesets, using multimedia routes including text messaging and ensuring leaflets are “young person friendly”. Some practitioners suggested including young people in the design of local information for their peers,
- **Some practitioners felt the list of printed information provided to young people could be expanded.** Some suggested the list could also include reference to ante natal care, LARC and general sexual health advice.

### 4.5.4 **Suggested Changes to Text**

Finally, a series of suggestions for change in the content of Draft Recommendation 5 were suggested during the fieldwork, as summarised in Table 4.5 below.

<b>Table 4.5: Suggested Changes to Draft Recommendation 5</b>	
<b>Section of Draft Text</b>	<b>Suggested Changes</b>
<b><i>Who is the target population?</i></b>	None
<b><i>Who should take action?</i></b>	<p>Overall participants felt school staff should be included.</p> <p>Other suggestions included: specialist services such as those dealing with drug and alcohol misuse, paediatricians, social workers, care professionals, education psychologists, CAMHS, health visitors, A&amp;E and terminations (TOP) staff.</p> <p>Local Authorities and PCTs could also be included.</p> <p>The fieldwork highlighted that the list should not overlook professionals working with the 18-25 age group.</p>
<b><i>What action should they take?</i></b>	Participants felt the recommendation could be worded more strongly so agencies

	<p>outside of health take more responsibility.</p> <p>The recommendation could refer to other methods of providing information than hard copy – in particular, what works for disadvantaged young people.</p> <p>Practitioners suggested that information needs to be “young person friendly”.</p> <p>Some practitioners suggested the list of printed information provided to young people could be expanded.</p> <p>The title of the draft recommendation is somewhat confusing and elements of this might be better placed elsewhere, in particular Recommendation 12.</p>
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## 4.6 Recommendation Six - Consent and Confidentiality

<p><b><u>Recommendation 6: consent and confidentiality</u></b></p> <p><b>Who is the target population?</b></p> <ul style="list-style-type: none"> <li>All young women and men.</li> </ul> <p><b>Who should take action?</b></p> <ul style="list-style-type: none"> <li>Managers, professionals and staff in services that provide contraception and contraceptive advice to young people, including pharmacies and voluntary and independent sector organisations.</li> <li>Managers and staff in children's services, social care organisations and young people's advisory and support services.</li> </ul> <p><b>What action should be taken?</b></p> <ul style="list-style-type: none"> <li>Ensure that all staff have received training that enables them to understand the need for confidentiality, according to the relevant recommendations and standards from their professional organisation.</li> <li>All staff should be familiar with, and work to, the best practice guidance on the provision of advice and treatment to young people under 16 years on contraception and sexual and reproductive health (Department of Health 2004) and local and national guidance on working with vulnerable young people. They should be able to assess the competence of young people under 16 to consent to contraceptive provision and treatment, their ability to understand information provided, to weigh up the risks and benefits, and to voluntarily express their own wishes.</li> <li>Ensure young people who use the services understand that confidentiality will be respected with regard to their personal information and the reason for their visit. Reassure young people that they will not be discussed without their explicit consent, except to seek or share guidance from immediate colleagues about their case, or under the provisions made by law if there are concerns about their wellbeing or safety, for example safeguarding. The organisation's confidentiality and complaints policy should be prominently displayed in waiting areas and reception areas and should be in a format that is appropriate for young people.</li> <li>Ensure that staff are adequately supported and supervised and have opportunities for debriefing within the organisation. This will ensure that staff are not tempted to breach confidentiality by seeking external support.</li> </ul>
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### 4.6.1 Findings

The importance of consent and confidentiality in the provision of contraceptive services for young people was emphasised in the responses to this draft recommendation – which was widely welcomed.

- Overall, fieldwork participants welcomed the recommendation, and felt it was very important in relation to services for young people.** Most clinical practitioners felt that confidentiality (and data protection) is well understood by contraceptive and sexual health staff and health professionals more broadly, but less so by other partners and schools staff. They also thought the draft recommendation could be a powerful tool to use with school leaders, in order to influence their practice on confidentiality and emphasise its importance.
- While the vast majority of participants thought the recommendation was useful and relevant to them, some practitioners (especially those outside health services) felt that more guidance in this area would be useful. In particular, the vast majority of all practitioners consulted thought that the recommendation would benefit from greater clarity and detail about the relationship of confidentiality to safeguarding;** with some saying there should be explicit mention in the recommendation to the importance of the Fraser guidelines on competence to all professionals working with young people.

*“It is essential to have this in the recommendations, but there needs to be more mention about safeguarding. There is conflict between confidentiality and safeguarding”*

- **Some practitioners also thought that the recommendation could be more strongly worded and explicitly mention that under 13s are entitled to confidential services if they are competent.**
- **The vast majority of participants felt strongly about the focus of the third bullet point, and felt its inclusion was important.** Many practitioners discussed how they provide information about confidentiality to young people, including the provision of a card to every young person with the service's confidentiality statement (an example given by a family nurse), and the use of a poster in consulting and waiting rooms with "*I'm here to listen, not to tell*" (an example given by a GP). Some participants also suggested that the bullet point could be split, and moved to the first part of the recommendation to reflect its importance and so priority.
- **However other practitioners suggested that the draft recommendation should be expanded to ensure that young people with literacy issues are also well informed about confidentiality;** they thought that health service and other professionals working with young people should be confident in 'modelling' confidentiality at all times, promoting confidentiality visually as well as verbally, and reinforcing this when opportunities arise (in part, this was also because some practitioners said that it was very difficult in some schools and other settings to display prominent posters about contraceptives and sexual health).
- **Prior knowledge of services' confidentiality policies, and the impression conveyed by the location and ease of access to a service, were felt to be as important, if not more so, than confidentiality once young people had made the decision to come to a service.** Many practitioners said that young people worry about who in their local community will see them and they suggested that young people will not initially engage with service provision if they are not clear about the confidentiality policy. For example, they may be concerned that the service will contact their parents. This reinforces the point that practitioners made above, that it is important that all professionals working with young people work towards creating a culture where there is a common understanding of confidentiality and safeguarding and how these priorities relate to each other (see below).

*"it's about other young people making assumptions about what they go in and out of a building for"*

*Nurse / commissioner for young people's sexual health and teenage pregnancy*

- **Some practitioners thought that it was important that the recommendation should also emphasise that young people should have the option to access at least some services entirely anonymously** – as this would result in greater access (condom distribution was one example given).
- **Another means of making services more confidential, which was raised by several practitioners, was to offer contraception and sexual health services as part of a wider, general health and wellbeing drop-in** in schools and other community settings. This was felt to have the advantage of a more holistic approach (young people can receive advice about healthy relationships and other risk taking behaviours) and would reduce stigma and other concerns that young people have about accessing such services – as well as allaying schools' and colleges' concerns about whether such services fit with their 'ethos'.
- **Participants particularly liked the emphasis in the draft recommendation on adequate support and supervision** for staff working with young people. However,

some organisations and participants felt there were potential barriers in implementing this owing to the lack of capacity to supervise. Some participants also felt that the support and debriefing opportunities varied between organisations.

*“Not everybody gets the opportunity of clinical supervision, particularly outside health”*

*Co-ordinator Services for Young People with Sexually Harmful Behaviour*

*“Managers can’t always supervise people because of stretched capacity and there needs to be more funding to allow for supervision”*

*Co-ordinator Services for Young People with Sexually Harmful Behaviour*

- **However, some practitioners felt strongly that the last bullet point in draft recommendation 6 should not use the wording, “tempted to breach confidentiality”, which was thought to be somewhat offensive.** Rather, the recommendation should recognise that supervision sometimes entails seeking external support; but that such support can be provided without discussing individual names and breaching confidentiality.

#### 4.6.2 **Barriers to Implementation**

Although the recommendation was widely welcomed, potential barriers to its implementation were also widely raised, including those posed by differences in policy and practice between organisations, resource availability and the inherent challenges of working with young people.

- **The vast majority of participants felt that the different policies of organisations are a barrier to young people feeling able to use services confidentially.** For example, school consent and confidentiality policies are set by head teachers and governors, so they could usefully be included in the ‘who should take action’ list.

*“Why are professionals [across different services] working to different standards? This is a minefield”.*

*Maternity services commissioner*

- **The vast majority of frontline health practitioners and those delivering CASH services in schools often felt that school staff had different interpretations, or poor understandings, of confidentiality.** According to some practitioners, schools may have a policy which commits them to informing the parents of young people about conceptions. Therefore most practitioners felt strongly that school staff should not only be aware of the “relevant recommendations and standards from their professional organisation”, but also work to health service standards on confidentiality in respect to health. Equally, they felt that schools staff (not only teachers, but all support staff) should be aware of the Fraser guidelines – which many practitioners thought should be mentioned explicitly in the recommendation – and be more aware of where to seek support when there is confusion over confidentiality and safeguarding procedures.

*“Awareness of safeguarding procedures can also create complications for school based provision of contraceptive services”.*

*Community sexual health nurse, Peer education coordinator*

*“there has always been a big issue about confidentiality and different understandings...teachers are not allowed to keep secrets, they have to tell parents the truth or they’re out. They would have to take risks that they are not willing to take”*

*Senior Advisor PSHE*

- **Breaches of confidentiality can, and do occur and some practitioners wanted to know more about best practice in contacting and following up young people.** For example, young people may provide the wrong contact details, and they frequently change their contact details, and often pass their mobile phones to others, so text messaging information such as test results can sometimes be problematic. Some practitioners also mentioned some young people provide services with the wrong mobile telephone numbers in order to remain anonymous.

*“Sometimes for our service where confidentiality is breached, it’s not due to us, it’s due to young people giving us the wrong mobile numbers”*

*Chlamydia screening programme coordinator*

- **Lack of confidential spaces when delivering clinics in community venues (such as schools) was seen as a potential barrier to implementing fully confidential services.** Many practitioners also thought that the provision of separate waiting areas for young people. However, the cost of such changes was thought to be a major barrier to making this possible for all services.

#### **4.6.3 Gaps in the Draft Recommendation**

Gaps suggested in the draft recommendation included adding to the ‘who should take action’ list, making references to training more explicit, and including references to standards for confidentiality and safeguarding (Fraser guidelines, You’re Welcome, etc.)

- **Participants suggested that gaps in the ‘who should take action’ list included GPs, social workers, interpreters and all support and administration staff (e.g. receptionists).** Many participants felt that reception staff should also be included within this recommendation as they can often unintentionally be an additional barrier to the engagement of young people. In addition, the vast majority of participants felt school staff should be included, especially head teachers and school governors.
- **Many practitioners thought that training should be more explicitly mentioned in the recommendation** as there was thought to be a lack of understanding around confidentiality outside of health services, and more specifically, confidentiality in relation to safeguarding responsibilities. Even within health services, some staff said that in adult services there is a shortage of nurses that can, or are willing to, work with young people because of a lack of up to date training, or a lack of skills in speaking with young people.
- **Most participants felt the recommendation should reference the Fraser guidelines and ‘You’re Welcome’:**

*“There are some aspects of this in You’re Welcome so that could be pulled out – it could be used to say what a minimum of service is and what the concept means – making it clear when there will be disclosure”*

*Director, Brook*

- **Some practitioners felt that the wording around the second bullet point in the ‘what action should be taken’ could be strengthened,** for instance from “All staff should be familiar with...” to “All staff *must* be familiar with”.

*“Young people don’t see the sign. It is about reinforcing it [verbally]”.*

*SRE co-ordinator*

#### **4.6.4 Suggested Changes to Text**

Finally, building on the gaps identified above, a series of suggestions for change in the content of Draft Recommendation 6 were suggested, as summarised in Table 4.6 below.



<b>Table 4.6: Suggested Changes to Draft Recommendation 6</b>	
<b>Section of Draft Text</b>	<b>Suggested Changes</b>
<b><i>Who is the target population?</i></b>	None
<b><i>Who should take action?</i></b>	<p>Practitioners suggested that the recommendation should also be addressed a wider audience, including schools and education settings.</p> <p>The following could be included in the list:</p> <ul style="list-style-type: none"> <li>▪ School staff – in particular Headteachers and governors;</li> <li>▪ GPs, all administrative and reception staff, interpreters, and social workers; and</li> <li>▪ All staff in contraceptive and sexual health services (including administrative staff).</li> </ul>
<b><i>What action should they take?</i></b>	<p>Practitioners suggested that the recommendation could be worded more strongly; e.g. all staff should observe health service standards of confidentiality, make the entitlement of under 13s to services clear.</p> <p>Practitioners suggested that confidentiality should be communicated verbally as well as visually, and the message reinforced throughout all services.</p> <p>The recommendation could mention the use of general health clinics as good practice.</p> <p>Practitioners felt the recommendation could give more detail about respecting young people's wishes to remain anonymous.</p> <p>Participants were unsure about the some of the wording, and suggested removing the reference to staff being 'tempted' to breach confidentiality.</p> <p>Practitioners suggested adding references to Fraser guidelines and 'You're Welcome'.</p> <p>Training on a range of issues, but notably confidentiality and safeguarding, could be mentioned explicitly.</p>

## 4.7 Recommendation Seven - Preventing Unintended Pregnancies Following a Birth

### **Recommendation 7: preventing unintended pregnancies following a birth**

#### **Who is the target population?**

- Young women who are pregnant or have had a baby, and their partners.

#### **Who should take action?**

- Midwives, GPs, pharmacists, health visitors, sexual health nurses and school nurses. Health professionals working in primary and community services (including family nurse partnerships), acute and emergency care, contraception, sexual and reproductive health services.

#### **What action should they take?**

- During pregnancy discuss post-birth contraception, explain the full range of contraceptive methods and help them to identify the most effective method that best meets their needs and how to obtain it.
- Midwives should:
  - discuss the full range of contraception with new mothers after the birth and should provide contraception wherever possible. If this is not possible, take responsibility for offering a referral to contraceptive services before discharge from midwifery services; and
  - be mindful that mothers who are breastfeeding will need particular advice about their choice of contraception.
- Offer contraceptive advice and choice of effective contraceptive methods to young women as soon as possible after the birth, to prevent them becoming pregnant again unintentionally. This will require liaison between maternity services, primary care and contraceptive and sexual health services and agreed local pathways. Maternity services and other professionals engaged with new mothers, such as health visitors and family nurse practitioners, should consider using outreach or home services to provide contraception and contraceptive information.
- Health visitors should check that new mothers have the opportunity to obtain contraception or discuss contraception during the handover from the midwife, and make any arrangements to enable them to obtain the information, advice and treatment they may need.

