NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Contraceptive services

Date of Quality Standards Advisory Committee post-consultation meeting:
12 May 2016.

2 Introduction

The draft quality standard for contraceptive services was made available on the NICE website for a 4-week public consultation period between 22 March and 20 April 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 26 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be put them in place?

3. Do you have an example from practice of implementing the NICE guidelines that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any treatment. Please describe any potential cost savings or opportunities for disinvestment.

5. Can you identify an area of contraceptive education outside that currently covered in the national curriculum, which is supported by evidence based guidance where

quality improvement is required? If so please provide details of the area and evidence based guidance.

Stakeholders were also invited to respond to the following statement specific questions:

1. For draft quality statement 1: Is the definition we have provided for open access accurate? Can you suggest any amendments that would expand on or improve the definition?

2. For draft quality statement 3: Guideline recommendations state that contraception should be discussed as soon as possible after an abortion as well as at assessment. Which group of healthcare professionals would have the discussion with women after an abortion, and when would this take place?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- There were some suggested amendments to overarching outcomes.
- The contraceptive methods listed in the introduction and definitions, exclude some methods.
- Stakeholders commented on the published date of the statistics in the introduction.
- One stakeholder commented that the data in the quality standard is related to community services, but about 80% if contraception is provided in general practice.
- The Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Health (FSRH), are jointly developing a ‘green-top’ guideline entitled “post pregnancy contraception” which will publish in September 2016.
- The mention of community pharmacy contraceptive services was welcomed.
- The draft quality standard reflects key areas for quality improvement and each of the statements should be achievable by local services. Although one stakeholder felt that it’s unrealistic as a reflection of everyday practice.
- The clinic times and venues need to be convenient to young people who may not want parents or carers to know that they are accessing sexual health services. This is especially important for those living in rural areas as they may need to account for travel costs. Consideration of travel costs is an equality and diversity issue.
- Some professionals object to perform or prescribe certain treatments within contraceptive services and multiple concerns were expressed around this.

Consultation question 1:

Generally, stakeholders felt the quality standard accurately reflected the key areas for quality improvement.

Consultation question 3:

Since the NICE LARC guidance has been published, there has been an increase in LARC provision and fits. One stakeholder highlighted the BPAS STAR project, an initiative to offer a contraceptive consultation and counselling via a central booking service. Since implementation of the system, there has been an increase in LARC fits and uptake at the time of an abortion.

Consultation question 5

Stakeholders identified the following areas of contraceptive education where quality improvement is required:

- a holistic approach that reflects young people's lives e.g. emotional intelligence and wellbeing, instead of the mechanics of contraceptive devices.
- Promoting the benefits of LARC for both contraception and improvement in adolescent and female health and wellbeing.
- Abortion and access to services in an unbiased way.
- Sexual and reproductive education delivery that includes teaching on all aspects of contraceptive methods, with the added facility of registering young people to free local condom schemes.
- Use of digital online websites to offer a full range of information on a full range of contraceptive methods, services and sexual health information.

Consultation comments on data collection

Responses to this consultation question were mixed. Some stakeholders reported that there were systems in place to collect the data for the proposed quality measure. However systems vary between contraceptive providers. Where there were no systems in place, stakeholders said it would be feasible to implement these systems.

Consultation comments on resource impact

There were multiple comments about the financial constraints on local authorities and impact this will have on services. One stakeholder suggested that the efficient use of technology and optimising the skill of the multidisciplinary team for sexual health screening, provision of core contraception and better prevention work would help fund these.

Two stakeholders commented that all the statements apart from statement 4 would be achievable.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

People requesting contraception from open access contraceptive services are given information about, and offered a choice of all methods.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Including access to all contraceptive methods in the quality standard was welcomed.
- Including that commissioners ensure all methods are provided within the quality standard was welcomed; there are increasing restrictions around who can access CaSH services due to a lack of funding and new contracts.
- The current BASHH standard has been used by many commissioners and providers as a key performance measure.
- Contraceptive services are commissioned by different commissioners. For an open access service to be feasible, the collation of data needs to be done centrally.
- When a form of contraception is refused to a patient due to contraindications, the prescriber must ensure that the patient understands the reasoning behind this.
- The phrase “open access” would be better replaced with “good quality” or “high standard”, as young people may not connect with “open access” as a phrase.
- Much contraceptive advice occurs in general practice, and so stakeholders queried how this statement applies to GPs.
- Service systems currently capture the number of patients prescribed contraception, but not the number who are offered contraception or when information has been given. Therefore this statement may be difficult to measure.
- The measure is unrealistic in terms of resources and it may encourage giving so much information that patients would feel overloaded and making a rational choice less, rather than more likely.

- When a contraceptive is not available at a service, women should be advised where this can be accessed in terms of geography and waiting times. Linking with other services could support this. Experts also need to be available for advice about complex patients.

Consultation question 6

Stakeholders made the following comments in relation to consultation question 6:

- Some stakeholders commented that the definition of open access was good, clear and accurate and would be easy for service users to understand. The inclusion of "confidential" in the definition was welcomed.
- There were a number of suggestions made about the definition of open access:
  - It doesn't mention pregnancy
  - It should include something about being non-discriminatory; be inclusive of transgender people, sexual orientation, number of partners
  - Maximum waiting time
  - Sensitive motivation of casual partners
  - Include 'non-judgemental' in the definition
  - Should be accessible and friendly for young people
  - Include having clear information for potential clients, how you will be seen and who is there
  - HIV and wider STI screening.
  - Consistency between pharmacies around emergency contraceptive provision
- Open access should continue to mean open access for CaSH services if current funding constraints allow.
- The term "open access'' may exclude GP practices. A revised statement wording was suggested *"People requesting contraception from any contraceptive services are given information about, and offered a choice of all appropriate methods".*
- Although the definition of open access is correct, it may be assumed that the guidance is only applicable to open access contraceptive services and not all providers.

5.2 Draft statement 2

Women requesting emergency hormonal contraception are informed that an intrauterine device is the most effective form of emergency contraception.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Best practice is already engrained within clinical culture and practice, and LARC is included within the Quality Outcomes Framework (QOF).
- There was some confusion around the intention of the statement. The rationale may need to be amended in order to rectify this.
- There were concerns around the word “women”. Transgender men and non-binary people may need to access emergency contraception, as well as people who don’t identify as ‘women’.
- The option of an IUD fitting for emergency contraception was welcomed. But there were concerns expressed about being able to getting it fit in time.
- Many young people were unaware of IUD’s use in emergency contraception as well as a form of LARC, and so would be unwilling to use it instead of oral emergency contraceptives.
- The importance of including more specific details about timing and availability for emergency IUD insertion was raised. There may not be equality of access to IUD provision, for example, for women living in rural areas.
- *“Emergency hormonal contraception”* should be reworded to *“emergency oral contraception”* as Ulipristal Acetate and the IUD are not hormonal.
- Current funding constraints may mean that the provision of services may need to be restricted. In these cases, services should be available to vulnerable groups. Emergency contraception should also be free to those who request it.
- Many commissioners dictate a specific LARC target. They suggested that it would be helpful for the quality standard to provide guidance as to whether or not this is the case.

- Offering and informing women about the full range of contraceptives available should be consistent throughout quality standard. This is not currently the case under statement 2, where the object seems to be to drive uptake of the IUD.
- Concerns were expressed about this statement. Extra resources and capacity would be needed in order to fit an IUD rapidly; this may make the statement difficult to implement. Therefore an additional measure was suggested to include the number of IUDs fitted.
- Monitoring the number of patients informed that the IUD is the most effective method of emergency contraception, would be difficult to capture and report.
- The wording of this quality statement may limit choice in relation to all effective methods of emergency contraception. It may also, impose the use of a specific method of long term contraception, when the focus is on emergency contraception.
- The statement is appropriate only for the minority of users of emergency contraception. Many request it “just in case” either for future use, or because they are not sure of the reliability of their existing method.
- Being informed about an IUD is not enough. Having a system in place to access an emergency IUD within the appropriate timeframe is more important.

5.3 Draft statement 3

Women who have an unplanned pregnancy and seek an abortion, discuss contraception and are given a choice of the full range of contraceptives at assessment for an abortion.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- The wording of the statement was *"offensive"*, *"preachy"*, *"condescending"* and *"judgemental"*, and suggested that clinicians should be reminded that an unwanted pregnancy may be due to a contraceptive failure.
- There were multiple comments about the timing of the contraceptive discussion and how to sensitively approach the subject in a timely manner.
- Some abortions take place where the pregnancy was not unplanned, so the statement wording should be amended.
- Women who have experienced contraceptive failure should be informed that LARC is the most effective way of preventing unplanned pregnancies.
- Many abortions are done medically and occur at home. They suggested a follow up measure about commissioning a follow-up appointment in primary care within 7 days for further discussion and check.
- Rather than being given a choice of contraception, women should be supported an informed discussion about the range of contraceptive methods.
- Where possible, contraception should be given / initiated prior to discharge, or a follow up for contraception offered.

Consultation question 7

Stakeholders made the following comments in relation to consultation question 7:

Who

- The general practitioner or one or both of the doctors signing the HAS 1 (Certificate A) form. If the abortion is being performed surgically, the doctor or nurse caring for the woman can discuss contraception.
- Abortion services would be best placed to discuss contraception with women after an abortion. GPs, practice nurses and healthcare professionals working in community clinics should also have the discussion if they are aware of a patient who has had a recent abortion.
- Discussions should be facilitated by GPs, nurses or at CASH services, or within sexual and reproductive health.
- Any healthcare professional who might be accessed by women after an abortion, GPs, GUM and SRH professionals, school nurses and gynaecologists.
- GPs may not be aware that an abortion has taken place, as women can self-refer, and primary care not always informed that the abortion has taken place. Also, women often do not receive or require follow up. So it is difficult to know who could give the abortion advice.

When

Discussions around contraceptives should take place:

- The discussion should take place at each point of abortion care.
- The full range of contraception should be discussed and offered at assessment and post abortion before discharge.
- Discussions could take place any time a healthcare professional encounters a woman who has had an abortion, regardless of when the abortion took place if she is not using adequate contraception.
- The discussion should take place at the pre-abortion counselling and a method of contraception provided at the time.

