NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Contraceptive services

Output: Prioritised quality improvement areas for development.

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for contraceptive services. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development sources) referenced in this briefing paper are:

Faculty of Sexual and Reproductive Health (2015) Progestogen-only pills clinical guideline

Contraceptive services with a focus on young people up to the age of 25. (2014) NICE guideline PH51

Faculty of Sexual and Reproductive Health (2012) Barrier methods for contraception and STI prevention clinical guideline

Prevention of sexually transmitted infections and under 18 conceptions. (2007) NICE guideline PH3

Long-acting reversible contraception (update) (2005) NICE guideline CG30

2 Overview

2.1 Focus of quality standard

This quality standard will cover contraceptive services and methods of contraception for men and women, including emergency contraceptives. It applies to young people (under 25) and adults. This includes all women of child bearing potential, and young people under 16 who are competent to consent to contraceptive treatment under the Department of Health's Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on

contraception, sexual and reproductive health. It will not cover sexual health or reducing sexually transmitted infections.

2.2 Definition

It is estimated that about 30% of pregnancies are unplanned[1]. Current contraceptive methods include long-acting reversible contraception (LARC), oral contraceptives and barrier methods. Contraceptive services aim to help men and women choose a method that best suits their individual needs and lifestyle, so making it more likely that contraception will be used effectively[2].

There are some groups who are at a greater risk of unplanned pregnancy, such as young people and vulnerable groups.

2.3 Incidence and prevalence

According to the 2000/01 'National survey of sexual attitudes and lifestyles' (Johnson et al. 2005), the median age of first intercourse was 16 years for both men and women. It is estimated that between one-quarter and one-third of all young people have sex before they reach age 16.

England has one of the highest rates of teenage pregnancy in Western Europe. Figures for England and Wales show that the 2010 under18 conception rate (35.5 conceptions per 1000) is the lowest estimated rate since 1969. The estimated number of under-18 conceptions fell to 24,306 in 2013 compared with 27,834 in 2012, a decrease of 13%.

Although 88% of women in a heterosexual relationship report using at least 1 method of contraception, abortion rates have increased since the Teenage Pregnancy Strategy was published (Office for National Statistics 2009).

In 2009, the highest abortion rate was in women aged 19–21, at 33 per 1000 pregnancies (DH 2010). The abortion rate for those under 16 was 4 per 1000, and for those under 18 the rate was 17.6 per 1000 (DH 2010). Repeat abortions accounted for 25% of all abortions in women under 25 in 2009[2].

Data have suggested that the male condom is a commonly used method of contraception in the UK. In 2008/2009, a survey found that less than 1% women reported using diaphragms and caps as a contraceptive method.

The effectiveness of the barrier method and oral contraceptive pills depends on their correct and consistent use. The effectiveness of long-acting reversible contraceptive (LARC) methods does not depend on daily concordance. The uptake of LARC has

[1] NICE guideline CG30 Long-acting reversible contraceptives 2005
[2] NICE guideline PH51 Contraceptive services for under 25s

been slowly increasing and in 2013/14, accounted for 31% of all women making contact with sexual and reproductive health services. Oral contraceptives remain the most common form of contraception in use and is the primary method for 47% of women[3].

2.4 Management

Usually, contraceptives can be accessed from individuals GP's, specialist contraceptive services and integrated sexual and reproductive health centres. Some pharmacists are able to provide emergency contraception although this is not consistent across all primary care and community services. It is estimated that the current spend on sexual health services account for one-quarter of the funds transferred to local authorities in 2013. However, evidence demonstrates that interventions and services are cost effective; for every £1 spent on contraception, £11 is saved in other healthcare costs[4].

2.5 National Outcome Frameworks

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

[3] Health and Social Care information Centre. (2014). NHS Contraceptive services: England, community contraceptive clinics. Statistics for 2013-14
[4] Department of Health. (2013). A framework for Sexual Health Improvement in England

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people i Males ii Females 1c Neonatal mortality and stillbirths ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease* 1.4 Under 75 mortality rate from cancer* **Reducing mortality in children** 1.6 i Infant mortality* ii Neonatal mortality and stillbirths
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** ***Improvement areas*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures *i Physical health-related procedures*
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services ii GP Out-of-hours services 4b Patient experience of hospital care *4d Patient experience characterised as poor or worse* *I Primary care* *ii Hospital care* ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving access to primary care services** 4.4 Access to i GP services **Improving children and young people's experience of healthcare** **Improving people's experience of integrated care** *4.9 People's experience of integrated care***
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicators*** *5a Deaths attributable to problems in healthcare* *5b Severe harm attributable to problems in healthcare* ***Improvement areas***

	Reducing the incidence of avoidable harm 5.1 Deaths from venous thromboembolism (VTE) related events 5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile **Improving the culture of safety reporting** 5.6 Patient safety incidents reported
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.11 Domestic abuse 1.12 Violent crime (including sexual violence)
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.4 Under 18 conceptions
3 Health protection	***Objective*** The population's health is protected from major incidents and other threats, whilst reducing health inequalities ***Indicators*** 3.2 Chlamydia detection rate (15–24 year olds) 3.4 People presenting with HIV at a late stage of infection
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.1 Infant mortality* 4.2 4.3 Mortality rate from causes considered preventable** 4.5 Under 75 mortality rate from cancer* 4.8 Mortality rate from communicable diseases
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary	

3 Summary of suggestions

3.1 Responses

In total 22 stakeholders responded to the 2-week engagement exercise 18/11/15-2/12/15.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 3 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Contraceptive service accessibility • Open access • Service information	SCM, RCP, PHE, OSHSGC, RCN, CSC-FSRH, BPAS, PCWHF, THT-BW, BASHH, CEU-FSRH
Service configuration and monitoring • Nurse led services • Integrated services • Service monitoring	RCP, BPlc, PHE, CSC-FSRH, SCM, PCWHF, BASHH, NHS-E,
Contraceptive choice • Contraceptive information • LARC • Emergency contraception • Side effects and clinical indicators	SCM, RCP, PHE, MSD, BPlc, OSHSGC, RCN, BPAS, PCWHF, THT-BW, BASHH, CEU-FSRH,
Vulnerable groups, children and young people • Contraceptive and sexual health education for young people • Patient safety and safeguarding • Unbiased and confidential service • Accessibility for vulnerable groups	SCM, CEU-FSRH, CSC-FSRH,
Additional areas • Staffing • More accessible training • Increased personal contraceptive control • Acknowledgement of contraception care in existing NICE guidance • Identification of domestic violence and child sex exploitation • Advice in postnatal care services • Advice in drugs and alcohol services • Patient safety • Dianette licencing and thrombotic risk	BPAS, PHE, RCN, THT-BW, SCM, CSC-FSRH, NU, RCP, OSHSGC, PCWHF, BASHH, CEU-FSRH

Suggested area for improvement	Stakeholders
BASHH, British Association for Sexual Health and HIV BPAS, British Pregnancy Advisory Service BPlc, Bayer plc CEU-FSRH, Clinical Effectiveness Unit of the faculty of Sexual and Reproductive health CSC-FSRH, Clinical Standards Committee – Faculty of Sexual and Reproductive Health MSD, Merck Sharp & Dohme NHS-E National Health Service England NU, Nottingham University OSHSGC, Office for Sexual Health South Gloucestershire Council PCWHF, Primary Care Women's Health Forum PHE, Public Health England RCN, Royal College of Nursing RCP, Royal College of Physicians SCM, Specialist Committee Member THT-BW, Terrence Higgins Trust – Bristol and West	

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 957 studies were identified for contraceptive services. In addition, current practice examples were suggested by stakeholders at topic engagement (108 studies) and internally at project scoping (3 studies).

Of these studies, 11 were assessed as having potential relevance to this topic and the suggested areas for quality improvement identified by stakeholders (see appendix 2). A summary of relevant studies is included in the current practice sections for each suggested area of improvement.

4 Suggested improvement areas

4.1 Contraceptive service accessibility

4.1.1 Summary of suggestions

Open access

Stakeholders suggested widening access to contraception to involve non-traditional providers such as pharmacies, and also extending the time contraception can be accessed to evenings and weekends. This would enable people to fit contraception access into their lives. Stakeholders also highlighted that contraceptive services should be accessible if individuals are not registered with a GP and that they should be conveniently located. Stakeholders also suggested that there should be services for young people under the age of 16 and that contraceptive access should be improved from pre- conception, post-natal contraception and those who have had an early pregnancy loss or terminated a pregnancy.

Service information

Stakeholders highlighted the importance of information about how to access the correct service. Some stakeholders suggested that current information is not always readily available and correct. Some stakeholders also suggested the use of technology to widen contraceptive access and to obtain information on different methods and to signpost to contraceptive services.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Open access	**Commissioning** NICE PH51 Recommendation 2 **Providing contraceptive services for young people** NICE PH51 Recommendation 3
Service information	**Tailoring services for socially disadvantaged young people** NICE PH51 Recommendation 4 **Providing school and education-based contraceptive services** NICE PH51 Recommendation 8 **Communicating with young people** NICE PH51 Recommendation 11 **Recommendation 5** NICE PH3 Recommendation 5 **Recommendation 6** NICE PH3 Recommendation 6

Open access

Commissioning

NICE PH51 – Recommendation 2

- Establish collaborative, evidence-based commissioning arrangements between different localities to ensure comprehensive, open-access services are sited in convenient locations, such as city centres, or near to colleges and schools. Ensure no young person is denied contraceptive services because of where they live.

Providing contraceptive services for young people

NICE PH51 – Recommendation 3

Service managers, with the support of doctors, nurses and other staff, should offer services that:

- are flexible, for example, offer 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

- provide appointments within 2 working days
- strive to ensure that scheduled appointments run on time and that the waiting time for drop-in consultations is less than 60 minutes
- inform young people about the amount of time they can expect to wait
- provide accurate information about opening times and make it clear whether they operate on a drop-in or appointment basis, or a mix of both
- are open to young people aged under 16 who present for any service without a parent or carer.

Service information

Tailoring services for socially disadvantaged young people

NICE PH51 Recommendation 4

- Provide outreach contraceptive services that offer information, advice, and the full range of options. This includes provision for those living in rural areas who cannot reach existing clinics and services.

Providing school and education-based contraceptive services

NICE PH51 Recommendation 8

- Ensure accurate and up-to-date contraceptive advice, information and support is readily available to all young women and men. Information on the location and hours of local services should be available outside designated clinic hours.

Communicating with young people

NICE PH51 Recommendation 11

- Use a range of methods, including the latest communication technologies, to provide young people, especially socially disadvantaged young people, with advice on sexual health and contraception. This could include using:
    - bespoke websites or dedicated pages on social networking sites which enable young people to discuss sensitive issues anonymously
    - NHS websites such as NHS Choices and NHS Direct
    - websites provided by specialist service providers such as Brook or FPA that provide reliable, up-to-date, evidence-based health information and

advice (schools and colleges should ensure their firewalls do not block these websites)

- telephone helplines offering up-to-date and accurate information and details about local services – for example, 'Ask Brook'. These should, where possible, use local numbers that qualify for free calls as part of many mobile phone contracts.

- Wherever possible, ensure schools, colleges, youth clubs and other places that young people visit have up-to-date and accessible information on contraceptive methods and local services.

- Ensure information is available in a range of formats. For example, it should be available in languages other than English, in large print, or text relay (for those who are deaf or hard of hearing). It should also be distributed via a range of media, for example, via mobile phones (text messaging or calls) or emails. (Practitioners should be mindful of confidentiality when using these media.)

Recommendation 5

NICE PH3 Recommendation 5

- Where appropriate, provide one to one sexual health advice on:
  - how to prevent and/or get tested for STIs and how to prevent unwanted pregnancies
  - all methods of reversible contraception, including long-acting reversible contraception (LARC) (in line with NICE clinical guideline 30)
  - how to get and use emergency contraception
  - other reproductive issues and concerns.
- Provide supporting information on the above in an appropriate format.

Recommendation 6

NICE PH3 Recommendation 6

- Discuss with them and their partner (where appropriate) how to prevent or get tested for STIs and how to prevent unwanted pregnancies. The discussion should cover:
  - all methods of reversible contraception, including LARC (in line with NICE clinical guideline 30), and how to get and use emergency contraception

  - health promotion advice, in line with NICE guidance on postnatal care (NICE clinical guideline 37)
  - opportunities for returning to education, training and employment in the future.

- Provide supporting information in an appropriate format.

4.1.3 Current UK practice

Open access

An audit carried out by the Advisory Group on contraception[5] in 2012, sent freedom of information requests to 151 PCT's. Of these, 126 responded providing a picture of how contraceptive services were being commissioned in England. The audit found that 3.2 million women of reproductive age (15-44) are living in areas where fully comprehensive services through community and/or primary care services, are not provided.

There were 2.21 million contacts with sexual and reproductive services made by 1.34 million individuals in 2013/14. The majority of these contacts took place in SRH services (97.3%), a small number occurred in educational locations (1.2%) or as domiciliary visits (0.2%)[6]. These domiciliary services have traditionally been provided to immobile individuals such as those with physical or learning difficulties. The areas in the above figures may now include outreach services for vulnerable groups such as teenage mothers, youth offenders or sex workers.

Emergency Hormonal Contraception (EHC) is currently available to buy by women aged over 16 from pharmacies without a prescription[4]. A prescription is still required for other contraceptive methods, such as combined oral contraceptives or LARC.

Service information

No current practice data has been identified describing information provision to aid accessibility. However Public Health England[7] state that women should be able to access information about contraceptives available and how effective these are. The chief medical officer (CMO)[8] reports that many women continue to think that contraceptive options are limited to condoms or the oral contraceptive pill. Public Health England[7] state that they will examine the benefits of using technology to

[5] Advisory Group on Contraception. (2012). Sex, Lives and Commissioning. An audit by the advisory group on contraception of the commissioning of contraceptive and abortion services in England.
[6] Health and Social Care Information Centre. (2014). NHS Contraceptive Services: England, Community Contraceptive Clinics. Statistics for 2013-14
[7] Public Health England. (2015). Health Promotion for Sexual and Reproductive Health and HIV. Strategic action plan, 2016 to 2019
[8] Chief Medical Officer. (2014). Annual report of the Chief Medical Officer, 2014. The health of the 51%: Women.

improve SRH services for example appointment and prescribing systems, remote access delivery systems in order to improve patient pathways.

4.2 Service configuration and monitoring

4.2.1 Summary of suggestions

Nurse led services

Stakeholders suggested expanding nurse-led services to increase provision and expand choice.

Integrated services

Stakeholders suggested the importance of integrating contraceptive and sexual and reproductive health services and for commissioning to be provided in order to do this effectively. This service would combine contraception advice with sexually transmitted infection screening and other specialist services. Stakeholders suggested this would prevent individuals being 'lost' in the system. Stakeholders also suggested that staff working within contraceptive and reproductive health services should be consultant led.

Service monitoring

Stakeholders suggested that service providers should continually monitor, evaluate and benchmark themselves to maintain outcomes and improve quality of care. Stakeholders suggested involving the patients to improve the quality of contraceptive services, but acknowledged the challenges surrounding this due to the sensitivity of the subject.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Nurse led services	No recommendations identified in NICE accredited guidance
Integrated service	**Commissioning coordinated and comprehensive services** NICE PH51 Recommendation 2 **Training and continuing professional development** NICE PH51 Recommendation 12
Service monitoring	**Sexually transmitted infections and under-18 conceptions: prevention** NICE PH3 Recommendation 4 **Commissioning coordinated and comprehensive services** NICE PH51 Recommendation 2 **Assessing local need and capacity to target services** NICE PH51 Recommendation 1 **Providing school and education based contraceptive services** NICE PH51 Recommendation 8

Integrated services

Commissioning coordinated and comprehensive services

NICE PH51 – Recommendation 2

- Establish collaborative, evidence-based commissioning arrangements between different localities to ensure comprehensive, open-access services are sited in convenient locations, such as city centres, or near to colleges and schools. Ensure no young person is denied contraceptive services because of where they live.

- Provide contraceptive services within genitourinary medicine and sexual health clinics, either as part of that clinic's services or by hosting contraceptive services provided by another organisation.

- Develop joint commissioning of needs-led contraceptive services for young people. This should include coordinated and managed service networks. It should also include comprehensive referral pathways that include abortion, maternity, genitourinary medicine, pharmacy and all other relevant health, social care and

children's services. Referral pathways should also cover youth and community services, education, and services offered by the voluntary and private sectors.

- Ensure pharmacies, walk-in centres and all organisations commissioned to provide contraceptive services (including those providing oral emergency contraception) maintain a consistent service. If this is not possible, staff should inform young people, without having to be asked, about appropriate alternative, timely and convenient services providing oral emergency contraception.

Training and continuing professional development

NICE PH51 – Recommendation 12

- Ensure all staff are aware of local contraceptive service referral pathways so that they know how to direct young people to the services they need – whether it is for advice on, or the provision of, contraceptives (including condoms and emergency contraception) or abortion services.

Service monitoring

Sexually transmitted infections and under-18 conceptions: prevention

NICE PH3 - Recommendation 4

- Ensure there is an audit and monitoring framework in place.

Commissioning coordinated and comprehensive services

NICE PH51 – recommendation 2

- Ensure all contraceptive services (including those provided in general practice) meet, as a minimum requirement, the You're welcome quality criteria. They should also meet the Service standards for sexual and reproductive healthcare specified by the Faculty of Sexual and Reproductive Healthcare. In addition, services should follow clinical guidance on contraceptive choices for young people

Assessing local need and capacity to target services

NICE PH51 Recommendation 1

- Regularly evaluate services in the context of this guidance and changing local needs. Use local accountability mechanisms (for example, health scrutiny reports) to examine specific issues.