### 4.7.1 Findings

This draft recommendation was welcomed both for its content and for highlighting the opportunity to engage with young people not using statutory health services. However the variations in practice and procedure in this area referred to earlier emerged again, here in terms of potential roles and the importance of referral pathways. It should be noted that many of the findings and challenges raised by practitioners under this recommendation are common to both recommendations 7 and 8.

- **The recommendation was welcomed by the vast majority of practitioners** and many felt the recommendation was important in building effective services to prevent unintended pregnancies following a birth for young women. Some practitioners felt that during this time, young women who have not historically engaged with health and other statutory services are most likely to do so when having a baby, and this was seen as a good opportunity to provide contraceptive services.
- **The reference at the outset to “young women... and their partners” was seen as an important step forward by many practitioners.** Contraception was seen as a shared decision. Partners also influence contraceptive choices and may also be undertaking risky sexual activity; their needs can be overlooked. Many practitioners felt strongly that there ought to be more mention of young boys and fathers throughout the other recommendations.
- **It was also thought by some practitioners that the contraceptive and sexual health needs of young women who have a miscarriage could also be addressed in this recommendation; as could the needs of young mothers who**

**live in hostels.** The latter are often unlikely to remain in the local area which means follow up can be very difficult.

- **The vast majority of practitioners highlighted the capacity issues in midwifery services, and the particular difficulties this caused in some areas in commissioning integrated services that meet the contraceptive and sexual health needs of young women and their partners.** Discussions centred on how contraception (and sexual health) could be made part of midwifery's core offer, both ante-natally and post-natally; it was clear that many practitioners (commissioners in particular) thought there was a lack of skills in bringing up the topic of contraception with pregnant women so effective referrals could be made to specialist contraceptive and sexual health services. Some areas highlighted what they thought to be local good practice e.g. employing a specialist teenage pregnancy midwife, which had a positive impact on young women's outcomes, and felt that this and other examples could be included in the recommendation.

*“the knowledge that midwives have of contraceptive services can be really limited... currently there is variation in the service of midwives – some discuss contraception in the last few weeks before birth and others do not”.*

*Advanced Nurse practitioner*

- **Across the fieldwork areas, practice in relation to the provision of contraceptive services in pregnancy / after birth was variable and provided by a variety of health services.** Midwives, health visitors and outreach provision could all play a role; a number of practitioners in family nurse partnership pilot areas discussed the provision of contraceptive services and advice through the family nurse staff, and the importance of establishing referral pathways where they were unable to provide such services.

*“Family nurse partnership staff discuss contraception with young women antenatal and postnatal, and discuss what methods can be used after birth, why they should consider contraception, family spacing etc, and then linking carefully with midwives and outreach workers”.*

*Family Nurse*

The issue of family spacing and positive planning was also thought to be an important part of health support among other fieldwork groups, as many myths can take hold in young people about the best time to have children, and other issues.

*“Let's empower young people to make good decisions in their life”*

*Fathers work development manager*

- **Many practitioners agreed with the draft recommendation on the importance of following up with an offer of contraception services after the birth. This was felt to be particularly important in the case of social disadvantage.** Some practitioners thought that current practice was limited in some circumstances to referring young women to their GP for contraception, which could lead to poor outcomes if the GP is unable to offer the full range of services; the use of specialists was preferred and they thought that the recommendation could be more strongly worded in this regard. Practitioners also thought that the recommendation could give more detail on when (i.e. how many days after birth) and how follow up should take place; practice varied from place to place.

#### 4.7.2 **Barriers to Implementation**

Here the barriers to implementation suggested by the practitioners related to the need for, and provision of, adequate training for staff from different work backgrounds, as well as capacity issues on the ground.

- **Many practitioners referred to a lack of training as a potential barrier to implementation.** This was particularly the case where the provision of contraception is not currently provided and would be an additional task, e.g. for midwives and health visitors. However, some commissioners welcomed the recommendation which could be used to argue the case for additional provision within existing service delivery.
- **Many practitioners felt the capacity of midwives and health visitors to deliver contraceptive services was a potential barrier** (as discussed above).

*“Capacity of midwives and health visitors is an issue too. They wouldn’t have the time to do this. Capacity is a big issue”*

*Voluntary and community sector representative*

#### 4.7.3 **Gaps in the Draft Recommendation**

The gaps in this draft recommendation referred to omissions from the ‘who should take action’ list, the coverage of the target population (to include women having miscarriages and others) and additional supportive actions for young people.

- **Many practitioners thought that the ‘who should take action’ list should not be limited to health and clinical staff** and should also include staff in children’s centres, staff in Children’s Trusts, social workers, Connexions workers, and the voluntary and community sector (e.g. Brook). The majority of practitioners also felt that commissioners could be included.
- **Some practitioners also thought that the recommendation should reference other agencies that vulnerable young people may be involved with.** For example, there may be social workers and other involved in care planning / Common Assessment Framework (CAF) activities and access to contraception could also be consideration for those agencies. Therefore it was thought to be important the list of ‘who should take action’ was wider than just clinicians.

*“the list of who should take action should not be limited to medical staff. While it is good that family nurse partnerships are included, the recommendation should recognise and encourage the contribution of non-clinical staff operating”*

*Health practitioner*

- **On a related theme, many practitioners felt the recommendation lacked reference to wider social support for young parents, and it was not acknowledged that not all teenage pregnancies are unintended.** In addition, some practitioners felt that the draft recommendation fails to include information around sex and relationships education (SRE) and the need for professionals working with young people to address some of the myths around sexual activity.

*“In [locality name] we have third and fourth generations of young mums, they might not even want a baby, but have to work within the confines of their community and cultural expectations.... some young people don’t even know how to catch a bus across town to access services”*

*GP Lead for sexual health service*

*“Some young mums are fantastic mums, but equally there are many for whom pregnancy is a substitute for something else”.*

*Senior Education Officer*

- **Many practitioners also wanted to see a reference made to STI screening and sexual health services as an unplanned pregnancy may be as a result of risky sexual activity.** While some practitioners recognised that the recommendations were about ‘contraception’, many felt strongly that sexual health screening was an important part of offering an integrated service to vulnerable young women and their partners, and ought to be mentioned in the recommendation.
- **Many practitioners also said that the recommendation should also cover the contraceptive needs of women that have had miscarriages, as well as women whose babies have been taken into care.** Practitioners felt that young women who have experienced a miscarriage, or who have had their babies taken into care or adopted, would require contraceptive and sexual health services, and in these cases, additional emotional and social support would be required as well.
- **Finally, some practitioners felt that the recommendation ought to acknowledge that the support needs of young parents under the age of 16 are different to the support needs of young parents over the age of 16.**

#### 4.7.4 **Suggested Changes to Text**

Finally, a series of suggestions for change in the content of Draft Recommendation 7 were suggested during the fieldwork, as summarised in Table 4.7 below.

<b>Table 4.7: Suggested Changes to Draft Recommendation 7</b>	
<b>Section of Draft Text</b>	<b>Suggested Changes</b>
<b><i>Who is the target population?</i></b>	<p>The fieldwork indicated that the needs of young women that have had a miscarriage could be mentioned.</p> <p>Practitioners suggested that young women in hostels or care could also be specifically mentioned.</p>
<b><i>Who should take action?</i></b>	<p>The fieldwork highlighted that the list should not be limited to clinical staff.</p> <p>The following could be included in the list:</p> <ul style="list-style-type: none"> <li>▪ Staff in children’s centres and Children’s Trusts;</li> <li>▪ Social workers;</li> <li>▪ Connexions;</li> <li>▪ the voluntary and community sector (e.g. Brook); and</li> <li>▪ Commissioners.</li> </ul>
<b><i>What action should they take?</i></b>	<p>The recommendation could acknowledge that specialist services for vulnerable young women and their partners are needed, as</p>

	<p>well as referral pathways.</p> <p>Practitioners suggested more detail could be given on following up after a birth.</p> <p>The fieldwork indicated that reference should be made to STI testing and sexual health advice before and after birth.</p> <p>Participants felt training needs could be mentioned – especially in relation to overcoming capacity and skills issues with midwifery.</p>
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## 4.8 Recommendation Eight - Preventing Unintended Pregnancies after an Abortion

### **Recommendation 8: preventing unintended pregnancies after an abortion**

#### **Who is the target population?**

- Young women who have an abortion and their partners.

#### **Who should take action?**

- GPs, primary care teams, contraception and sexual health teams, abortion providers, counsellors working with abortion services.

#### **What action should they take?**

- Before and as soon as possible after an abortion, discuss contraception and explain the full range of contraceptive methods. Help young women and their partners to identify and obtain the most effective method that best meets their needs.
- Offer contraceptive advice and contraception to prevent a repeat unwanted or unintended pregnancy. If this is not possible, the young woman should be offered a prompt referral to appropriate contraceptive services
- Offer to follow up all young women after an abortion using a method of their choice (for example by text messages), to offer advice and support to help choose the most effective and suitable method of contraception for them.
- Services should consider using outreach or home services to provide contraception and contraceptive information.

### 4.8.1 Findings

In common with the previous recommendation on preventing unintended pregnancies following a birth, this draft recommendation was also welcomed as an opportunity to engage with young people not using statutory health services. Indeed many examples of current practice in this area were reported, although some fieldwork area groups reported issues around repeat abortions.

- **Overall the vast majority of practitioners recognised the importance of the draft recommendation.** Many practitioners felt the draft recommendation could be implemented; and, as with recommendation 7, welcomed the inclusion of partners (although some felt that this could be emphasised more strongly).
- **The provision of contraceptive services and methods varied across the consultation groups.** In a number of areas, according to participants, TOP and CASH services already work together. For example in some fieldwork areas, CASH service nurses or family planning nurses attend pre-assessment appointments to talk about contraception. However, focus group participants in some fieldwork areas described a lack of communication and partnership working between CASH and TOP services.

*“[The recommendation] is a good thing because she [nurse] can talk to them [patient] about it [contraception] before and then they also know who she is so that afterwards they feel comfortable coming to wherever she is”*

*CASH service team leader*

- **In some fieldwork areas, participants referred to good practice in keeping with the recommendation, including offering LARC to young women while they are in hospital.** This was mentioned in more than one fieldwork area and participants thought it was effective. Many practitioners said that offering LARC to young women who have had a termination was important, and that the draft recommendation was a useful tool to promote the provision of LARC immediately following a termination.

*“The next time you see them [young people], it’s for EHC or a pregnancy test. They [young women] need to go out with something”*

*Sexual health outreach nurse*

- **Many practitioners felt repeat abortions were an issue about which practitioners needed to know more information**, which was not included in the draft recommendation. Many practitioners suggested a reference to repeat terminations would increase the impact of the recommendation.
- **Practitioners’ views were mixed about the provision of outreach services.** While some practitioners thought the provision of outreach services would be effective, others felt the provision of outreach services could be expensive, or could carry the risk of breaching confidentiality, especially where young people’s parents were not aware of the termination. Where this was mentioned, participants felt it would be helpful to have examples in the guidance of outreach models which can be used.

*“I think the most exciting thing in this is the services should consider outreach or home services to provide contraception and contraceptive information”*

*Public Health Manager*

#### **4.8.2 Barriers to Implementation**

At the same time, mixed views were reported regarding the practicality of the draft recommendation, including potential barriers to follow-up activity.

- **Some practitioners thought that providing contraceptive advice and information about contraceptive options was not practical following a termination;** they thought that providing advice and information about contraception was better discussed during pre-assessment appointments (while other practitioners thought that doing both was a good idea).

*“Many women wish to leave TOP services as quickly as possible – it would be beneficial for the recommendation to acknowledge and address this”.*

*Practitioner*

- **Many practitioners thought that young people who self refer to TOP services, and access a service outside of their local area were difficult to follow up.** Some GPs also thought it was difficult to follow up with young people, as they do not necessarily get told if a young person has had a termination. One GP suggested when they receive information about a patient who has had a TOP, they could ‘flag’ their record to enable the GP to discuss contraception when the young person next visits their GP. Young women have the right to be seen confidentially, so some practitioners said that one way to deal with this could be to commission TOP and CASH services to work together so contraception can be offered without the need for further referrals, as the draft recommendation states.

*“Patients can self refer to TOP providers so they might not be seen by a health professional and this could make follow up difficult”*

*Chlamydia Screening Programme Coordinator*

#### **4.8.3 Gaps in the Draft Recommendation**

Gaps in the draft recommendation mentioned by practitioners included groups missing from the ‘target population’ and ‘who should take action’ lists; practitioners also thought that the recommendation could be stronger on the importance of ‘pathways’ and emotional support and counselling.



- **Some practitioners felt that the recommendation could be worded more strongly to emphasise the importance to commissioners of designing service pathways for young people.** This was particularly important where TOP services do not provide LARC or contraceptive advice.
- **Participants thought there were some groups missing from the list of ‘who should take action’** including school nurses, and workers in youth services, Connexions, youth offending services, drug and alcohol services, counselling services, and commissioners. As with recommendation 7, they thought that it was important to widen the list of ‘who should take action’ to professionals working with young people outside the health service. Some participants also said the ‘target population’ should also include young women who have an abortion that are also looked after children, living in hostels and those outside of mainstream education services as these groups are likely to be particularly vulnerable.
- **Many participants felt the recommendation lacked any references to emotional support and counselling following a termination; and access to STI screening (as above).** They thought that these were important elements of an integrated TOP, contraception and sexual health service.

*“We know from evidence that some, particularly amongst young people who’ve been for an abortion – you know, that loss, that grief, you know the answer is actually to get pregnant again”*

*Voluntary and community sector representative*

#### 4.8.4 Suggested Changes to Text

Finally, a series of suggestions for change in the content of Draft Recommendation 8 were suggested during the fieldwork, as summarised in Table 4.8 below.