- Depends on the area. The contraception should be decided and provided either before the abortion or a method fitted at the time of an abortion.
- Within 7 days of the abortion.

5.4 Draft statement 4

Women who have been pregnant discuss contraception with their midwife within 7 days after pregnancy ends.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Multiple stakeholders agreed with this statement. However, one stakeholder highlighted that this could be difficult if the women has a poor relationship with her midwife.
- There were several comments about the timing of the discussion and the wording of the statement.
- Women who have had a failed pregnancy would not see a midwife; they expressed the importance that they have access to contraception.
- Pregnancy data is not always READ coded, so the statement may be difficult to measure.
- Multiple concerns about difficulties measuring this statement. Midwives contracts do not include discussing contraception. Midwives, also, cannot prescribe contraception, so women would require a further referral onto a GP or community contraceptive clinic. Conversely, another stakeholder advised that is was part of normal good practice.
- Some stakeholders suggested changing ‘midwife’ to ‘healthcare professionals’ to encompass all pregnancy outcomes.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- A statement that specifically states that all providers of contraception should have an up to date understanding and training around the methods of contraception available and where to get these.
- There were a number of key areas highlighted such as choice of service, hard to reach populations, quick starting contraceptives and reducing waits for LARC, which have not been included within the draft quality standard.

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Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row
1	BASHH	General	General	It is crucial that the following statement in the standard is adhered to by commissioners of contraception services: "The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services." It is of concern that some commissioners are apparently not interested in adhering to the tenets of integrated sexual healthcare and this should be robustly challenged.
2	British Pregnancy Advisory Service (BPAS)	General	General	BPAS believes improvements in "repeat abortion" should not be listed as an outcome for the quality standard. The quality standard should focus on a reduction in unwanted pregnancy - not seek to stigmatise one particular outcome of that pregnancy and therefore the woman who decides to end an unwanted pregnancy on more than one occasion. Secondly improvement in the use of LARCS should not be an outcome target - rather improvements in the availability of all forms of contraception to all women, so they can make their own choice accordingly.
3	Faculty of Sexual and Reproductive Health Care	General	General	The FSRH is the recognised organisation producing standards for contraceptive services. Their training curricula and standards for contraceptive provision are applicable to both doctors and nurses
4	Faculty of Sexual and Reproductive Health Care	General	General P12 and P19	The word ‘progesterone’ is used but this should be ‘progestogen’
5	Faculty of Sexual and Reproductive Health Care	General	General	The term ‘ Repeat abortion’ is sometimes felt to be a judgemental phrase – May be a better term would be ‘women who have had more than one abortion
6	Faculty of Sexual and Reproductive Health Care	General	General	There is a lot of emphasis on information giving rather than outcomes

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row
7	Faculty of Sexual and Reproductive Health Care	General	General P1	The Wellings study quoted on Page 1 shows that the unplanned pregnancy rate is higher than 19 % as 29% of women were 'ambivalent' about their pregnancies
8	Faculty of Sexual and Reproductive Health Care	General	General P2	The contraceptive methods summarised are LARC , oral and barrier – This excludes some methods Should the statement be ' LARC methods, combined hormonal methods, oral methods, barriers and sterilisation" ?
9	Faculty of Sexual and Reproductive Health Care	General	General P3	The abortion statics used are from 2009 are there any more recent statistics ?
10	Primary Care Women's Health Forum	General	General	Q 1/ There is a need to recognise that the individual statements may affect different healthcare providers. Ie Statement 4 is clearly for midwives, whereas pharmacists may only find statements 1 and 2 relevant. Because of the number of providers and different commissioners it is difficult for anyone to have a clear overview of the local implications of this QS. With acknowledgement of the above comment the QS does cover most of the key areas for quality improvement. I would add a 5th statement which is important for quality – about all providers of contraception have an up to date understanding of the methods of contraception available and advise where these are available and that they have participated in appropriate training. This could be measured – number of healthcare providers delivering contraception advice Number of HCPs who can demonstrate engagement with training in the previous 5 years
11	RCGP	General	General	The RCGP feels that the underlying principles look completely sound in this document, but also feels quite unrealistic as a reflection of sensible everyday clinical practice. It can be considered an attempt to impose uniformity on an area of practice that may not need it, and which follows a path directly against patient-centred medicine. (DJ)
12	RCGP	General	General	The RCGP finds that most of the data related to community services in the document but about 80% of contraception is dealt with in General Practice. (AB)
13	RCGP	General	Introduction	The RCGP agrees with the description of open access clinics but examples in the text such as the use of oral contraceptives and the initiation of LARCs relate only to those accessing through

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row
				community clinics. The text is slightly misleading. The RCGP impression is that the majority of women use a variety of methods of contraception and keep switching. The RCGP misses studies on the persistence with particular methods. Condoms are most popular. (JA)
14	Royal College of Obstetricians and Gynaecologists (RCOG)	General	General	This is a well-written and clear document. These NICE quality standards should probably acknowledge or refer to the document 'A Quality Standard for Contraceptive Services' produced by the Faculty of Sexual & Reproductive Healthcare (FSRH) in April 2014. There is a fair amount of overlap between the NICE and FSRH documents (http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf). NICE should be aware that RCOG and FSRH are jointly developing a 'Green-top' Guideline entitled 'Post Pregnancy Contraception'. This will have auditable standards and implementation tools that may be relevant to these quality standards.
15	Royal College of Physicians (RCP)	General	General	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Joint Specialty Committee for Genitourinary Medicine and the British Association for Sexual Health and HIV and wish to make the following comments.
16	Royal College of Physicians (RCP)	General	General	Our experts note that the document is welcome and appears to address all the areas necessary to deliver high quality contraceptive services as long as the standards are implemented. Our experts believe it is crucial that the following statement in the standard is adhered to by commissioners of contraception services: 'The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services.' Our experts raise concern that some commissioners appear disinterested in adhering to the tenets of integrated sexual healthcare and believe that this should be robustly challenged.
17	Royal Pharmaceutical Society	General	General	The Royal Pharmaceutical Society welcomes the quality standard for contraceptive services. We welcome the mention of community pharmacy contraceptive services. There are several locally commissioned contraceptive services offered around the country. You can find examples of some of these services pm the Pharmaceutical Services Negotiating Committee Services database: http://psnc.org.uk/services-commissioning/services-database/. Many commissioners require pharmacists providing Oral contraception service with the use of a patient group direction to

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row
				complete a declaration of competence to assure them that pharmacists "are service-ready and have the appropriate knowledge, skills and behaviours to deliver high-quality, consistent services". You can find further details of the declaration of competence on the following page: https://www.cppe.ac.uk/services/declaration-of-competence#navTop.
18	The Royal College of Midwives	General	General	The RCM considers that draft quality standard reflects key areas for quality improvement.
19	The Royal College of Midwives	General	General	Each of the statements should be achievable by local services.
20	The Young Women's Outreach Project	General	General	The clinic times and venues need to be convenient to young people who may not want to inform parents / carers that they are accessing sexual health services e.g. near a school so they could call in on way from school without being missed. This may be especially so if they live in a more rural area and may have to account for their whereabouts if they need to travel any distance for services. Regarding equality and diversity this may be an issue, as may transport costs.
21	Department of Health	General	General	Para 1, is the *best practice guidance for doctors… on contraception etc.* the most recent guidance (2004)? I suggest we say that this guidance has not been updated to reflect issues such as CSE. Recommend instead that they reference statutory guidance *Working Together to Safeguard Children* and NHS England's *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework.*
22	Department of Health	General	General P2	Para 2, we need to provide latest data on conception rates for U18s and poss some text on how conception rates have reduced/lowest for 40 years etc.
23	Department of Health	General	General P3	Para 1&2 need to flag up that new abortion data due to be published and taken into account.
24	Department of Health	General	General P4	Para 2, bullet points refer to frameworks that expire this year; are they being revised?
Statement 1				
25	Bayer Plc	QS1	QS1	Concerns there are increasing restrictions on who can access CaSH services due to lack of funding and new contracts. The Faculty of Sexual and Reproductive Health published their survey of GPs about the provision of LARC services via GPs. Amongst those that had reduced LARC provision reasons given included: - 34% said it was to reduced funding; 14% due to funding stopping, 26% due to revised priorities; and 45% due to reduced clinical capacity. (http://www.fsrh.org/pdfs/GP_LARC_survey_analysis.pdf)

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row
26	Berkshire Healthcare NHS Foundation Trust – Sexual Health Service	QS1	QS1	**People requesting contraception from open access contraception services are given information about and offered a choice of all contraceptive methods.** The current BASHH standard that has been adopted by many commissioners and providers as a key performance indicator is: 100% of women attending sexual health services should have access to and availability of the full range of contraceptive method (including choice within products). The proposed standard in the consultation does not appear to offer any further guidance than that which is already in existence.
27	Brook	QS1	QS1	Brook’s young people’s Northern panel said that when a particular form of contraception is refused to a patient because of contra-indications, the prescriber must ensure that the client understands the reasoning behind this decision.
28	Brook	QS1	QS1	Statement 1 was seen as the minimum requirement for a ‘good’ service by the Southern panel.
29	Brook	QS1	QS1	The information offered to patients must be “*medically accurate and up to date”*, said the Southern panel.
30	Brook	QS1	QS1	The phrase “*open access*” would be better replaced by “*good quality*” or “*high standard*”, according to the Southern panel.
31	Brook	QS1	QS1	The young people in the Southern panel said they found the term “open access” opaque in terms of meaning - “*As a young person, I don’t connect with the phrase ‘open access’*.” Young man, 19
32	Faculty of Sexual and Reproductive Health Care	QS1	QS1	It is welcomed that access to all contraceptive methods is mentioned but a specific measure for quality improvement could be increased LARC Provision
33	Faculty of Sexual and Reproductive Health Care	QS1	QS1	Information given would need to be of a specified standard, evidence based and from a non biased resource – There has been a significant reduction of funding in this area
34	Faculty of Sexual and Reproductive Health Care	QS1	QS1	It is welcomed that as a statement all methods should be available from ‘open access contraceptive services’ but much contraceptive advice / provision occurs in general practice Is there going to be a specification as to what general practice/ primary care should provide ?
35	Faculty of Sexual	QS1	QS1	It is noted that the document specifies that commissioners should ensure all methods are provided

