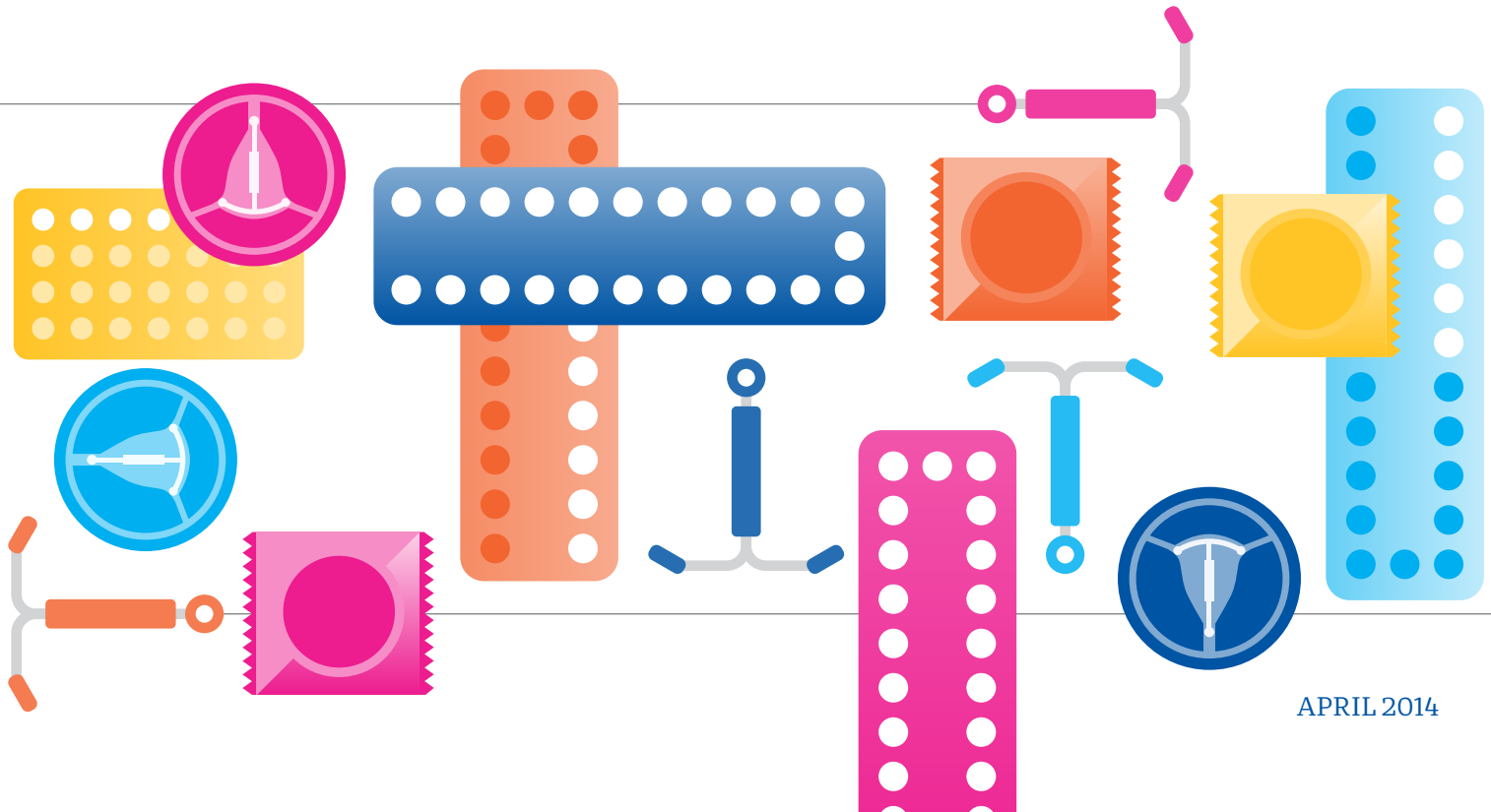
FACULTY OF SEXUAL & REPRODUCTIVE HEALTHCARE

ROYAL COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

A QUALITY STANDARD FOR CONTRACEPTIVE SERVICES



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ABOUT THE FACULTY OF SEXUAL & REPRODUCTIVE HEALTHCARE

The FSRH is a Faculty of the Royal College of Obstetricians and Gynaecologists, however it is an independent organisation and has many of the functions of a Royal College. The current UK membership stands at approximately 15,000 doctors and nurses working in sexual and reproductive healthcare (SRH), general practitioner (GP), genitourinary medicine (GUM) and obstetrics and gynaecology (O&G). Unlike most other clinical faculties and colleges the FSRH is a cross specialty and cross professional organisation. Members of the Faculty from all its constituencies are involved in the work of the FSRH to set standards and clinical guidance for training and the delivery of sexual & reproductive healthcare in the UK.