Table 4.8: Suggested Changes to Draft Recommendation 8	
Section of Draft Text	Suggested Changes
<b><i>Who is the target population?</i></b>	Practitioners suggested the recommendation could make specific reference to young women who have an abortion that are also looked after children, living in hostels and those outside of mainstream education services.
<b><i>Who should take action?</i></b>	The fieldwork indicated that the list should not be limited to clinical staff. Participants suggested the following could be included in the list: <ul style="list-style-type: none"> <li>▪ School nurses;</li> <li>▪ Youth Offending Services;</li> <li>▪ Drug and alcohol services;</li> <li>▪ Social workers;</li> <li>▪ Connexions workers;</li> <li>▪ The voluntary and community sector (e.g. Brook);</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Counselling services; and</li> <li>▪ Commissioners.</li> </ul>
<p><b><i>What action should they take?</i></b></p>	<p>Practitioners felt references to repeat terminations could be included.</p> <p>More advice on good practice in follow-up and outreach services following a termination would be beneficial to participants.</p> <p>The fieldwork highlighted that reference should be made to the importance of commissioning / offering emotional support and counselling following a termination; and access to STI screening.</p>

## 4.9 Recommendation Nine - School and Education-Based Services

### **Recommendation 9: school and education-based services**

#### **Who is the target population?**

- *All young men and women in education or of school age.*

#### **Who should take action?**

- *Contraceptive services within, or associated with, schools, further education colleges, universities and other education-based settings, including pupil referral units and young offender institutes.*
- *Head teachers, teachers, school governors in schools, pupil referral units, and young offender institutes, principals and tutors in colleges and further and higher education.*

#### **What action should they take?**

- *Involve young people in the design, implementation, promotion and review of on-site and outreach contraception and sexual health services in and near schools, colleges and other education settings.*
- *School nurses, doctors and counsellors working with individual children and young people in schools, colleges and universities should conform to health service standards of confidentiality and to those set by their professional body. All young people should be made aware that one-to-one consultations with health professionals and counsellors in school will be confidential except under the provisions made by law, for example safeguarding.*
- *Ensure that accurate and up-to-date contraceptive advice, information and support is readily available to all young men and women as well as information on the location and hours of local services. This information should be available outside of designated clinic hours.*
- *Ensure that contraception and sexual health advice, pregnancy testing and the full range of contraception methods, including both long-acting and emergency contraception, is easily available. If the full range of methods is not available, young people should be seamlessly referred into appropriate services.*
- *Ensure continuity of service provision, for example, by making clear to young people when and where services are available during school or college holidays.*
- *Ensure services not only provide contraception to young people, but are staffed by people trained to be respectful and non-judgmental and to support young men and women through identifying, choosing and using the most appropriate contraception for them.*
- *Ensure the service provides clear and easy referral into specialist services that can meet young people's contraception and sexual health needs that cannot be met in the school or college setting.*
- *School nurses should have clear referral pathways into contraception and sexual health services and should have up-to-date information about local services.*

### 4.9.1 Findings

There was clear support for this draft recommendation, and for the inclusion of young people in the design, delivery and review of contraceptive services. However, the focus on the school/education setting, however broadly defined, risked missing out key groups such as young people not in education, employment or training (NEET), those engaged with private training providers or in employment (given the focus of the recommendations on young people up to the age of 25).

- **The vast majority of participants strongly welcomed the draft recommendation, although many thought that the wording could be made stronger in order to give stronger direction to schools.** Many participants argued that partnership working between contraceptive and sexual health services, and schools was in need of improvement. They thought the recommendation would help to persuade schools of the importance of contraception and sexual health and giving support to a consistent service for young people. In order to make the language stronger still, some participants suggested using 'must' where 'should' was used. Some

participants also noted their agreement with the recommendation on wraparound service provision, emphasising the need for service provision during school holidays.

*“for any young person having to move out of their immediate area, for some of them you’re asking them to go to the moon and that’s why school [clinics] work so well because they’re on the doorstep”.*

*School based service coordinator*

- **The vast majority of practitioners thought it was important that all schools are aware of the sexual health needs of their students as a whole** (instead of denying that sexual activity is taking place among students, for example). Some fieldwork areas have planned services around schools that were targeted because of higher rates of teenage pregnancy and deprivation.
- **The vast majority of practitioners strongly agreed with the draft recommendation on the inclusion of young people in the design, implementation, promotion and review of services.** Some participants thought that the ‘You’re Welcome’ criteria could usefully be referenced again in the text. Many participants referred to effective local practice engaging young people in the design and implementation of services (see responses to recommendation 1).
- **There were concerns among many focus group participants that young people not engaged in mainstream education would be missed, including those who are NEET, or employed.** Some practitioners felt that some socially disadvantaged young people would be less likely to be found in formal education. Therefore it was important that the recommendation referred not only to FE provision, but also to non-mainstream educational settings (Pupil Referral Units, special schools, care settings, foster care, home schooling) and training providers such as apprenticeship providers and foundation learning providers (some of these are not mentioned in the draft recommendation). Many practitioners wanted to know more about how services could reach young people who are NEET (see responses to recommendation 4).

*“The type of young people we’re talking about. I’m not making assumptions but, quite a large proportion of them will not be attending schools, so I was really surprised [as this seemed to be missing in the recommendation]”*

*Senior Public Health Development advisor*

*“Reference to young people who are in employment should be made, and the difficulty this might present for them to take time off to attend a clinic”.*

*Voluntary and community sector representative*

- **There was debate in some fieldwork focus groups about the inclusion of universities.** Practitioners’ views varied, on whether most students were ‘socially disadvantaged’; however, other argued that regardless of socioeconomic characteristics, students engage in risk-taking behaviour which means that CASH services must be tailored to their needs too. Some other practitioners thought that universities themselves should plan and fund provision, particularly in cities with a large student population.

*“It’s not really practical to include university students in [location] because there’s such a large number of students and other groups are more of a priority”*

*Public Health Manager*

*“The vast majority of students aren’t socially disadvantaged, but there are some... but they have chaotic lifestyles”*

*General practitioner*

#### 4.9.2 **Barriers to Implementation**

While the references to school based services were welcomed, a series of barriers to implementation were reported based on the experiences of practitioners in the field

- **The vast majority of practitioners had encountered difficulties in trying to engage school staff basing services within some schools.** Most participants felt that it was difficult to engage schools (especially faith schools) and persuade them to host a service for young people. There were a number of factors mentioned for poor links with some schools, including competing priorities such as educational attainment, a fear of parents' reactions, a perception that the school is promoting risk taking behaviour and a belief within Senior Management Teams and Governing bodies that their school does not need the services:

*“The barrier is usually the board of governors and the head. If they say no, that’s it. they could have the highest teenage pregnancy rate in the county, and we wouldn’t have a leg to stand on”*

*School nursing manager*

Some practitioners had tried to get around this barrier by offering general health and wellbeing drop-ins or information services in schools, where young people can receive advice about healthy relationships and other risk taking behaviours. This approach was described in one focus group area:

*“The school I work in is a faith school – Church of England. The school and the governors needed to feel very confident that the service we were going to use would support their ethos of treating each student as part of a family and a family approach. The Head Teacher and myself needed to put together a strategy of how we were going to work out confidentiality and we’ve done that and we’re into our third year now. Although we don’t prescribe or give out contraceptives or pregnancy testing kits, we signpost into local services... which has made us in a position where we have the confidence of the parents, the confidence of the governors, the confidence of the staff in school as well as the students, so that should a student want to come into [the service] they don’t have any reserve of doing that”*

*Service Coordinator*

- **The vast majority of contraceptive and sexual health practitioners had encountered difficulties with confidentiality in schools, and were concerned as to whether school staff received adequate training.** The issues raised by practitioners, including whether further reference could be made in these recommendations to a uniform standard of confidentiality across all services, and the perceived need for specific reference to access to services for under 13s and the Fraser guidelines, are discussed in greater length in the responses to recommendation 6.
- **Practitioners reported that some staff in educational settings felt uncomfortable talking about sexual health and contraception with their students.** Practitioners raised a number of issues concerning training needs, including greater awareness of safeguarding and confidentiality (to ensure a consistent approach), knowledge of sexual health issues and local services, sex and relationships education (SRE) and tailoring approaches to students' gender, and 'sex and the law' (this could also be used to start a conversation with young people about asserting ownership of their own bodies, for instance). Some practitioners had become actively involved in local SRE initiatives.

- **Some practitioners expressed uncertainty about the future status of SRE and PSHE in education, and were concerned about the potential impact on schools' attitudes to contraceptive and sexual health provision.**

#### 4.9.3 **Gaps in the Draft Recommendation**

A series of additional points were raised that would be useful additions to the draft recommendation, including to the comprehensiveness of coverage in terms of targeting and who should take action:

- **Some practitioners thought it would be useful if the recommendation referred to guidance outside the clinical field** that might resonate with a wider group of professionals working with young people. Suggested references included 'Improving Access to Sexual Health Services for Young People in Further Education Settings' (DCSF and DH, 2007); 'Enabling Young People to access Contraceptive and Sexual Health Information and Advice' (DCSF, 2004) and the 'Here By Right' standards (National Youth Agency).

*"The recommendation makes reference to clinical guidance but when it talks of certain groups (NEETs, BME, young people with learning difficulties) it should make reference to other strategies in operation for example NEET strategy. That might engage services beyond the clinical"*

*Voluntary and community sector representative*

- **Many participants felt the draft recommendation could include more guidance on the location of services within schools.** It was thought that the way in which schools manage access to school based services can impact on the outcomes of young people. Schools may require young people to make requests to 'gatekeepers', denying students time off lessons, and locating services in close proximity to figures of authority such as the head teacher, which can make access more difficult in schools. Some participants also thought the recommendation should stress the need for confidential spaces and waiting areas for clinics.
- **Many practitioners felt the 'who should take action' list could be expanded to include wider frontline professionals,** as well as health workers and managers in schools and education settings. Suggested additions to the 'who should take action' list included school nurses, school health services, education welfare officers, young people's services/youth services, youth offending services, Connexions, parent support advisors, SRE advisors, teaching assistants, and private training providers.

#### 4.9.4 **Suggested Changes to Text**

Finally, a series of suggestions for change in the content of Draft Recommendation 9 were suggested during the fieldwork, as summarised in Table 4.9 below.

<b>Table 4.9: Suggested Changes to Draft Recommendation 9</b>	
<b>Section of Draft Text</b>	<b>Suggested Changes</b>
<b><i>Who is the target population?</i></b>	The recommendation could add those young people in informal education, work-based learning or other settings outside mainstream education (e.g. children learning outside of school whilst in care).
<b><i>Who should take action?</i></b>	Suggested additions to the list include:

	<ul style="list-style-type: none"> <li>▪ School nurses;</li> <li>▪ Education welfare officers;</li> <li>▪ Young people’s services/youth services;</li> <li>▪ Youth offending services;</li> <li>▪ Connexions workers;</li> <li>▪ Parent support advisors;</li> <li>▪ SRE advisors;</li> <li>▪ Teaching assistants; and</li> <li>▪ Private training providers.</li> </ul>
<p><b><i>What action should they take?</i></b></p>	<p>Practitioners felt the language could be made stronger in order to give clearer direction to schools.</p> <p>The fieldwork indicated that more detail could be given on good practice in engaging with schools e.g. through using ‘health’ drop-ins.</p> <p>Participants suggested that more reference could be made to other sources of guidance that are relevant to schools and education settings.</p> <p>The fieldwork highlighted more reference could be made to the location and management of services within schools.</p> <p>(See also responses to Recommendation 6 on Consent and Confidentiality.)</p>

## 4.10 Recommendation Ten - Emergency Contraception

<p><b><u>Recommendation 10: emergency contraception</u></b></p> <p><b>Who is the target population?</b></p> <ul style="list-style-type: none"> <li>▪ Young women and young men</li> </ul> <p><b>Who should take action?</b></p> <ul style="list-style-type: none"> <li>▪ Managers, doctors, nurses, pharmacists and staff in contraception and sexual health services, including primary and community care, acute and emergency services, pharmacies, walk-in centres, the voluntary and independent sector.</li> </ul> <p><b>What action should they take?</b></p> <ul style="list-style-type: none"> <li>▪ Ensure all young women are able to obtain free emergency hormonal contraception, including advance provision.</li> <li>▪ Alongside emergency hormonal contraception, young women should be:             <ul style="list-style-type: none"> <li>– encouraged to consider their contraceptive needs and to make a choice that is appropriate and suitable for them;</li> <li>– referred to or given information about local services;</li> <li>– advised that emergency contraception is more effective the sooner it is used;</li> <li>– advised that an intrauterine device is a more effective form of emergency contraception and can also be used for continuing contraception; and</li> <li>– given information about the limitations of emergency hormonal contraception as a primary method of contraception and the need for a pregnancy test after taking emergency hormonal contraception.</li> </ul> </li> <li>▪ Ensure young men and young women know where to obtain free advanced provision of emergency hormonal contraception</li> <li>▪ In addition to providing emergency hormonal contraception, professionals should ensure that all young women who obtain emergency hormonal contraception are offered clear information about, and referral to, contraception and sexual health services. Ensure that all professionals dispensing emergency hormonal contraception are aware that young women under 16 years old are entitled to emergency hormonal contraception without an adult's presence, in accordance with best practice guidance on the provision of advice and treatment to young people under 16 years (Department of Health 2004).</li> </ul>
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### 4.10.1 Findings

This recommendation was welcomed by the vast majority of the practitioners consulted, although there was considerable debate about the provision of emergency hormonal contraception (EHC), particularly arrangements for advance provision.

- **The vast majority of practitioners welcomed the draft recommendation and the points within it, including the reference to availability of advance provision, and the reference to targeting both young women and men.**

*"I was very excited to see about the advanced provision bit because I do that with not all my client group, but some of my client group who I think are particularly vulnerable".*

*Young People's Contraceptive Nurse*

- **Current practice across the fieldwork areas appeared to vary considerably; this made the consistent approach suggested in the draft recommendation important, however, some fieldwork areas would find the recommendation more challenging to implement than others.** Out of hours services were thought to be very important, but provision varied. According to practitioners, this is because



EHC is not licensed for use in advance, and therefore local areas need to develop patient group directives (PGDs) for pharmacists to dispense it; train pharmacists and nurse prescribers; and pay pharmacies for the service. Funding streams also change frequently. This led to very inconsistent services in some areas, with provision in pharmacies dependent on who was on duty and some young people being asked to pay depending on which pharmacy they visited. This had led to some fieldwork areas establishing services that did not depend on pharmacies, and trying to develop referral pathways to ensure that young people were able to access services.

- **Many practitioners described young people's experiences which have been poor due to inconsistency in the provision of EHC.** For example, participants in one focus group discussed that among pharmacists the provision of EHC is patchy and locum pharmacists are unable to dispense it, this can be *"frustrating and harmful to young people"* trying to obtain EHC from pharmacists.