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row
	and Reproductive Health Care			and this is welcomed as some areas a restricted in what they can provide by commissioning arrangements e.g. some areas where open access clinics can only see young people
36	FPA	QS1	QS1	We believe that, as part of the information that should be provided regarding the risks and benefits of contraception in cases of both typical use and perfect use should be explained to the patient.
37	FPA	QS1	QS1	Irreversible methods of contraception (for example vasectomy, tubal occlusion or hysteroscopic sterilisation) have not been referenced in the definition of 'all methods of contraception'. We would suggest referencing these in a third group, 'methods that do not depend on the person remembering to take or use them and are irreversible'
38	London Borough of Newham	QS1	QS1	The rational for contraceptive information and methods should also include reducing unplanned pregnancies and repeat abortion. The principles of "Women Centred Care" should be embedded in the language used throughout the document.
39	London Borough of Newham	QS1	QS1	This statement may be hard to measure because our systems currently capture the number of patients prescribed contraception method and not offered rates.
40	London Borough of Newham	QS1	QS1	Cultural and religion perceptions of different cohorts of patients need to be considered and will influence the use and choice of contraception.
41	RCGP	QS1	QS1	The statement mentions 15 different methods of contraception, and then lists 10 items of information for each one (p11-12). To emphasise, under process on p9 the numerator is defined as *'the number in the denominator who are given information about all methods.'* This is unrealistic in terms of resources and it may encourage giving so much information that patients would feel overloaded, making rational choice less rather then more likely. (DJ)
42	RCGP	QS1	QS1	This statement is difficult to measure. How is the information to be given? Many service users have already accessed information on-line or have spoken to friends and family. The statement would be easier to measure if it were more specific and related to the service user's actual needs such as information is given about possible side effects or difficulties with the chosen method and appropriate follow up. (This would avoid early discontinuation). (JA)
43	RCGP	QS1	QS1	This statement should include advising the women where to obtain the method if not at that service. The quality statement should be encouraging providers within an area to be linking together ensuring clear understandings of availability as contraception has a variety of commissioner and is delivered by a variety of providers within one area. (AB)
44	RCGP	QS1	QS1	There is a second tier to being offered an option in that it needs to be accessible in terms of geography and waiting time – something that you can only have in 3 months time 50 miles away is

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row
				not really an option. (SG)
45	RCGP	QS1	QS1	The third tier is availability of expert advice for complex patients. (SG)
46	Royal College of Obstetricians and Gynaecologists (RCOG)	QS1	QS1	Suggest including ‘side effects’ in list of information.
47	Salford Royal Foundation Trust	QS1	QS1	How would this be measured – with an electronic system there would need to be some way of ‘coding’ that the contraceptive discussion re: all methods had taken place. (Good in principle but quality of information variable – would it be worth advocating a source eg FPA?) This will be powerful aid to gain buy-in from commissioners to ensure services are supported to provide full range of methods. It is difficult to introduce new methods to services.
48	Secular Medical Forum	QS1	QS1	We agree with this quality standard. We note that some healthcare professionals express conscientious objections to performing or prescribing certain treatment options particularly related to contraceptive services. At present there is no requirement on such professionals to choose to work in areas that do not bring their personal beliefs into conflict with the reasonable, legal treatment options chosen by the patient. We recommend that this quality standard make explicit mention of such potential conflict and advises healthcare professionals working in the area of contraception to ensure that they do not obstruct a patients’ own choice of reasonable, legal treatment options. This might be achieved either by choosing not to work in areas of potential conflict or by ensuring that professionals always give primacy to the patients’ own beliefs and choices except where mandated by law such as the 1967 Abortion Act.
49	Secular Medical Forum	QS1	QS1	Failure to achieve this quality standard in all cases may sometimes result from this conflict of interest. For example, some healthcare professionals object to the use of emergency contraception of any type because of their own personal beliefs. An overlapping group of healthcare professionals may object to the use of the IUD or IUS methods of contraception for similar reasons. We recommend that there be an additional measure to determine to what extent individual healthcare professionals may have contributed to the failure. This may be achieved perhaps by adding an additional process to measure adherence to written clinical protocols in such cases.
50	The Royal College of Midwives	QS1	QS1	It should be clearer what is being referred to by ‘health services information centre data’

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row
51	The Royal College of Midwives	QS1	QS1	The list of the information that should be covered is clear and helpful.
52	Department of Health	QS1	QS1	Methods of contraception, cites 15 but fails to include vasectomy & sterilisation
Statement 2				
53	Berkshire Healthcare NHS Foundation Trust – Sexual Health Service	QS2	QS2	**Statement 2,** **Women requesting emergency hormonal contraception are informed that an IUD is the most effective from of contraception.** This is not new guidance. It is enshrined in Faculty of Sexual and Reproductive Healthcare Clinical Guidance on emergency contraception from the Faculty's Clinical Effectiveness Unit January 2012 . This best practice is already in current culture and practice. The standard does not appear to enhance quality and current guidance has already shaped practice. Uptake of LARC is included in current BASHH performance metrics and is a local and national key performance indicator.
54	British Pregnancy Advisory Service (BPAS)	QS2	QS2	BPAS has serious concerns about statement 2 on emergency contraception. The recommendation is extremely limited in tackling the problems women face trying to access EC, particularly the many women who are excluded from PGD schemes at pharmacies. Moreover the statement does not appear to treat women as autonomous individuals, rather it appears to be based on the assumption that women requesting EC have proven themselves poor at using contraception and should be directed to an intrauterine device to provide them with long lasting protection. While the intrauterine device may be the most effective method of EC (and EHC is in any event highly effective) the decision to have an IUD inserted requires adequate consultation, and if it is to be used as EC swift and straightforward referral pathways. Sadly this is often not the case. If a woman is referred, she should be given the option of also taking EHC in case there are difficulties obtaining an appointment or she changes her mind. Otherwise she is indeed at risk of unwanted pregnancy. Sexually active women must not be viewed as objects needing to have a LARC inserted at the first available opportunity - rather as NICE itself states, they should be "treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions." If a woman seeks emergency contraception, she should not expect any method to be promoted over another, rather she should receive unbiased information about all her

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				treatment options. This statement should be urgently revised.
55	Brook	QS2	QS2	The non-binary young person in the Southern group was concerned about the use of the word 'women', and explained that trans men and non-binary people may need to access emergency contraception, as well as people who identify as 'women' – "*Not everyone with a vagina and ovaries identifies as a woman*."
56	Brook	QS2	QS2	While the option of an IUD fitting for emergency contraception was welcomed, young people in the Southern panel were concerned about access to fitting sessions due to difficulty in finding appointments in time – "*I'm worried about the accessibility. This needs to be offered as advice but its contingent on getting an opportunity. You can't push this with budget cuts as IUD fitting might not be available*."
57	Brook	QS2	QS2	Many of the young people in both panels were unaware of the IUD's use as emergency contraception as well as a form of LARC and felt that their peers would be unwilling to choose the IUD over oral emergency contraceptives - The Northern panel said there was no point promoting something as most effective "*if it isn't an option people would use*".
58	Brook	QS2	QS2	The Northern panel suggested an alternative wording for Statement 2: "*Women are informed about all options for emergency contraception and are able to choose the best method for their specific needs."*
59	Faculty of Sexual and Reproductive Health Care	QS2	QS2	FSRH welcomes Statement 2 but recognises that it is important to have more specific details about timing and availability of emergency IUD insertion – There may not be equality of access to IUD provision
60	Faculty of Sexual and Reproductive Health Care	QS2	QS2	The term ' emergency hormonal contraception' is used – This should be 'emergency oral contraception' as Ulipristal Acetate is not hormonal
61	Faculty of Sexual and Reproductive Health Care	QS2	QS2	Is there place for a specific target around the availability of emergency IUD insertion e.g within 24 hours of presentation (if appropriate for insertion)
62	FPA	QS2	QS2	We agree that accessing an appointment for an intrauterine device may be difficult for women living in rural areas. The increasingly limited access to LARC in primary care (mentioned in Comment 1) is particularly concerning for women who have to long distance to travel to their nearest community

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				clinic. It is also worth noting that the fractured system of reproductive health commissioning means that women living in urban areas are unable to access to comprehensive range of contraceptives. For example, the campaign group Women of Walthamstow was established three years ago when local women were unable to access contraception from their local GP practice.
63	HRA Pharma UK & Ireland Ltd	QS2	QS2	Based on the stated ambition of the Quality Standard for measurable improvements in patient safety, patient experience and clinical effectiveness, we believe there should be acknowledgement of the desire for women to access Emergency Hormonal Contraception (EHC) in Pharmacy due to the anonymity. We estimate that 77% of women access EHC directly in Pharmacy. We understand the difficulty of implementing the quality standard at a local level when local financial constraints need to be taken into consideration.
64	HRA Pharma UK & Ireland Ltd	QS2	QS2	Given current funding constraints in the NHS, provision of services may need to be restricted and it would seem appropriate to limit these to the most vulnerable groups, such as those under 16, women on benefits, women immediately following a pregnancy, etc. The national framework of providing free prescriptions to these more vulnerable groups would appear to be an example of how services could be focused on those most in need. There are numerous examples of community services limiting availability of emergency contraception to women based on age (for example, women under the age of 25) and this suggests that these women are all of a similar vulnerability, which is not the case. However, the free prescription scheme does not follow these same “age” restrictions and encompasses a wide range of vulnerable individuals. Given pressures to restrict services, but also to ensure that the most vulnerable continue to have access to emergency contraception, it may be appropriate to consider the same model as an indicator of the need for free provision. The eligibility for free prescriptions is applied nationally and it would seem to provide a model that may be replicated for the provision of emergency contraception.
65	HRA Pharma UK & Ireland Ltd	QS2	QS2	The rationale of offering and informing women about the full range of contraceptives available should be consistent throughout the document. This is not currently the case under statement 2, where the object seems to be to drive uptake of the IUD. We believe that women seeking Emergency Contraception (EC) and those seeking contraception following pregnancy should expect to be told about all options - including EHC - and to have the advantages and drawbacks of each option explained fully to them. To do other than this is highly irresponsible. IUDs will not suit all women and many will still not opt for it, even when they are given a full explanation of all options. It currently comprises a tiny fraction of EC use, despite having been available for many years.
66	HRA Pharma UK &	QS2	QS2	Equally, if the driver of the QS is to inform women of the most effective options available to them,