- Ensure the mapping process involves young women and men, including those who are socially disadvantaged, in assessing the need for services (including the type of services needed, opening hours and location).

- Involve young men and women, including those who are socially disadvantaged, in planning, monitoring and evaluating services.

Providing school and education based contraceptive services

NICE PH51 Recommendation 8

- Involve young people in the design, implementation, promotion and review of on-site and outreach contraceptive services in and near schools, colleges and other education settings.

4.2.3 Current UK practice

Nurse-led services

Wiggins et al[9] distributed a survey to 92 Genito-urinary medicine (GUM)/ integrated GUM/contraceptive services. Of these, 56 delivered a combined doctor and nurse delivered service. There was only 1 specific nurse delivered service; this was a Contraceptive and Sexual Health (CASH) service. Many of the prescriptions (96%) provided in the services utilised Patient Group Directions (PGD)[10], sixty one percent had independent non-medical prescribers.

Practice nurses within GP practices are also able to provide contraception[11]. Medication may be re-issued as part of a patients 'pill check'; however some practices nurses are able to prescribe medication independently as a non-medical prescriber. No literature detailing the variation in practice in this area has been found.

Integrated services

The chief medical officer[12] (CMO) 2014 annual report focusses on the benefits of good contraceptive care. The CMO advocates integrating pre-contraceptive care with contraceptive care. The report highlights that commissioning has become fragmented since the introduction of the Health and social care act 2012, which has

[9] Wiggins. H., Crosti. J., Kell. P., Joshi. U., and Rajamanoharan. S. (2014). A survey of the nurse-led/delivered services within genitourinary medicine clinics across the United Kingdom, conducted by the British Co-operative Clinical Group (BCCG). British HIV Association, HIV Medicine 15(suppl. 3); 17-159

[10] Medicines and Healthcare products Regulatory Agency. (2014). Patient group directions: who can use them

[11] Wilson, E. (2014). Nurse-led management of contraceptive services. Nursing Standard. 28(43): 45-49

[12] Chief Medical Officer. (2014). Annual report of the Chief Medical Officer, 2014. The health of the 51%: Women.

adversely influenced access to and the choice of contraception for women wishing to avoid pregnancy.

The Department of Health reported that integrating contraceptive and sexual health services will provide a 'one stop shop' where the majority of sexual health and contraceptive needs can be met at one site, usually within one consultation[13]. Additionally, integrating contraceptive information and services into other SRH services will potentially increase the accessibility of services[14].

Service monitoring

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

[13] Department of Health. (2013). Integrated Sexual Health Services: National Service Specification. A suggested service specification for integrated sexual health services
[14] World Health Organisation (2014). Ensuring human rights in the provision of contraceptive information and services. Guidance and recommendations

4.3 Contraceptive choice

4.3.1 Summary of suggestions

Contraceptive information

Stakeholders highlighted that services should provide information on possible contraceptives and that all forms of information should be easily accessible to all women of fertile age.

Stakeholders also suggested that individuals should have access to a wide range of contraception including Long Acting Reversible Contraception (LARC), emergency contraception, condoms and combined hormonal contraception.

LARC

Stakeholders suggested the contraceptive services and GP practices should provide LARC. Stakeholders also highlighted the importance of providing advice about LARC to those who are terminating a pregnancy or who are accessing emergency contraception and also young people aged under 25. Stakeholders suggested that these steps could increase LARC uptake.

Emergency contraception

Stakeholders also highlighted that there was a lack of intrauterine emergency contraception devices being provided. Stakeholders also suggested that emergency contraception should be available to all women of fertile age from all contraceptive services. One stakeholder expressed that EllaOne provision guidelines should be consistent across the country. Other stakeholders highlighted the importance of quick starting post EllaOne.

Side effects and clinical indicators

Stakeholders suggested improving clinical assessments for women experiencing bleeding on hormonal contraceptives. One stakeholder also suggested that contraceptive services should prevent problems following administration of LARC. One stakeholder suggested that co-morbidities should be considered when deciding which contraceptives to prescribe to promote the wellbeing of the woman and their child's mental and physical health.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Contraceptive information	**Providing contraceptive services for young people** NICE PH51 Recommendation 3 **Providing school and education-based contraceptive services** NICE PH51 Recommendation 8 **Communicating with young people** NICE PH51 Recommendation 11
LARC	**Recommendation 5** NICE PH3 Recommendation 5 **Contraception and principles of care** NICE CG30 Recommendation 1.1.1.1 **Contraception and principles of care** NICE CG30 Recommendation 1.1.3.3
Emergency contraception	**Providing emergency contraception** NICE PH51 Recommendation 9 **Recommendation 5** NICE PH3 Recommendation 5
Side effects and clinical indicators	**Managing bleeding problems on women using a POP** FSRH Progesterone only pills 2015 section 9 **Contraceptive prescribing** NICE CG30 Recommendation 1.1.3.3 **Who is eligible to use POP?** FSRH Progesterone only pills 2015 section 5

Contraceptive information

Providing contraceptive services for young people

NICE PH51 Recommendation 3

- provide information about the full range of contraceptives available, including emergency contraception (both oral and intrauterine) and long-acting reversible contraception (LARC)[3], and the benefits and side effects
- offer advice on the most effective methods and how to use them effectively and consistently

Providing school and education-based contraceptive services

NICE PH51 Recommendation 8

- Ensure accurate and up-to-date contraceptive advice, information and support is readily available to all young women and men. Information on the location and hours of local services should be available outside designated clinic hours.

Communicating with young people

NICE PH51 Recommendation 11

- Use a range of methods, including the latest communication technologies, to provide young people, especially socially disadvantaged young people, with advice on sexual health and contraception. This could include using:
    - bespoke websites or dedicated pages on social networking sites which enable young people to discuss sensitive issues anonymously
    - NHS websites such as NHS Choices and NHS Direct
    - websites provided by specialist service providers such as Brook or FPA that provide reliable, up-to-date, evidence-based health information and advice (schools and colleges should ensure their firewalls do not block these websites)
    - telephone helplines offering up-to-date and accurate information and details about local services – for example, 'Ask Brook'. These should, where possible, use local numbers that qualify for free calls as part of many mobile phone contracts.
- Wherever possible, ensure schools, colleges, youth clubs and other places that young people visit have up-to-date and accessible information on contraceptive methods and local services.
- Ensure information is available in a range of formats. For example, it should be available in languages other than English, in large print, or text relay (for those who are deaf or hard of hearing). It should also be distributed via a range of media, for example, via mobile phones (text messaging or calls) or emails. (Practitioners should be mindful of confidentiality when using these media.)

LARC

Recommendation 5

NICE PH3 Recommendation 5

- Where appropriate, provide one to one sexual health advice on:
    - all methods of reversible contraception, including long-acting reversible contraception (LARC) (in line with NICE clinical guideline 30)

Contraception and principles of care

NICE CG30 Recommendation 1.1.1.1(Key Priority for Implementation)

- Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods. [2005]

Contraception and principles of care

NICE CG30 Recommendation 1.1.3.3

When considering choice of LARC methods for specific groups of women and women with medical conditions, healthcare professionals should be aware of and discuss with each woman any issues that might affect her choice. [2005]

Emergency Contraception

Providing emergency contraception

NICE PH51 Recommendation 9

- Establish patient group directions (PGDs)[4] and local arrangements to ensure all young women can easily obtain free oral emergency contraception.
- Ensure young women (and young men) know where to obtain free emergency contraception.
- Inform young women that an intrauterine device is a more effective form of emergency contraception than the oral method and can also be used on an ongoing basis.
- Ensure young women have timely access to emergency contraception using an intrauterine device.
- Ensure young women who are given oral emergency contraception are:
    - advised that this needs to be used as soon as possible after sex and that it is only effective if taken within a limited time

    - advised that other methods are more effective and reliable as a primary method of contraception
    - encouraged to consider and choose a suitable form of contraception for their future needs
    - referred to, or given clear information about, local contraceptive services
    - offered immediate referral for an intrauterine device, if they choose this method

- Ensure all health professionals providing oral emergency contraception are aware that they can provide this to young women aged under 16 without parental knowledge or consent, in accordance with best practice guidance[1]. Also ensure they are aware that they have a duty of care and confidentiality to young people under the age of 16.

- Health professionals, including pharmacists, who are unwilling (or unable) to provide emergency contraception should give young women details of other local services where they can be seen urgently.

- Ensure arrangements are in place to provide a course of oral emergency contraception in advance, in specific circumstances where the regular contraceptive method being used, for example condoms or the pill, is subject to 'user failure'[5].

Recommendation 5

NICE PH3 Recommendation 5

- Where appropriate, provide one to one sexual health advice on:
    - how to get and use emergency contraception

Side effects and clinical indicators

Managing bleeding problems on women using a POP

FSRH Progesterone only pills 2015 section 9

- There is no evidence that changing the type and dose of POPs will improve bleeding but it may help some individuals.

Contraceptive prescribing

NICE CG30 Recommendation 1.1.3.3

- When considering choice of LARC methods for specific groups of women and women with medical conditions, healthcare professionals should be aware of and discuss with each woman any issues that might affect her choice. [2005]

Who is eligible to use POP?

FSRH Progesterone only pills 2015 section 5

Few medical conditions restrict the use of the POP. UKMEC2 provides evidence-based recommendations for the use of contraceptive methods in the presence of a range of medical conditions and social factors. Health professionals should refer to UKMEC (http://www.fsrh.org/pages/clinical_guidance.asp) when assessing an individual's eligibility for any contraceptive, including the POP. Unless specifically stated, UKMEC does not consider multiple conditions. Assessing an individual's eligibility in the presence of multiple medical and social factors requires clinical judgement based on the evidence available.

4.3.3 Current UK practice

Contraceptive information

No current practice data has been identified describing information provision to aid accessibility. However Public Health England[15] state that women should be able to access information about contraceptives available and how effective these are. The chief medical officer (CMO)[16] reports that many women continue to think that contraceptive options are limited to condoms or the oral contraceptive pill.

LARC

Over the last 10 years, the proportion of women using Long Acting Reversible Contraception (LARC) has been increasing. The number of individuals using user dependent methods (such as condoms or oral contraceptives) has been decreasing.

The chief medical officer (CMO)[16] highlights the benefits of LARC rather than barrier methods or oral contraceptives in its effectiveness in preventing pregnancy and its cost benefits.

[15] Public Health England. (2015). Health Promotion for Sexual and Reproductive Health and HIV. Strategic action plan, 2016 to 2019

[16] Chief Medical Officer. (2014). Annual report of the Chief Medical Officer, 2014. The health of the 51%: Women.

Emergency Contraception

Oral contraceptives remain the most common form of contraception and is the main method for 45% of women[17]. The amount of emergency contraceptives provided to women by both SRH services and other locations in the community was approximately 318,000 in 2014/15. This figure has decreased approximately 39% in the last 10 years.

Public Health England state that local authorities are required to offer a broad range of contraception free to patients in order to prevent unplanned pregnancy[15]. The Department of Health have made recommendations in line with those made by Public Health England and also advocate that these regulations should cover both LARC, regular and emergency contraception[18].

Side effects and clinical indicators

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience

[17] Health and Social Care Information Centre. (2015). Sexual and Reproductive Health Services, England 2014-15

[18] Department of Health. (2013). Commissioning Sexual Health Services and Interventions. Best practice guidance for local authorities.

4.4 Vulnerable groups, children and young people

4.4.1 Summary of suggestions

Contraceptive and sexual health education for young people

Stakeholders suggested that young people under the age of 25 should be educated on the risks of unprotected sex, different contraceptive options and where contraception can be obtained from.

Patient safety and safeguarding

Stakeholders highlighted the importance of ensuring that contraceptive services have robust safeguarding procedures in place and that staff are aware of these. Stakeholders suggest that services need to be aware of the links between provision of contraceptives to those aged under 16 and risks for child exploitation and sexual abuse.

Unbiased and confidential service

Stakeholders highlighted the importance that young people under the age of 25 understand that contraceptive services they are attending are unbiased and confidential.

Accessibility for vulnerable groups

Stakeholders highlighted the importance of reducing inequalities and ensuring that the vulnerable individuals have access to the contraceptive services. This may reduce the number of under 18 conceptions and increase contact with these groups.

4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Contraceptive and sexual health education for young people	**Providing school and education-based contraceptive services** NICE PH51 Recommendation 8
Patient safety and safeguarding	**Tailoring services for socially disadvantaged young people** NICE PH51 Recommendation 4 **Contraception for special groups** NICE CG30 Recommendation 1.1.5.1
Unbiased and confidential service	**Providing contraceptive services for young people** NICE PH51 Recommendation 3 **Tailoring services for socially disadvantaged young people** NICE PH51 Recommendation 4 **Seeking consent and ensuring confidentiality** NICE PH51 Recommendation 5 **Providing school and education-based contraceptive services** NICE PH51 Recommendation 8
Accessibility for vulnerable groups	**Tailoring services for socially disadvantaged young people** NICE PH51 Recommendation 4

Contraceptive and sexual health education for young people

Providing school and education-based contraceptive services

NICE PH51 Recommendation 8

- School nurses, doctors and counsellors working with 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 them will be confidential, except under the provisions made by law, for example, in relation to child protection.

- Ensure accurate and up-to-date contraceptive advice, information and support is readily available to all young women and men. Information on the location and hours of local services should be available outside designated clinic hours.

- Ensure contraceptive advice, free and confidential pregnancy testing and the full range of contraceptive methods, including both LARC and emergency contraception, is easily available. If the full range is not available, offer prompt and easy referral to appropriate local contraceptive services outside the school or college.

- Ensure continuity of service, for example by making it clear to young people when and where local services are available during school, college or university holidays.

- Ensure services not only provide contraceptives but are staffed by people trained to be respectful and non-judgmental. They should also be trained to help young men and women identify, choose and use contraception that is the most appropriate for them.

Patient safety and safeguarding

Tailoring services for socially disadvantaged young people

NICE PH51 Recommendation 4

- Offer support and referral to specialist services (including counselling) to those who may need it. For example, young people who misuse drugs or alcohol and those who may have been (or who may be at risk of being) sexually exploited or trafficked may need such support. The same is true of those who have been the victim of sexual violence.

Contraception for special groups

NICE CG30 Recommendation 1.1.5.1

- Healthcare professionals should be aware of the law relating to the provision of advice and contraception for young people and for people with learning disabilities. Child protection issues and the Fraser guidelines should be considered when providing contraception for women younger than 16 years[1]. [2005]

Unbiased and confidential service

Providing contraceptive services for young people

NICE PH51 Recommendation 3

- Doctors, nurses and pharmacists should:
    - offer culturally appropriate, confidential, non-judgmental, empathic advice and guidance according to the needs of each young person

Tailoring services for socially disadvantaged young people

NICE PH51 Recommendation 4

- Offer culturally appropriate, confidential, non-judgmental, empathic advice and support tailored to the needs of the young person. Tailored support might involve, for example, providing relevant information in small manageable amounts, checking whether it has been understood, and reiterating and revising information if required. It could also include using more pictures and diagrams than text.

Seeking consent and ensuring confidentiality

NICE PH51 Recommendation 5

- Ensure staff are trained to understand the duty of confidentiality and adhere to the recommendations and standards laid out in their organisation's confidentiality policy.

- Ensure young people understand that their personal information and the reason why they are using the service will be confidential. Even if it is decided that a young person is not mature enough to consent to contraceptive advice and treatment, the discussion should remain confidential.

- Ensure the organisation's confidentiality and complaints policy is prominently displayed in waiting and reception areas, and is in a format that is appropriate for all young people.

Providing school and education-based contraceptive services

NICE PH51 Recommendation 8

- Ensure services not only provide contraceptives but are staffed by people trained to be respectful and non-judgmental. They should also be trained to help young men and women identify, choose and use contraception that is the most appropriate for them.
- Ensure accurate and up-to-date contraceptive advice, information and support is readily available to all young women and men. Information on the location and hours of local services should be available outside designated clinic hours.

Accessibility for vulnerable groups

Tailoring services for socially disadvantaged young people

NICE PH51 Recommendation 4

- Provide additional support for socially disadvantaged young people to help them gain immediate access to contraceptive services and to support them, as necessary, to use the services. This could include providing access to trained interpreters or offering one-to-one sessions. It could also include introducing special facilities for those with physical and sensory disabilities and assistance for those with learning disabilities.
- Encourage and help young mothers (including teenage mothers) to use contraceptive services, for example, by working with family nurse partnerships or children's centres.
- Offer support and referral to specialist services (including counselling) to those who may need it. For example, young people who misuse drugs or alcohol and those who may have been (or who may be at risk of being) sexually exploited or trafficked may need such support. The same is true of those who have been the victim of sexual violence.
- Provide outreach contraceptive services that offer information, advice, and the full range of options. This includes provision for those living in rural areas who cannot reach existing clinics and services.
- Offer culturally appropriate, confidential, non-judgmental, empathic advice and support tailored to the needs of the young person. Tailored support might involve, for example, providing relevant information in small manageable amounts, checking whether it has been understood, and reiterating and revising information if required. It could also include using more pictures and diagrams than text.