*"There is an issue in pharmacies where EHC was being provided but now will not be because the funding is stopping. Young people will go to these pharmacies and find that the service isn't there anymore".*

*Team leader, young people's drug team*

- **Some practitioners questioned the evidence base for advance provision – although in the majority said that more advance provision was to be welcomed.** Where discussion took place regarding evidence it centred on cost effectiveness, or whether advanced provision of EHC might encourage young people to have unprotected sexual intercourse.

*"The science as I understand it says that emergency contraception doesn't make people have more unprotected sex. So it doesn't cause any harm, but there's nothing to say it does any good, there's no evidence that giving emergency contraception actually reduces unintended pregnancies either".*

*General practitioner*

- **Most participants thought that the provision of EHC provides an opportunity to discuss ongoing contraception with young people.** Some participants therefore suggested that the draft recommendation should make clearer reference to having a discussion with young people about their sexual health screening at the same time, as well as pregnancy testing following the use of EHC. Some participants felt this would not be possible if specialists were not involved.
- **In addition, focus group participants in some areas were concerned about appropriately assessing risk and offering information about side effects, as well as other contraceptive and sexual health provision and advice at the same time as giving EHC.** In some fieldwork areas it can only be taken in the presence of a professional or even on health service premises. Views diverged across the different fieldwork areas about what was most appropriate and important – ease of access, or assessing risk – and therefore many practitioners wanted to see more clarity on this. In the case of practitioners who were in favour of the guidance given in the final bullet point of recommendation 10, some wanted to see stronger wording about advance provision, including reference to commissioners and PCTs actively facilitating access to it.

#### 4.10.2 **Barriers to Implementation**

A range of barriers to the draft recommendation were reported, including:

- **The majority of practitioners thought that the current licensing regime is a barrier to the provision of advanced EHC,** although some areas have overcome

this through the use of PGDs. In the case of using PGDs, ensuring that training is available and taken up at the local level was an issue.

*“The manufacturers would have to go back to the licensing authority to ask for licensing to be changed, otherwise anyone that provides advanced provision is breaking licensing”.*

*Senior commissioning manager*

- **Current local practice was also thought by many practitioners to be a barrier to implementation**, with confusion about referral pathways, how reliable information could be given about where EHC could be obtained, and how information about young people at risk could be followed up and young people signposted to more effective and appropriate contraception, including LARC:

*“Another concern is sharing information – everyone works from different systems so they don’t know how many times [young women] may have had EHC in their cycle”*

*Clinical nurse lead*

- **Some practitioners raised concerns as to whether young people would keep EHC in a safe place, ensure it was not out of date and take it as prescribed.** Some practitioners wanted to see the draft recommendation expanded in order to give more detail about what advice should be given alongside EHC.
- **Many practitioners mentioned that the draft recommendation is not clear as to what ought to be provided to young men.** Some practitioners said that young men cannot obtain EHC from a pharmacy on their own, and some expressed concern about prescribing EHC to young men and potential consent issues this could raise.

*“[the draft recommendation] sort of suggests that we’re going to give it to young men, and I think that there are big issues with that. I really do think that there are big issues in terms of coercion”*

*General practitioner*

#### 4.10.3 Gaps in the Draft Recommendation

Comments regarding gaps in the recommendation referred to the inclusion of STI testing and aftercare support:

- **Many practitioners felt that recommendation should include information about STIs testing or referral to an STI screen when EHC is provided, or shortly afterwards.** This was not seen to be explicit enough within the draft recommendation.

*“It needs to be more explicit about the fact that a young person might need to be screened for STI’s when you get emergency contraception”.*

*General practitioner*

- **The recommendation should include information about the provision of aftercare including education.** For example, the use of the term ‘morning after pill’ can be misleading for young people, who may not realise it can be taken up to 72 hours later (or that there are other methods which are effective after that time window).
- **Some practitioners felt the draft recommendation should reemphasise the age range of the target population** (up to the age of 25), because the provision of free EHC varies considerably across areas, and according to age. They pointed out that if

the recommendation is stating that all young women up to the age of 25 should have access to free EHC, this needs to be made clear in the text.

**4.10.4 Suggested Changes to Text**

Finally, a series of suggestions for change in the content of Draft Recommendation 10 were suggested during the fieldwork, as summarised in Table 4.10 below.

<b>Table 4.10: Suggested Changes to Draft Recommendation 10</b>	
<b>Section of Draft Text</b>	<b>Suggested Changes</b>
<b><i>Who is the target population?</i></b>	None
<b><i>Who should take action?</i></b>	The recommendation could include commissioners.
<b><i>What action should they take?</i></b>	<p>The recommendation could use stronger language and suggest that commissioners use PGDs and other means to facilitate local provision of emergency contraception.</p> <p>Practitioners suggested reference could be made to the importance of STI screens and pregnancy tests.</p> <p>Training may need to be noted as an challenge to be overcome.</p> <p>More information could be given about the appropriate advice to give young people about the use of EHC.</p> <p>The fieldwork highlighted more clarity is required on what ought to be provided to young men.</p> <p>The practitioners felt more clarity is needed about the age range of people for which free EHC ought to be provided.</p>

## 4.11 Recommendation Eleven - Condom Provision in Addition to other Methods of Contraception

### **Recommendation 11: condom provision in addition to other methods of contraception**

#### **Who is the target population?**

- All young men and women.

#### **Who should take action?**

- Managers, doctors, nurses, pharmacists and staff of NHS and NHS funded contraception and sexual health services (including GP services, pharmacies, walk-in centres, acute and emergency care), the voluntary and independent sector.
- Professionals with a responsibility for the health and wellbeing of young women and men in social care, children's services, voluntary and independent sector organisations including youth workers, drug and alcohol services, youth workers and counsellors, Connexions personal advisers and people working in C-Card schemes.
- Public health specialists, PSHE education and sex and relationships education coordinators and teachers, and all those providing information about contraception, sexual and reproductive health.

#### **What action should they take?**

- Encourage all young people to use condoms and lubricant in every sexual encounter, irrespective of their other contraceptive choices, because condoms help to prevent the transmission of STIs. Condoms should be provided alongside other methods of contraception.
- Young people should be informed that condoms alone are not the most effective method of contraception.
- Ensure free condoms are readily accessible (this could include, for example, at schools and youth clubs). These condoms should be available in a range of types and sizes.
- Information on the use of condoms should be available at all condom distribution points, and where possible, young people should be shown how to use them properly.
- In addition to the provision of condoms young men and women should be informed about emergency contraception and other contraceptive services, including when, where and how to access them locally.
- If unable to provide free condoms inform young people where and when free provision is available.
- Encourage young men and women to carry and use condoms irrespective of their contraceptive choices or those of their sexual partners.

### 4.11.1 Findings

The vast majority of practitioners welcomed this recommendation, although practice in the provision of condoms and lubricant was variable, and issues were raised regarding potential barriers to open access to free condoms, which could deter young people from condom use.

- **Overall, the vast majority of participants welcomed the draft recommendation.** Across the fieldwork areas, the means of providing condoms and lubricant was varied, although there is widespread use of the C-Card scheme or local variants (Some participants suggested the term 'condom distribution schemes' might be better understood). The vast majority of practitioners felt the draft recommendation reflected current practice, and most of the areas were implementing many of the actions suggested within it. There was some debate over the extent to which a condom teach (and what level of detail this should take) should be given at the same time as free condoms are given out (see below).
- **Some practitioners expressed concern about the wording, "young people should be informed that condoms alone are not the most effective method of contraception",** and thought that a more positive wording, such as 'double protection' or 'double Dutch' was more appropriate in order to highlight both the importance of preventing unintended pregnancies as well as STIs.

#### 4.11.2 **Barriers to Implementation**

The potential barriers reported to this draft recommendation focussed primarily on training and the availability of resources:

- **Training, capacity and the resources to provide training were all mentioned as barriers to implementation.** Differences in opinion between practitioners demonstrated the variable information given to young people. In some areas, practitioners have to be trained to distribute condoms under condom distribution schemes. This is costly and time-consuming for practitioners, and where it restricts the number of staff that can give out condoms, some practitioners thought that relaxing those training requirements could open up ready access to free condoms much more. Many practitioners thought that repeating condom teaches could also act as a barrier to young people accessing the service, as it can be repetitive for young people. On the other hand, some groups felt that training was very important and that otherwise, quality of service would be compromised and young people would receive mixed messages.

*“We can’t promote just giving out condoms and letting young people do whatever they want because they need support and guidance but at the same time I would say a huge proportion of young people do not want a one to one about having sex for the first time or the second time. They don’t want the conversation... In the education head you know that you need to educate them to make a better informed decision, but then your common sense of being a normal person knows I wouldn’t want to sit down with a worker and talk about how to put a condom on”*

*Teenage pregnancy co-ordinator*

*“The recommendation doesn’t mention Delay principles and making sure that professionals are training in Delay – it’s a key part of what young people should be told... young people should know and understand their right to choose not to have sex as well”*

*Reintegration officer for young people*

- **Funding can be an issue for widespread condom provision in local areas,** and some practitioners felt that lubricant is often the first thing to be stopped when funding is tight.
- **Many practitioners agreed with the draft recommendation that teachers and other school staff should also give out condoms and lubricant,** but some considered this to be unrealistic:

*“The inclusion of teachers as part of those who should take action is considered unrealistic, as teachers are highly unlikely to give condoms out”.*

*Sexual health commissioner*

#### 4.11.3 **Gaps in the Draft Recommendation**

The perceived gaps in the recommendation included:

- **Some practitioners said that other barrier methods were omitted from the draft recommendation,** including the female condom and dental dam.
- **Some practitioners wanted to see the term ‘lubricant’ clarified as ‘water-based lubricant’.**
- **The ‘who should take action list’ could be expanded** to include ‘all services working with young people’. Some participants suggested that youth services,

housing, parents, family nurse partnerships, commissioners, those who work with LAC and social workers could also be included.

#### 4.11.4 **Suggested Changes to Text**

Finally, a series of suggestions for change in the content of Draft Recommendation 11 were suggested during the fieldwork, as summarised in Table 4.11 below.

<b>Table 4.11: Suggested Changes to Draft Recommendation 11</b>	
<b>Section of Draft Text</b>	<b>Suggested Changes</b>
<b><i>Who is the target population?</i></b>	None
<b><i>Who should take action?</i></b>	The recommendation could include all professionals working with young people.
<b><i>What action should they take?</i></b>	<p>Practitioners suggested a change in terminology: 'condom distribution schemes' and 'double protection' may be better understood.</p> <p>The fieldwork highlighted that more clarity may be needed on what information needs to be available at condom distribution points, how this ought to be provided and what training is needed to provide this information.</p> <p>Some practitioners felt female condoms and dental dams are missing.</p> <p>Some participants suggested adding 'water-based lubricant'.</p>

## 4.12 Recommendation Twelve – Communication

<p><b>Recommendation 12: communication</b></p> <p><b>Who is the target population?</b></p> <ul style="list-style-type: none"> <li>▪ <i>All young people who use contraception and sexual health services or who might need contraceptive and sexual health information.</i></li> </ul> <p><b>Who should take action?</b></p> <ul style="list-style-type: none"> <li>▪ <i>Those providing/commissioning contraception and sexual health services.</i></li> <li>▪ <i>Those providing information services: for example, libraries, job centres, Connexions.</i></li> </ul> <p><b>What action should they take?</b></p> <ul style="list-style-type: none"> <li>▪ <i>Use a range of methods including up-to-date communication technology to support young people, especially socially disadvantaged young people, with sexual health advice and in making their contraceptive choices. This could include the use of websites that link with national government and NHS contraception and sexual health campaign sites including:</i> <ul style="list-style-type: none"> <li>– <i>bespoke websites or dedicated pages in social networking sites to enable young people to discuss sensitive information anonymously</i></li> <li>– <i>NHS websites such as NHS Choices</i></li> <li>– <i>websites provided by specialist service providers such as Brook or fpa that provide reliable, up-to-date, evidence-based health information and advice to adults and agencies that work with young people</i></li> <li>– <i>telephone helplines offering up-to-date and accurate information and details about local services, such as the fpa telephone helpline – these should be publicised.</i></li> </ul> </li> <li>▪ <i>Wherever possible, places that young people visit should have a library of information on contraception methods and local services.</i></li> <li>▪ <i>Ensure all communication is available in a range of formats.</i></li> <li>▪ <i>Ensure a choice of communication is offered to young people who are using services, for example text messages or emails to remind them about appointments or test results, rather than letters or telephone calls to the family home.</i></li> </ul>
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### 4.12.1 Findings

The recommendation on communication, emphasising its importance and value, was welcomed by the practitioners; and a range of communication approaches for young people were described.

- **The vast majority of practitioners welcomed the recommendation and were glad that the value of communication was emphasised.** Many practitioners discussed the local communication strategies in place, which contained many of the actions suggested within the draft recommendation. For many practitioners that took part in the fieldwork, the draft recommendation was a useful tool to measure their current practice and communication against. Some practitioners said that young people are aware of national television and radio campaigns.
- **Many practitioners referred to current communication methods such as text messaging.** Where participants referred to the use of text messaging, it was used in a number of ways, including reminding young people about appointments, providing young people with test results, and a service where young people can text their post code and find their nearest service.
- **Across the focus groups for the fieldwork and within focus groups, there was discussion about the use of peer-led campaigns** and whether they should be

included within the draft recommendation. Where practitioners advocated the use of peer communication, they had implemented it successfully in their local areas. However, they said that ongoing effort was required in order to support young people taking part in an effective way.

- **Many participants thought that they could improve their communication with young people, and some said that the recommendation ought to give more detail about the importance of communicating with young people from disadvantaged groups.** They may have limited access to technology such as the internet, may not be literate, or may not be able to read or speak English. Some practitioners thought that outreach and trying to promote word of mouth communication was the best way to reach disadvantaged young people. Some participants felt that where telephone numbers are used, they felt strongly that these should be free so as to incentivise their use. Finally, some participants thought that the recommendation should state that communication methods should be tailored to different age groups.

#### 4.12.2 **Barriers to Implementation**

The barriers reported for this draft recommendation included access to on-line services and the challenges of keeping communication materials up to date:

- **Computers provided by Local Authorities, within schools and NHS organisations block a great deal of online content** such as social networking sites and websites which may contain sexual health information. This was seen as a very challenging barrier because it means that sexual health professionals and other workers, as well as young people themselves, have difficulties in managing or accessing such sites with ease whether at work or in school. However, one fieldwork area was successful in working with education providers to develop a system on school computers which provides local information and health promotion messages. While young people may not be able to access other sites, they are at least provided with some useful health related information.
- **Many practitioners explored the difficulties in maintaining local information and ensuring this is kept up to date.** Some participants felt that funding and staff resource was necessary to maintain up to date directories of service provision, which can often change. In addition, some practitioners said that leaflets can quickly go out of date.