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	Ireland Ltd			then they should be provided with a ranking of efficacy, which is 1. IUD, 2. EllaOne and 3. Levonorgestrel. In England at present, women are widely offered only the least effective of these three options.
67	London Borough of Bromley Public Health Sexual Health Team	QS2	QS2	YES - We agree discussion should take place and informed to 100%. It is written in our local LA Service Specs but no data is collected on % offered and ultimately accepting emergency IUD. However, implementation would require extra resource and capacity to be able to offer rapid access to IUD fit which is an issue not just affecting those live in rural areas (as suggested in the consultation document). This may limit offer/uptake of emergency IUD in every setting and lead to more oral EC being used for these reasons: • Only 1 part-time LARC fitting GP (or nurse) per GP practice, or none • Wait for C&RH LARC fit appointment • Signposting to a provider from a pharmacy etc. while oral EC can be taken immediately. Again, EC is commissioned by different commissioners in different settings – EC is co-commissioned by NHS England/CCG in the GP core contract whereas EC provided by Community Pharmacies is commissioned by LAs. Hence, central co-ordination and collation is required (see above comments). Process – suggest to have an additional measure that include the number of IUD actually fitted (numerator) with the same denominator.
68	London Borough of Newham	QS2	QS2	Monitoring the number of patients informed IUD is the most effective method of EHC locally will be difficult to capture and report.
69	London Borough of Newham	QS2	QS2	Women requesting EHC should be advised and if necessary signposted to LARC services.
70	London Borough of Newham	QS2	QS2	Cultural and religion perceptions of different cohorts of patients need to be considered and will influence the use and choice of contraception.
71	Merck Sharp & Dohme	QS2	QS2	MSD considers that the wording of this quality statement (i.e. the focus on intrauterine devices) may limit choice in relation to all effective methods of emergency contraception. Moreover, it may impose the use of a specific method of long term contraception, when the focus is on emergency contraception. MSD suggest re-wording the quality statement to: “Women requesting emergency contraception are informed of all effective methods of emergency contraception; and are offered a consultation on

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				routine contraception (link to QS1) where they are informed that long acting reversible contraception (LARC) is the most effective method of contraception ”
72	RCGP	QS2	QS2	The RCGP feels that this statement is quite sensible. However in long experience of consultations about emergency contraception, and often GPs offering the option of IUD, there was not common to find a patient who opted for the IUD. So this looks like a quality standard that makes sense but the RCGP feels that it is extremely unlikely to make any difference to long-term health outcomes. (DJ)
73	RCGP	QS2	QS2	This statement is appropriate only for the minority of users of emergency hormonal contraception, as many request it “just in case” either for future use or because they are not sure of the reliability of their other method such as the pill or condom. Also it is impracticable as coils can only be accessed through some GPs and community clinics at certain times and not open in the same way as hormonal contraception. It would be more appropriate to measure advice given about other contraceptive methods, including the emergency coil. (JA)
74	RCGP	QS2	QS2	This statement should add that these women are also advised where an emergency intrauterine device can be fitted. (AB)
75	RCGP	QS2	QS2	Whilst statement 2 is correct, there is very limited access to emergency IUCD. At the same time women can get Levonelle free of charge from a wide range of providers including : • contraception clinics • Brook centres • most sexual health clinics, also known as genitourinary medicine (GUM) clinics • most NHS walk-in centres (England only) • most NHS minor injuries units (MIUs) • most GP surgeries • some hospital accident and emergency (A&E) departments Women can also buy Levonelle from most pharmacies and some private clinics if they 16 or over. Prices vary, but it's likely to cost around £25. (MH)
76	RCGP	QS2	QS2	Being informed about is not enough – having a system in place to access a postcoital IUD within the appropriate time frame is as important. (SG)
77	Royal College of Obstetricians and Gynaecologists	QS2	QS2	This statement is flawed as request for ‘hormonal’ contraception automatically excludes IUD which is a nonhormonal method. A much more common scenario is when patients request ‘emergency contraception’ and not ‘emergency hormonal contraception’. Hence, best to delete the word

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	(RCOG)			'hormonal' and stick to 'women requesting emergency contraception'.
78	Salford Royal Foundation Trust	QS2	QS2	Again – how would this be measured/data collected. Electronic template/coding could be used in some EPRs such as S1 but not sure re: other computer systems such as Lillie Would also be beneficial if the statement recommended that a pathway is in place for em IUD provision too,.
79	Secular Medical Forum	QS2	QS2	As per our comments re: statement 1. We note that some healthcare professionals, particularly those belonging to certain religious groups (see http://www.christiancontraception.com/iud.php) conscientiously object to intrauterine contraceptive devices. Healthcare professionals with such views may choose not to share the relevant information about IUDs with women seeking emergency contraception. This statement may be hard to measure particularly in the primary care setting due to the lack of a requirement or willingness for GP practices to share information. We recommend that this measure explicitly notes this potential conflict of interest of a healthcare professional's personal beliefs with their professional responsibilities and advises healthcare commissioners such as CCGs in England and Local Health Boards in Wales to include regular local assessment of primary care staff on their commitment to this measure.
Statement 3				
80	Berkshire Healthcare NHS Foundation Trust – Sexual Health Service	QS3	QS3	**Statement 3** **Women who have an unplanned pregnancy and seek an abortion discuss contraception and are given a choice of full range of contraceptives at assessment for abortion.** We agree with the statement however the services best placed to comment on this are the providers of termination of pregnancy. Ideally the providers of termination services should have provisions to offer a full range of contraception to women undergoing termination of pregnancies. Perhaps commissioners have this statement as a KPI for providers of termination services. We agree that it is appropriate to sow the seeds of empowerment over fertility in a supportive way. It is always important to communicate that women have choices and that effective contraception is available..
81	Brook	QS3	QS3	Southern panel: This statement read to them as "*offensive*" "*preachy*" and "*condescending*" and that clinicians should be reminded to bear in mind that a pregnancy may result from contraceptive failure. The Northern panel agreed and said they felt the tone was "*preachy*", and that "*unplanned pregnancy was always linked to something going wrong with contraception*" in a way that seemed "*judgemental*" to them.
82	Brook	QS3	QS3	While one young person from the Southern panel was concerned that this consultation might not be

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				the best time to talk about contraceptive options, if the individual was feeling very distressed or could only think about the abortion and suggested giving the individual the option to have a contraceptive consultation at a later date, other group members felt that moving the contraception consultation could lead to missed opportunities to find the best form of contraception for a patient. The Northern panel agreed with this, independently.
83	Brook	QS3	QS3	The Northern panel felt strongly that, although they understood why this discussion might be useful, it should up to "*individuals to choose how or when is right for them to talk about it."* The Southern panel's conclusion: this discussion should take place as part of the referral consultation, as long as it was approached very sensitively and in the right way to ensure that it did not cause any harm; the discussion should take place with a specialist sexual health professional, such as a doctor, nurse or counsellor, or a GP as long as they had up-to-date training; the statement should be re-phrased to talk about "*people who have an unplanned pregnancy*" as this would be just as clear and more inclusive to the trans community.
84	Brook	QS3	QS3	Southern panel: As some abortions take place for pregnancies which are not unplanned, the wording should be changed to "*people who get pregnant and seek an abortion".*
85	Brook	QS3	QS3	Southern panel: The non-binary young person mentioned the importance of the clinicians having knowledge of hormone replacement therapies that might be being used by people who are transitioning, and how that might impact on their contraceptive choices due to contraindications
	Faculty of Sexual and Reproductive Health Care	QS3	QS3	This is a key area for quality improvement – Many commissioners dictate a specific LARC target It would be helpful if this document were to provide guidance as to whether or not this should be the case
86	Merck Sharp & Dohme	QS3	QS3	MSD considers that there are two key elements that should be reflected within this statement: MSD considers that women who have experienced contraceptive failure should be informed that a LARC is the most effective method of reducing unplanned pregnancies; MSD considers that the most appropriate point in time to provide contraceptive advice will vary, depending on individual circumstances. For example, at the time of assessment for an abortion, some women may be focused only on pregnancy termination, so the discussion of contraception should be reinforced after the abortion.
87	RCGP	QS3	QS3	This raises an important and difficult question. Ensuring that women have the opportunity for effective contraception after an abortion is self-evidently good medical practice, but timing may be an issue. Most women discussing abortions are too preoccupied with the immediate decision to want to discuss longer-term contraception, and it's probably right that they should be. But after the abortion

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				they don't seem keen to come and see a GP or nurse again soon after. There may be scope here for research to try to identify the best time to offer advice. One option, for instance, would be for the nurse/doctor/other staff discharging them from the abortion service to give them a leaflet and make an early appointment to attend their own doctor (ie not leave it up to the patient to make the appointment but make it for them). (DJ)
88	RCGP	QS3	QS3	The statement and measure are appropriate as a start. Both the GP giving information about the abortion services and the nurse practitioner in the abortion service are in the position to give advice and it could be recorded and measured. Many abortions are done medically and occur at home. A follow-up measure could be commissioning a follow-up appointment in primary care within 7 days for further discussion and check. (JA)
89	RCGP	QS3	QS3	Rather than being given a 'choice' women should be 'advised of the full range of contraception' or more appropriately 'supported with an informed discussion of the range of contraceptive methods' which suggests the assessor has the appropriate knowledge and training to inform and deliver. (AB)
90	Salford Royal Foundation Trust	QS3	QS3	…and wherever possible contraception be initiated/provided prior to discharge following abortion procedure or arrangements for follow-up for contraception be offered.
91	Secular Medical Forum	QS3	QS3	For the reasons stated above, **we recommend** that all healthcare professionals involved in seeing women for abortion assessment, are questioned on their willingness to discuss all forms of contraception with women seeking an abortion. Without explicit questioning and monitoring it would be very difficult to discover whether individual healthcare professionals are allowing their own personal views to obstruct patient choice of all appropriate forms of contraception.
92	Department of Health	QS3	QS3	Para 2, Statement 3, perhaps should be rephrased in line with RSOP 12?
93	Department of Health	QS3	QS3	Quality measures, Data sources, is this information collected locally? Do clinics provide data?
94	Department of Health	QS3	QS3	Data source, again, would this data be available locally?
95	Department of Health	QS3	QS3	Definitions, again, not all methods of contraception listed.
Statement 4				
96	Berkshire	QS4	QS4	**Statement 4**