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CONTENTS

The abbreviations used in this document are listed in Appendix 1.

FOREWORD

A quality contraceptive service is vital in giving women and men of all ages choice and control over their reproduction, and is key to avoiding unplanned pregnancies and planning families. Contraception is a highly cost-effective intervention, which plays an important public health role in improving the lives of individuals, families and communities.

Across the United Kingdom, several million individuals access contraceptive care each year either from their GP or specialist open-access sexual & reproductive health services. These services are available, free of charge, to all those in need, which is something the UK should be proud of.

Access and choice are fundamental to the provision of contraceptive services. Within the context of individualised clinical care delivered by trained clinicians, women and men should be offered a choice of all contraceptive methods, including long-acting reversible contraceptives, and should have equitable access, irrespective of age and GP registration.

This Quality Standard sets out the contraceptive care that individuals using services should expect and be entitled to receive. The ultimate goal of the Quality Standard is to help those that commission and provide services work with an individual to ensure the best possible outcomes, maximising the opportunities afforded by health policies across the UK.

The Quality Standard will help deliver what good looks like for all those who require contraception.

Dr Chris Wilkinson
President of the Faculty of Sexual and Reproductive Healthcare

Dr Chris Wilkinson
President of the Faculty of Sexual and Reproductive Healthcare

Professor Kevin Fenton
National Director of Health and Wellbeing
Public Health England

A QUALITY STANDARD FOR CONTRACEPTIVE SERVICES

I am delighted to support this Quality Standard for contraceptive services, which allows people to know what they are entitled to expect: access to services which are equitable, which offer choice, which are delivered competently and on a timely basis. Defining this benchmark is part of ensuring that these vital services are, and continue to be, of the highest quality.

Comprehensive and open access to the full range of contraceptive methods is fundamental to people's health and wellbeing and to that of their families. It is a cornerstone of good public health. This Quality Standard plays a key role in describing how we achieve this in practice.

Professor Kevin Fenton
National Director of Health and Wellbeing Public Health England

The Quality Standard for Contraceptive Services

MAPPED AREAS OF CARE: CONTRACEPTION

ACCESS

Every individual requiring contraception to minimise the risk of unintended pregnancy should have access to contraception both from a GP and/or an alternative open access specialist provider to whom GPs can also refer for specialist advice and care.

All individuals within the area requiring contraception to minimise the risk of unintended pregnancy should have access to all methods of contraception directly through a contraceptive provider or by effective referral pathways.

Individuals should have timely access to the method of contraception of choice and to urgent contraceptive care.

SERVICE USER INPUT

The design and review of services should include input from the service users and the public.

STAFFING

Individuals requesting contraception to minimise their risk of unintended pregnancy have the right to expect appropriately trained and competent staff.

GOVERNANCE

Individuals have the right to expect all contraceptive providers to continually monitor, evaluate and benchmark themselves to maintain and improve the quality of care.

INTRODUCTION

This Quality Standard describes high-quality care for contraceptive services within the scope outlined below. It is intended for use in any service that provides contraceptive care. It brings together best practice and existing guidance, and aims to meet the needs of commissioners of services. It supports the delivery of the best outcomes for individuals who use these services. Although the focus is on England, the Quality Standard is intended to also have relevance in Scotland, Wales and Northern Ireland.

SCOPE

- Access
- Service user and public input into service design and delivery
- Staffing
- Governance

OUTCOMES

This Quality Standard contributes to improving the effectiveness, safety and experience of care for individuals requiring contraception.

DIVERSITY, EQUALITY AND LANGUAGE

Good communication between healthcare professionals and the individual is essential. The treatment and care, and the information, should be culturally appropriate. It should be accessible to individuals with additional needs such as physical, psychological, sensory or learning disabilities. Those who do not speak or read the local language should have access to an interpreter or advocate if needed.

BACKGROUND

This guidance was developed by a working group established by the Faculty of Sexual & Reproductive Healthcare (FSRH) (Appendix 2). This group consulted widely with stakeholders, including Faculty members, commissioners, the Department of Health, the Royal College of Obstetricians and Gynaecologists (RCOG), the British Association for Sexual Health and HIV (BASHH), the Medical Foundation for HIV & Sexual Health (MEDFASH), the Family Planning Association (FPA), Brook, specialists in public health, service users and local Healthwatch.

The Health and Social Care Act 2012[1] in England made provision for the transfer of commissioning responsibility for sexual health, along with public health, to local authorities, who now have a broad set of commissioning responsibilities in health and social care. *A Framework for Sexual Health Improvement in England*[2] was published shortly after the Act, and describes how commissioning sexual health services closer to individuals will help ensure that their needs are met. However, the Framework also warns that "these opportunities will only be realised if local authorities, CCGs and the NHS Commissioning Board [now NHS England] show leadership, commit to innovation and work together in the interests of their local population". This recognises that general practitioner (GP) provision, and specialised services such as HIV, fall outside the local authority commissioning remit. One of the major focuses of the FSRH is to minimise the impact of multiple components to sexual health commissioning, especially as this relates to contraception.