*“There used to be an online directory of services – that was good but funding stopped”*

*Health advisor – Chlamydia screening programme*

- **Lack of funding was seen as a barrier to ongoing communication:**

*“We do have a communication strategy, but we haven’t got any money – its similar to what is in the recommendation but there’s no funding to have people updating websites – it just can’t be set up and left”.*

*Lead for Risk and Resilience Agenda*

- **However, some practitioners saw an opportunity to be ‘smarter’ about communication and cooperate with other PCT areas and national campaigns,** as at the current time many areas all have their own separate websites and sexual health schemes – such as condom distribution or chlamydia screening. Practitioners pointed out that there are few recognisable ‘brands’ that young people are familiar with, and they wanted the recommendation to give a greater emphasis to different



organisations working together to make contraceptive and sexual health services more widely recognised and used.

#### 4.12.3 Gaps in the Draft Recommendation

The gaps in the recommendations cited by practitioners included the involvement of young people in designing communications materials, and a more strategic approach to communications

- **Many practitioners felt there were some groups missing from the ‘who should take action’ list**, including the voluntary and community sector and youth services, youth offending services, and alternative education providers. In general, it was thought that a wider group of professionals working with young people (such as teachers and support staff) should also be engaged in giving out consistent messages about local services, as the other draft recommendations suggested.
- **Some practitioners thought that young people could be included in the design of communication materials.**

*“Asking young people [about] how they wish to be communicated [with] will help to improve communication with them and this should be recommended”*

*Health practitioner*

- **Some practitioners suggested the draft recommendation should include the creation and implementation of a communication strategy and partnership working** (see above). Some practitioners also felt guidance on developing a communication strategy would be useful in the recommendation. However, they recognised such a strategy should not be prescriptive as different areas have different needs.

*“One size doesn’t fit all. A communication strategy that works in one local authority doesn’t necessarily fit in other local authorities”*

*Commissioning manager for young people’s sexual health and teenage pregnancy*

#### 4.12.4 Suggested Changes to Text

Finally, a series of suggestions for change in the content of Draft Recommendation 2 were suggested during the fieldwork, as summarised in Table 4.12 below.

Table 4.12: Suggested Changes to Draft Recommendation 12	
Section of Draft Text	Suggested Changes
<b><i>Who is the target population?</i></b>	None
<b><i>Who should take action?</i></b>	The fieldwork indicated the draft recommendation could include all professionals working with young people, including schools.
<b><i>What action should they take?</i></b>	Participants suggested peer-led approaches to communication could be included.  The recommendation could be more strongly worded in a way that might facilitate the use of social networking and other websites for professionals and young

	<p>people.</p> <p>The recommendation could encourage partnership working and developing communication strategies.</p> <p>Practitioners suggested that young people should be involved.</p>
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## 4.13 Recommendation Thirteen – Training

<p><b><u>Recommendation 13: training</u></b></p> <p><b>Who is the target population?</b></p> <ul style="list-style-type: none"> <li>▪ <i>Doctors, nurses, pharmacists and other health professionals providing contraception, sexual and reproductive health services.</i></li> <li>▪ <i>Managers and staff working in or involved with young people’s Contraception, sexual and reproductive health services.</i></li> </ul> <p><b>Who should take action?</b></p> <ul style="list-style-type: none"> <li>▪ <i>Royal colleges and professional associations such as the Royal College of General Practitioners, the Faculty of Sexual and Reproductive Health of the Royal College of Obstetricians and Gynaecologists, Royal College of Nursing, Royal College of Midwives, Royal Pharmaceutical Society of Great Britain.</i></li> <li>▪ <i>British Association for Sexual Health and HIV, Society of Sexual Health Advisers.</i></li> <li>▪ <i>Voluntary sector organisations including fpa, National Youth Agency.</i></li> <li>▪ <i>Commissioners and managers of contraception and sexual health services for young people, primary and community care services, children’s services, social services, young people’s advisory and support services including Connexions.</i></li> <li>▪ <i>Further and higher education institutions.</i></li> </ul> <p><b>What action should they take?</b></p> <ul style="list-style-type: none"> <li>▪ <i>Ensure all doctors, nurses, pharmacists and other health professionals working in contraceptive services have received the initial training required by their professional body and can show evidence of maintaining their skills and competencies.</i></li> <li>▪ <i>All staff working with young people, particularly socially disadvantaged young people should have an understanding and experience of working with young people – especially communications skills for working with young people, and cultural awareness and sensitivity training.</i></li> <li>▪ <i>All staff who work in contraception, sexual and reproductive health services with young people should receive training, both formal training and on-the-job training, in offering basic information and advice about contraception. They should understand the range of methods, the advantages and disadvantages of each method, the measures that can be taken to ameliorate any side effects and an understanding of pregnancy and abortion. Training should be regularly updated and tailored to individual needs to ensure staff have the necessary skills and knowledge relevant to their role.</i></li> <li>▪ <i>Ensure all staff, including administrative staff have knowledge of confidentiality issues and safeguarding issues/legislation.</i></li> <li>▪ <i>Ensure that all staff working with young people receive appropriate training on the best practice guidance on the provision of advice and treatment to young people under 16 years, are alert to the possibility of exploitation or coercion and are aware of local mechanisms for reporting concerns according to safeguarding policy and procedures.</i></li> <li>▪ <i>Ensure all staff know the location of and referral pathways into local services (including abortion services) so that they can direct young people to services where they can get advice on relationships and contraception, can obtain the most effective contraception for them, and can obtain condoms and emergency contraception.</i></li> <li>▪ <i>As part of their continuing professional development, develop a multi-professional training strategy for health professionals, including doctors, nurses, pharmacists, youth workers and counsellors to promote and support contraception advice and provision.</i></li> <li>▪ <i>Ensure that performance management and appraisal systems are in place for all staff and that they are kept up to date. If possible, take into account the opinions of young people as part of the performance management process.</i></li> </ul>
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### 4.13.1 Findings

The issue of training was referred to in many of the previous draft recommendations, with Recommendation 13 being considered particularly welcomed by the practitioners as it summarised their previous reflections on the importance of training.

- **Participants considered this to be one of the most important recommendations which had an impact on all service providers and practitioners.** This was particularly the case for practitioners who do not work in young people's contraceptive and sexual health, or for practitioners who do not have the skills, knowledge or confidence to work with young people to provide advice and support.
- **Training and the importance of up to date training was referred to throughout the fieldwork, and mentioned in responses to most of the draft recommendations.** The vast majority of participants also referred to staff having knowledge of the most appropriate local services and referral pathways as equally important. Given the importance participants attributed to funding training and making it available for all, some participants suggested the recommendation for training could be moved to the start of the guidance.

#### 4.13.2 **Barriers to Implementation**

The main barriers to the implementation of this particular recommendation related to the availability of funding and suitable provision – although support alongside training to effectively implement learning was also recognised as an issue. Many practitioners also reported the absence of appropriate standards for training at different levels for contraceptive and sexual health.

- **Funding of training and a lack of suitable training opportunities were mentioned as potential barriers to implementation.** Many practitioners felt that public spending cuts within the public sector and health services would result in less training for all staff working with young people.

*“At the moment there is a big lack of training opportunities for nurses in contraception”*

*CASH Nurse*

*“There is good training out there but it is expensive and usually London based – it would be good to make it more accessible”.*

*Operational lead for Youth Services*

- **Practitioners within services discussed how training did not always lead to learning being implemented.** Many practitioners felt that training alone is not enough to improve practice, and that staff require support to implement their learning and put the skills and knowledge acquired into practice; they felt the recommendation could do more to make this point as a key part of continuing professional development. Some participants felt that staff should be encouraged to take ownership of their own training, rather than leaving it to their line managers.

*“The recommendation should suggest impact audits of training, to ensure its making a difference. This will also make training more likely to be commissioned”*

*Sexual Health Commissioner*

- **Some practitioners noted that voluntary and community sector providers who are commissioned by the NHS did not always have the same opportunities to undertake NHS training.**
- **There are currently no standards or quality assurance of sexual health training.** Some practitioners were concerned that the lack of quality assurance could result in young people being misinformed. Some practitioners suggested a similar approach to the DANOS standards for drug and alcohol services.

### 4.13.3 Gaps in the Draft Recommendation

Gaps identified in this recommendation are described below.

- **The vast majority of practitioners thought that the list of ‘who should take action’ was very much oriented towards health service staff**, and thought that the recommendation should include all staff working with young people. These included teachers, governors, local authority staff, reception staff, staff and volunteers within voluntary and community service providers, and foster carers.
- **Some practitioners also said that the list of ‘who should take action’ did not include professional regulatory bodies.** For example, the Royal College of Nursing sets standards for nurses and midwives, but is also a trade union, and the regulator is the Nursing and Midwifery Council (NMC) as well as local midwifery supervising authorities (LSAs).
- **Some practitioners suggested that a reference should be made to the importance of knowledge and awareness of the Fraser guidelines, and the Department of Health standards ‘Recommended Quality Standards for Sexual Health Training’ (DH, 2005).** In addition, some practitioners felt the draft recommendation should not only refer to medical and clinical competencies, but also include training about working with and communicating with young people.
- **Some practitioners felt strongly that young people should be involved in delivering training;** where this had been tried it was thought to have a greater impact on the professionals taking part.

### 4.13.4 Suggested Changes to Text

Finally, a series of suggestions for change in the content of Draft Recommendation 13 were suggested during the fieldwork, as summarised in Table 4.13 below.

Table 4.13: Suggested Changes to Draft Recommendation 13	
Section of Draft Text	Suggested Changes
<b><i>Who is the target population?</i></b>	The recommendation could include all staff working with young people.
<b><i>Who should take action?</i></b>	The practitioners suggested that the recommendation could include all staff working with young people.  Some practitioners felt professional regulatory bodies should be included.
<b><i>What action should they take?</i></b>	The fieldwork highlighted that practitioners felt the recommendation could emphasise more strongly the importance of implementing training in practice and supporting staff to do so.  Participants suggested reference to Fraser guidelines and DH guidance.  Training could include skills in working with and communicating with young people.

	The fieldwork highlighted that young people could also be involved.
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## 5 CONCLUSIONS

This section presents the key findings from the fieldwork, with suggestions for improving the content of the draft recommendations and their dissemination.

### 5.1 Key Findings

Overall the draft recommendations were welcomed by the practitioners taking part in the focus groups and individual interviews, where they were considered to be useful and relevant to their day to day practice. Furthermore, the vast majority of participants were pleased to see references throughout key recommendations to both young women and their partners, as well as references to the involvement of young people.

The main findings, based on the feedback from the 162 practitioners that participated in the consultation, are summarised below:

- **The practitioners found little to disagree with about the content and order of the recommendations themselves.** The vast majority of practitioners welcomed the content of the draft recommendations, although some areas stimulated more discussion than others. These include the advanced provision of EHC, the coverage and definition of 'social disadvantage', and access to contraception and sexual health in schools.
- **The majority of participants felt the ordering of the draft recommendations was logical.** However, some felt that the recommendation five (young peoples' services) could be condensed into recommendation 12 (communication) as there was some overlap in terms of content.
- **Responses to the draft recommendations and actions varied between "something we aspire to" and "something we are doing already".** Where practitioners felt the draft recommendations were something they could aspire to, they were regarded as providing guidance on "gold standard" services for young people. However, where practitioners felt they were already implementing the recommended actions, they were a useful tool to establish the extent to which their services could be improved, as well underlining and vindicating their current approaches.
- **Many practitioners felt that some of the wording used could be changed to strengthen the impact of the draft recommendations.** In addition to the specific suggestions for change in the individual draft recommendations listed in this report, many practitioners felt that they could be seen as submissive and could be changed to strengthen the actions to be taken, for example, using 'should' instead of 'could'.
- Throughout the consultation **practitioners reiterated that contraceptive services should not be seen separately from sexual health services.** As a result, many practitioners felt that the recommendations should refer consistently to contraceptive and sexual health services. The vast majority of practitioners that work with young people tended to view contraception and sexual health as a holistic service, which in their daily practice is not separated. Therefore, the vast majority of practitioners felt the recommendations should include more explicit reference to STI testing, or where relevant, it should make reference to other NICE guidance available.
- **Many practitioners also felt that by providing a holistic service, some of the draft recommendations referring to service provision should not exclude**

**reference to young people's sexual orientation**, and include provision for lesbian, gay, bisexual and transgender (LGBT) young people.

- **Participants discussed the provision of services for socially disadvantaged young people, and the provision of services for all young people.** Many participants felt that 'socially disadvantaged' could be more clearly defined for the draft recommendations. However, there was debate across the consultation whether the draft recommendations should be specific in relation to socially disadvantaged groups, or whether an overarching definition could be used to prevent some groups from being stigmatised or omitted from potentially targeted services. Where practitioners felt the draft recommendations should be more prescriptive about the types of young people to be targeted, they felt some socially disadvantaged groups were omitted, including travellers, migrant workers, asylum seekers and refugees, young people with drug and alcohol addictions, and young offenders. Where participants felt an overall 'catch all' description could be used, they often referred to the risk factors for teenage pregnancy.
- **Many participants felt the draft recommendations are medically focused and do not take into account the additional services provided by other organisations.** The vast majority of participants felt the content was aimed at clinical and health staff. Across the board, there was a strong view that a holistic approach (including support such as counselling and mentoring) with young people results in better outcomes. Overall, the vast majority of practitioners felt that contraceptive and sexual health for young people was 'everyone's business' as opposed to being solely within the remit of health services. As a result, the vast majority of participants felt the remit and 'who should take action' lists could and should be expanded.
- **In addition, the vast majority of participants felt the recommendations were applicable to all young people**, as opposed to just those facing social disadvantage.
- **Many practitioners felt additional information on why the services are important would support the recommendations.** Equally commonly, **practitioners felt the draft recommendations could provide examples of service delivery** which is effective in engaging socially disadvantaged young people.
- **The links in the recommendations to other key policies and documents could also be strengthened.** Many practitioners felt the draft recommendations lacked links to other guidance documentation. This includes for example making explicit links to other related NICE Guidance, and to other relevant guidance such as the Department for Children, Schools and Families (now Department for Education) guidance on contraceptive provision in schools.