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	Healthcare NHS Foundation Trust – Sexual Health Service			**Women who have been pregnant discuss contraception with the midwife within 7 days after the pregnancy ends.** Whilst we support this statement it is for comment by Obstetrics and Gynaecology Departments and Midwives.
97	British Pregnancy Advisory Service (BPAS)	QS4	QS4	BPAS would like to see the same commitment to offering women who have abortions with the full range of contraceptive option extended to women who have just delivered. The postpartum period is one in which women may seriously struggle to access that choice, and be vulnerable to unwanted pregnancy as a result.
98	Brook	QS4	QS4	The Northern panel were generally happy with this wording, with the caveat that if someone had a poor relationship with their midwife, they should have the option of attending a clinic for a consultation.
99	Brook	QS4	QS4	The Southern panel found Statement 4 "*confusing"* as they assumed that this meant following a live birth, as they didn't think that people would have a midwife in any other circumstances, but wondered why the phrase "*after pregnancy ends*" was used.
100	Brook	QS4	QS4	The Southern panel were concerned that within seven days of giving birth the person might be too exhausted to think about contraceptive options, and instead suggested that this conversation should take place at an earlier stage, as part of their antenatal care. For example "*people who are pregnant are given the option to discuss future contraception during the third trimester."*
101	Brook	QS4	QS4	Southern panel: the statement could become trans inclusive by changing "*women*" to "*people*".
102	Faculty of Sexual and Reproductive Health Care	QS4	QS4	This is a very important area – It used to be routine for women to have a contraceptive consultation before leaving hospital. There have been several projects where postnatal ward contraception has been piloted (particularly LARC for vulnerable women) and these have had very successful results e.g. Edinburgh, Lewisham and Greenwich It is also important to ensure that women who have a failed pregnancy e.g. miscarriage, ectopic, molar pregnancy have adequate access to contraception and these women would not have access to a midwife If these women are not to be included then it should be reworded ' post childbirth/ partum' The FSRH is just about to publish new Guidance on 'Post pregnancy contraception'

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103	London Borough of Bromley Public Health Sexual Health Team	QS4	QS4	YES. Agree contraception must be discussed repeatedly postnatally until method started. Health visitors as well as midwives are best placed to offer comprehensive contraception advice and record this initial conversation as part of their service specification to do so. This could be strengthened as there are the opportunities to repeat the discussion during one of the post-natal checks or child surveillance milestone appointments if appropriate. At 7 days post-natal, many women may not be able to focus on a conversation regarding starting a contraception method and may not resume sexual activity for 4-6 weeks although some do so earlier. Sound advice regarding choice of contraception methods and suitable start dates that can be safely taken whilst breast feeding should be made clear. Advice on the use of condoms (possibly free condoms should be provided) with encouragement and information to see their GP or CASH clinic for other contraception methods. Discussion opportunities: • Midwife before leave hospital and again by community midwife at home first week and up to 10 days post-natal • Health Visitor – 10 days – 2 weeks • GP or practice nurse during 6-8 week post-natal check for them and baby when contraception could be discussed and method started if possible if not before. • Provide on-line website details that will provide information regarding a range of contraception methods and suitable post-delivery start times. Again, these services are commissioned and provided by different organisations and providers, central co-ordination and collation is the potential solution as no one commissioning authority or provider has the remit to collect data on this. NICE suggestion of local data collection on unplanned pregnancy rates in women who have been pregnant before and contraception uptake rates in post-natal women is impractical as LA Public Health budget cuts mean there are fewer staff available to liaise with primary care (loss of 2 Sexual health GP leads I Bromley PH for example) Primary Care would be far too busy to run unfunded extra audits on this. Many pregnancies are unplanned but still wanted by women. This data is not always recorded and

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				not READ coded at booking in primary care and not searchable on primary care IT systems. PHE already publishes TOP rates and repeat TOP rates. TOP providers can record method of contraception used pre and post TOP intentions if included in contract monitoring data by CCG commissioners as a KPI requirement Repeat abortion rate can be measured but not repeat conception rate as it is impractical to collect this data. Suggestion of ‘Snap Shot’ audit questionnaires for a given period of time instead, may be a way of understanding this more.
104	Merck Sharp & Dohme	QS4	QS4	MSD suggests that the timeframe for delivery of this quality statement should include pre and post natal contraceptive planning, to account for individual circumstances.
105	Primary Care Women’s Health Forum	QS4	QS4	Unfortunately the recent National Maternity Review does not specify the need for midwives to provide contraception advice. As the number of midwife providers increases this will be hard to measure unless specifically added to any contracts. There would also be a requirement for extra training for midwives updating them on the different contraceptives available.
106	RCGP	QS4	QS4	As above, the timing is the critical matter. ‘Within 7 days’ is likely to be inappropriately early for many women, and much too rigid as a standard. An alternative would be ‘Women to have received appropriate advice by 6 weeks postpartum’ (GPs are aware that it is possible for women to have become pregnant by 6 weeks, though it is very rare. The RCGP also knows that most women have received advice from a midwife if not by 7 days then at least by the time care is transferred from midwifes to health visitors). A more flexible standard would leave room for individual preference among women, as well as for local variations in practice. (DJ)
107	RCGP	QS4	QS4	This is normal good practice by the attending midwife and straightforward to measure. The difficulty is that the midwife cannot prescribe contraception so the parents need to take action to implement that discussion by making an appointment with their GP practice or community clinic. (JA)
108	RCGP	QS4	QS4	This statement is only meaningful if the midwife has the appropriate knowledge and training which is not mentioned. (AB)
109	Royal College of	QS4	QS4	Suggest replacing 'midwife' with ‘healthcare professional' to encompass all pregnancy outcomes.

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	Obstetricians and Gynaecologists (RCOG)			
110	Salford Royal Foundation Trust	QS4	QS4	Difficult to measure – this post-natal conversation could be on ward/community M/W/GP – all using different records/systems.
111	Secular Medical Forum	QS4	QS4	Whilst we agree that the patient's own beliefs/culture may play a part in her choice of contraception after a pregnancy, it is important that no assumptions are made about a person's beliefs or culture before the discussion takes place. The explanatory paragraph in the consultation document implies that the discussion of contraceptive options might be limited by the woman's belief or culture. This would be unhelpful and may result in some appropriate options not being discussed due to a perception of the woman's choice based on current knowledge of her religion or culture. Instead, the full range of options should still be discussed allowing the woman herself to decide which is the most appropriate method for her. We recommend that the paragraph be rewritten along the following lines: 'Age, religion and culture may affect which contraceptive methods are suitable. The discussion of appropriate options should allow the woman herself to choose the method which best suits her based on all medically appropriate options.'
112	The Royal College of Midwives	QS4	QS4	There should be further opportunities highlighted in the standard for discussing contraception both antenatally and revisited in the postnatal period eg at the 6 week visit as many women do not actively engage with this discussion in the first seven days.
Consultation questions				
113	Association of Directors of Public Health (ADPH) UK	Question 1	Question 1	The draft quality standard generally reflects the key areas for quality improvement - but fails to include the need for providers to ensure that staff are trained adequately (now that services are integrated) to offer the full range of advice and contraception at all SH services.Throughout the quality statement reference is made to GUM services - when a large proportion of commissioned services are **Integrated Sexual Health Services** providing a full range of sexual health services provided by dual trained clinicians. In Devon County Council, we are progressing with a nurse model for the fitting and removal of contraceptive sub-dermal implants (SDI's), to particularly improve access in primary care. We are concerned however that the quality of the reproductive sexual health offer that nurses are able to provide should not be compromised by simply training high numbers of "fitting technicians". Effective pre and post counselling for SDI's should be embedded within competence based, quality reproductive sexual health training to maximise the contraception and sexual health offer to the

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				client, and prolong the use of the SDI.
114	BASHH	Question 1	Question 1	Yes
115	Faculty of Sexual and Reproductive Health Care	Question 1	Question 1	These standards are achievable and if all were achieved would improve standards. There is no mention of 'Choice of Site / Type of service' which was always fundamental to contraceptive service provision in the past The document would benefit from the addition of a specific target around appropriately trained staff There is no specific mention of 'hard to reach/ vulnerable populations and these groups are particularly important in terms of key sexual and reproductive health outcomes such as improving teenage pregnancy rates and reducing abortion.
116	FPA	Question 1	Question 1	We agree that maintaining is access the key area for quality improvement, particularly as the Advisory Group on Contraception estimate that over 3.2 million women of reproductive age (15-44) are living in areas where fully comprehensive contraceptive services are not provided through primary or community care, representing almost one-third of women in England of reproductive age. We particularly welcome the references to access via GPs, as there is increasing concern among clinicians that, under the current commissioning system, access to long acting reversible contraception (LARC) via primary care is under threat. This is due to the fact that by providing services outside of the GP contract, practices can lose money if funding from local authorities is insufficient to cover clinician and equipment costs.
117	HRA Pharma UK & Ireland Ltd	Question 1	Question 1	For the reasons, stated above, we do not believe that the current draft of the QS does reflect all of the key areas for quality improvement. Women are not routinely informed of all the options open to them, nor do they have the advantages and disadvantages of each explained to them in most cases. This needs to be addressed and the QS offers the ideal way in which to make a recommendation to address these shortcomings.
118	London Borough of Bromley Public Health Sexual Health Team	Question 1	Question 1	Broadly except Statements 2 and 4 where implementation may not be feasible (statement 2 – see comments above) and challenging due to resource constraints (statement 4 – see comments above)
119	London Borough of Newham	Question 1	Question 1	The quality statements broadly reflect areas of improvement. Quality statement 1 - whilst intrauterine device maybe the most effective form of emergency contraception all forms of LARC including