4.4.3 Current UK practice

Contraceptive and sexual health information for young people

Under 18 conceptions in the UK are the highest in Europe (24.3 conceptions per 1000 women aged 15-17)[19]. Public Health England[19] note the importance of supporting the implementation of high quality accessible information resources in order to empower young people to manage their own reproductive health needs, and so they can make an informed choice on their contraceptives and care.

The chief medical officer (CMO)[20] recommends that the 4 Ps (pregnancy prevention, pregnancy planning, pregnancy preparation and preparing for adulthood) should become a core element of school sex and relationship education to increase SRH literacy.

Patient safety and safeguarding

Between April 2014 and March 2015 almost 1 million (941,169) women contacted sexual and reproductive (SRH) services for contraception. Three percent of these (31,765) were aged under 16[21]. In England, Wales and Northern Ireland, young people can access contraception at any age if they are deemed to be 'Fraser competent' according to the Fraser guidelines[22].

Unbiased confidential service

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Accessibility for vulnerable groups

Individuals from minority groups, people who have disabilities, people living with HIV, sex workers, drug users, transgender and intersex individuals can experience discriminated against and coerced or forced into contraception[23]. The World Health Organisation advise that people who live in rural areas may not have the same access to SRH services as those who live in urban areas, and are therefore being discriminated on the grounds of residence. International human rights law requires health care facilities, commodities and services should be accessible to everyone

[19] Public Health England. (2015). Health Promotion for sexual and reproductive health and HIV. Strategic action plan, 2016 to 2019.
[20] Chief Medical Officer. (2014). Annual report of the Chief Medical Officer, 2014. The health of the 51%: Women.
[21] Health and Social Care Information Centre. (2015). Sexual and Reproductive Health Services, England 2014-15
[22] Straw. F., and Porter. C. (2012). Sexual health and Contraception. Archives of Disease in Childhood. Education and Practice Edition. 0(1-8)

without discrimination[23]. Therefore SRH health services should be available and accessible for all, along with a range of contraceptives.

Women of all ages should have access to SRH services, including contraceptive services[24]. They advocate that all reproductive services should be open access and not limited to the services of local GP's. Improved access contributes to young people and socially excluded vulnerable groups and establishes links with the appropriate agencies[24].

[23] World Health Organisation (2014). Ensuring human rights in the provision of contraceptive information and services. Guidance and recommendations

[24] Advisory Group on Contraception. (2012). Sex, Lives and Commissioning. An audit by the advisory group on contraception of the commissioning of contraceptive and abortion services in England.

4.5 Additional areas

4.5.1 Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 14th January 2015.

Staffing

Stakeholders highlighted the importance of ensuring that all services that provide contraception are appropriately staffed by trained healthcare professionals. Quality Standards do not determine staffing levels.

More accessible training

Stakeholders suggested that contraceptive training needs to be more accessible as there is currently no qualification with a national body available. Stakeholders suggested that there should be clear standards of competence or qualifications required for all practitioners working in all aspects of contraceptive care. There should also be clear training on LARC and further continued professional development. Quality standards do not cover training of healthcare professionals as staff being trained and competent is an underpinning concept of all quality standards.

Increased personal contraceptive control

Stakeholders suggested using services such as pharmacies to access contraceptives (such as subcutaneous progesterone) for self-administration to increase contraceptive control. This area was not covered in the existing underpinning guidance sources.

Acknowledgement of contraception care in existing NICE guidance

Stakeholders suggested that contraception should be included in all NICE guidance specifically in relation to the preconception care of women undergoing treatment and taking other medications. The development of NICE guidance is considered separately to quality standards.

Identification of domestic violence and child sex exploitation

Stakeholders suggested that contraceptive services could act as pathways for identifying domestic violence and child sex exploitation, a separate quality standard is in development for domestic violence.

Advice in postnatal care services

Stakeholders suggested improving access and advice on contraception postnatally. Advice on postnatal services is covered within Quality Standard (QS37).

Advice in drugs and alcohol services

Stakeholders suggested improving access within other services, such as drug and alcohol services. Advice on drugs and alcohol is not within the scope of this referral.

Patient safety

Stakeholders suggested that contraceptive services should have appropriate resuscitation equipment, chaperones (in the event of a collapse during intrauterine instrumentation) and must have completed a comprehensive risk assessment for all services provided and procedures performed. This area is likely to be considered as part of other prioritised areas.

Dianette licencing and thrombotic risk

One of the stakeholders highlighted the licencing of Dianette (co-cyprindiol) and its thrombotic risk. Quality standards do not cover drug licensing.

Appendix 1: Key priorities for implementation (CG30)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

Contraceptive provision

- Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods. [1.1.1.1]

- Contraceptive service providers should be aware that:
    - all currently available LARC methods (intrauterine devices, the intrauterine system, injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use
    - intrauterine devices, the intrauterine system and implants are more cost effective than the injectable contraceptives
    - increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies. [1.1.1.3]

Counselling and provision of information

- Women considering LARC methods should receive detailed information – both verbal and written – that will enable them to choose a method and use it effectively. This information should take into consideration their individual needs and should include:
    - contraceptive efficacy
    - duration of use
    - risks and possible side effects
    - non-contraceptive benefits
    - the procedure for initiation and removal/discontinuation
    - when to seek help while using the method. [1.1.2.1]

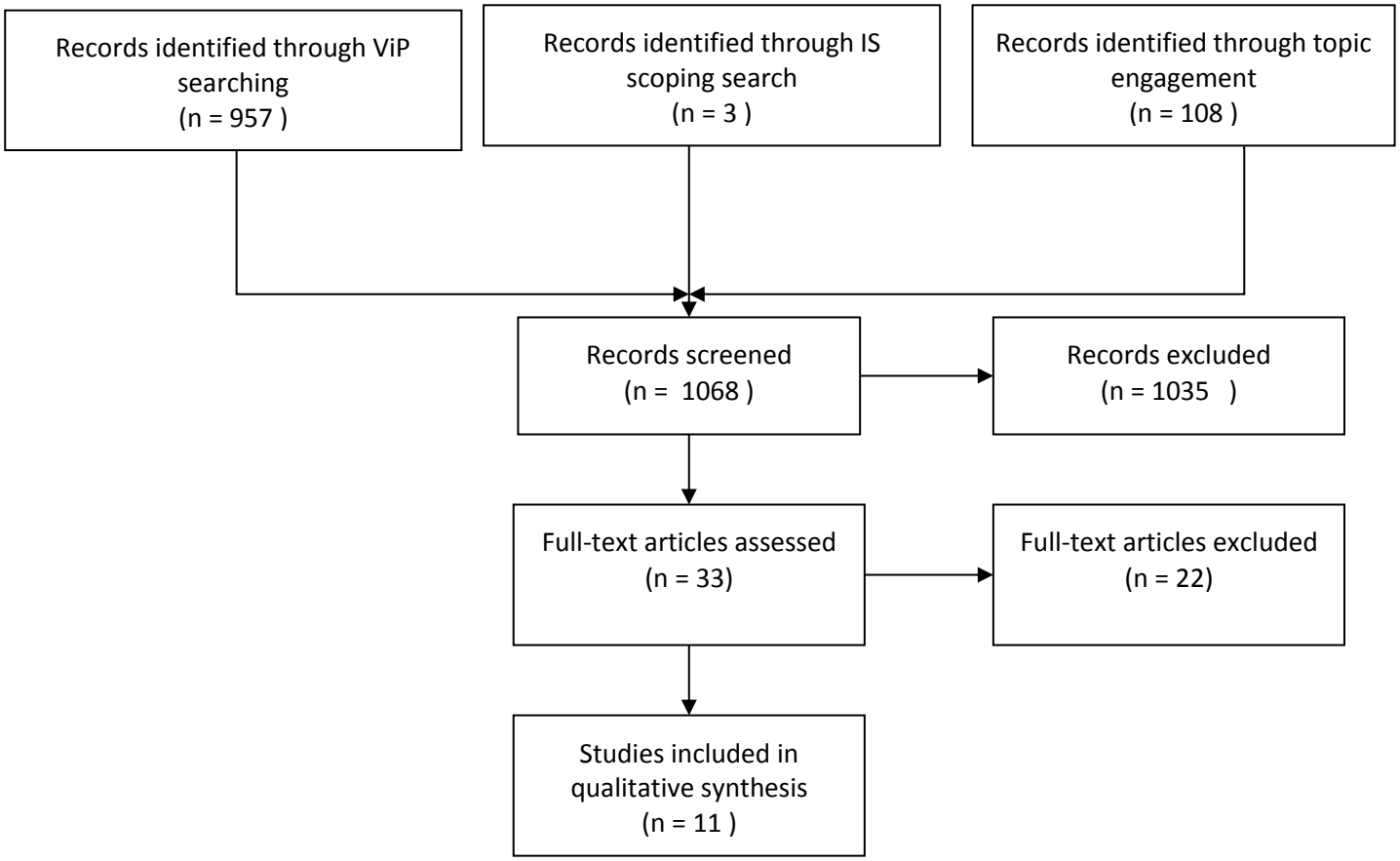
Training of healthcare professionals in contraceptive care

- Healthcare professionals advising women about contraceptive choices should be competent to:

    - help women to consider and compare the risks and benefits of all methods relevant to their individual needs
    - manage common side effects and problems. [1.1.6.1]

- Contraceptive service providers who do not provide LARC within their own practice or service should have an agreed mechanism in place for referring women for LARC. [1.1.6.2]
- Healthcare professionals providing intrauterine or subdermal contraceptives should receive training to develop and maintain the relevant skills to provide these methods. [1.1.6.3]

Appendix 2: Review flowchart



Appendix 3: Suggestions from stakeholder engagement exercise – registered stakeholders

National Institute for Health and Care Excellence

Contraceptive services
Quality Standard Topic Engagement Comments Table – registered stakeholders

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
1	4.1	SCM2	Providing and communicating contraceptive services for young people (under 25)	As unprotected sex is most likely to happen in the youngest age groups, services must be communicated to young people to ensure they understand what they can access and the services that are available. The median age of first intercourse for men and women is 16, it's therefore essential that before they become sexually active they know how to keep safe, healthy and avoid pregnancies and STI's. The nature of these services need to ensure that young people are able to access these and feel comfortable and assured that confidentiality of their information is a must. Due to the high percentage of conceptions among women under 25 that end in abortion demonstrates that	This age group is most likely to have unprotected sex therefore its essential that the services and options available for them is integrated, accessible and educated about. This will hopefully affect the levels of STI's unwanted pregnancies and abortion rates in under 25's. It is paramount that under 25's know where to go and why to ensure that services are utilised and cost-effective.	Contraceptive services with a focus on young people up to the age of 25. (2014) NICE guideline PH51

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				many of these pregnancies are unwanted. Suggesting that contraceptive services are failing the needs of young people Under 25's should have access to a network of contraceptive services that offer fundamental advice on contraceptive methods, in a timely manner. Under 25's need education on where they can go for what service and at what time. It seems young people are still unclear about out-reach services and only refer to GP's for these appointments. When GP's have limited availability then these people are particularly at risk that they need the advice of equally accessible and competent services. It is vital that every community has access to a local 'drop in' service where under 25's are able to access confidential advice without waiting over an hour.		
2	4.1	SCM1	Access to contraceptive services for all patients	Women of all ages are likely to require contraceptive services at some point	Access to contraception will contribute to the lowering of teenage conceptions and unplanned pregnancies in women of all	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210726/Service_Specificati

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				across the life course and this should be at a time, which is convenient without having to take time out of work or education. Prevent unplanned pregnancies.	ages. Opportunity for 1:1 consultation with a qualified health professional will allow for key health improvement advice to be given (substance misuse including smoking) to address wider public health issues as well as the contraception need. Clear pathways between services: eg. Maternity for post natal contraceptives; post abortion contraceptives – including where the abortion provider has commenced a method	on_with_covering_note.pdf http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf - page 7 SRHAD Data (previously KT31) Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors NICE guidelines [CG110]
3	4.1	SCM1	Additional developmental areas of emergent practice	Explore extending access to service using partner professionals such as Pharmacists and self administration of contraceptives (subcutaneous progesterone)	More control for women – self care Reduced number of visits to services/including specialist services	
4	4.1	SCM2	Accessibility and the co-ordination of contraceptive services	Evidence shows that if young people have access to a wide range of contraceptive services they are more likely to access them. If the individuals are accessing these services in a timely manner they are more likely to attend and therefore prevent any potential repercussion. Every individual in need of contraception to minimise	Young people tend to prefer community contraception services over primary care however these services have suffered disinvestment (Independent Advisory Group on Sexual Health and HIV 2009) Local Authorities have a mandatory responsibility for commissioning and delivering all community and pharmacy contraceptive services. Therefore there should be a quality standards ensuring this responsibility is being met, to a high standard.	Contraceptive services with a focus on young people up to the age of 25. (2014) NICE guideline PH51

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				the risk of unintended pregnancies should have access to contraception from a GP and an open-access-specialist. It is essential that even if an individual is not registered to a local GP they are still able to access contraceptive services and advice in a timely and confidential manner. This will minimise the risk of unintended pregnancies, STI's, use of emergency contraception and terminations. Individuals should be entitled to a contraceptive service that has the ability to refer the individual to 'specialist services' to ensure they receive an integrated service that prohibits individuals getting 'lost in the system'. It is extremely important for patients to be able to access contraceptive 7 days a week with extended hours to ensure people are able to access and utilise these services. Operating a 9-5 Monday to Friday service eradicates a large	Nice guidelines (2014) have identified variations in services across the UK, especially in rural area. Therefore this could have detrimental effects on socially disadvantaged young people, who already have very high statistics of teenage pregnancies, terminations and STI's. To increase accessibility to contraception services in order to decrease the amount of individuals with STI's, unwanted pregnancies, terminations and HIV levels.	

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				proportion of society who are unable to access those services at those times due to working/lifestyle commitments. Having these services are just as important as educating service users of opening times and their purposes. Individuals require confidence that the quality and level of your contraceptive consultation will be the same no matter what service that individual utilises. In the past I have had bad experiences where different services are not communicating and slowing down my treatment. I have now become wary of using an out-reach clinics as when referrals are needed you will then need to get an appointment with the GP. This put me off as it is more convenient for me to go to my GP first.		
5	4.1	SCM2	Accessibility to emergency contraception	Socially disadvantaged young people sometimes find it hard to access emergency contraceptive services. However, they find it easy to access community	The high teenage pregnancy rates and overall abortion levels indicate that people are dealing with unwanted pregnancies. Therefore there is a need for this service and it needs to be accessible for the needs of these	

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				and outreach services i.e. local supermarket. The extremely high teenage pregnancy rate and abortion rate indicate that emergency contraception services are failing the needs of individuals. Having emergency contraception available from a wide range of sources means individuals are able to access this service conveniently and in a crucial timely manner. It is also essential that once this service is provided long term contraceptive advice needs to be offered or they need to be referred to another service to prevent the situation repeating	individuals to reduce teenage pregnancies and abortions. The services/treatments following on from unwanted pregnancies are costly for the NHS. Therefore intercepting at an early stage and providing emergency contraception is extremely cost beneficial and reduces referrals to services such as counselling. Also, this service should be easily accessible for under 16's to decrease the amounts of teenage pregnancies. The services need to instil confidence that under 16's will not be judged or discriminated against on the basis of their age, however the law and safeguarding is still paramount.	
6	4.1	SCM2	Under 16's contraceptive services	Statistics shows that the number of teenagers under 16 whom are sexually active is growing. According to Nice's 2014 guidance ¼-1/3 of all young people have sex before 16. This indicates that services need to educate individuals before they become sexually active to prevent pregnancies, STI's and abortions. Also, men and women need to be	It is clear from under 16's statistics on teenage pregnancies that contraceptive services to under 16's are not meeting their needs. It is essential to educate, prevent and provide long term contraceptive services before under 16's become sexually active. It is naïve to assume that because the legal age for sexual activity is 16 that it does not happen. Also, services can integrate safeguarding ensuring these vulnerable groups are	Health Talk – Contraceptive services

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				aware of the risks of sexual activity and the emotional impact of engaging in sexual activities. Healthtalk indicates that young people are unaware of the emotional impact it will have on them, causing greater health issues i.e. anxiety, eating disorder and depression. With unprotected sex is more likely for the youngest age groups (Johnson et al. 2001. It is clear that this age group need education and a new approach to ensuring they are using protective measures. Utilising schools and education based centres targets students that may not be forthcoming to use the services. However, they will access guidance, advice and information that will hopefully prevent them having unprotected sex. England has one of the highest rates of teenage pregnancy in western Europe. It's clear that our under 16's approach is not effective and not meeting the needs of the individuals. Teenage pregnancies are	protected from exploitation and abuse. Educating under 16's will also equip them with essential required knowledge to make informed decisions about their health. I.e. risks of not using condoms and becoming pregnant	

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				estimated to have cost the NHS £63 million. Therefore, integrating schools, colleges and sixth forms will target under 16's who would not normally access formal contraceptive services in their communities.		
7	4.1	Royal College of Physicians	Open access to contraceptive services	Open access to contraceptive services is crucial to addressing unwanted pregnancy. Restricting access either by inadequate opening hours, lack of variety of appointment types (walk-in or appointment slots), and forcing people to attend services in inconvenient locations, risks service users being unable to access the care they need.	There is huge variability in the accessibility of contraception services. Some services are open at weekends and during the evening and others are not. There is also variability in the type of services delivered by individual providers and service users are often confused about how to access the care they need.	NICE Guidance on LARC (CG30) http://www.nice.org.uk/guidance/cg30/chapter/introduction Contraceptive services for under 25s http://www.nice.org.uk/guidance/ph51 Contraceptive services http://www.nice.org.uk/guidance/service-delivery--organisation-and-staffing/contraceptive-services
8	4.1	Royal College of Physicians	Additional developmental areas of emergent practice	Other areas to consider are: • Increasing the use of technology to enable remote or self-assessment of appropriateness of different methods. • Widening access to contraception (beyond emergency contraception) to involve non-traditional providers (e.g. pharmacies,	Possible moves to restrict access to contraceptive services to general practice and SRH clinics only means that many individuals will be unable to access the advice they need at a time that is suitable for them. It is crucial that these are faced down.	See above