## 5.2 Implementation - Barriers and Enablers

However, despite the draft recommendations being welcomed, a series of potential barriers to their implementation were also suggested. In part these related to the challenges of implementation in an environment where the structuring and allocation of roles regarding the provision of contraceptive services and sexual health services for young people varies considerably across the country, as identified in the fieldwork events. This variation will have implications for the roll out and implementation of the final recommendations and guidance.

More broadly, additional potential barriers referred to included:

- Funding – not surprisingly given the current economic climate and public sector spending cuts.



- Competing health priorities and services, with sexual health and contraceptive services not being seen as a priority within public health.
- Variation in service provision by age group, with many practitioners referring to provision for under 18's which could not be accessed by those aged 18-25. In addition, many service providers felt that the needs of those under 18 would be different.
- A lack of knowledge in identifying and engaging with young people that are deemed to be at social disadvantage was thought to be a barrier; and practitioners thought that the recommendations could provide more guidance on this.
- Contraceptive services and sexual health provision such as STI testing are viewed by many participants and frontline staff as joined up – therefore, the vast majority of participants felt that the provision of contraception should be offered alongside (where appropriate) STI information and testing.
- Poor partnerships between different services and commissioners are seen as a barrier in some areas. This can lead to several issues, including difficulties in following people up, poor provision of information, and the more frequent use of signposting rather than following properly managed referral pathways.
- Changes in requirements for PSHE education were seen as one of several potential barriers to service delivery within schools. The other major barrier in some schools was the response of school leaders and staff themselves, who may not understand the need for contraceptive services or have different interpretations of confidentiality and safeguarding to health service staff.
- Some participants suggested NICE and NICE guidance/recommendations had a lower profile in non-clinical and non-health sectors such as education, which could influence the dissemination of the final guidance. Where this was mentioned, especially in relation to schools, participants suggested the information could be circulated by governing bodies and representative groups. Some participants were concerned that contraceptive services would not be provided in schools unless they were promoted by OFSTED.
- Local authority, health service and school computer filters were seen as a barrier to practitioners making full use of social media, and young people accessing information about sex and contraception.
- Across all services – including some health services – it was thought that professionals lacked skills in speaking with young people and responding to their needs. Training is required, but learning lessons and implementing them is difficult when many services face day to day problems such as a lack of capacity.

While these potential barriers were reported, other practitioners described approaches implemented locally which had managed to negotiate, or at least reduce the impact of, many of the barriers mentioned. Examples of such approaches, or 'enablers', included:

- Commissioning specialist teenage pregnancy midwives; this service can deal with the needs of vulnerable young women and their partners in a holistic manner, by providing support and advice on contraception and relationships from the early stages of pregnancy, as well as tackling wider issues around risk-taking behaviour e.g. drugs and alcohol.

- Some fieldwork areas had started to offer contraception and sexual health services as part of a wider, general health and wellbeing drop-in service in schools and other community settings. This was felt to have the advantage of a more holistic approach (young people can receive advice about healthy relationships and other risk taking behaviours) and would reduce stigma and other concerns that young people have about accessing such services – as well as allaying schools' and colleges' concerns about whether such services fit with their 'ethos'.
- One local area had persuaded schools to provide health information on sex and contraception via the school intranet, getting around the problem of filters.

Many of the participants also felt the draft recommendations could themselves be used to approach commissioners and other influencers to highlight the importance of sexual health and contraceptive services.

### **5.3 Suggested Changes to the Recommendations**

Finally, the practitioners provided a series of suggestions to enhance the draft recommendations – in terms of the target population for the recommendation, who should take action and what action should they take. These suggestions have been listed throughout the report, and by individual recommendation in Section 4, with Table 5.1 below consolidating the suggested changes across the 13 draft recommendations.

**Table 5.1: Consolidated Suggestions for Changes to Draft Recommendations**

Draft Recommendation	Target Population	Who Should Take Action?	What Action Should they Take?
1	None	The list was thought to be comprehensive, but some practitioners suggested that one agency should be responsible for leading on implementing the recommendation.	<p>Practitioners suggested that the draft recommendation could describe / give examples of how common difficulties could be overcome.</p> <p>The fieldwork suggested the draft recommendation could give greater clarity about what type of data to collect to inform needs assessment and auditing capacity.</p> <p>Practitioners suggested that Children and Young People's Plans could be a useful vehicle for action plans.</p>
2	None	The voluntary and community sector, and practice based commissioning / GP consortia could be mentioned.	<p>Participants felt greater clarity might help to ensure better understanding of the terms 'integrated', 'referral pathways' and 'joint commissioning'.</p> <p>The draft recommendation could give examples of good practice in designing referral pathways and commissioning services, particularly where schools are involved.</p> <p>The draft recommendation could add references to other strategies and guidance.</p> <p>Some participants felt the draft recommendation could mention CRB clearance.</p>
3	None, but many practitioners believed the recommendation should make it clear that this is the standard expected of services that work with all young people (and not only the 'socially disadvantaged').	<p>In general, practitioners wanted to see a wider range of target professionals included (not only clinical ones) including:</p> <ul style="list-style-type: none"> <li>▪ Commissioners;</li> <li>▪ Staff in schools, colleges and other education settings;</li> </ul>	<p>The fieldwork indicated that terms such as 'without delay' and access time targets for appointments and drop in services could be clarified further.</p> <p>The recommendation could refer to training, communication and access to schools.</p> <p>Participants suggested the recommendation could refer to how some of the barriers to delivering</p>

Draft Recommendation	Target Population	Who Should Take Action?	What Action Should they Take?
		<ul style="list-style-type: none"> <li>▪ Youth workers and young people's services;</li> <li>▪ Learning disabilities teams working with young people;</li> <li>▪ Children's centres; and</li> </ul> <p>Outreach workers and support groups working with young people, in particular voluntary sector agencies.</p>	<p>flexible services can be overcome.</p> <p>The recommendation could make reference to young people wishing to change their choice of contraceptive, and the Fraser guidelines.</p> <p>The fieldwork indicated that practitioners would welcome signposting practitioners to other relevant NICE guidance.</p>
<p><b>4</b></p>	<p>The vast majority of participants thought that the list could be more inclusive.</p> <p>Participants felt 'young people in care/looked after children' and 'young people leaving care' could be added.</p> <p>Other suggested omissions included the Traveller community, homeless young people, drug and alcohol users, asylum seekers and refugees, young people in socially deprived areas, young carers, youth offenders, young people in rural locations, young people who are physically abused, sexually exploited young people, and young people with mental health issues.</p> <p>The participants highlighted that the language should be careful not to stigmatise.</p> <p>Consider whether more clarity is needed in relation to 'social disadvantage' and 'vulnerable / at risk' (as suggested).</p>	<p>Participants suggested widening the group for who should take action to a range of services that are relevant to socially disadvantaged young people and adults – with suggestions including:</p> <ul style="list-style-type: none"> <li>▪ Children's Centres;</li> <li>▪ Connexions;</li> <li>▪ Social services;</li> <li>▪ Integrated youth support services;</li> <li>▪ The Police;</li> <li>▪ Youth offending services;</li> <li>▪ Other services where NEET young people and other vulnerable groups are likely to be engaged with; and</li> <li>▪ The voluntary and community sector.</li> </ul> <p>Reflecting the age range covered by the recommendation, include Jobcentres, and the probation, prison or adult social services.</p>	<p>The fieldwork indicated that more advice and guidance could be included on how best to identify, engage and maintain contact with vulnerable young people.</p> <p>Participants suggested considering replacing "small manageable amounts" of information with a reference to the quality / effectiveness of delivery.</p> <p>Throughout the fieldwork, participants felt the recommendation could include references to other relevant guidance on vulnerable groups and their health (e.g. NICE guidance on looked after children).</p>
<p><b>5</b></p>	<p>None</p>	<p>Overall participants felt school staff should be included.</p>	<p>Participants felt the recommendation could be worded more strongly so agencies outside of</p>

Draft Recommendation	Target Population	Who Should Take Action?	What Action Should they Take?
		<p>Other suggestions included: specialist services such as those dealing with drug and alcohol misuse, paediatricians, social workers, care professionals, education psychologists, CAMHS, health visitors, A&amp;E and terminations (TOP) staff.</p> <p>Local Authorities and PCTs could also be included.</p> <p>The fieldwork highlighted that the list should not overlook professionals working with the 18-25 age group.</p>	<p>health take more responsibility.</p> <p>The recommendation could refer to other methods of providing information than hard copy – in particular, what works for disadvantaged young people.</p> <p>Practitioners suggested that information needs to be “young person friendly”.</p> <p>Some practitioners suggested the list of printed information provided to young people could be expanded.</p> <p>The title of the recommendation is confusing and elements of this might be better placed elsewhere, in particular Recommendation 12.</p>
6	None	<p>Practitioners suggested that the recommendation should also be addressed a wider audience, including schools and education settings.</p> <p>The following could be included in the list:</p> <ul style="list-style-type: none"> <li>▪ School staff – in particular Headteachers and governors;</li> <li>▪ GPs, all administrative and reception staff, interpreters, and social workers; and</li> <li>▪ All staff in contraceptive and sexual health services (including administrative staff).</li> </ul>	<p>Practitioners suggested that the recommendation could be worded more strongly; e.g. all staff should observe health service standards of confidentiality, make the entitlement of under 13s to services clear.</p> <p>Practitioners suggested that confidentiality should be communicated verbally as well as visually, and the message reinforced throughout all services.</p> <p>The recommendation could mention the use of general health clinics as good practice.</p> <p>Practitioners felt the recommendation could give more detail about respecting young people’s wishes to remain anonymous.</p> <p>Participants were unsure about some of the wording, and suggested removing the reference to staff being ‘tempted’ to breach confidentiality.</p> <p>Practitioners suggested adding references to</p>

Draft Recommendation	Target Population	Who Should Take Action?	What Action Should they Take?
			<p>Fraser guidelines and ‘You’re Welcome’.</p> <p>Training on a range of issues, but notably confidentiality and safeguarding, could be mentioned explicitly.</p>
<p><b>7</b></p>	<p>The fieldwork indicated that the needs of young women that have had a miscarriage could be mentioned.</p> <p>Practitioners suggested that young women in hostels or care could also be specifically mentioned.</p>	<p>The fieldwork highlighted that the list should not be limited to clinical staff.</p> <p>The following could be included in the list:</p> <ul style="list-style-type: none"> <li>▪ Staff in children’s centres and Children’s Trusts;</li> <li>▪ Social workers;</li> <li>▪ Connexions;</li> <li>▪ the voluntary and community sector (e.g. Brook); and</li> <li>▪ Commissioners.</li> </ul>	<p>The recommendation could acknowledge that specialist services for vulnerable young women and their partners are needed, as well as referral pathways.</p> <p>Practitioners suggested more detail could be given on following up after a birth.</p> <p>The fieldwork indicated that reference should be made to STI testing and sexual health advice before and after birth.</p> <p>Participants felt training needs could be mentioned – especially in relation to overcoming capacity and skills issues with midwifery.</p>
<p><b>8</b></p>	<p>Practitioners suggested the recommendation could make specific reference to young women who have an abortion that are also looked after children, living in hostels and those outside of mainstream education services.</p>	<p>The fieldwork indicated that the list should not be limited to clinical staff.</p> <p>Participants suggested the following could be included in the list:</p> <ul style="list-style-type: none"> <li>▪ School nurses;</li> <li>▪ Youth Offending Services;</li> <li>▪ Drug and alcohol services;</li> <li>▪ Social workers;</li> <li>▪ Connexions workers;</li> <li>▪ The voluntary and community sector (e.g. Brook);</li> <li>▪ Counselling services; and</li> </ul>	<p>Practitioners felt references to repeat terminations could be included.</p> <p>More advice on good practice in follow-up and outreach services following a termination would be beneficial to participants.</p> <p>The fieldwork highlighted that reference should be made to the importance of commissioning / offering emotional support and counselling following a termination; and access to STI screening.</p>

Draft Recommendation	Target Population	Who Should Take Action?	What Action Should they Take?
9	The recommendation could add those young people in informal education, work-based learning or other settings outside mainstream education (e.g. children learning outside of school whilst in care).	<p>Commissioners.</p> <p>Suggested additions to the list include:</p> <ul style="list-style-type: none"> <li>▪ School nurses;</li> <li>▪ Education welfare officers;</li> <li>▪ Young people’s services/youth services;</li> <li>▪ Youth offending services;</li> <li>▪ Connexions workers;</li> <li>▪ Parent support advisors;</li> <li>▪ SRE advisors;</li> <li>▪ Teaching assistants; and</li> <li>▪ Private training providers.</li> </ul>	<p>Practitioners felt the language could be made stronger in order to give clearer direction to schools.</p> <p>The fieldwork indicated that more detail could be given on good practice in engaging with schools e.g. through using ‘health’ drop-ins.</p> <p>Participants suggested that more reference could be made to other sources of guidance that are relevant to schools and education settings.</p> <p>The fieldwork highlighted more reference could be made to the location and management of services within schools.</p> <p>(See also responses to Recommendation 6 on Consent and Confidentiality.)</p>
10	None	The recommendation could include commissioners.	<p>The recommendation could use stronger language and suggest that commissioners use PGDs and other means to facilitate local provision of emergency contraception.</p> <p>Practitioners suggested reference could be made to the importance of STI screens and pregnancy tests.</p> <p>Training may need to be noted as an challenge to be overcome.</p> <p>More information could be given about the appropriate advice to give young people about the use of EHC.</p> <p>The fieldwork highlighted more clarity is required on what ought to be provided to young men.</p> <p>The practitioners felt more clarity is needed about</p>

Draft Recommendation	Target Population	Who Should Take Action?	What Action Should they Take?
			the age range of people for which free EHC ought to be provided.
11	None	The recommendation could include all professionals working with young people.	<p>Practitioners suggested a change in terminology: 'condom distribution schemes' and 'double protection' may be better understood.</p> <p>The fieldwork highlighted that more clarity may be needed on what information needs to be available at condom distribution points, how this ought to be provided and what training is needed to provide this information.</p> <p>Some practitioners felt female condoms and dental dams are missing.</p> <p>Some participants suggested adding 'water-based lubricant'.</p>
12	None	The fieldwork indicated the draft recommendation could include all professionals working with young people, including schools.	<p>Participants suggested peer-led approaches to communication could be included.</p> <p>The recommendation could be more strongly worded in a way that might facilitate the use of social networking and other websites for professionals and young people.</p> <p>The recommendation could encourage partnership working and developing communication strategies.</p> <p>Practitioners suggested that young people should be involved.</p>
13	The recommendation should include all staff working with young people.	<p>The practitioners suggested that the recommendation could include all staff working with young people.</p> <p>Some practitioners felt professional regulatory bodies should be included.</p>	<p>The fieldwork highlighted that practitioners felt the recommendation could emphasise more strongly the importance of implementing training in practice and supporting staff to do so.</p> <p>Participants suggested reference to Fraser guidelines and DH guidance.</p> <p>Training could include skills in working with and</p>



Draft Recommendation	Target Population	Who Should Take Action?	What Action Should they Take?
			communicating with young people. The fieldwork highlighted that young people could also be involved.