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				implants should be captured within this statement.
120	Royal College of Physicians (RCP)	Question 1	Question 1	**Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?** Our experts agree that the draft quality standard accurately reflects the key areas for quality improvement.
121	Salford Royal Foundation Trust	Question 1	Question 1	Partially. Does not address quickstarting – initiating contraception without delay where possible and reducing waits for LARCs
122	Secular Medical Forum	Question 1	Question 1	We agree that this draft quality standard accurately reflects the key areas for quality improvement with the following caveat. Commissioning bodies might take extra steps to ensure that healthcare professionals working in the area of contraceptive services are willing to comply with the quality statements. We advise further monitoring of services to ensure that patients are not inconvenienced or disadvantaged in any way because of the practitioner's own faith or beliefs.
123	London Borough of Bromley Public Health Sexual Health Team	Questions 1,2,4 and 7	Questions 1,2,4 and 7	YES - contraception should be discussed and offered before and after TOP procedures. Contraception discussion and advice clearly should be part of the TOP service contract both pre-TOP procedure and after TOP for 100% of clients. CCGs commission abortion services so they would need to include this in contractual KPIs along with provision of good quality counselling and offer a choice of all contraception methods. TOP service contract should include: • Follow-up phone call 2 weeks later to check OK and if contraception started if not accepted at time of procedure • Use of technology - possibly reminder texts to attend a local clinic or their GP and that they are vulnerable to a further pregnancy • Include in the TOP providers contractual KPIs Primary Care is often unaware a patient has been pregnant and TOP has occurred. Patients may not see their own GP for some time after a TOP and are often reluctant to mention or discuss they have undergone this intervention if not originally referred by their GP. However, GPs and practice nurses should clearly discuss contraception opportunistically at next attendance too if they are aware of patient has had a TOP recently. There is no contractual arrangement between LA and GPs or TOP providers to collect this data or enforce good practice.

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				There is a need for PH commissioners to liaise with CCGs commissioner of TOP services to share data if NICE recommend data collection and analysis but Public Health budget cuts are leading to fewer PH staff to be able to do this. Central co-ordination and collation would help to achieve this recommendation.
124	Association of Directors of Public Health (ADPH) UK	Question 2	Question 2	The systems are in place for this data to be collected.
125	Faculty of Sexual and Reproductive Health Care	Question 2	Question 2	There are several data collection templates in operation e.g. SHRAD There would need to be an extension for data collection in all other contraceptive provision settings e.g. post abortion, in community pharmacy and this may be quite complex to arrange It would be difficult to collect data around the quality of information provided to a patient It would be easier to quantify the method provided rather than the method discussed For Statement 4 – it would be difficult to collect data on information provided by community midwives for those women who have home birth or who have a rapid discharge from hospital
126	FPA	Question 2	Question 2	We are concerned that the local systems and structures are not currently in place to collect the data for proposed quality measures. Due to the fact that multiple commissioners and service providers are involved in contraceptive care, we also believe that developing a system of local data collection that could be centralised to measure the Quality Standards. One of the key findings of the APPG on Sexual and Reproductive Health's report 'Breaking Down the Barriers' was that is not data currently in one place, which could provide a full picture and a lack of available data, particularly in general practice. The APPG recommended that, in order to ensure that the correct structures are in place, Public Health England should be tasked to collect all the relevant data sets in order that they can be used together to measure progress and monitor the impact of innovations in reproductive health services. Public Health England should also be required to act on the findings from these data, by supporting and challenging local authority and NHS commissioners, health and wellbeing boards, and Directors of Public Health.

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127	London Borough of Bromley Public Health Sexual Health Team	Question 2	Question 2	From a local authority perspective, we already have included most of the quality standards described in the consultation document in our service specifications but have not measured them in a rigorously way so we welcome the suggestion of measures. While general practices and community clinics may have the potential to collect the data through their existing systems but it may be more difficult for community pharmacies. The additional resource required for data collection will have resource implications which commissioners may not wish to fund, making implementation more difficult in some areas. Please also see comments on resource implications referred to in each quality statement above.
128	RCGP	Question 2	Question 2	There are no structures in place to collect national primary care data about contraception which is why the current quality and delivery of contraception provision is not auditable. (AB)
129	Royal College of Obstetricians and Gynaecologists (RCOG)	Question 2	Question 2	Yes – we believe that systems and structures are in place to collect the data for these quality standards.
130	Royal College of Obstetricians and Gynaecologists (RCOG)	Question 2	Question 2	Yes – we believe that systems and structures are in place to collect the data for these quality standards.
131	Royal College of Physicians (RCP)	Question 2	Question 2	**Question 2 Are local systems and structures in place to collect the data for the proposed quality measures? If not, how feasible would it be for these systems and structures to be put in place?** Our experts are uncertain whether structures are in place everywhere, but note that where they don't exist, it should be straightforward to replicate existing systems
132	Royal Pharmaceutical Society	Question 2	Question 2	Pharmacist 'write' access to patient records would provide a suitable method to record any advice that is provided and ensure continuity of care, as other healthcare professionals will be able to see any advice and action taken. This will also support in measuring whether each of the four quality standards are consistently being met.
133	Salford Royal Foundation Trust	Question 2	Question 2	Not currently in place but achievable with systmOne – not sure how achievable these would be on alternatives eg Lillie
134	Secular Medical	Question	Question 2	We have concerns from numerous anecdotal reports that there may be some healthcare

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	Forum	2		professionals with conscientious objection to providing any part of contraceptive services who nevertheless choose to work in these areas. Monitoring of their practice, particularly in the primary care setting, may be difficult for a variety of reasons including unwillingness to complain, lack of awareness of alternative options and the fact that such discussions are taking place in local communities. As per our previous recommendations, **we recommend** an explicit acknowledgment of this potential conflict of interest between a healthcare professional's personal beliefs and their professional responsibilities. We recommend that all healthcare professionals who put themselves in a position to advise women on contraception or abortion services should be asked and measured on their willingness to comply with these quality standards.
135	Primary Care Women's Health Forum	Question 2	Question 2	Q2 Data can be collected if entered into a database. As there are a number of providers it is difficult to know whether each provider has IT systems in place to collect the data. Ie NHS hospital abortion providers or maternity services. There are no structures in place to collect national primary care data about contraception which is why the current quality and delivery of contraception provision is not auditable.
136	BASHH	Question 2	Question 2	Not sure that structures are in place everywhere, but where they don't exist, it should be easy enough to replicate existing systems
137	Faculty of Sexual and Reproductive Health Care	Question 3	Question 3	Many contraceptive standards have seen an increase in provision of LARC since the NICE LARC Guidance was introduced. NICE Heavy Menstrual Bleeding recommends the Intrauterine System for management of heavy menstrual bleeding – Unfortunately because this pathway is commissioned by CCGs rather than Local Authorities , many services are not able to offer this service
138	London Borough of Bromley Public Health Sexual Health Team	Question 3	Question 3	BPAS STAR project is an excellent initiative to offer a contraception consultation and counselling via a Central Booking Service and has increased LARC fits and contraception uptake at time of TOP for Bromley residents. But in our experience only 30% of TOP clients take up this offer. This leads us to believe there is a need for more robust performance management regarding the quality of the contraception counselling, both pre and post abortion procedure. This is particularly important for those women who go on to have repeat abortions.
139	FPA	Question 4	Question 4	FPA does not believe that local authorities in particular will be able to deliver the objectives of many of the statements in the draft Quality Standard, as resources are strained. In June 2015, the Chancellor announced plans to cut in-year local authority public health grant by £200 million,

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				resulting in every public health commissioner having to make a 6.2% reduction in spending. We are concerned that the measures announced the in Spending Review (which include an additional average annual real-terms savings of 3.9% over the next 5 years to the public health system) will add to the increasing pressure on frontline services and the ability of commissioners to maintain services. The long-term future of funding is even more unclear, with the Spending Review also announcing that the Government plans to consult on options to fully fund local authorities' public health spending from their retained business rates receipts from 2018, as part of the move towards 100% business rate retention.
140	Association of Directors of Public Health (ADPH) UK	Question 4	Question 4	All the statements are achievable without additional resource as the standards reflect best practice and rely on clear pathways and agreement. Integrated Sexual Health Providers (via effective commissioning) should be addressing the fact that the full range of contraceptive services should be available and accessible across **all** service sites - particularly the provision of LARC as a first choice as indicated in the statement.
141	BASHH	Question 4	Question 4	Co-operation between local services will be necessary to achieve the outcomes detailed in the document as not all services will have the resources to deliver everything that has been outlined. The challenge will be how to do this in a health economy where services are funded differently and operate different models of care. "The quality standard for contraceptive services specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole contraceptive service care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people in contraceptive services."
142	Faculty of Sexual and Reproductive Health Care	Question 4	Question 4	A data collection package would be required for those services not currently collecting any mandatory data collection sets e.g. community pharmacy/ abortion services/ general practice
143	HRA Pharma UK & Ireland Ltd	Question 4	Question 4	Local services may not have sufficient resources in the current climate. This is why we have suggested that pharmacy-based EC, including EHC, should be focussed on the most vulnerable groups only, whilst other users should be encouraged to pay for their treatment. Anyone who did not wish to do this would still be able to access EC via their GP on prescription.
144	London Borough of Bromley Public Health Sexual Health Team	Question 4	Question 4	Statement 1 – Achievable but would require provider agreement and their system capable of such data collection so it is not a resource intensive exercise. Statement 2 – It is achievable to inform women that an IUD is the most effective form of emergency contraception but getting rapid access would not be feasible without additional funding to support