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				online). Robustly opposing restriction to open access to SRH services.		
9	4.1	Public Health England	Access to Emergency IUDs	This is the most effective emergency contraceptive but needs trained professionals in specific clinical settings to fit. The majority of NHS funded oral EC is from community pharmacies, or bought OTC from same, and is also provided by GPs not trained in IUD fitting, or outreach services, .	Local networks are required to facilitate this; make it easy for the patient to move through the pathways. Should be commissioned ; whole system approach https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf If not commenced on regular contraception , the will risk again. Higher failure rate for EC than LARC, P only and CHC contraceptives. Probably also barrier methods (typical user rates) To reduce unplanned pregnancies; priorities in the Public health Outcome Framework and the DH Framework for Sexual health Improvement in England. The CU-IUD is the most effective form of EC because of the low failure rate (1 in 1000 pregnancy when Cu-IUD used as EC). Faculty of Sexual & Reproductive Healthcare. Emergency Contraception. 2011. http://www.fsrh.org/pdfs/CEUguidanceEmergencyContraception11.pdf	FSRH Emergency contraception http://www.fsrh.org/pdfs/CEUguidanceEmergencyContraception11.pdf Reducing unplanned pregnancies. A Framework for Sexual Health Improvement in England 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf .
10	4.1	Office for Sexual Health, South Gloucestershire Council	Increase Access to full range of contraception within other services i.e midwifery services, ToP, drugs and alcohol	• Reducing unplanned pregnancies is an Ambition in the Department of health Framework for Sexual Health Improvement • Reducing Under 18	Provision of contraception following pregnancy and abortion are recommendation in the NICE guidance 51. The guidance for post pregnancy recommends that midwives and other health professional supporting new mothers should ensure that advice on contraception has been given. It also recommends that midwives should	

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				Conceptions is a Public Health Outcome Indicator. • Department of Health guidance on best practice in Commissioning Sexual Health services and interventions recognises the contribution that Abortion providers can make in improving access to contraception and reducing further unplanned pregnancies • Reducing unplanned pregnancy can lead to savings for the Local Authority and the NHS	provide the contraception of choice before discharge or make appropriate referrals. The post abortion guidance recommends abortion providers support discussion of contraceptive choices and help 'identify and obtain' their chosen method. By ensuring access to contraception through other health service pathways, uptake can be increased and vulnerable and at risk groups better supported to avoid unplanned pregnancy.	
11	4.1	Royal College of Nursing	Maintain access and services for contraception and sexual health	To improve and maintain access to services for all women	To limit access will limit choice and availability.	
12	4.1	Clinical Standards Committee - Faculty of Sexual	Access to contraceptive services and contraceptive specialists	All women should be able to have timely access to a specialist contraception provider and all GPs should have access to a specialist to support their work and provide advice and referral	Women should be able to have access and emergency access to all contraceptive methods and emergency contraceptive methods . e.g. A Copper IUD is the most reliable form of emergency contraception but not all GPs may provide this service and insertion	A Quality Standard for Contraceptive Services, FSRH 2014 Service Standards for Sexual and reproductive Health , FSRH 2013 www.fsrh.org

ID	Related section	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		and Reproductive Healthcare		pathways	procedures may be more complex	
13	4.1	British Pregnancy Advisory Service (BPAS)	**Maintain access to contraceptive services**	Cuts to the public health budget risk women's access to contraception, which consequently risks an increase in unplanned pregnancies.	A drop in quality or provision of contraceptive services will result in unplanned pregnancies, which will cause distress to women and additional cost to the NHS. Recent reports from women to BPAS' contraceptive nurses highlight the problems women are encountering accessing the contraceptive method of their choice. Increasingly women tell BPAS staff that they were actively trying to avoid pregnancy but were unable to access contraception for a variety of reasons. Below are comments from women from November 2015. These were recorded by our contraceptive nurses. All these had an abortion because of an unplanned pregnancy. 'Told no staff working who could to fit emergency coil – now I'm pregnant' 'I'm not getting the implant as there are no nurses to remove it.' 'I can never get an appointment to fit a coil – now I am pregnant' 'Have to travel too far to get contraceptive advice on two buses then I got turned away.' 'I was happy using Cerazette (form of oral contraceptive Pill) with no problems then the GP gave me a cheaper one and it didn't suit me.' Our nurses are also hearing pill users	Please see Advisory Group on Contraception Sex, lives and commissioning II: A report by the Advisory Group on Contraception on the commissioning of contraceptive services in England – May 2014 -

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					complain that in the past they used to be given a 1 year supply whereas now they are only being given 3 months because of cost-cutting. The risk in this is obvious. Pressures on primary care mean that it is increasingly difficult to get a timely GP appointment. If women have been refused a year's supply of the pill some may struggle to make return visits every three months. It is also an additional waste of resource if the appointment is clinically unnecessary. The quality standard must make clear that all women of reproductive age need access to all methods of contraception in a timely manner.	
14	4.1	SCM4	Choice of access to contraception both from a GP and/or an alternative open access specialist provider to whom GPs can also refer for specialist advice and care.	This provides a range of timings and locations esp for certain groups eg young people. Complex contraception can then be managed in the community avoiding a hospital gynaecology referral		FSRH Quality Standards at http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf
15	4.1	SCM4	Additional developmental areas of emergent practice	Provision to hard to reach groups eg outreach service.		
16	4.1	Primary Care Women's Health Forum	People requiring contraception can access quality contraception care, from a choice of provider, in a timely manner.	Good access to contraceptive care is essential to improve public health outcomes by preventing ill health, improving wellbeing and reducing inequalities.	The responsibility for commissioning SRH provision is fragmented and complex. Specialist SRH and enhanced primary care LARC services, pharmacy emergency contraception schemes and condom distribution are commissioned	Unprotected Nation 2015. http://www.fpa.org.uk/influencing-sexual-health-policy/unprotected-nation-2015 APPG report – Breaking Down the Barriers.

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				It is important that ALL individuals can access this care from a choice of providers - including specialist SRH services, Primary care, Pharmacy, school nurses, other commissioned services including abortion providers, in a timely manner.	via Public Health, Core contraception from primary care is commissioned from NHS England and abortion services and subsequent contraception is under the remit of the Clinical Commissioning Groups. This fragmentation of commissioning and funding responsibilities is causing concern as the services are not providing stream-lined, open access and easy to access care. The individuals most at risk of failing to negotiate the complexities of the system and any funding cuts are those who are already most vulnerable.	http://www.fpa.org.uk/sites/default/files/breaking-down-the-barriers-report-appg-srhuk.pdf Department of Health. A framework for Sexual Health Improvement in England. 2013 http://www.gove.uk/government/publications/a-framework-for-sexual-health-improvement-in-england
17	4.1	Primary Care Women's Health Forum	People requiring contraception receive acceptable, accessible and appropriate quality of care.	SRH clinic attendees are reluctant to complain if their care is not adequate because of their perceived embarrassment for requiring these services. It is important that the 'user voice' is heard when there are service changes to access, place of delivery, timings etc. It is essential to ensure that any service alterations are acceptable to those who are most vulnerable, i.e those with specific social or cultural needs.	Service changes are inevitable with the financial cuts to LA funding as well as the increasing demand for primary care appointments. Users of SRH services are often reluctant to complain. It is important that those who use, and do not use, the service are included in decisions about changes to service provision wherever that is delivered,to include: Clinic times Waiting times Family and friends test Accessibility of clinics.	
18	4.1	Terrence Higgins Trust Bristol and West	Ensuring open access and choice of contraception including emergency contraception is maintained for all			

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			women of a fertile age			
19	4.1	British Association for Sexual Health and HIV	Open access to contraceptive services	Open access to contraceptive services is crucial to addressing unwanted pregnancy. Restricting access either by inadequate opening hours, lack of variety of appointment types (walk-in or appointment slots), forcing people to attend services in inconvenient locations risks service users being unable to access the care they need.	There is huge variability in the accessibility of contraception services – some services being open at weekends and during the evening and others not. There is also variability in the type of services delivered by individual providers and service users are often confused about how to access the care they need. Individuals are not always able to attend services at their own convenience and are often forced to attend services local to where they live, even if it is more convenient for them to access services where they work.	NICE Guidance on LARC (CG30) http://www.nice.org.uk/guidance/cg30/chapter/introduction Contraceptive services for under 25s http://www.nice.org.uk/guidance/ph51 Contraceptive services http://www.nice.org.uk/guidance/service-delivery--organisation-and-staffing/contraceptive-services
20	4.1	British Association for Sexual Health and HIV	Additional developmental areas of emergent practice	Other areas to consider are increasing the use of technology to enable remote or self-assessment of appropriateness of different methods Widening access to contraception (beyond emergency contraception) to involve non-traditional providers (e.g. pharmacies, online). Robustly opposing restriction to open access to SRH services.	Possible moves to restrict access to contraceptive services to general practice and SRH clinics only means that many individuals will be unable to access the advice they need at a time that is suitable for them. It is crucial that these are faced down.	See above
21	4.1	SCM5	Accessibility of contraceptive services in terms of locations, opening times and choice of services	Evidence shows young people in particular want services that are available 6 days a week or at a minimum late afternoon/ evenings and Saturday	Evidence (Comres Survey for FSRH, 2015) suggests that young people in particular continue to experience difficulties accessing services because they are not open at convenient times or waiting times are too long. There are	

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				afternoons. Services need to be conveniently situated and accessible by public transport so that young people can access them independently of parents/carers. There is mixed evidence about young people's preference for accessing local services vs more anonymous centrally located services therefore it is crucial to maintain open access to a choice of venues and providers. The physical environment, especially waiting areas is particularly important to young people. Young people say environments need to be pleasant, informal and non-clinical with entertainment systems to make waiting less stressful.	regional variations in provision and accessibility. Brook/FPA Xes: we can't go backwards campaign found inconvenient opening hours was one of the main explanations for giving a service a poor rating.	
22	4.1	Clinical Effectiveness Unit (CEU) of the Faculty of Sexual	Improve equity of contraceptive service provision, by ensuring services are located close to and are accessible by those who have difficulty	Access must not be restricted by physical, mental or learning disability or by language barrier. Vulnerable women such as drugs	When vulnerable women have unplanned pregnancies following chaotic or non-use of contraception, they place a significant burden of care on maternity services and	FSRH. *A Quality Standard for Contraceptive Services April 2014*. http://www.fsrh.org/pdfs/FSRHQualitySta ndardContraceptiveServices.pdf (accessed 30/11/2015) FSRH. Service *Standards for*

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		and Reproductive Health (FSRH)	travelling and accessing services.	users, sex workers or those with alcohol problems are much less likely to use contraception effectively. Such vulnerable groups of women may be much less likely to attend services that involve travelling away from their local area.	outcomes for both mother and child are often poor. Inter-pregnancy intervals may be short, resulting in poorer pregnancy outcomes. Vulnerable women need to be able to access high quality contraceptive care in their local communities to prevent unplanned pregnancies in this group	*Sexual and Reproductive Healthcare 2013*: Standard 2.7 http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf (accessed 30/11/2015) A framework for sexual health improvement in England 2013. https://www.gov.uk/government/uploads/ system/uploads/attachment_data/file/142 592/9287-2900714-TSOSexualHealthPolicyNW_ACCESSIBLE.pdf (accessed 01/12/2015) Mohllajee AP, Curtis KM, Morrow B, *et al*. Pregnancy intention and its relationship to birth and maternal outcomes. *Obstet Gynecol 2007;**109**:* 678-686 Shah PS, Balkhair T, Ohlsson A, *et al*. Intention to become pregnant and low birth weight and preterm birth: a systematic review. *Matern Child Health J* 2011;**15**: 205–216 Smith G, Pell J, Dobbie R. Interpregnancy interval and the risk of preterm birth and neonatal death: Retrospective cohort study. *BMJ 2003*;

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						327:313
23	4.1	SCM6	GP prescribed LARC rate, excluding injections	We know that women have a high level of trust with their GP, including for the purposes of discussion and support of family planning.	Rates vary across the country, plus where we see apparently higher GP prescribing rates for LARC, all too often this can primarily be injections. This is perhaps not surprising given that *"injections are easily given in primary care and do not require the resources and training that other LARC methods require"*, however other methods of LARC should be promoted as *"injections have a higher failure rate than the other LARC methods"* (Public Health England 'Fingertips' – Indicator Definitions and Supporting Information).	
24	4.1	SCM7		Provision of out of hours emergency contraception	Geographical difference with regards to ease of obtaining advice and provision of PCC.	I work in a student practice and commonly come across the comments- it is so much easier to obtain help at the weekend at home (usually Birmingham) rather than here. The most common reason/excuse that hear for later presentation when the 'accident' has been at a weekend.
25	4.2	Royal College of Physicians	Integration of sexual health and contraceptive services	The same factors that put individuals at risk of unwanted pregnancy put them at risk of sexually transmitted infections. It does not make sense that people who attend for contraceptive services should not have access to sexual health services in the same place and vice versa.	Requiring individuals who attend a service for one sexual health need (STI screening/treatment or contraception) to attend another service for another sexual need risks non-attendance at the other service and the potential for unwanted pregnancy and non-treatment/complications/transmission of STI(s). It also fails to recognize the fact that people lead busy lives and do not have	Integrated sexual health services: national service specification https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210726/Service_Specification_with_covering_note.pdf One to one interventions to reduce the transmission of sexually transmitted infections (STI)s including HIV, and to reduce the rate of under 18 conceptions,

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				The importance of collaborative working to deliver integrated services has been recognized in many guidance documents. Without proper resourcing (including funding) for integration, clinics end up trying to deliver integrated sexual health services without taking into account the complexity of the services they may provide. For example, many GUM clinics provide contraception (including complex contraception) but are paid the same tariff as for an STI screening attendance. Conversely many SRH services are funded under a block contract which does not take into account the nuances of complex service provision or that an individual who attends for contraception may have complex sexual health needs.	time to spend hours and days attending multiple different services. The cost of non-integration for individuals who attend services include unwanted pregnancy, untreated STIs and risk of onward transmission/complications, unnecessary time off work or school with potential loss of income or education/training. For clinical services, non-integration risks continuing inadequate provision of funding/resources to properly address the sexual health needs of their patients and means that they continue to provide services for which they are not or are inadequately funded.	especially among vulnerable and at risk groups www.nice.org.uk Making it work http://www.medfash.org.uk/uploads/images/file/Making_it_work_Annexes%20FINAL.pdf A quality standard for contraceptive services http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf
26	4.2	Royal College of Physicians	Patient involvement	Patient involvement can improve the quality of public health activities and the DoH and NICE are committed to involving service users in the shaping of services. Input by patients into the	Patient involvement in contraception services is inconsistent, likely because of the sensitivities involved in this area of healthcare and embarrassment at being identified as a user of SRH services.	User and carer involvement in service planning http://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4c-equality-equity-policy/user-carer-involvement Health and Social Care Act

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				services that they use enables services to be tailored around their needs and ensures that service providers can respond to these needs but also that they can address and resolve any misconceptions that service users may have about how services are run.		Public and patient involvement policy http://www.nice.org.uk/about/nice-communities/public-involvement/patient-and-public-involvement-policy http://www.legislation.gov.uk/ukpga/2012/7/part/5/chapter/1/enacted A quality standard for contraceptive services http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf
27	4.2	Bayer Plc	Health and wellbeing boards, including directors of public health, local public health leads and local authorities, should carry out and publish the results of comprehensive joint strategic needs assessments for young people's contraceptive services and use the data to establish collaborative, evidence-based commissioning arrangements to ensure comprehensive, open-access services.			
28	4.2	Public Health England	Access to the most effective long lasting contraceptives, all	To reduce unplanned pregnancies; priorities in the Public health Outcome	Intrauterine and subdemal contraceptives are in the top tier of effectivesness with additional health	Long-acting reversible contraception (update) (2005) NICE guideline CG30; the potential

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			health settings	Framework and the DH Framework for Sexual health Improvement in England.	benefits e.g. menstrual control.. Trussell J, Guthrie KA. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D, Policar M (eds). *Contraceptive Technology: Twentieth Revised Edition*. New York NY: Ardent Media; 2011. p. 45-74 alongside male and female sterilisation, hence effective in reducing unplanned pregnancy Access varies across the country http://fingertips.phe.org.uk/profile/health-profiles and Sexual and Reproductive Health Services, England - 2014-15 [NS] Publication date: October 14, 2015 http://www.hscic.gov.uk/searchcatalogue?productid=18929&topics=2%2fPublic+health%2fLifestyle%2fContraception&sort=Relevance&size=10&page=1#top Reduced access to services 2ndry to changes in commissioning has been flagged up. http://www.fsrh.org/pdfs/APPGSRHBreakingDowntheBarriersReport.pdf but addressable by whole system commissioning. commissioning https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf This approach in the USA saw unprecedented LARC uptake and reduction in teen conceptions; births, abortions, repeat abortions, unrelated to cost in further publications. Preventing Unintended Pregnancy:	reduction in unplanned pregnancy if LARC use increased. https://www.nice.org.uk/guidance/cg30 Contraceptive services for under 25s . NICE Guidelines PH51. http://www.nice.org.uk/guidance/ph51 FSRH Guidelines Contraceptive Choices for Young People. http://www.fsrh.org/pdfs/ceuGuidanceYoungPeople2010.pdf Intrauterine Contraception http://www.fsrh.org/pdfs/CEUGuidanceIntrauterineContraception.pdf Progestogen only implants http://www.fsrh.org/pdfs/CEUGuidanceProgestogenOnlyImplants.pdf Heavy Menstrual bleeding; assessment and management . NICE CG44https://www.nice.org.uk/guidance/cg44 Reducing unplanned pregnancies. A Framework for Sexual Health Improvement in England 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf . And PHOF to reduce teen conceptions.https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/400155/PHOF_at_a_glance_February_2015.pdf

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					The Contraceptive CHOICE Project in Review Natalia E. Birgisson, BS, Qiuhong Zhao, MS, Gina M. Secura, PhD, MPH,Tessa Madden, MD, MPH, and Jeffrey F. Peipert, MD, PhD JOURNAL OF WOMEN'S HEALTH Volume 24, Number 5, 2015	
29	4.2	Clinical Standards Committee - Faculty of Sexual and Reproductive Healthcare	Clinical Governance	To ensure that services continually monitor, evaluate and benchmark themselves to improve quality of care	To ensure that patients receive high quality care in whatever clinical setting in which they are seen Should be audit against FSRH Standards	A Quality Standard for Contraceptive Services , FSRH 2014 Service Standards for Sexual and Reproductive Healthcare FSRH 2013 Service Standards for record keeping FSRH 2014 www.fsrh.org
30	4.2	SCM4	Governance: Service providers should continually monitor and evaluate their performance and implement initiatives to maintain and improve outcomes.	This will ensure the highest quality of care is provided which is safe and effective.		FSRH Quality Standards at http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf
31	4.2	SCM4	The design and review of services should include input from the service users and the public.	To ensure that services are responsive to and meet the needs of the population they serve.		FSRH Quality Standards at http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf
32	4.2	Primary Care Women's	Contraceptive care wherever it is provided is monitored and	The profile of contraception care is undervalued and not included routinely in audits,	There is no current evaluation process of the care provided delivering contraception wherever that is delivered.	