## ANNEX A – FINAL DISCUSSION GUIDE

5 m	<b>Introduction</b>
	<p><b>Introduce GHK, the facilitator (and scribe).</b></p> <p><b>Introduce NICE and why the focus group / interview is taking place:</b></p> <ul style="list-style-type: none"> <li>- why the recommendations on contraceptive services for socially disadvantaged young people (up to age 25) are being produced</li> <li>- why the audience’s input is <b>important and valued</b> <i>‘this is your opportunity to influence national recommendations on the provision of contraceptive services ...’</i>, and how it contributes to the development of the final recommendations</li> <li>- explain if necessary how NICE’s work complements other guidance on preventing sexually transmitted infections and under-18 conceptions, looked after children, long acting reversible contraception, personal social and health education focusing on sex and relationships and alcohol education.</li> <li>- also be prepared to explain a little about the process by which the recommendations were developed and the evidence (explain if necessary that practitioners are being consulted on the recommendations only, rather than the whole draft guidance document)</li> <li>- explain that NICE wishes to <b>learn from practitioners’ / other staff’s</b> experience and current good practice ... <i>‘we would like you to give examples throughout and draw our attention to any good practice that you feel that other practitioners could learn from...’</i></li> </ul> <p><b><u>Introduce consent and confidentiality</u></b></p> <ul style="list-style-type: none"> <li>- focus groups will be recorded for audit purposes</li> <li>- all views will be treated in confidence and anonymised, neither individuals or their organisations will be named</li> </ul> <p><b>Remind respondents that they must fill in the sign in sheet and give consent if they wish to take part</b> (if they have not already done so)</p> <ul style="list-style-type: none"> <li>- offer respondents the opportunity to ask questions at any point</li> </ul> <p><b>Ask whether participants have read the draft recommendations</b></p> <ul style="list-style-type: none"> <li>- If most have not, explain that they will be introduced as the focus group progresses (ensure copies of the recommendations are on hand)</li> </ul>
5 m	<b>Warm up</b>
	<p><b>Respondents to introduce self, role and responsibilities</b></p> <p>Have you heard of NICE and what would you expect NICE’s involvement in this area to achieve?</p> <p>How optimistic do you feel that contraceptive services for socially disadvantaged young people can be improved? What are the main problems, in your view?</p> <p>In relation to the following sections, ask respondents to think about examples when feeding back on the individual recommendations.</p>
Approximately 10 m	<b>Recommendation 1: Assessing local need and capacity to target services</b>
	[Be prepared to start with a general question and follow up respondents’ feedback throughout]

	<p><b>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</b></p> <ul style="list-style-type: none"> <li>- is this recommendation useful to you and colleagues in the services you work for?</li> <li>- what is your opinion on how effective it might be?</li> <li>- do you think that all the key issues in relation to assessing local need and capacity are covered?</li> <li>- what impact might it have on current or future services or policy?</li> <li>- what factors might influence its implementation or effectiveness?</li> <li>- what barriers might there be to implementing it? Are there any barriers to assessing local needs and local capacity to target contraceptive services?</li> </ul> <p><b>Who should take action on this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><i>Specific questions/prompts:</i></p> <ul style="list-style-type: none"> <li>▪ To what extent are local needs assessments and service provision mapping exercises undertaken?</li> <li>▪ Do you currently have shared action plans for setting out responsibilities in this area?</li> <li>▪ Do you currently evaluate these services in the context of changes in local needs?</li> </ul>
<p>Approximately 10 m</p>	<p><b>Recommendation 2: Commission integrated and comprehensive services</b></p>
	<p><b>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</b></p> <ul style="list-style-type: none"> <li>- is this recommendation useful to you and colleagues in the services you work for?</li> <li>- what is your opinion on how effective it might be?</li> <li>- do you think that all the key issues in relation to assessing local need and capacity are covered?</li> <li>- what impact might it have on current of future services or policy?</li> <li>- what factors might influence its implementation or effectiveness?</li> <li>- what barriers might there be to implementing it? Are there any barriers to assessing local needs and local capacity to target contraceptive services?</li> </ul> <p><b>Who should take action on this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><i>Specific questions/prompts:</i></p> <ul style="list-style-type: none"> <li>▪ Do you have local priorities and targets for contraceptive service use – and what are the challenges in establishing them?</li> <li>▪ Are evidence based commissioning arrangements in place – and what are challenges do they pose?</li> <li>▪ Are joint service commissioning approaches in place – and what are the challenges in establishing them?</li> <li>▪ Are comprehensive referral pathways in place across the range of</li> </ul>

	<p>services in your area, and what barriers exist for referrals between agencies?</p>
Approximately 10 m	<p><b>Recommendation 3: Contraceptive services for young people</b></p>
	<p>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</p> <ul style="list-style-type: none"> <li>- is this recommendation useful to you and colleagues in the services you work for?</li> <li>- what is your opinion on how effective it might be?</li> <li>- do you think that all the key issues in relation to assessing local need and capacity are covered?</li> <li>- what impact might it have on current of future services or policy?</li> <li>- what factors might influence its implementation or effectiveness?</li> <li>- what barriers might there be to implementing it? Are there any barriers to assessing local needs and local capacity to target contraceptive services?</li> </ul> <p>Who should take action on this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</p> <p>Is the recommendation easily understood and clearly worded?</p> <p><i>Specific questions/prompts:</i></p> <ul style="list-style-type: none"> <li>▪ Do young people have rapid access to dedicated confidential contraception/sexual health services which meet the quality criteria set out in the guidance?</li> <li>▪ Do contraceptive services in your area provide the full range of contraceptive methods listed in the guidance?</li> <li>▪ What is key to ensuring that services are provided in a culturally sensitive, confidential, non-judgemental and empathic manner?</li> <li>▪ What are the issues raised by providing flexible, out of hours and evening contraceptive services to socially disadvantaged young people? Are services available within the time-frames suggested in the guidance?</li> <li>▪ Are there any specific issues relating to service provision by type and nature of location – e.g. urban vs rural, transport barriers, urban isolation, etc?</li> <li>▪ How are contraceptive services in your area currently promoted/information on them made available? How does this vary by recipient, and what communication formats/methods appeal particularly to young people?</li> </ul>
Approximately 10 m	<p><b>Recommendation 4: Socially disadvantaged young people</b></p>
	<p>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</p> <ul style="list-style-type: none"> <li>- is this recommendation useful to you and colleagues in the services you work for?</li> <li>- what is your opinion on how effective it might be?</li> <li>- do you think that all the key issues in relation to assessing local need and capacity are covered?</li> <li>- what impact might it have on current of future services or policy?</li> </ul>

	<p><b>- what factors might influence its implementation or effectiveness?</b></p> <p><b>- what barriers might there be to implementing it?</b> Are there any barriers to assessing local needs and local capacity to target contraceptive services?</p> <p><b>Who should be take action on this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><i>Specific questions/prompts:</i></p> <ul style="list-style-type: none"> <li>▪ <b>What additional support is used/effective in engaging with socially disadvantaged young people around contraceptive services?</b></li> <li>▪ <b>How do you get/enable teenage and young mothers to attend services?</b></li> <li>▪ <b>Do contraceptive services also link/refer to other specialist services – e.g. for drug/alcohol misusers, victims of sexual exploitation/violence?</b></li> <li>▪ <b>Do you currently provide outreach services to address access issues?</b></li> <li>▪ <b>How are services provided to ensure they are culturally sensitive, confidential, non-judgemental and empathic?</b></li> <li>▪ <b>Are services tailored to the needs of the individual young person?</b></li> </ul>
<p><b>Approximately 10 m</b></p>	<p><b>Recommendation 5: Young people’s services</b></p>
	<p><b>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</b></p> <p><b>- is this recommendation useful to you and colleagues in the services you work for?</b></p> <p><b>- what is your opinion on how effective it might be?</b></p> <p><b>- do you think that all the key issues in relation to assessing local need and capacity are covered?</b></p> <p><b>- what impact might it have on current of future services or policy?</b></p> <p><b>- what factors might influence its implementation or effectiveness?</b></p> <p><b>- what barriers might there be to implementing it?</b> Are there any barriers to assessing local needs and local capacity to target contraceptive services?</p> <p><b>Who should take action on of this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><i>Specific questions/prompts:</i></p> <ul style="list-style-type: none"> <li>▪ <b>Do you provide information on the location and opening times of local contraception and sexual health services, and when providing related interventions, e.g. screening for/treating STIs, pregnancy testing, etc?</b></li> <li>▪ <b>What innovative ways have you used to offer information and advice about contraception and sexual health?</b></li> </ul>
<p><b>Approximately 10 m</b></p>	<p><b>Recommendation 6: Consent and confidentiality</b></p>
	<p><b>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</b></p> <p><b>- is this recommendation useful to you and colleagues in the services you work for?</b></p>

	<p>- what is your opinion on how effective it might be?</p> <p>- do you think that all the key issues in relation to assessing local need and capacity are covered?</p> <p>- what impact might it have on current of future services or policy?</p> <p>- what factors might influence its implementation or effectiveness?</p> <p>- what barriers might there be to implementing it? Are there any barriers to assessing local needs and local capacity to target contraceptive services?</p> <p><b>Who should take action on of this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><b><i>Specific questions/prompts:</i></b></p> <ul style="list-style-type: none"> <li>▪ <b>What training do staff working in this area currently receive? Does this include:</b> <ul style="list-style-type: none"> <li>▪ <b>Understanding the need for confidentiality?</b></li> <li>▪ <b>Best practice approaches for young people under 16 years and vulnerable young people?</b></li> </ul> </li> <li>▪ <b>How do you inform young people about service confidentiality? Are complaints and confidentiality policies displayed in waiting areas?</b></li> </ul>
<p><b>Approximately 10 m</b></p>	<p><b>Recommendation 7: Preventing unintended pregnancies following a birth</b></p>
	<p><b>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</b></p> <p>- is this recommendation useful to you and colleagues in the services you work for?</p> <p>- what is your opinion on how effective it might be?</p> <p>- do you think that all the key issues in relation to assessing local need and capacity are covered?</p> <p>- what impact might it have on current of future services or policy?</p> <p>- what factors might influence its implementation or effectiveness?</p> <p>- what barriers might there be to implementing it? Are there any barriers to assessing local needs and local capacity to target contraceptive services?</p> <p><b>Who should take action on of this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><b><i>Specific questions/prompts:</i></b></p> <ul style="list-style-type: none"> <li>▪ <b>Is contraception routinely discussed as part of ante-natal and post-birth services, and at handovers between midwives and health visitors?</b></li> <li>▪ <b>Are all staff suitably trained to offer the most appropriate contraceptive options?</b></li> <li>▪ <b>Are agreed pathways in place between maternity services, primary care and contraceptive and sexual health services to ensure that contraceptive advice is provided as soon as possible after birth?</b></li> </ul>
<p><b>Approximately 10 m</b></p>	<p><b>Recommendation 8: Preventing unintended pregnancies after an abortion</b></p>

	<p><b>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</b></p> <ul style="list-style-type: none"> <li>- is this recommendation useful to you and colleagues in the services you work for?</li> <li>- what is your opinion on how effective it might be?</li> <li>- do you think that all the key issues in relation to assessing local need and capacity are covered?</li> <li>- what impact might it have on current of future services or policy?</li> <li>- what factors might influence its implementation or effectiveness?</li> <li>- what barriers might there be to implementing it? Are there any barriers to assessing local needs and local capacity to target contraceptive services?</li> </ul> <p><b>Who should take action on of this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><i>Specific questions/prompts:</i></p> <p><b>Is contraception routinely discussed, or the offer of a referral to appropriate services made, as soon as possible following an abortion?</b></p> <p><b>Do you routinely offer to follow up all young women following an abortion through a method of their choice (e.g. by text) to offer information, advice and support?</b></p> <p><b>Do you use outreach or home services to provide contraception and contraceptive information? What are the challenges in delivering such a service?</b></p>
<p><b>Approximately 10 m</b></p>	<p><b>Recommendation 9: School and education-based services</b></p>
	<p><b>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</b></p> <ul style="list-style-type: none"> <li>- is this recommendation useful to you and colleagues in the services you work for?</li> <li>- what is your opinion on how effective it might be?</li> <li>- do you think that all the key issues in relation to assessing local need and capacity are covered?</li> <li>- what impact might it have on current of future services or policy?</li> <li>- what factors might influence its implementation or effectiveness?</li> <li>- what barriers might there be to implementing it? Are there any barriers to assessing local needs and local capacity to target contraceptive services?</li> </ul> <p><b>Who should take action on of this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><i>Specific questions/prompts:</i></p> <ul style="list-style-type: none"> <li>▪ <b>What services are currently provided in education settings? Who provides these services?</b></li> <li>▪ <b>Does the type of services differ between types of educational setting?</b></li> <li>▪ <b>Do you involve young people in the design, implementation, promotion and review of contraception and sexual health services in your area?</b></li> </ul>