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				delivery in both urban and rural areas. Statement 3 – Achievable if CCGs who are commissioners of TOP services are able to see their abortion spend reduced. Statement 4 – Not feasible to have discussions within 7 days. Additional comments: From Dr. Brander - Free colour FPA printed leaflets should be provided free to all practices as the electronic copies available on-line are lengthy to print/read. Suspect few patients /GPs bother to read/print all. BRING BACK FREE LEAFLETS please. However, there is a place to ensure that good up to date digital information is available on line which must be made easily accessible from respected contraception and sexual health sources.
145	London Borough of Newham	Question 4	Question 4	Effective promotion, equity of access and timely delivery of LARC is dependent on ensuring sufficient supply and distribution of LARC trained nurses within primary care.
146	Primary Care Women’s Health Forum	Question 4	Question 4	Q4. Access to LARC is reducing because of LA funding cuts. Reduction to enhanced service provision from primary care and to SRH clinic access will mean a reduction in provision of LARC. If increasing numbers of women are provided with information about the benefits of LARC and more women want to access this then the resource to deliver this care will have to be increased. ‘Smarter’ use of technology and optimising the skills of the multidisciplinary team for sexual health screening and provision of core contraception, including better prevention work could produce cost efficiencies to fund this – but would take time to deliver.
147	Royal College of Physicians (RCP)	Question 4	Question 4	Question 4: Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources required to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Our experts believe that co-operation between local services will be necessary to achieve the outcomes detailed in the document as not all services will have the resources to deliver everything that has been outlined. Our experts note the challenge of doing this in a health economy where services are funded differently and operate different models of care. ‘The quality standard for contraceptive services specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole contraceptive service care pathway. A person-

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				centred, integrated approach to providing services is fundamental to delivering high-quality care to people in contraceptive services.’
148	Salford Royal Foundation Trust	Question 4	Question 4	All achievable by local services and indeed is what is happening already with the exception of standard 4.
149	Association of Directors of Public Health (ADPH) UK	Question 5	Question 5	Firstly, sex positive meaningful education within and outside of the national curriculum is woefully inadequate - as this is not mandated. Education in relation to contraception - should not be based on the mechanics of contraceptive devices etc. - but should be based on a more holistic approach that reflects young people’s lives - e.g. emotional intelligence and wellbeing. Ofsted and many other bodies say that the current woeful provision is too little too late and too biological. Ofsted recognise the value of suitably trained teachers to improve quality of Relationship and Sex Education programmes. Within Warwickshire Public Health, we commission sex positive and comprehensive programmes that are evidence based as they have been used in Holland with success for over 30 years.
150	Faculty of Sexual and Reproductive Health Care	Question 5	Question 5	Much of the SRE Curriculum is focussed on relationships and sexual health. This would be an ideal time to promote the benefits of LARC – not only for contraception but also improvement in adolescent female health and wellbeing
151	FPA	Question 5	Question 5	Although not a method of contraception, it is important that abortion and access to services are taught within the national curriculum in an unbiased way. Some teachers and external speakers delivering lessons on abortion have been found to be using materials which are inaccurate, biased, and often stigmatise abortion as a pregnancy option. According to Education for Choice, the three main anti-abortion groups regularly invited into schools to speak to thousands of young people have all claimed that abortion is linked to an increased risk of breast cancer (despite cancer organisations and respected medical bodies dismissing this link).
152	RCGP	Question 5	Question 5	It is not clear which national curriculum as document refers to potentially different healthcare professionals eg GP, midwife, nurse. (AB)
153	London Borough of Bromley Public Health Sexual Health Team	Question 5	Question 5	SRE delivery that includes teaching on all aspects of contraception methods, with the added facility of registering young people to free local condom schemes, is unfortunately NOT a statutory provision in schools at the moment. The delivery of this SRE resource relies on School Nurses and Health Improvement Service [HIS] to provide the programme in all schools and it is of concern that cuts to the Public Health grant are making SRE delivery extremely vulnerable. Local members are keen to

<table>
<tr><th>ID</th><th>Stakeholder</th><th>Statement No</th><th>Comment on</th><th>Comments
Please insert each new comment in a new row</th></tr>
<tr><td></td><td></td><td></td><td></td><td>limit Public Health spend to Statutory services ONLY as a way of meeting budget cut requirements. These cuts also make School Health and Health Improvement Services particularly vulnerable at this time and therefore delivery of any kind of equitable SRE in all schools is at risk.

The fact that our state schools have become or are becoming academies and out of Local Authority control will also make it difficult to influence the curriculum in our local schools. Current SRE providers could be encouraged and supported to bid independently to provide SRE services in schools and for Academies to commission the service directly from them. This may be even more challenging in Faith schools.

Some suggestions for consideration:

• Digital online websites - Making the best use of current user friendly digital technology and offer information on a full range of contraception methods, services and sexual health information, could be provided on specific sexual health websites. Promotion of these websites should be key to improving SRE delivery in schools in a more innovative way.
• Statutory SRE - Prioritise the inclusion of SRE in a wider PSHE curriculum or make this programme a statutory requirement in ALL schools that will be subject to OFSTED inspections and published accordingly.

It is only this response that can guarantee SRE being delivered in an equitable way, both nationally and across all boroughs that will help ensure that the most vulnerable of those in need in our society do not become victims of an SRE ‘postcode lottery’ and left uninformed.</td></tr>
<tr><td>154</td><td>Primary Care Women’s Health Forum</td><td>Question 5</td><td>Question 5</td><td>Q5 There is no standardised educational requirements for any of the professional groups and no measurement of quality of care provided, unless this is a requirement of PH commissioners for the SRH services they commission.</td></tr>
<tr><td>155</td><td>Association of Directors of Public Health (ADPH) UK</td><td>QS1</td><td>Question 6</td><td>yes</td></tr>
<tr><td>156</td><td>Brook</td><td>QS1</td><td>Question 6</td><td>Suggestions from the Southern panel on what to change about the definition of “open access” to make it more young people-friendly included:
- “It doesn’t mention anything about pregnancy”
- “It should include something about being non-discriminatory, like inclusive of trans people,</td></tr>
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				sexual orientation, number of partners" - "*How are partners notified?" "It would have to be done really sensitively*." Young panellists also questioned how one night stand partners could be notified - The inclusion of "confidential" in the definition was welcomed "*I would expect to see 'non-judgemental' here [in the definition] too"*
157	Brook	QS1	Question 6	Northern panel: "Is the definition we have provided for open access accurate?" - The young people felt that the definition was "*good*" and "*clear*", and that the definition would be easy for patients/service users to understand as it was not "*convoluted*" and it "*covers a lot*".
158	Brook	QS1	Question 6	Northern panel: The group felt very strongly that the definition should include a specific point about being accessible and friendly for young people; "*it should say something about under 16s and confidentiality especially from parents and carers."*
159	Brook	QS1	Question 6	Northern panel: Re "*accessibility",* services should have clear information about location, services available, and opening times available for potential service users; if a session is drop-in or requires appointments must be made clear before the visit.
160	Brook	QS1	Question 6	Northern panel: The young people felt that the definition should include a point about having "*clear information for potential clients – how you will be seen, who is there etc*."
161	FPA	QS1	Question 6	Although a definition of an 'open access' service is welcome, it remains unclear as to what 'reasonable access' to all methods of contraception specifically constitutes. For example, does this mean all methods as long as there are no contraindications? We would suggest rephrasing the statement to read 'offers free contraception and access to all methods of contraception,' as the clarification about limited options for certain people is covered in the equality and diversity considerations.
162	BASHH	QS1	Question 6	Definition is accurate; there are concerns, though, about the issue of open access as we have become aware of some LAs wanting to force patients to attend GPs for contraception rather than attending GUM services, for example as it is "too expensive", which clearly calls into question the whole issue of open access.
163	Faculty of Sexual and Reproductive Health Care		Question 6	We agree with the definition of open access contraceptive service but note that the guidance as a whole is aimed at all providers of contraceptive services – Is it therefore to be assumed that Statement 1 is only applicable to open access services ?
164	London Borough of Bromley	QS1	Question 6	YES - Agree in principle that this should occur.

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	Public Health Sexual Health Team			Bearing in mind, contraception services are commissioned by different commissioners and for this to be feasible, the collation of data needs to be done centrally, requiring submission from all providers in a local system so the measure can reflect the overall proportion in a local area and not just a single provider etc
165	London Borough of Newham	QS1	Question 6	Open access definition needs to include HIV screening. Screening opportunities should be promoted and accessible to all patients presenting in sexual health settings.
166	London Borough of Bromley Public Health Sexual Health Team	QS1	Question 6	**Open Access** It is agreed that open access should continue to mean open access for CASH services if current funding constraints allow. Whilst Bromley C&RH service does not restrict access to any of their clinics, it has been redesigned to encourage the under 25s to attend by changing opening times that start from when schools close at 3.30 in the afternoon. As one neighbouring borough's community CASH clinic access is already limited by age < 25 years or borough of residence, if others follow it may impact on our residents who live/work near borough boundaries. Most GP services are not truly open access walk-in facilities; most need a booked appointment due to huge demand/numbers seen each day. Some specialised GP SH services commissioned to offer walk-in service but not in Bromley. We have 8 Level 2 SH practices seeing other practices' patients by GP referral. Given the reality of financial constraints, would it be better to reconsider the concept of open access. Should focus be on offering services by providers in different settings at times that are convenient and likely to be accessed by service users to cover different scenarios including emergency contraception provision rather than a blanket requirement of open access.
167	Merck Sharp & Dohme	QS1	Question 6	MSD considers that the wording of this quality statement (i.e. the definition of "open access services") may exclude general practitioner (GP) practices. Therefore MSD suggests this statement be re-worded to: "People requesting contraception from **any** contraceptive services are given information about, and offered a choice of all appropriate methods".
168	Primary Care Women's Health Forum	QS1	Question 6	Q6 the use of the word service is inappropriate for primary care contraception provision. This care is usually provided as opportunistic, holistic care and not as a specific 'service'. Use of the word 'service' implies the SRH services commissioned by PH. Most primary care providers do not provide