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		Health Forum	evaluated.	monitoring, service improvements, benchmarking etc.	There is no standardised assessment of: provider qualifications, access to appointments, reporting structures, benchmarking data pathways etc. GP CQC assessments should include assessing who is providing care, referral pathways and user satisfaction.	
33	4.2	British Association for Sexual Health and HIV	Integration of sexual health and contraceptive services	The same factors that put individuals at risk of unwanted pregnancy put them at risk of sexually transmitted infections. It does not make sense that people who attend for contraceptive services should not have access to sexual health services in the same place and vice versa. The importance of collaborative working to deliver integrated services has been recognized in many guidance documents. Without proper resourcing (including funding) for integration, clinics end up trying to deliver integrated sexual health services without taking into account the complexity of the services they may provide. For example, many GUM clinics provide contraception (including complex	Requiring individuals who attend a service for one sexual health need (STI screening/treatment or contraception) to attend another service for another sexual need risks non-attendance at the other service and the potential for unwanted pregnancy and non-treatment/complications/transmission of STI(s). It also fails to recognize the fact that people lead busy lives and do not have time to spend hours and days attending multiple different services. The cost of non-integration for individuals who attend services include unwanted pregnancy, untreated STIs and risk of onward transmission/complications, unnecessary time off work or school with potential loss of income or education/training. For clinical services, non-integration risks continuing inadequate provision of funding/resources to properly address the sexual health needs of their patients and means that they continue to provide services for which they are not or are	Integrated sexual health services: national service specification https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210726/Service_Specification_with_covering_note.pdf One to one interventions to reduce the transmission of sexually transmitted infections (STI)s including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups www.nice.org.uk Making it work http://www.medfash.org.uk/uploads/images/file/Making_it_work_Annexes%20FINAL.pdf A quality standard for contraceptive services http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf

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				contraception) but are paid the same tariff as for an STI screening attendance. Conversely many SRH services are funded under a block contract which does not take into account the nuances of complex service provision or that an individual who attends for contraception may have complex sexual health needs.	inadequately funded.	
34	4.2	British Association for Sexual Health and HIV	Patient involvement	Patient involvement can improve the quality of public health activities and the DoH and NICE are committed to involving service users in the shaping of services. Input by patients into the services that they use enables services to be tailored around their needs and ensures that service providers can respond to these needs but also that they can address and resolve any misconceptions that service users may have about how services are run.	Patient involvement in contraception services is inconsistent, likely because of the sensitivities involved in this area of healthcare and embarrassment at being identified as a user of SRH services.	User and carer involvement in service planning http://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4c-equality-equity-policy/user-carer-involvement Health and Social Care Act Public and patient involvement policy http://www.nice.org.uk/about/nice-communities/public-involvement/patient-and-public-involvement-policy http://www.legislation.gov.uk/ukpga/2012/7/part/5/chapter/1/enacted A quality standard for contraceptive services http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf
35	4.2	SCM5	Additional	Nurse-led services are less	Cuts to public health funding make it	

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			developmental areas of emergent practice There is scope to increase the role of nurses in the provision of contraception, through use of patient group directions, nurse prescribing and nurse-led services	expensive whilst still providing all methods of contraception and can therefore increase provision and expand choice	crucial to deliver services in the most cost-effective way possible whilst maintaining quality of service.	
36	4.2	SCM6	Clinical Governance	It is important to ensure that everyone who is fitting LARCs is fitting according to FSRH standards and has up to date Letters of Competence, or an in-house/ local equivalent, which is updated every 5 years.		
37	4.2	SCM6	Integration of contraceptive services with STI/ sexual health services	Women should be able to address both their sexual health and contraceptive needs during one visit to a clinic or primary care facility.	Integration of sexual health and contraceptive services has been strategic aim of policy makers and commissioners for almost fifteen years. *"A whole range of professionals plays some part in sexual health services, but often they offer too narrow a service. This can mean that people have to make contact with several different services before they get all the care they need. For example, family planning clinics may provide an excellent contraception service but rarely offer comprehensive advice on avoiding, diagnosing or treating STIs"*. This is from The national	

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					strategy for sexual health and HIV (Department of Health 2001). Unfortunately, though almost fifteen years has passed since this document calling for greater integration was published, women are often still having to visit multiple services to have their needs met.	
38	4.2	NHS England		Capturing and responding to the experience of care fed back by users of services will improve patient outcomes and the effectiveness of the service delivered.	Not all services currently capture feedback on user experiences and can demonstrate actions taken as a result of this information in the design and delivery of services. Not all services have mechanisms for capturing feedback on experiences from seldom heard groups, for example young people who have learning disabilities who require contraceptive services.	The H&SC Act (2012) requires the system to involve people not only in the individual care but also in the design and delivery of services. The UN Convention on the Rights of the Child, Article 12 states that children and young people have the right to be involved in their care.
39	4.3	SCM1	Information about services available is clear for service users	This is one of the key reasons for the development of NICE Quality Standards. The information about how to access the correct service is not always readily available and if it is, there is no guarantee that it is correct. Consider that all services have the ability to have an online presence or be able to signpost to right service first time	People receiving health and social care services, their families and carers and the public to find information about the quality of services and care they should expect from their health and social care provider. Service users know what the options are for accessing services – right service first time approach (signposting to levels 1,2 or 3 – service users need to understand which methods are available at each service, including access to emergency hormonal contraception.)	www.nhs.uk - not all service information is correct Anecdotal evidence

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40	4.3	Royal College of Physicians	Access to appropriate choice of contraception	Individuals who are distrustful or intolerant of a contraceptive method are unlikely to continue to use it, putting them at risk of unwanted pregnancy, or in some cases, physical or psychological morbidity.	Many women are forced to accept a method of contraception that may be unsuitable because their service provider is unable to supply them with a method acceptable to them and fails to help them identify an easily accessible provider who is able to discuss and provide an satisfactory method.	Contraceptive services: What NICE says http://www.nice.org.uk/advice/lgb17/chapter/What-NICE-says NICE Guidance on LARC (CG30) http://www.nice.org.uk/guidance/cg30/chapter/introduction A quality standard for contraceptive services http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf
41	4.3	Public Health England	Linking the provision of emergency contraception to ongoing contraception	Emergency contraception gives every woman a 2nd chance (at avoiding an unwanted pregnancy) but she needs facilitation to move onto regular effective contraception. This is not the case other than pilot schemes where EC is provided by pharmacies/ bought over the counter/ provided by GPs who are not trained IUD fitters/ outreach contraception services. However, it is achievable by PGD supply of oral contraception and/ or but needs to be commissioned. condoms	To reduce unplanned pregnancies; priorities in the Public health Outcome Framework and the DH Framework for Sexual health Improvement in England. All contraception is effective, some contraceptives more than others. Trussell J, Guthrie KA. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D, Policar M (eds). *Contraceptive Technology: Twentieth Revised Edition*. New York NY: Ardent Media; 2011. This is easy in community clinics and general practice but less se in pharmacies. Emergency hormonal contraception; http://www2.sandyford.org/media/280325/3%20emergency%20hormonal%20contraception%20-%20michie.pdf OTC oral contraception: reducing unplanned pregnancies http://onlinelibrary.wiley.com/doi/10.1002/psb.935/pdf	Reducing unplanned pregnancies. A Framework for Sexual Health Improvement in England 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf . And PHOF to reduce teen conceptions.https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/400155/PHOF_at_a_glance_February_2015.pdf Emergency contraception http://www.fsrh.org/pdfs/CEUguidanceEmergencyContraception11.pdf Quick starting contraception http://www.fsrh.org/pdfs/CEUGuidanceQuickStartingContraception.pdf and after Ulipristal Acetate http://www.fsrh.org/pdfs/CEUStatementQuickStartingAfterUPA.pdf
42	4.3	SCM3	All local authorities and	*Sex, Lives and*	Access to the full range of contraceptive	*Sex, Lives and Commissioning*

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			CCGs must provide unrestricted access to all forms of contraception for people who need them including men, women and young people.	*Commissioning* identified that around one third of women aged between 15 and 44 in England don't have access to comprehensive contraceptive and sexual health advisory services An audit (*Sex, lives and commissioning II* A report by the Advisory Group on Contraception on the commissioning of contraceptive services in England)found evidence of commissioners applying restrictions in access to contraceptive services that would appear to be against national policy and clinical guidance The restrictions reported or identified did not necessarily reflect a city or borough-wide policy, but, in some instances, a policy for a specific service. Examples of the restrictions identified include services not being available to women over a certain age or because of their place of residence	methods at a location and time that meets the needs of the population is vital to minimise the risks and consequences of unintended pregnancy.	http://theagc.org.uk/wp-content/uploads/2013/11/Sex-lives-and-commissioning-April-2012.pdf Sex, lives and commissioning II A report by the Advisory Group on Contraception on the commissioning of contraceptive services in England http://theagc.org.uk/wp-content/uploads/2013/08/Sex-lives-and-commissioning-two-FINAL1.pdf
43	4.3	MSD	Ensure that	Choice of the most		8. The Royal College of

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			information/advice and contraception are provided at key touch points with the healthcare service - Emergency contraception/Post-partum/ Post termination	adequate contraception depends upon patient preferences and medical history. Comprehensive contraceptive services should ensure that advice and appropriate contraception are provided to all women at key touch points with the healthcare service - Emergency contraception/Post-partum/ Post termination. The Royal College of Obstetricians & Gynaecologists best practice paper states that immediately after surgical abortion is an optimal time to advise women of the greater effectiveness of long-acting reversible methods of contraception (LARC: implants and IUDs) and encourage them (but not coerce) to choose these contraceptive methods.[8]		Obstetricians & Gynaecologists. Best practice in comprehensive abortion care. Best Practice Paper No. 2 June 2015. Available at https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf [Accessed November 2015]
44	4.3	SCM4	Access to the full range of contraception including LARC	Report of the Advisory Group on Contraception (AGC) found that 3.2 million women aged between 15 and 44 experience restrictions in obtaining sexual health and contraceptive services. FSRH rolling survey of		FSRH survey, Primary Care Women's Health Forum survey, report of Advisory Group on Contraception (AGC), Unprotected Nation report

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				clinicians working in Sexual and Reproductive Health (SRH) corroborates this. Availability of the whole range will ensure that they are informed of the choice of options and are able to get the option of their choice.		
45	4.3	SCM1	Full range of contraception options available	There are a variety of contraceptive methods available depending on choice for women/partners – the choice may differ across the life course.	It would be easy for service providers to offer only a couple of contraceptive methods without offering women the full choice. Longer acting methods are the most cost effective if the method is used for a minimum of 1 year (NICE Guidance).	NICE Long Acting Reversible Contraception (CG30)
46	4.3	Bayer Plc	Contraceptive services should provide information about the full range of contraceptives available, including emergency contraception (both oral and intrauterine) and LARC, and the benefits and side effects.	This will help men and women make an informed choice about the method that best suits their individual needs and lifestyle, so making it more likely that they will use contraception and use it effectively.	Recent market research carried out among 1000 UK patients between April and May 2015 showed that patients aided awareness of LARC methods was still lower than that for combined oral contraceptives (COCs); for example that for the levenorgestrel containing intrauterine systems (IUS'), at less than 30% vs more than 80% for COCs.[1]	When developing this quality standard, consideration should also be given to the existing Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists (FSRH) Service Standards for Sexual and Reproductive Healthcare (2013),[2] and the FSRH Quality Standard for Contraceptive Services (2014).[3] 1. Bayer HealthCare. Data on file. Market research. August 2015 (available on request). 2. Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists. Service Standards for Sexual and

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						Reproductive Healthcare. January 2013. http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf (Accessed 01/12/2015) 3. Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists. A quality standard for contraceptive services. April 2014. http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf (Accessed 01/12/2015)
47	4.3	Bayer Plc	Contraceptive services should provide the full range of contraceptive methods, including LARC, condoms and emergency contraception either directly or by effective and timely referral pathways.	This is in line with NICE guideline recommendations that *"women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods"*, and that *"women should be provided with the method of contraception that is most acceptable to them, provided it is not contraindicated."*[4] Also with the Faculty of Sexual and Reproductive Health (FSRH) Service Standards for Sexual and Reproductive Health Services which includes that *"access to and availability of the full range of contraceptive methods*		When developing this quality standard, consideration should also be given to the existing Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists Service Standards for Sexual and Reproductive Healthcare (2013),[2] and the FSRH Quality Standard for Contraceptive Services (2014).[3] 2. Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists. Service Standards for Sexual and Reproductive Healthcare. January 2013. http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf (Accessed 01/12/2015) 3. Faculty of Sexual and Reproductive Healthcare of the

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				should be available and include choice within products, e.g. a range of different combined oral contraceptives and IUDs, to maximise patient acceptability". Also that *"services should provide comprehensive sexual and reproductive healthcare. This should include access to all methods of contraception…, and referral where in house services are not available."*[2]		Royal College of Obstetricians and Gynaecologists. A quality standard for contraceptive services. April 2014. http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf (Accessed 01/12/2015) 4. National Collaborating Centre for Women's and Children's Health. CG30 Long-acting reversible contraception. October 2005. http://www.nice.org.uk/nicemedia/live/10974/29912/29912.pdf (Accessed 01/12/2015)
48	4.3	Office for Sexual Health, South Gloucestershire Council	Open access and choice of contraception including emergency contraception is maintained for all women of a fertile age	• Local Authorities are mandated to provide comprehensive, open access contraception services but are under increasing financial pressure. This is exacerbated by inconsistent approaches to cross charging for contraception, which could impact ability to provide open access services. • Reducing unplanned pregnancies is an Ambition in the Department of health Framework for Sexual Health Improvement	Whilst under 18 and 16 conceptions have significantly reduced England continues to have the highest rates in Europe. NATSAL 3 estimates 16.2% of pregnancies are unplanned with 6% resulting in a birth and the framework for sexual health improvement suggests that up to 50% of pregnancies are unplanned with more recent data showing abortion rates in the over 35 age group is increasing. Abortion rates and repeat abortion rates are considered to be an indication of ineffective use of contraception, access issues or poor referral pathways. The NICE guidance 51 states that abortion in the under 25 age group 'demonstrates that many of these pregnancies are unwanted' and that young women are 'not getting access to effective methods	

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				• Reducing Under 18 Conceptions is a Public Health Outcome Indicator. • There is Local anecdotal evidence that access to contraception and choice of service in some areas is being restricted and capped with waiting lists for LARC procedures. • Department of Health best practice guidance on Commissioning Sexual Health services and interventions recognises that open access services are 'essential' to reducing unplanned pregnancies. • Reducing unplanned pregnancy can lead to savings for the Local Authority and the NHS	of contraception and advice about using contraception effectively' (p27). Ensuring open access and choice of service and contraception including emergency contraception is an important component in strategies to reduce unplanned pregnancy and sustain the progress in reducing under 18 conception rates. The pill continues to be the most used form of contraception although NICE guidance GC30 has showed that using LARC can be more cost effective and are more effective in pregnancy prevention than other hormonal methods. NICE public health guidance 51 advocates that women under 25 should have access to free emergency contraception and access to intrauterine devices for emergency contraception purposes but anecdotal evidence suggests intrauterine devices are not routinely available.	
49	4.3	Royal College of Nursing	Investigations for women who bleed on contraception	Women experiencing problematic bleeding on hormonal contraceptives. Looking at clinical assessments for underlying problems (e.g. Sexually Transmitted Infections) versus bleeding associated with	To maintain compliance and satisfaction	http://www.fsrh.org/pdfs/CEUGuidanceProblematicBleedingHormonalContraception.pdf