<p>Approximately 10 m</p>	<p><b>Recommendation 10: Emergency contraception</b></p>
	<p>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</p> <ul style="list-style-type: none"> <li>- is this recommendation useful to you and colleagues in the services you work for?</li> <li>- what is your opinion on how effective it might be?</li> <li>- do you think that all the key issues in relation to assessing local need and capacity are covered?</li> <li>- what impact might it have on current of future services or policy?</li> <li>- what factors might influence its implementation or effectiveness?</li> <li>- what barriers might there be to implementing it? Are there any barriers to assessing local needs and local capacity to target contraceptive services?</li> </ul> <p>Who should take action on of this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</p> <p>Is the recommendation easily understood and clearly worded?</p> <p><i>Specific questions/prompts:</i></p> <ul style="list-style-type: none"> <li>▪ Which services in your area provide free emergency hormonal contraception, and advance provision of emergency contraception?</li> <li>▪ To what extent are young people informed;             <ul style="list-style-type: none"> <li>▪ About other local service providers?</li> <li>▪ That emergency contraception is more effective the sooner it is used?</li> <li>▪ The use of an intrauterine device is a more effective form of emergency contraception and can be used for continuing contraception?</li> </ul> </li> </ul>
<p>Approximately 10 m</p>	<p><b>Recommendation 11: Condom provision in addition to other methods of contraception</b></p>
	<p>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</p> <ul style="list-style-type: none"> <li>- is this recommendation useful to you and colleagues in the services you work for?</li> <li>- what is your opinion on how effective it might be?</li> <li>- do you think that all the key issues in relation to assessing local need and capacity are covered?</li> <li>- what impact might it have on current of future services or policy?</li> <li>- what factors might influence its implementation or effectiveness?</li> <li>- what barriers might there be to implementing it? Are there any barriers to assessing local needs and local capacity to target contraceptive services?</li> </ul> <p>Who should take action on of this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</p> <p>Is the recommendation easily understood and clearly worded?</p> <p><i>Specific questions/prompts:</i></p> <ul style="list-style-type: none"> <li>▪ Which service providers in your area provide condoms? What other information, advice and guidance is provided to young people who</li> </ul>



	<p><b>access free condoms?</b></p> <ul style="list-style-type: none"> <li>▪ <b>Is condom/lubricant usage encouraged irrespective of young people’s contraceptive choice?</b></li> </ul>
<b>Approximately 10 m</b>	<b>Recommendation 12: Communication</b>
	<p><b>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</b></p> <ul style="list-style-type: none"> <li>- <b>is this recommendation useful to you and colleagues in the services you work for?</b></li> <li>- <b>what is your opinion on how effective it might be?</b></li> <li>- <b>do you think that all the key issues in relation to assessing local need and capacity are covered?</b></li> <li>- <b>what impact might it have on current of future services or policy?</b></li> <li>- <b>what factors might influence its implementation or effectiveness?</b></li> <li>- <b>what barriers might there be to implementing it?</b> Are there any barriers to assessing local needs and local capacity to target contraceptive services?</li> </ul> <p><b>Who should take action on of this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><i><b>Specific questions/prompts:</b></i></p> <ul style="list-style-type: none"> <li>▪ <b>What can be done to improve the information provided to young people, and the ways in which they access the information?</b></li> <li>▪ <b>Are young people signposted to other information websites/helplines when engaging with services? Which sites/help lines?</b></li> </ul>
<b>Approximately 10 m</b>	<b>Recommendation 13: Training</b>
	<p><b>Will this recommendation help you in your efforts to deliver contraceptive services to socially disadvantaged young people?</b></p> <ul style="list-style-type: none"> <li>- <b>is this recommendation useful to you and colleagues in the services you work for?</b></li> <li>- <b>what is your opinion on how effective it might be?</b></li> <li>- <b>do you think that all the key issues in relation to assessing local need and capacity are covered?</b></li> <li>- <b>what impact might it have on current of future services or policy?</b></li> <li>- <b>what factors might influence its implementation or effectiveness?</b></li> <li>- <b>what barriers might there be to implementing it?</b> Are there any barriers to assessing local needs and local capacity to target contraceptive services?</li> </ul> <p><b>Who should take action on of this recommendation? (prompt for views on whether the ‘who should take action’ list is comprehensive)</b></p> <p><b>Is the recommendation easily understood and clearly worded?</b></p> <p><i><b>Specific questions/prompts:</b></i></p> <p><b>Do all doctors, nurses, pharmacists and other health professionals working in contraceptive services received the training required by their respective professional bodies?</b></p>

	<p><b>Do current staff have experience of working with young people? Are all staff (incl. administrators) aware of confidentiality and safeguarding issues/legislation?</b></p> <p><b>Does your area have a multi-professional training strategy for health professionals to support contraceptive advice and provision?</b></p> <p><b>Do you include the opinions of young people in the performance management process? If so, how?</b></p>
<b>15 m</b>	<b>General overview</b>
	<p><b>How relevant are these recommendations to your day to day practice? Why?</b></p> <p><b>To what extent will these recommendations influence your practice or the practice of your organisation? Why?</b></p> <p><b>How practical is it to implement these recommendations overall?</b> Is it realistic to implement them – are you confident that they would work?</p> <p>What are the biggest barriers likely to be? How can these be overcome?</p> <p><b>Do you think there are any gaps in the coverage of these recommendations?</b> What are they?</p> <p>How clear is the wording of the recommendations? How easy are they to understand?</p> <p>Are you aware of any duplication or overlap with any existing guidance aimed at professionals that work with young people up to the age of 25?</p> <p>Are there any potential negative impacts of these recommendations? Why?</p> <p>Would you say that you have trust in these recommendations? Why?</p> <p>Did anything surprise you in relation to the content of the guidance?</p> <p>What could NICE do to raise awareness of the recommendations and communicate them to your professional group?</p> <p>Do you have any more comments about the recommendations?</p>
<b>5 m</b>	<b>Close and thank respondents for their time</b>
	<p>Remind participants to <b>leave sign in sheets and consent forms behind</b> and make sure these are collected at the exit.</p> <p><b>Give participants notice that we will send them a summary of the main points and themes that emerged from the focus group, to give them the opportunity to check them for accuracy/ comment on them if they wish to do so.</b></p> <p>Ensure that the <b>event organiser is thanked</b> and that any expenses for catering are collected.</p>

## ANNEX B – CONSENT LETTER



Name

Address

Tuesday, 07 May 2013

Dear [insert name]

**Re: NICE Fieldwork for Guidance on Contraceptive Services for Socially Disadvantaged Young People (up to the age of 25) – Draft Recommendations and Consent**

Thank you for agreeing to take part in [an interview / focus group] with our researchers as part of the above fieldwork. Your contribution is appreciated and will help ensure that NICE's recommendations on Contraceptive Services for socially disadvantaged young people are relevant, appropriate, useful, feasible and capable of being implemented effectively. **Thank you also for agreeing to host the focus group and allowing us to use your facilities [insert as relevant].**

Please find enclosed a copy of the **draft NICE recommendations**, so that you have an opportunity to read them prior to the interview/focus group taking place. While we hope that you will have time to read the recommendations in advance, they will also be introduced at the start of each **focus group / interview**.

We also enclose a short **reading task** which may assist you to structure your feedback on the recommendations. Although completion of this task is not obligatory, it may help you to structure your thoughts around the following important aspects:

- the usefulness, appropriateness, and relevance of NICE's recommendations;
- their coverage of the key issues;
- the possible barriers to their implementation;
- the potential consequences of the draft recommendations, and which recommendations are most likely to make a difference to practice; and
- any additional information which ought to be taken into account in the final guidance.

**[For focus group attendees only] A sign in sheet is also enclosed, which we would be grateful if you could complete and bring with you on the day, as this will help ensure that the focus group can begin to time.**

Finally, and in accordance with NICE practice, we confirm that your **focus group/interview [delete as appropriate]** will be recorded by a digital recorder. The recordings will be handled in accordance with standard NICE practice, and will be held securely and destroyed after five years. Your identity, and that of the organisation you represent, will not be revealed in any final reports produced, with any quotes included in the final report being on an anonymous basis. At the end of the **focus group/interview [delete as appropriate]** the facilitator will summarise the main themes that emerged, and circulate them in an email to give you the opportunity to check them for accuracy. There is no obligation to comment at that stage unless you wish to raise specific issues. The final report produced

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as a result of all the interviews/focus groups will be used by NICE to inform the final version of the recommendations, and the report will be published on the NICE website.

We would be grateful if you would complete the details below and fax, post or email a copy of this letter to the address give above. Your signature indicates that you have read and understood the information provided above, that you willingly agree to participate, that you understand your right to discontinue participation without penalty, and that you have received a copy of this letter.

Printed Name \_\_\_\_\_ Organisation \_\_\_\_\_

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

If you have any questions regarding the information in this letter or your rights as a participant, you can contact Heather Rose (Project Manager) at [heather.rose@ghkint.com](mailto:heather.rose@ghkint.com) or by telephone 01752 262244.

Yours sincerely

## ANNEX C – PRIOR READING TASK

Please read through the draft recommendations attached. NICE are interested in how useful, relevant and appropriate these recommendations are for a wide variety of professional groups working with socially disadvantaged young people, as well as the barriers that might prevent the recommendations from being implemented.

The following task will help you to structure your feedback. We would be grateful if you could complete this and bring it with you to the meeting.

Which of the recommendations do you think are most useful to you and why?
Do you think these recommendations will change the way that you, your organisation or professional group deliver services? Why / why not?
Do you think that the recommendations are practical and realistic? Why / why not?
Do you think there are any gaps in these recommendations? What needs to be added to them to make them comprehensive?

Are you aware of any good practice in your local area in the provision of contraceptive services to socially disadvantaged young people that you would like to draw to NICE's attention?

## ANNEX D – SIGN IN SHEETS

### Sign in Sheet for NHS Staff or Employees of NHS Funded Young People’s Sexual Health Services

Please fill in the following sheet in order that we can know a little more about the background of people attending today:

Your name: \_\_\_\_\_

Your role: \_\_\_\_\_

Your organisation: \_\_\_\_\_

Email: \_\_\_\_\_

#### Q1) How would you define your main role? (TICK ONE BOX ONLY)

Commissioning or coordinating local services for young people's sexual health (i.e. 'commissioner')	
Managing or planning service delivery for young people's sexual health (i.e. manager or clinical lead)	
Frontline delivery staff - I work with young people on a daily basis	
None of the above	

#### Q2) What is your job role? (TICK ONE BOX ONLY)

<b>Counsellor</b> / mental health and wellbeing worker	
<b>Doctor</b> – GP	
<b>Doctor</b> - gynaecologist	
<b>Doctor</b> – other	
<b>Drugs or alcohol worker</b>	
<b>Health visitor</b>	
<b>Midwife</b>	
<b>Non - clinical</b> - manager	
<b>Non - clinical</b> - other admin and clerical staff	
<b>Nurse</b> - Family Nurse Partnership	
<b>Nurse</b> - GP practice nurse	
<b>Nurse</b> – GUM	
<b>Nurse</b> - school nurse	
<b>Nurse</b> - sexual health specialist	
<b>Nurse</b> - termination of pregnancy (TOP)	
<b>Nurse</b> – other	
<b>Pharmacist</b>	
<b>Public health specialist with remit for young people / sexual health</b> - commissioning role	

<b>Public health specialist with remit for young people / sexual health</b> – other	
<b>Teenage Pregnancy Coordinator</b>	
<b>Sexual Health Adviser</b>	
<b>Clinical support staff</b> (e.g. Healthcare Assistant) <i>Please state the service that you work in:</i>	
<b>Other</b> <i>Please state :</i>	
<i>N.B. If you are a youth worker, social worker, Connexions adviser or a TP coordinator, please fill in the sign in sheet for Non-NHS Staff</i>	

**Q3) What setting do you work in? (TICK ONE BOX ONLY)**

Acute setting	
Community - young people's sexual health services	
Community – schools	
Community - GP practice	
Community - Administrative or Other	

**Q4) What type is your employer? (TICK ONE BOX ONLY)**

NHS - PCT commissioning arm	
Provider - NHS Trust	
Provider - Community provider	



**Sign in Sheet for Non- NHS Staff**

Please fill in the following sheet in order that we can know a little more about the background of people attending today:

**Your name:** \_\_\_\_\_

**Your role:** \_\_\_\_\_

**Your organisation:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Q1) How would you define your main role? (TICK ONE BOX ONLY)**

Commissioning or coordinating local services for young people's sexual health (i.e. Commissioner)	
Managing or planning service delivery for young people's sexual health (i.e. Provider)	
Frontline delivery staff - working with young people on a daily basis	
None of the above (please specify)	

**Q2) What is your job role? (TICK ONE BOX ONLY)**

Advice and guidance - Connexions adviser	
Advice and guidance – Other	
Counsellor / mental health and wellbeing worker	
Drugs or alcohol worker	
Homelessness worker	
Probation / youth offending worker	
Social worker / Educational Welfare Officer	
Teenage Pregnancy Coordinator / Specialist	
Youth worker	
Other	
<i>N.B. If you are a young people's healthcare worker or work for the NHS, please fill in the sign in sheet for NHS staff or employees of NHS funded young people's sexual health services</i>	

**Q3) What type of organisation is your employer? (TICK ONE BOX ONLY)**

Statutory sector - Local authority / local authority led partnership	
Statutory sector – Other	
Voluntary or community sector provider	

**Q4) If you work for a voluntary or community sector employer, is your organisation:**

Faith based	
Representing an ethnic minority group (s)	
Targeting specific groups of young people (please specify):	
Working specifically with socially disadvantaged young people	

## ANNEX E – EQUALITIES MONITORING DATA

### Equalities monitoring form

What is your ethnic group?

White – British	
White – Any Other White background	
Mixed - White and Black Caribbean	
Mixed - White and Black African	
Mixed - White and Asian	
Mixed - Any Other Mixed background	
Black or Black British - Caribbean	
Black or Black British – African	
Black or Black British – Other Black background	
Asian or Asian British - Indian	
Asian or Asian British - Pakistani	
Asian or Asian British - Bangladeshi	
Asian or Asian British – Any Other Asian background	
Chinese or other ethnic group - Chinese	
Any other ethnic group	

Do you consider yourself to have a disability?

Yes	
No	

**Equalities monitoring data – all practitioners consulted**

<b>Equalities information</b>	<b>Total</b>
White – British	127
White – Any Other White background	13
Mixed - White and Black Caribbean	2
Mixed - White and Black African	0
Mixed - White and Asian	0
Mixed - Any Other Mixed background	3
Black or Black British - Caribbean	0
Black or Black British – African	2
Black or Black British – Other Black background	0
Asian or Asian British - Indian	4
Asian or Asian British - Pakistani	0
Asian or Asian British - Bangladeshi	1
Asian or Asian British – Any Other Asian background	0
Chinese or other ethnic group - Chinese	0
Any other ethnic group	3
Ethnicity not answered	7
Considers oneself to have a disability	3
Does not consider oneself to have a disability	158
Disability not answered	1
<b>Total – all participants</b>	<b>162</b>