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				open access for contraception either, unless they are specifically commissioned to or chose to provide an open access clinic for young people. The wording should be altered to 'Whereever people choose to access their contraception people are given information about……' This is then applicable to pharmacy services and abortion providers as well as primary care.
169	Royal College of Obstetricians and Gynaecologists (RCOG)	QS1	Question 6	A definition of 'open access contraceptive services' is provided by the 'Advisory Group on Contraception' 2012 and by the FSRH 2014. In addition to what is given in this quality standard, the FSRH definition includes: "open access services, by their nature, are non-discriminatory, ensure equitable access to care and contribute to the reduction of health inequalities". 'Open access' is defined in the FSRH document Quality standards contraceptive service as: '…means that individuals should be able to self-refer to a contraceptive provider regardless of age, place of residence, or GP registration. Access should be timely and provision should be non-discriminatory and inclusive'. Consider including this.
170	Royal College of Physicians (RCP)	QS1	Question 6	Quality Statement 1: People requesting contraception from open access contraceptive services are given information about, and offered a choice of all appropriate methods. Question 6 For draft quality statement 1: Is the definition we have provided for open access accurate? Can you suggest any amendments that would expand on or improve the definition? Our experts agree that this definition is accurate but have concerns about the issue of open access some local authorities want to force patients to attend GPs for contraception rather than attending GUM services, for example as it is 'too expensive', which calls into question the issue of open access.
171	The Royal College of Midwives	QS1	Question 6	We think there is a good definition of open access provided here.
172	Salford Royal Foundation Trust	QS1	Question 6	Yes – definition of open access accurate
173	Department of Health	QS1	Question 6	Definitions on open access, 3rd bullet point, should we add HIV or is this implicit?
174	Department of	QS1	Question 6	Question for consultation – presume we would have a view on this?

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	Health			
175	Royal College of Obstetricians and Gynaecologists (RCOG)	QS3	Question 7	Which group of healthcare professionals would have the discussion with women after an abortion, and when would this take place? General practitioner, one or both doctors signing the HAS 1 (certificate A), the doctor who undertakes the abortion if surgical, the nurses caring for the woman (both medical and surgical). The discussion should take place at each point of care.
176	British Pregnancy Advisory Service (BPAS)	QS3	Question 7	For the reasons outlined in Comment 1 BPAS asks that the objective of reducing future repeat abortions is removed and instead the objective changed to reducing future unwanted pregnancies. At BPAS delivery of contraceptive care is outlined in our Consultation Procedures: Contraception Discussion. All patients accessing BPAS abortion services are offered the chance to discuss contraception. Staff members have a responsibility to educate women about highly effective methods and to respect the autonomy of those who do not wish to use these or any methods. The contraception discussion is conducted by a clinician who has the relevant knowledge and skills. Clinicians must have an accurate and up-to-date understanding of contraception, including eligibility criteria and contra-indications to use of methods. The patient will be asked whether they would like to discuss contraception before the conversation begins. If they decline, the clinician should offer to provide information about other local services, including family planning clinics, and document the discussion. A copy of My Guide to Contraception is given to the patient. Condoms and EC are also offered to the patient. Women will be informed of where to seek help for problems with contraception (e.g. their GP, Sexual Health or Family Planning clinic). Women desiring a contraceptive method must leave the consultation centre with a clear plan of action. Referral to another provider is not sufficient, unless this is specifically requested by the patient.
177	London Borough of Bromley Public Health Sexual Health Team	QS3	Question 7	TOP providers would be best placed to have the discussion with women after an abortion. However, GPs, practice nurses and healthcare professionals working in community clinics should also have the discussions if they are aware of a patient who has had a recent abortion.
178	London Borough of Newham	QS3	Question 7	The full range of contraception should be discussed and offered at assessment and post abortion. Contraception should be promoted and provided earliest opportunity following an abortion. Discussions should be facilitated by GP's, nurses or at CASH services. What is the role of community based maternity / midwifery nurses role in promoting contraception?
179	Association of Directors of Public	QS3	Question 7	Contraception discussed at assessment for abortion has enabled women in Warwickshire to understand what method of contraception they will select after an abortion and should be is the

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	Health (ADPH) UK			preferred approach. Post abortion this should be undertaken by any trained professional nurse or doctor or health care assistant this should be undertaken before discharge (if admission was undertaken) or by phone at a time that is convenient to the client as soon as possible after the abortion.
180	BASHH	QS3	Question 7	HCP who might be accessed by women after an abortion include GPs, GUM and SRH professionals, school nurses, gynaecologists; discussions could take place whenever such professionals encounter a woman who has had an abortion if she is identified as not using adequate contraception, regardless of when the abortion took place.
181	Faculty of Sexual and Reproductive Health Care	QS3	Question 7	The earlier the contraceptive discussion is done, the better. Ideally this should be done at pre-abortion counselling and a method provided at the time of procedure. LARC methods are once again most effective but there should be care given that there is no coercion practised
182	Royal College of Physicians (RCP)	QS3	Question 7	Quality Statement 3: Women who have an unplanned pregnancy and seek an abortion, discuss contraception and are given a choice of the full range of contraceptives at assessment for an abortion. Question 7 Guideline recommendations state that contraception should be discussed as soon as possible after an abortion as well as at assessment. Which group of healthcare professionals would have the discussion with women after an abortion, and when would this take place? Our experts note that healthcare professionals who might be accessed by women after an abortion include GPs, GUM and SRH professionals, school nurses, or gynecologists. Discussions could take place whenever such professionals encounter a woman who has had an abortion if she is identified as not using adequate contraception, regardless of when the abortion took place.
183	RCGP	QS3	Question 7	Depends on the area. The contraception should ideally be decided and provided either before the abortion or a method fitted at the time of the abortion. (AB)
184	Salford Royal Foundation Trust	QS3	Question 7	Abortion provider – nurse/Dr, GP. At time of TOP and at time of counselling/consent.
185	Department of	QS3	Question 7	Para 2, Question 7, again, perhaps phrased in line with RSOP 12.

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	Health			
186	Brook	QS3	Question 7	The Northern panel thought that there should be an option for this discussion as soon as possible after an abortion. The group weren't emphatic about a time frame, but they thought that "*within seven days*" might make sense, to bring this in line with Statement 4. See also Comment 16 for Southern panel.
187	Brook	QS3	Question 7	Northern panel: "*Which group of healthcare professionals would have the discussion with women after an abortion, and when would this take place?*" - The group felt that they would want to talk to "*a specialist*" who could give them clear information about contraceptive choices; most felt a nurse would be the best person for this discussion. Some of the young people suggested that somebody who had been involved in supporting the woman throughout might be best placed for this because "*it might be strange if a new person turns up and starts talking about contraception*". Most of the group agreed it would need to be someone "*who had or could make a good relationship with the woman*." See also comment 11 for Southern panel.
188	Merck Sharp & Dohme	QS3	Question 7	MSD considers that this question is best answered by the healthcare practitioners, to make sure this quality statement is achievable at all settings.
189	FPA	QS3	Question 7	FPA agrees with the guidelines that contraception should be discussed at an abortion assessment, in a non-directive manner. If a woman chooses to go to a follow-up appointment at the abortion service within two weeks of the procedure, this may also be a good opportunity for a nurse or other healthcare professional to offer a discussion on contraception. Due to reasons of confidentiality, GPs and community clinics may not be aware of their patient's abortion, which means that the Quality Standard cannot rely on discussions happening in these environments.
190	London Borough of Bromley Public Health Sexual Health Team	QS3	Question 7	YES - contraception should be discussed and offered before and after TOP procedures.
191	Primary Care Women's Health Forum	QS3	Question 7	Q7 Abortion can be accessed by self referral and the GP may not be made aware. Medical abortion is also increasingly being provided, and if early the abortion takes place at home. These women do not often receive or require follow up. Provision of high quality contraception information and signposting to a contraceptive provider or provision of contraception at the consultation for the abortion is important. Primary care is not always informed of the abortion and there is no expectation to contact women to offer contraceptive advice unless she attends the surgery for another health need. So it is difficult to understand who would be giving the post abortion advice.
192	Merck Sharp & Dohme	QS3	Question 7	MSD considers that the most appropriate point in time to provide contraceptive advice will vary, depending on individual circumstances. For example, at the time of assessment for an abortion,

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				some women may be focused only on pregnancy termination, so the discussion of contraception should be reinforced after the abortion.
No comment				
193	Royal College of Nursing	General	General	Nurses were invited to review the draft quality standard on contraceptive services. There are no further comments to make on this document on behalf of the Royal College of Nursing. Thank you for the opportunity to participate.
194	Royal College of Paediatrics and Child Health	General	General	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.
195	Royal College of Surgeons	General	General	Thank you for your e-mail. Unfortunately, we are unable to feedback during this consultation.
196	NHS England	General	General	Thank you for the opportunity to comment on the above QS I wish to confirm that NHS England has no substantive comments to make regarding this consultation.

Registered stakeholders who submitted comments at consultation

- Association of Directors of Public Health (ADPH) UK
- Bayer Plc
- Berkshire Healthcare NHS Foundation Trust – Sexual Health Service
- British Association for Sexual Health and HIV (BASHH)
- British Pregnancy Advisory Service (BPAS)
- Brook
- Department of Health
- Faculty of Sexual and Reproductive Health Care (FSRH)
- Family Planning Association (FPA)
- HRA Pharma UK & Ireland Ltd
- London Borough of Bromley Public Health Sexual Health Team
- London Borough of Newham
- Merck Sharp & Dohme
- NHS England
- Primary Care Women's Health Forum
- Royal College of General Practitioners (RCGP)
- Royal College of Nursing
- Royal College of Obstetricians and Gynaecologists (RCOG)
- Royal College of Paediatrics and Child Health
- Royal College of Physicians (RCP)
- Royal College of Surgeons
- Royal Pharmaceutical Society
- Salford Royal Foundation Trust
- Secular Medical Forum
- The Royal College of Midwives
- The Young Women's Outreach Project