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				contraceptives.		
50	4.3	SCM3	Ensure women who have had abortions are given advice about contraception including LARC	According to National Statistics, in 2014, 37% of abortions were to women who had already had one or more abortions. Repeat unintended pregnancy and subsequent abortion is a complex issue associated with increased age as it allows longer for exposure to pregnancy risks. It is therefore not a problem for just women under 25.	One study has shown a higher rate of return for another abortion with longer time after the initial abortion and suggested this could be significantly reduced by use of long acting reversible contraception (LARC) soon after a first abortion, especially in younger women	National statistics. Abortion Statistics, England and Wales: 2014. London: Department of Health; 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/433437/2014_Commentary__5_.pdf Rose SB, Stanley J, Lawton BA. Time to second abortion or continued pregnancy following a first abortion: a retrospective cohort study. Hum Reprod. 2015;30(1):214-21.
51	4.3	British Pregnancy Advisory Service (BPAS)	Access to emergency contraception	Access to emergency contraception needs to be improved for women of all ages. Significant barriers exist to women's access to emergency hormonal contraception (EHC). As a healthcare provider that cares for women with unplanned pregnancies we know that women consider getting EHC but do not. If barriers are reduced or removed unplanned pregnancies may be prevented.	Women in England have three routes for accessing EHC: it is available via prescription from a GP, CASH clinic or A&E, via a Patient Group Direction (PGD), from locations participating in a local scheme, or they can purchase it from a pharmacy (OTC). However, each route can present challenges. The earlier it is taken, the more effective it is. However women can struggle to obtain a timely GP appointment, and even when the need for EC is stated, an appropriate appointment may still not be offered. CASH clinics have closed or have reduced opening times as a result of budget cuts, equally creating difficulties obtaining a timely appointment. At the same time, variation in both the provision and the eligibility criteria of PGDs for EHC mean the access women have to NHS-funded	Please see Open University research 'Young women's experiences of unintended pregnancy' which recommends providing an advance supply of EHC for women using user-dependent methods of contraception. http://www.open.ac.uk/health-and-social-care/main/files/hsc-pa/file/ecms/web-content/research-web-content/MSI_quali-report_final000000000.pdf

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					EHC from a local pharmacist may vary between local areas and be dependent on them being the 'right age' for their area's PGD. This means women may be expected to purchase EHC, however the costs of the P version of these products: Levonelle, Boots Emergency Contraceptive and EllaOne (up to £45) are prohibitive. It is worth noting that women in the UK are charged more than women anywhere else in Europe for OTC access. In addition, there is huge variation in what women are asked during a "consultation" with the pharmacist when obtaining EHC, with some women reporting intrusive and unnecessary questions. We are very concerned that the current framework for providing EHC acts as deterrent to women obtaining it. Given that at least a quarter of sexually active women rely on condoms as their main form of contraception, we must ensure access to EHC as a back-up when that method fails, or is not used properly, is straightforward and equitable. To promote best practice and address variation in access and quality of EHC, Public Health England should develop a national service specification for emergency contraceptive services and the use of Patient Group Directions for emergency hormonal contraceptives, promoting free access to women of all ages. Providers should be supported and	

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					incentivised to ensure appropriate awareness of how emergency hormonal contraception can be accessed for free, through a PGD, or on prescription. Local NHS commissioners should ensure there are no barriers to the prescribing of emergency hormonal contraception and put in place appropriate funding arrangements to support those community pharmacies who provide a full range of emergency contraceptives at a location and time convenient for women, and encourage more to do so where necessary. The Medicines and Healthcare products Regulatory Agency should explore, based on the well-established use, the possibility of placing methods of emergency hormonal contraception onto the general sales list to increase availability and ideally reduce the financial burden to women, and in turn the NHS.	
52	4.3	MSD	Ensure that all women of child bearing potential are given clear information/advice abo ut the full range of contraceptive methods available and how to use them effectively and consistently	The National Institute for Health and Clinical Excellence (NICE) Clinical Guidance (GC30) puts choice of method at the centre of good contraceptive care.[1] NICE recommendations advocate providing information and	England has the highest rate of teenage pregnancies in western Europe. The percentage of conceptions among women under 25 that end in abortion demonstrates that many of these pregnancies are unwanted.[5] This provides evidence that contraceptive services are failing to meet the needs of young people, who are not getting	1. National Institute for Health and Care Excellence. Long-Acting Reversible Contraception (CG30). October 2005. Available at https://www.nice.org.uk/guidance/cg30 [Accessed November 2015] 2. National Institute for Health and

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				advice on all types of contraception available, with focus on the most effective methods and how to use them effectively and consistently.[1,2] This guidance builds on The Framework for Sexual Health Improvement in England, which aims to reduce unwanted pregnancies by ensuring people have access to the full range of contraception and can obtain their chosen method quickly and easily.[3] Both NICE and the Faculty of Sexual & Reproductive Healthcare (FSRH) Quality Standards[4] recommend audit measures to monitor contraceptive service levels, that include "the number of women who have been offered information on contraception, including long-acting reversible contraception (LARC) methods."	access to effective methods of contraception and advice about using contraception effectively. The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPG) has also expressed concerned that restrictions in access to the full range of contraception are impeding people's ability to make an informed choice about their contraception; which goes against the principles of patient choice enshrined in the NHS Constitution.[6]	Care Excellence. Contraceptive services for under 25s (PH51). March 2014. Available at https://www.nice.org.uk/guidance/ph51 [Accessed November 2015] 3. A Quality Standard for Contraceptive Services. Faculty of Sexual and Reproductive Healthcare. April 2014. Available at http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf [Accessed November 2015] 4. A Framework for Sexual Health Improvement in England. DH and cross Government. March 2013. Avilable at https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england [Accessed November 2015] 5. Conceptions in England and Wales 2014. Office for National Statistics (ONS) February 2014. Available at http://www.ons.gov.uk/ons/dcp171778_353922.pdf [Accessed November 2015] 6. All-Party Parliamentary Group on Sexual and Reproductive Health in the UK. Healthy women, healthy lives? The cost of curbing access to contraception services. 2012. Available at http://www.fpa.org.uk/sites/default/f

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						iles/healthy-women-healthy-lives-full-report-july-2012.pdf [Accessed November 2015]
53	4.3	MSD	Ensure that all women of child bearing potential have access to a LARC fitter/administrator (directly or by referral) Ensure equity in access to contraceptive products within practice at the time of consultation.	The effectiveness of LARC methods has been shown to be superior to other types of birth control. These contraceptives have the highest rates of satisfaction and continuation of all reversible contraceptives; and have demonstrated to be cost saving.[1] Women under 25s are at high risk of unintended pregnancy and may benefit from increased access to LARC methods. Therefore, in cases where LARC fitting is not available (because of a lack of available trained staff) referral networks should be in place to ensure patients have reasonable/timely access to LARC.[2] Both NICE and FSRH recommend audit measures to monitor contraceptive service levels, that include "the uptake of LARC methods."	The NICE demonstrated that LARC is more cost effective than condoms and the pill, and if more women chose to use these methods there would be cost savings.[1] Moreover, LARC methods are recognised as being much more effective at reducing unplanned pregnancies than shorter-acting forms of contraception. It has been recognised that increased used of LARCs may help local areas to deliver one of the targets in the public health outcomes framework for health improvement—specifically, to reduce conceptions in women under 18 years (Department of Health).[7] However, the uptake of LARCs is still low, and this is often indicative of barriers to accessing services; particularly a lack of trained practitioners and lack of contraceptive products available within practice at the time of consultation.	7. Public health outcomes framework for England 2013 to 2016. London: DH, 2012. Available at www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency [Accessed November 2015]
54	4.3	MSD	Ensure that all women fulfil the criteria of eligibility for use of	Combined hormonal contraceptives (CHCs) are the most widely	Since publication of the UK Medical Eligibility Criteria for Contraceptive Use (UKMEC)	9. Lidegaard O, Lokkegaard E, Svendsen AL, *et al*. Hormonal contraception and risk of venous

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			combined hormonal contraception (UKMEC) before initiating this contraceptive method	prescribed contraceptive methods in the UK; however, their use is associated with significant cardiovascular risk for women with some medical conditions and risk factors.[9,10]	in 2006, a statistically significant reduction in the prescribing of CHCs to women with Category 3 or 4 risk factors has occurred. However, a large number of women with Category 3 or 4 risk factors are still prescribed CHCs. The increased risk of cardiovascular events is unnecessary for many of these women given the availability of alternative contraceptive methods.[11]	thromboembolism: national follow-up study. BMJ 2009;339:b2890. 10. van Hylckama Vlieg A, Helmerhorst FM, Vandenbroucke JP, *et al*. The venous thrombotic risk of oral contraceptives, effects of oestrogen dose and progestogen type: results of the MEGA case-control study. BMJ 2009;339:b2921. 11. Briggs PE, Praet CA, Humphreys SC, Zhao C.Impact of UK Medical Eligibility Criteria implementation on prescribing of combined hormonal contraceptives.J Fam Plann Reprod Health Care. 2013 Jul;39(3):190-6. doi: 10.1136/jfprhc-2012-100376. Epub 2013 Jan 7.
55	4.3	Primary Care Women's Health Forum	All women requiring contraception have access to all methods of contraception if clinically appropriate and to the information to make their choice .	Long-acting reversible contraception are more effective at reducing unplanned pregnancy than the user-dependant methods. It is essential that all women have access to provision of all methods of contraception, including LARC methods, whatever their age, place of residence or primary care provider. They are also entitled to make an informed choice by being provided with correct, uptodate evidence.	NICE clinical guidance on LARC (CG30) 2005 provided excellent evidence supporting the increased use of LARC methods. To achieve and maintain this priority requires women to be able to access the correct information to make their choice about their contraceptive method, access to trained providers who are able to insert the methods if clinically appropriate and financial arrangements for these to be provided. Contraceptive care is under prioritised in primary care despite most women receiving this for their GP practice. There is an urgent need to raise the profile by increasing the number of QoF	National Institute for Health and Care Excellence. Long-Acting Reversible Contraception (CG30). http://www.nice.org.uk/cg030

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					points and by including this in any CQC inspection.	
56	4.3	Terrence Higgins Trust Bristol and West	Preventing complications following administration of LARC			
57	4.3	British Association for Sexual Health and HIV	Access to appropriate choice of contraception	Individuals who are distrustful or intolerant of a contraceptive method are unlikely to continue to use it, putting them at risk of unwanted pregnancy, or in some cases, physical or psychological morbidity.	Many women are forced to accept a method of contraception that may be unsuitable because their service provider is unable to supply them with a method acceptable to them and fails to help them identify an easily accessible provider who is able to discuss and provide an satisfactory method. Provision of LARC is patchy and even if a LARC method is deemed to be suitable, it is often difficult for patients to get at appointment	Contraceptive services: What NICE says http://www.nice.org.uk/advice/lgb17/chapter/What-NICE-says NICE Guidance on LARC (CG30) http://www.nice.org.uk/guidance/cg30/chapter/introduction A quality standard for contraceptive services http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf
58	4.3	SCM5	Provision of all methods of contraception (including all LARC and emergency contraception methods) and service users are able to exercise choice	Young women should have the right to choose from the whole range of methods of contraception so that they can select the method which best suits their lifestyles and medical histories and which they are happy to use. Women are less likely to continue to use a method that doesn't suit their requirements or use it less effectively	Brook/FPA Xes: we can't go backwards campaign found that one of the explanations given for rating a service poorly was the inability to obtain their method of choice Evidence (Comres Survey for FSRH, 2015) suggests that some women continue to experience difficulties obtaining the contraceptive method of their choice. There are regional variations in how easily women can obtain their method of choice. Anecdotal evidence from Brook services suggests that access to professionals competent to fit IUT is limited in some	

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					areas, restricting access to the most effective method of emergency contraception.	
59	4.3	Clinical Effectiveness Unit (CEU) of the Faculty of Sexual and Reproductive Health (FSRH)	Ensure all women have access to the full range of contraceptive methods including emergency contraception.	Choice of contraceptive method is a personal decision. Provision may be restricted because of cost, out-dated evidence or lack of trained staff able to offer women the best possible advice and methods to suit them as individuals.	All women should be able to choose and commence the most appropriate method to suit them from the full range of methods, after receiving individual advice. This will improve uptake and continuation of contraception and reduce risk of unplanned pregnancies	FSRH. *Service Standards for Sexual and Reproductive Healthcare 2013*. Standard statement 2 on Service provision 2013 – Section 2.1 Contraception. http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf (accessed 30/11/2015)
60	4.3	Clinical Effectiveness Unit (CEU) of the Faculty of Sexual and Reproductive Health (FSRH)	Increase uptake of long acting contraception methods (LARC) in the UK population.	LARC methods, especially contraceptive implants and intrauterine contraception (vLARC), are associated with higher effectiveness than contraceptive pills, patches, rings and condoms.	All vLARC methods are cost-effective even if they are not used for their full duration. Use of vLARC methods reduces risk of unplanned pregnancy Including teenage pregnancy, abortions and repeat abortions.	NICE CG30: *Long-acting reversible contraception* https://www.nice.org.uk/guidance/cg30 (Accessed 01/12/2015) Cameron ST, Glasier A, Chen ZE, *et al.* Effect of contraception provided at termination of pregnancy and incidence of subsequent termination of pregnancy. *BJOG. 2012*;**119**:1074-1080. McNicholas C, Madden T, Secura G, *et al*. The contraceptive CHOICE project round up: what we did and what we learned. *Clin Obstet Gynecol. 2014*;**57**:635-643 Trussell J. Contraceptive failure in

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						the United States. *Contraception 2011* May;**83**:397-404. Trussell J, Hassan F, Lowin J, *et al*. Achieving cost-neutrality with long-acting reversible contraceptive methods. *Contraception. 2015*;**91:**49-56.
61	4.3	SCM6	Equitable Access to a broad range of contraceptive methods, including LARC.	*"The consistent and correct use of effective contraception is the best way for sexually active women and their male partners to avoid an unplanned pregnancy".* (Commissioning Sexual Health services and interventions, Department of Health, March 2013) *"There is a correlation between good contraception services and lowering rates of teenage conceptions"* (J Santelli et al, American Journal of Public Health, 2007)	We do not currently have universal, equitable access. Prior to the commissioning for much of contraception moving to local authorities in 2013, and continuing since, we see that emergency contraceptives are, in many areas, only free in some settings to women under 25 years of age. Now, with increasing financial strains on local authorities, and a lack of clarity over some areas of the relevant statute on open access services, we hear of clinics being commissioned to only see this younger age group too and/ or to only see residents of its geographical authority. Also, for over a decade effort and finance has gone into lowering teenage/ under 25s unplanned pregnancy and abortion rates. Broadly the success is significant with pregnancy, live birth, and abortion rates all lower. However, in over 25 cohorts we see 'stagnant' and rising numbers of unplanned pregnancies and abortions, including repeat abortion rates. It is undoubtedly likely that this is more than a coincidence.	

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62	4.3	SCM7		EllaOne- provision differs across the country. An example is that in Leicester city the local guidelines are that we can prescribe EllaOne from 72-120 hours but it is black listed from 0-72 hours regardless of timing in cycle.	After copper coil , EllaO is the most effective form of post coital contraception (compared to levonelle) at any stage in the cycle, and as such all patients should have equal access to this choice of PCC- with the usual proviso of trying to get them on to a more effective form of contraception to prevent further episodes of unprotected sex.	I have attached a talk that I gave in support of this initiative in January of 2015.- EllaOne presentation. As yet the situation has not changed.
63	4.3	SCM7		Early fit of iucd/ius post termination of pregnancy.	Prevention of repeat terminations in an at risk population. More likely to keep method longer term and if left may not return to have intrauterine contraception fitted. The FSRH guidance discussed post partum fitting- can this data /advice be extrapolated to post TOP?	Faculty guideline on intrauterine contraception april 2015. There is some data from Edinburough- a few years ago they looked at this issue but at present I cannot find the exact reference – will keep looking
64	4.3	SCM3	Ensuring young women under 25 are given advice about long acting reversible contraception	Long acting reversible contraception (LARC) has been shown to be cost effective in reducing unplanned pregnancies and offer reliable method of fertility control. NICE guidance was published in 2005 which recommended women should be given information about full range of contraceptive options including LARC if there are no contraindications for their use.	Abortion is the only measurable outcome that is related to unplanned and/or unwanted pregnancy. Abortion rates have reduced slightly over the last 10 years but women under 25 are over represented in the abortion figures. This has not has not changed between 2003 and 2013. There are opportunities to prevent the first and subsequent abortions with better access to effective contraception. However, the quality and outcomes framework (QOF) of the GP contract only concentrated on offering advice to women who request emergency contraception or are using oral	NICE guidance on long acting reversible contraception. http://www.nice.org.uk/guidance/cg30/chapter/1-Recommendations National statistics. Abortion Statistics, England and Wales: 2014. London: Department of Health; 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/433437/2014_Commentary__5_.pdf

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					contraception – this means LARC advice is given to women already motivated enough to consult to prevent unwanted pregnancy. Unlike the previous GP contract, there is so far no incentive to offer advice on effective contraception to all sexually active women of reproductive age.	
65	4.3	Royal College of Nursing	Adherence with quick starting post ellaone	There is new data suggesting that hormonal contraception should not be started for at least 5 days after using ellaone (ECH).	To improve effectiveness of emergency contraception	http://www.fsrh.org/pdfs/CEUStatementQuickStartingAfterUPA.pdf
66	4.4	SCM5	Staff attitudes and values	Staff attitudes are crucial to young people's willingness to use services. Young people want to be treated as equals by staff who demonstrate respectful and non-judgemental attitudes. Staff need to be trained to engage sensitively and confidently with young people.	Embarrassment and a fear of being judged remain deterrents to use of services. Staff who are easy to talk to is one of the most important aspects of a quality service to young people Staff need to understand how to manage sensitive consultations to safeguard young people from harm as well as enable them to enjoy positive sexual health	
67	4.4	SCM5	Ensuring services are perceived to be confidential in terms of polices, processes and environment	The importance of confidentiality in encouraging young people to use sexual health services cannot be overestimated and must feature prominently in all service advertising and be promoted in the service itself. In addition to	Young people consistently say that confidentiality is one of their top concerns when visiting a sexual health service and that worries about confidentiality are a major deterrent to service uptake.	

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				confidentiality policies services should address how confidentiality and privacy can be maintained through the physical layout of the service and in the way staff work with young people.		
68	4.4	Clinical Effectiveness Unit (CEU) of the Faculty of Sexual and Reproductive Health (FSRH)	Offer choice of contraceptive services for advice and provision, particularly for young people.	Many individuals, especially young people, may not be willing to attend their own GP for issues relating to contraception and sexual health. An alternative provider such as a community sexual and reproductive clinic is often perceived as being more confidential, friendlier and offering a wider range of contraceptive options. Such services may also offer more accessible opening hours.	The UK has one of the highest rates of teenage pregnancy and abortion in western Europe. Teenage pregnancy is associated with poor outcomes in terms of the baby's health, the mother's emotional health and wellbeing and the likelihood of both parent and child living in longterm poverty. Strategies to reduce teenage pregnancy include the provision of dedicated young people's clinics that are young person friendly and easily accessible.	NICE guideline. *Contraceptive Services for under 25s 2014* https://www.nice.org.uk/guidance/ph51/chapter/1-Recommendations (accessed 30/11/2015) Teenage Pregnancy Strategy: *Beyond 2010* https://www.education.gov.uk/consultations/downloadableDocs/4287_Teenage%20pregnancy%20strategy_aw8.pdf (Accessed 01/1/2/2015) Fullerton D, Burtney E. An overview of the effectiveness of sexual health improvement interventions: *Final Report. Edinburgh:NHS Health Scotland 2010*. http://www.healthscotland.com/uploads/documents/13786-REO28-OverviewEffectivenessSexualHealthInterventions.pdf

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69	4.4	SCM1	Targeted interventions for vulnerable groups	Vulnerable groups are identified in the Public Health Outcome Framework and in NICE Quality Standards for LAC, Public Health Guidance for Contraceptive Services for under 25's. To ensure those groups who are most vulnerable are able to access contraceptive services. Reducing inequalities. The services are available to vulnerable groups, which addresses all needs in one place. The practitioners are available with the knowledge, skills and competencies to meet the needs of the vulnerable person (pregnancy options, sub-dermal implants, etc..)	With a reduction in Public Health funds available it is important that those who are disadvantaged or vulnerable in society are given access to services that meet their specific needs. Being able to offer contraception plus screening for chlamydia and HIV at one clinic will enhance the service available and allow for early detection of chlamydia and HIV (level 2 services) Increasing incidences of child sexual exploitation – priority area for local safeguarding children's boards/police and other multi-agencies. Need to ensure these young people have access to expert contraceptive services – the need to be flexible to meet their needs linked to times of access, venue, specialist practitioners. Increasing opportunities for discussion points with vulnerable/targeted groups	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf Public Health Outcomes Framework – 3 priority areas: under 18 conceptions; chlamydia diagnoses in 15-24 year old; late HIV diagnoses https://www.nice.org.uk/guidance/qs31 Quality standards for looked after children with 'The aspiration is that looked-after children and young people receive services when needed and should not be subject to delays in access'. Looked After Children and Young People (PH28) Behaviour change: individual approaches (PH49) Contraceptive services for under 25s (PH51) Teenage Pregnancy Knowledge Exchange Previous Teenage Pregnancy Strategies and conception data
70	4.4	Clinical Standards Committe	Ensure all contraceptive services have robust safeguarding	To ensure safeguarding of all service users	To embed risk assessment in all contraceptive service to maximise patient safety. In particular there is Guidance on assessment of Child	Service Standards for Consultations in SRH , FSRH 2015 Spotting the Signs national Pro-forma Brook /BASHH

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		e - Faculty of Sexual and Reproductive Healthcare	procedures		Sexual exploitation, female genital mutilation, assessment of consent and mental capacity and assessment of gender based abuse/ domestic violence	Female Genital Mutilation Risk and Guidelines DH 2015 Service Standards in Obtaining valid consent FSRH 2015 www.fsrh.org
71	4.4	SCM7		Contraception in HIV positive individuals		
72	4.5	British Pregnancy Advisory Service (BPAS)	Improve access to post-natal contraception	BPAS counsels more than 70,000 women a year with unplanned pregnancy or a pregnancy they feel they cannot carry to term. We regularly see women experiencing an unplanned pregnancy in the year after giving birth.	Research presented last year at the European Society of Contraception and Reproductive Health found that around 10% of women presenting with unplanned pregnancy at one NHS clinic had given birth in the last 12 months. In this study, unplanned pregnancy within a year of birth was significantly more prevalent than after abortion within the same space of time. • Women should be informed that if they are not breastfeeding contraceptive protection is required from day 21 after the birth if pregnancy is to be avoided and provided with information about all contraceptive options available, including when breastfeeding provides contraceptive cover and the criteria that should be met for it to work effectively, as well as what contraception can be used while breastfeeding. • It should be recalled that it may be more than a year since a woman last used contraception, that the method she was using may have let her down, and that a method which may	Please see BPAS research on women's experiences 'Sex and Contraception after Childbirth' https://www.bpas.org/media/1187/sex-and-contraception-after-childbirth.pdf NICE guidance 'Post-natal care up to 8 week after birth'. http://www.nice.org.uk/guidance/cg37/chapter/1-recommendations#maternal-health

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					have suited her then may not suit her with a new baby. This means it is important that she has access to comprehensive information about all the methods available – including rings and patches, which could be a good option for women in between babies who do not want a daily pill but are reluctant for take on a long acting form. The NICE guidance on post-natal care up to 8 weeks after births states that 'Methods and timing of resumption of contraception should be discussed within the first week of the birth', however this may not be the most period appropriate to discuss contraception for all women. Discussion and provision of information in the antenatal period when women have more time to think about their options may be useful. • Greater understanding of how mode of delivery influences resumption of sex may enable healthcare professionals to time the provision of contraception information and support more effectively, while recognising that every woman will have her own personal needs. • The last midwife home visit at 10 days, when the health visitor takes over care, may be a particularly opportune moment, but it also appears many women would value the offer of a discussion during various interactions with healthcare professionals in the first year. • If women have made	

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					their mind up about their contraception in the antenatal period, it would be ideal if these could be provided before she leaves hospital. Midwives who wish to take on a role in the provision of contraception, and in particular long acting reversible forms, would require on going training and support. This would necessitate closer links between maternity services and sexual and reproductive health services, which at the very least might also make it easier for midwives to refer women directly for contraception appointments, which many women would appreciate. Emergency Hormonal Contraception (EHC) is a safe and effective back-up for women when their regular contraception fails or has not been to hand. The Levonelle morning-after-pill can, as noted, be safely used by breastfeeding women up to 72 hours after an episode of unprotected sex. Consideration should be given to the advance provision of EHC to new mothers in order that women have it at home if and when they should need it.	
73	4.5	Public Health England	Post pregnancy contraception; maternity, abortion and early pregnancy loss	Women are open to prevention of a mistimed or unwanted pregnancy at the time of an existing pregnancy when they have interaction with health care professionals who could inform/ provide yet - contraception with	• High abortion rates compared to the rest of Western Europe. http://www.johnstonsarchive.net/policy/abortion/ as are teen births http://www.ons.gov.uk/ons/rel/vsob1/births-by-area-of-usual-residence-of-mother--england-and-wales/2012/sty-international-comparisons-of-teenage-pregnancy.html	Long-acting reversible contraception (update) (2005) NICE guideline CG30; the potential reduction in unplanned pregnancy if LARC use increased. https://www.nice.org.uk/guidance/cg30 Unplanned pregnancy; 1. Wellings K, Jones KG,

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				abortion is not always commissioned, ovulation has been shown to occur within one month of first trimester abortion in over 90% of women. - contraception with early pregnancy loss is not commissioned (not in NICE guidance) and is required because a) not all early pregnancy losses are planned pregnancy and b) management of ectopics with methotrexate means pregnancy avoidance for 3 months and women who have suffered gestational trophoblastic disease should avoid pregnancy for 6 months and c) pre-conceptual care for the next pregnancy should be addressed and timing of the next pregnancy may	• DH abortion statistics reveal the number of women who have abortions yet have previously had maternity / abortion/ pregnancy loss care where there was an opportunity for contraceptive education and provision. (e.g. https://www.gov.uk/government/statistical-data-sets/abortion-statistics-england-and-wales-2014) Particularly relevant stats for women under 19 and under 25. Unwanted pregnancy leads to mental health problems. (http://www.aomrc.org.uk/doc_view/9432-induced-abortion-and-mental-health) Every £1 spent on contraception saves the NHS £11 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-) and cost to the NHS (Montouchet C, Trussell J. Unintended pregnancies in England in 2010: costs to the National Health Service (NHS). Contraception 2013;87: • 149–53.) no ROI work on savings to social care/ justice system other than FPA document Unprotected Nation (not peer reviewed). http://www.fpa.org.uk/influencing-sexual-health-policy/unprotected-nation-2015 • Post partum contraception; strong argument for moving delivery of this from the post natal delivery to birth. Glasier AF, Logan J, McGlew TJ. Who gives advice about postpartum contraception?	Mercer CH, Tanton C, Clifton S, Datta J, Copas AJ, Erens B, Gibson LJ, Macdowall W, Sonnenberg P, Phelps P, Johnson AM. Unplanned pregnancy in Britain: prevalence, associated factors and context; findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal 3). *Lancet*. 2013; 382: 1807-1816.http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2962071-1/fulltext 2. Lakha F, Glasier A. Unintended pregnancy and use of emergency contraception among a large cohort of women attending for antenatal care or abortion in Scotland. Lancet 2006;368:1782–7. Aiken AR, Aiken CE, Trussell J, Guthrie KA. Immediate postpartum provision of highly effective reversible contraception. BJOG 2015; • 122(8):1050–1. • To reduce unplanned pregnancies; A Framework for Sexual Health Improvement in England 2013 https://www.gov.uk/government/upl

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				require contraception in the interim NATSAL 3 reported of deliveries, 6% were unplanned, 28% ambivalent and 66% were planned pregnancies. Contraceptive information given is highly variable and interventions are not commissioned from maternity services. By the 6 week post natal visit, up to 60% of women have resumed sexual intercourse by 6 weeks after childbirth. In non-breastfeeding women, ovulation has been reported as early as 25 days post-delivery. DH abortion statistics reveal the number of women who have abortions yet have previously had maternity / abortion/ pregnancy loss care where there was an opportunity for contraceptive education and provision.	*Contraception* 1996;**53**:217–20. • The reduction in teen conceptions is a public health outcome indicator https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/400155/PHOF_at_a_glance_February_2015.pdf • • All contraception is effective, some contraceptives more than others. Trussell J, Guthrie KA. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D, Policar M (eds). *Contraceptive Technology: Twentieth Revised Edition*. New York NY: Ardent Media; 2011. Choices project in the USA saw unprecedented LARC uptake and reduction in teen conceptions; births, abortions, repeat abortions, unrelated to cost in further publications. Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review Natalia E. Birgisson, BS, Qiuhong Zhao, MS, Gina M. Secura, PhD, MPH,Tessa Madden, MD, MPH, and Jeffrey F. Peipert, MD, PhD JOURNAL OF WOMEN'S HEALTH Volume 24, Number 5, 2015 LARC at termination reduces repeat abortion rates. Effect of contraception provided at termination of pregnancy and incidence of subsequent termination	oads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf . • And PHOF to reduce teen conceptions.https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/400155/PHOF_at_a_glance_February_2015.pdf UKMEC support post partum contraceptive use and outlines the current *UK Medical Eligibility Criteria for Contraceptive Use* (UKMEC)[21] which applies to postpartum women (breastfeeding and non-breastfeeding). http://www.fsrh.org/pdfs/UKMEC2009.pdf NICE Guideline post natal care CG37. Post natal care up to 8 weeks after birth https://www.nice.org.uk/guidance/cg37

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					of pregnancy Cameron, S. T., Glasier, A., Chen, Z. E., Johnstone, A., Dunlop, C. & Heller, R. Aug 2012 In : BJOG: An International Journal of Obstetrics and Gynaecology. 119, 9, p. 1074-80 The risk of a woman who has had an abortion and presenting for another abortion is associated with the type of contraceptive method she uses post abortion. Observational studies from a number of countries have reported that women provided with LARC methods immediately after abortion have a significantly reduced likelihood of having another abortion in the next year or two compared with women provided with medium-acting, short-acting or no methods. e.g. Rose SB, Lawton BA. Impact of long-acting reversible contraception on return for repeat abortion. Am J Obstet Gynecol 2012;206:37.e1–6. doi:10.1016/j.ajog.2011.06.102 Poatnatal Sexual and Reproductive Health http://www.fsrh.org/pdfs/CeuguidancepostnatalI09.pdf	
74	4.5	Royal College of Nursing	Commissioners to fund the full range of contraception at termination of pregnancy	To prevent further pregnancies	There is evidence that by not funding all methods of contraception at the time of termination, any interval before contraception is started increases the chance of further unplanned pregnancy	RCOG, 2011, Care of women requesting induced abortion. P81-84 https://www.rcog.org.uk/en/guidelines-research-services/guidelines/the-care-of-women-requesting-induced-

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						abortion/
75	4.5	Terrence Higgins Trust Bristol and West	Ensuring Access to full range of contraception within other services i.e midwifery services, ToP, drugs and alcohol			
76	4.5	SCM6	Postnatal contraception	With links to the equitable access issue, there are specific needs of quality of service in delivering to the contraceptive needs of women postnatally.	There is confidence that tackling the issue of contraception for women postnatally will lower rates of unintended pregnancy and abortions for women. Contraception advice should also be a key element of supporting couples in planning their family and the intervals they wish to see between planned pregnancies. It is important that midwives (and/ or perhaps health visitors) receive education on contraception, with regular updates, aligned to (potentially provided by) the local sexual and reproductive health services. There should be a antenatal contraception discussion and plan made for postnatal contraception, and ideally method given/fitted when patient leaves maternity unit or IUD/IUS fitted post-delivery (at LSCS or post vaginal delivery).	
77	4.5	Public Health England	Contraception included in all NICE Clinical Guidance	If women have medical conditions, planning a pregnancy may well be critical to the wellbeing of mother and child mental and physical health; (pre-conceptual care) plus contraception may interfere	Every child deserves the Best Start in Life because of subsequent poor quality of life and health and social care http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/give-every-child-best-start-life Poorly timed/ unplanned pregnancy	Why Should we Consider a Life Course Approach to Women's Health Care? Scientific Impact Paper No. 27 August 2011 RCOG https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_27.pdf and life course approach within A

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				with treatment, medication and vice versa, and medication may risk fetal abnormality. Appreciate this may sound very generic but 50% of the population are women, vast majority spend 30 years of their lives avoiding pregnancy and there is an impact of some sort where there are co-morbidities. Guidance does not need to include details but the need to address this aspect of care should be raised because sexuality is not something patients raise due to embarrassment. Nothing in Ectopic pregnancy and miscarriage https://www.nice.org.uk/guidance/cg154 or management of type 2 diabetes http://www.nice.org.uk/guidance/cg87/evidence/cg66-full-guideline-243645375 or chronic kidney disease http://www.nice.org.uk/guidance/cg182/evidence/update-full-guideline-191905165 Obesity Identification, assessment and management of overweight and obesity in children, young people and adults http://www.nice.org.uk/guidance/cg189/evidence/obesity-	affects women's health and may lead to abortion due to risk to maternal health. Clause A+B: 260 cases in 2014. Ground A= A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated (Abortion Act, 1967 as amended, section 1(1)(c)). Ground B= B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman (section 1(1)(b)) https://www.gov.uk/government/statistical-data-sets/abortion-statistics-england-and-wales-2014 All contraception is effective, some contraceptives more than others. Trussell J, Guthrie KA. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D, Policar M (eds). *Contraceptive Technology: Twentieth Revised Edition*. New York NY: Ardent Media; 2011.	Framework for Sexual Health Improvement in England 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf . This document also had the ambition; AMBITION: Reduce unwanted pregnancies among all women of fertile age • Increase knowledge and awareness of all methods of contraception among all groups in the local population. • Increase access to all methods of contraception, including long-acting reversible contraception (LARC) methods and emergency hormonal contraception, for women of all ages and their partners. UK Medical Eligibility Criteria for Contraceptive Use http://www.fsrh.org/pdfs/UKMEC2009.pdf Preconception care to reduce maternal and childhood mortality and morbidity Meeting report and packages of interventions:WHOhttp://www.who.int/maternal_child_adolescent/documents/concensus_preconception_care/en/

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				update-full-guideline-193342429		
78	4.5	Clinical Standards Committee - Faculty of Sexual and Reproductive Healthcare	Safety of Contraceptive Services	Contraceptive services should ensure patient safety	All services must have appropriate resuscitation equipment , chaperones available for intrauterine instrumentation (in case of collapse) and a comprehensive risk assessment must be undertaken for all services provided and procedures performed	Service Standards for Risk management , FSRH 2014 Service Standards for Resuscitation FSRH 2014 Service Standards for Sexual and Reproductive Healthcare FSRH 2013 www.fsrh.org
79	4.5	Terrence Higgins Trust Bristol and West	Contraceptive services as pathway for identifying Domestic Violence and CSE	Rates of DV in heterosexual relationships underreported. Rates of DV in LGBT relationships disproportionately under reported.	Lack of service provision for LGBT DV when reported, screening inadequate.	http://www.endthefear.co.uk/information/help-and-advice/same-sex-domestic-abuse/
80	4.5	Nottingham University	Risks of facilitating child abuse which can occur when providing contraception to minors.	Child sexual abuse is a significant issue in many settings and many parts of the country. There is now significant evidence that provision of sexual health services to minors under existing guidelines has contributed to a general culture in which underage sexual activity linked to abuse is not challenged effectively. An improvement to this Quality Standard could help to reduce the risk that the	At least 5 serious case reviews investigating the causes of child sexual abuse have highlighted ways in which the provision of sexual health services to minors has contributed to abuse being unchallenged and/or has contributed to a culture in which there is professional tolerance of underage sexual activity which may include abuse. Several specific points from the various reviews are worth noting. The 2015 Oxfordshire Serious Case Review, found evidence of “confusion related to a national culture where children are sexualised at an ever	Oxfordshire Safeguarding Children Board, “Serious Case Review into Child Sexual Exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E, and F”, 26th Feb, 2015, www.oscb.org.uk/wp-content/uploads/SCR-into-CSE-in-Oxfordshire-FINAL-FOR-WEBSITE.pdf • Rochdale Borough Safeguarding Children Board , “The Overview Report of the Serious Case Review in respect of Young People 1,2,3,4,5 & 6”, 20th Dec, 2013,

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				provision of contraceptive services perpetuates abuse. Two improvements in particular are necessary: (i) The Quality Standard should require health professionals to undertake a risk assessment for abuse for any minor who is being provided with contraception or abortion. (ii) The Quality Standard should make clear to health professionals that minors under the age of 16 should rarely if ever be considered mature enough to consent to sexual activity.	younger age and deemed able to consent to … contraception long before they are able legally to have sex. A professional tolerance to knowing young teenagers were having sex with adults seems to have developed." (Section 1.3). In relation to the Fraser Guidelines, the Review also criticises "health guidance which determines a child's ability to consent to sexual health advice and get contraception for an act which the child might be legally unable to consent to. The law regards underage sex between peers over 13 as not something that should have any intervention, and it is not much more of a step to see sex between say a 14-year-old and a young adult as 'one of those things'." (Section 8.52). • The 2013 Torbay Serious Case Review makes the important point that, "Underage sexual activity by young people between thirteen and sixteen years old is judged on the perception that if it takes place with partners of a similar age, it is by mutual consent. This perception has to be reconsidered in light of the growing evidence in this case that the abusers were not much older than the girls and also that the girls, who often did not consider that they were being abused, lied about the age of their partners as they were aware of the potential professional response."	www.rochdaleonline.co.uk/uploads/f1/news/document/20131220_93449.pdf Rochdale Borough Safeguarding Children Board, "The Overview Report of the Serious Case Review in respect of Young Person 7", 20th Dec, 2013, www.rbscb.org/UserFiles/Docs/YP%207%20SCR%20RBSCB%2020.12.13.pdf Torbay Safeguarding Children Board, "Torbay Serious Case Review C26", 2013, www.torbay.gov.uk/c26executivesummary.pdf Thurrock Local Safeguarding Children Board, "Serious Case Review: "Julia"", 2014 www.thurrocklscb.org.uk/app/download/16506679/Thurrock+Julia+SCR.pdf

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					The review also criticises the Fraser guidelines and Gillick Competencies arguing that, “There appears to be a need to review current national guidelines to examine if they are sufficiently robust to account fully for the growing evidence around sexual activity and its links to sexual exploitation.” (section 5.12). Similar issues were raised by the 2013 Rochdale Serious Case Reviews (see for example, Section 4.3.2 of the Review of Young People 1-6) The Thurrock Serious Case Review, states: “There is a pattern whereby national and local policy agendas have driven practice in relation to underage sexual activity to have a stronger focus on sexual health and teenage pregnancy rather than sexual abuse/exploitation” (Finding 1). Further, section 3.13 states: “Although this policy guidance now makes clear that all professionals providing sexual health advice must be aware of child protection and safeguarding issues as well as having guidelines and referral pathways in place for risk assessment and management of child sexual abuse, there remains a potential contradiction between the responsibility to address sexual exploitation and promote positive sexual health.”	

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					The Thurrock Review explains how the current guidelines had meant that health professional failed to intervene to stop the abuse of “Julia”. Following disclosure that “Julia”, had been raped on several occasions, “Julia” was assessed at the age of 13 as “Gillick Competent under the Fraser Guidelines” and “was provided with condoms”. The Review reports that “Julia” sought sexual health advice on “numerous occasions” and “on each occasion there was a stronger professional focus on advice-giving rather than exploring issues of consent and abuse.” • The Rochdale Serious Case Review for people 1-6 similarly identifies a situation where a pregnant and vulnerable 14 year old discussed the option of a termination having reported that she had had sex with a man considerably older than her “but there is no evidence that the fact that this 14 year old girl had had sex with a man considerably older than her was pursued any further.” (Section 4.3.29). She subsequently presented for a termination but the Report finds “no evidence that consideration was given to safeguarding concerns “ (Section 4.3.30) Given the disturbing evidence presented in these reviews, it is clear that there is a systematic problem in the provision of contraception and abortion to minors at	

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					the moment. The quality standards should make clear to health professionals that children under the age of 16 should rarely if ever be considered mature enough to consent to sexual activity. Further, the quality standards should insist that any minor presenting for contraception or abortion should be formally assessed for risk of sexual abuse.	
81	4.5	SCM1	Standards of qualification/competence required for practitioners working in all aspects of contraceptive care (Levels 1,2 and 3)	To ensure a standard approach to expected levels of competence/training/qualifications of the professional delivering the care. The quality standard could recommend the level of qualifications for the multi-disciplinary approach to delivery of contraceptive services – this would be auditable and allow services to monitor their quality against the standards and allow commissioners to have measurable standards for their key performance indicators. Patients are supported by healthcare professionals who understand all relevant	There are currently no national standards of education/qualification/competence for Nurses as there is no national body with a responsibility for this. There are some standards from Faculty of Sexual and Reproductive Health but this uses a very medical modelled approach and requires practitioners to be a member of their organisation in order to gain letters of competence for long acting methods of contraception/diploma This excludes many Nurses (across all levels of services) due to cost of joining and annual fee required plus cost per course/letter of competence achieved and cost to maintain this every 5 years. Need to work with Health Education England to ensure there are programmes of education to meet the expected qualification/competency	http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf - page 8

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				treatment options, including benefits, risks and potential consequences – having the knowledge, skills and competency to supply/administer the agreed contraceptive.	standards to allow for suitable courses to be commissioned.	
82	4.5	Royal College of Physicians	Staff training	High quality services cannot be delivered without adequate numbers of appropriately trained staff.	The skill-mix in many services providing contraception is not appropriate to the diversity (or lack thereof) of the users of the service meaning that the needs of patients are not addressed or the skills of staff are underutilized.	A quality standard for contraceptive services http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf Liberating the NHS: developing the healthcare workforce https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216421/dh_132087.pdf
83	4.5	Office for Sexual Health, South Gloucestershire Council	LARC Training and CPD	• Ensuring health professionals responsible for providing advice and provision of contraception are up to date with new products and or clinical practice is essential in ensuring all women have access to the full range of contraception methods. • That those working with high risk or	NICE Guidance 51 recommends training and continuing professional development across the workforce and makes specific reference to staff being able support high risk or vulnerable groups. Anecdotal evidence suggest that better governance for implant insertions may be needed as some health professionals encounter a large number of deep removals, which could indicate the need for improved training. Myths about using intrauterine devices being unsuitable for younger women persist and concerns about GPs refusing contraception to under 16s have been	http://www2.gre.ac.uk/__data/assets/pdf_file/0009/793179/D8153-13_LARC_Full_Report_WEB.pdf

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				vulnerable groups are able to respond to their contraceptive needs appropriately.	raised. Ensuring the workforce understands confidentiality and the Frazer Guidelines is essential in ensuring timely access to contraception for those seeking it. NHS and University of Greenwich Research 'Understanding LARC Adherence: An in-depth investigation into sub-dermal implant removal among young women in London' found that women had not been adequately informed about side-effects, that's post fitting support could be improved and young women experienced resistance to removal when they could no longer tolerate the side effects. Inadequate information pre insertion and resistance to removal could result in women disengaging in contraception use. Ensuring consistent, robust training for LARC and effective CPD for the established workforce can reduce complications, increase choice of contraception and ensure best practice is implemented.	
84	4.5	Royal College of Nursing	Funding for training and development for staff working in integrated sexual health and contraception clinics. To increase number of nurses with qualifications in this specialist area	The need for integrated services and training so Nurses can deliver both sexual health and contraception provision. The Faculty of Sexual and Reproductive Health Diploma is now suited for both doctors and nurses working in this area.	An integrated service model aims to improve sexual and reproductive health outcomes by providing easy access to services where the majority of sexual health and contraceptive needs can be met at one site	www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf http://www.fsrh.org/pages/Diploma_of_the_FSRH.asp

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85	4.5	Clinical Standards Committee - Faculty of Sexual and Reproductive Healthcare	Ensuring that all staff providing contraceptive care are appropriately qualified and are led by Consultants in Sexual and Reproductive Healthcare	To ensure that all providers have knowledge of all available contraceptive methods, be appropriately qualified to perform LARC procedures and have broad knowledge of sexual and reproductive healthcare to perform a holistic needs assessment	It would ensure maximum patient choice and safety Holistic care can be provided with opportunities to perform opportunistic care e.g. sexual health testing , cervical screening	A Quality standard for Contraceptive Care, FSRH 2014 Service Standards for Sexual and Reproductive Healthcare FSRH 2013 www.fsrh.org
86	4.5	SCM4	Staff should be trained and competent with appropriate leadership	Leadership of Contraceptive/ SRH services is variable esp in Integrated services and it is important to ensure that the services are consultant led. Also staff should be trained for the level of service they provide eg Implants		FSRH Service Standards at http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf NICE guidance on LARC CG30
87	4.5	Primary Care Women's Health Forum	All health care and allied health care professionals delivering contraceptive care, wherever it is delivered, have appropriate standardisation of competencies.	Contraceptive care, wherever it is delivered, must be provided by clinicians who are skilled to do so. All clinicians must be qualified and updated to deliver the level of care that they are providing. Where specialist care is required there must be referral pathways in place to allow access to the specialist provider in a timely manner.	Contraceptive care is delivered from a number of providers including SRH services, primary care providers, pharmacists, school nurses, abortion providers and others. The nationally recognised qualifications are recommended by the Faculty of Sexual and Reproductive Healthcare; including DFSRH, and the Letters of competence. 80% of contraception is currently provided from primary care with the majority delivered by practice nurses. As the pressure on primary care appointments increases, with extra	FSRH A Quality Standard for Contraceptive Services. http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf

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					demand and the focus on admission avoidance and long-term condition management, training for providing contraception by GPs and their practice nurses is not considered to be a priority. There is no current standardisation of training or competence levels these providers are required to have. There is an urgent need to standardise competencies to ensure safe delivery of care.	
88	4.5	Terrence Higgins Trust Bristol and West	LARC Training and CPD			
89	4.5	British Association for Sexual Health and HIV	Staff training	High quality services cannot be delivered without adequate numbers of appropriately trained staff.	The skill-mix in many services providing contraception is not appropriate to the diversity (or lack thereof) of the users of the service meaning that the needs of patients are not addressed or the skills of staff are underutilized.	A quality standard for contraceptive services http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf Liberating the NHS: developing the healthcare workforce https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216421/dh_132087.pdf
90	4.5	SCM5	Ensuring sufficient numbers of trained staff, who are competent to provide all methods and who have access to continuing professional development	Shortage of appropriately qualified staff and lack of ongoing training for existing staff is a barrier to high quality service provision.	There is evidence of services struggling to recruit staff with specialist post-graduate sexual health qualifications Staff need to be trained and competent to deliver all methods of contraception to improve access and maintain choice of method.	

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					Skilling up nurses to fit implants and IUT increases the availability of these LARC methods Availability of recognised trainers to support staff to acquire Letters of Competence to fit implants and IUT is variable across the country	
91	4.5	Clinical Effectiveness Unit (CEU) of the Faculty of Sexual and Reproductive Health (FSRH)	Ensure that all services that offer contraception in the UK are staffed by appropriately trained healthcare professionals. Training of staff for insertion of vLARC methods needs to increase within primary care and other settings such as abortion facilities and in hospital for women immediately following childbirth.	Staff who counsel and prescribe contraception to women should have received appropriate training and be re-accredited according to national standards. In particular, insertion of contraceptive implants and intrauterine contraception requires particular training and skills that must be properly accredited according to national standards.	As contraception is now increasingly prescribed by non-medical healthcare professionals, it is important to ensure that all providers are trained to high standards and remained accredited by national programmes similar to those which are undertaken by doctors.	FSRH. *A Quality Standard for Contraceptive Services April 2014*. http://www.fsrh.org/pdfs/FSRHQualitySta ndardContraceptiveServices.pdf (accessed 30/11/2015) FSRH. *Service Standards for Sexual and Reproductive Healthcare 2013*: Service Standard 6 – Standard statement on Training. http://www.fsrh.org/pdfs/All_Service_stan dards_January_2013.pdf (accessed 30/11/2015)
92	4.5	SCM7		Dianette (co-cyprindiol) Licence and thrombotic risk	Guidance re ongoing use under specialist care when acne is severe and not responded to oral antibiotics.	Significant concerns re thrombosis risk. Some countires (France and Canada) have banned this drug. But- significant improvement in acne in some patients- then very reticent to stop despite warnings.
93	General	SCM1	Additional evidence sources for consideration	Alison Hadley – previously Teenage Pregnancy Lead for Department of Health – now lead Teenage Knowledge Exchange with Bedford University:		

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94	General	Royal College of Physicians	General	General	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with experts in genitourinary medicine and would like to make the following comments:	N/A
95	General	Bayer Plc	General	We agree that the quality standard should cover young people (under 25) *and adults*. Including *all* women of child bearing potential, and young people under 16 who are competent to consent to contraceptive treatment. This is consistent with the ambition of the Department of Health 'Framework for Sexual Health Improvement in England' (March 2013),[5] in improving the sexual health of the whole population, key objectives of which include to *"reduce unintended pregnancies among all women of fertile age"* as well as to *"continue to reduce the rate of under 16 and under 18 conceptions".* Unintended pregnancy is an on-going issue throughout reproductive life. Using abortion rates as a proxy for unintended pregnancy, it can be seen that in 2012,		5. Department of Health. A Framework for Sexual Health Improvement in England. March 2013. Available at: https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england (Accessed 12/12/2013) 6. Department of Health. Abortion Statistics, England and Wales 2012. July 2013. Available at: https://www.gov.uk/government/publications/report-on-abortion-statistics-in-england-and-wales-for-2012 (Accessed 01/12/2015) 7. All-Party Parliamentary Group on Sexual and Reproductive Health in the UK. Healthy women healthy lives? July 2012. Available at: http://www.fpa.org.uk/sites/default/files/healthy-women-healthy-lives-full-report-july-2012.pdf (Accessed 01/12/2015) 8. Advisory Group on Contraception. Sex, lives and commissioning. April 2012. Available at: http://cleregolfserver.co.uk/bayer/sex-lives-and-commissioning/index.html

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				over 80% of legal abortions in England and Wales were carried out in women aged 20 and over, with the highest rate at 31/1000 for women aged 21.[6] These statistics also show that whilst progress has been made over the past 10 years in decreasing abortion rates in teenagers and younger women, the same improvement has not been seen in those aged 25 and over.[6] Publications by the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK[7] and the Advisory Group on Contraception[8] have highlighted concerns that in some areas there is evidence that either access to contraceptive services, or to certain methods by service, is being restricted by age.		(Accessed 01/12/2015)
96	General	Primary Care Women's Health Forum	Additional developmental areas of emergent practice	Data collection		
97	General	Royal College of Paediatrics and	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the contraceptive services consultation. We have not received any responses for this consultation			

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		Child Health				
98	General	SCM5	Additional evidence sources for consideration	FSRH Clinical Guidance Combined Hormonal Contraception You're Welcome Quality Criteria for young people friendly services		