Although the National Institute for Health and Care Excellence (NICE) is based in England, the Quality Standard can be extended to ensure high-quality contraceptive provision in all nations of the UK. Therefore this Quality Standard will also complement and support *Sexual Health Services: Standards – March 2008*[3] in Scotland, the *Sexual Health Promotion Strategy and Action Plan 2008–2013*[4] in Northern Ireland, and the *Sexual Health and Wellbeing Action Plan for Wales 2010–2015*[5].

This Quality Standard has utilised the FSRH *Service Standards for Sexual and Reproductive Healthcare*[6] and is presented in a similar way to the NICE Quality Standards. There are six quality statements and each includes a 'quality measure', a "description of what the quality measure means for each audience", a 'definition', which includes references for further information and, where possible, recommended 'data sources'.

THE QUALITY STATEMENTS IN SUMMARY

The first three quality statements cover access to contraceptive provision, including ensuring individuals have 'open access' to a full range of contraceptive services. This 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.

The fourth quality statement covers input from service users and the public around the design and review of services.

The fifth quality statement is focused on training, continuing professional development and clinical leadership.

The final quality statement concerns governance and audit.

QUALITY STATEMENT

1

ACCESS TO SERVICES

Every individual requiring contraception to minimise the risk of unintended pregnancy should have access to contraception both from a GP and/or an alternative open access specialist provider to whom GPs can also refer for specialist advice and care.

QUALITY MEASURE STRUCTURE	Evidence of both of the above services being commissioned and delivered in response to a needs assessment to document the contraceptive requirements of individuals in that locality.
QUALITY MEASURE PROCESS	a. Evidence of implementation of local needs assessment that includes the contraceptive requirements of individuals (men and women) in the area. b. Evidence that all general practices are commissioned to provide core contraceptive care and where not, that alternative arrangements in primary care are in place. Numerator – the number of GP practices commissioned Denominator – the total number of GP practices c. Evidence that an open access specialist (Level 3: see Appendix 3)[7] community contraceptive service has been commissioned. Local data: local evidence that an open access specialist contraceptive service has been commissioned and is being provided.
DESCRIPTION OF WHAT THE QUALITY MEASURE MEANS FOR EACH AUDIENCE	**Service providers** of open access contraceptive services should ensure that individuals can access the service regardless of their age, place of residence or GP registration and that such services are accessible by those who have limited voice. **Health and social care professionals** should be aware of open access contraceptive services in their area and should be able to signpost to these services. **Commissioners** ensure that, in addition to primary care, they commission open access community contraceptive services, including community-based specialist care and, where appropriate, specialist services for specific groups and services through pharmacy and outreach. **Individuals** should expect to be able to obtain contraceptive care from a network of providers irrespective of their age, place of residence or GP registration and to receive specialist care when required.
DEFINITION	Open access means individuals can access contraceptive provision via self-referral, not limited by age, place of residence or GP registration. Open access services, by their nature, are non-discriminatory, ensure equitable access to care and contribute to the reduction of health inequalities. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013[8] makes it a statutory requirement that "each local authority shall provide, or shall make arrangements to secure the provision of, open access sexual health services in its area". Each commissioner will have a tailored network of providers, according to their local needs. A typical network should include a specialist community sexual and reproductive healthcare (SRH) service, pharmacies, GP practices and outreach services. FSRH Service Standard 2.9.1[6] states that "Specialist services should be involved in establishing local sexual health networks and there should be clear referral pathways between services".
DATA SOURCES PROCESS	Local data sources
SOURCE GUIDANCE	Health and Social Care Act 2012[1] FSRH Service Standard 2.9.1[6]

QUALITY STATEMENT

2

ACCESS TO ALL METHODS OF CONTRACEPTION

All individuals within the area requiring contraception to minimise the risk of unintended pregnancy should have access to all methods of contraception directly through a contraceptive provider or by effective referral pathways.

QUALITY MEASURE STRUCTURE	Evidence of the full range of contraceptive methods being commissioned and delivered at the level indicated by the needs assessment.
QUALITY MEASURE PROCESS	a. Evidence of all methods that are available: see Appendix 4. Numerator –the number of providers offering all methods Denominator – the number of contraceptive providers b. Evidence of effective referral pathways. Local data
DESCRIPTION OF WHAT THE QUALITY MEASURE MEANS FOR EACH AUDIENCE	**Service providers** should provide all methods as specified in Appendix 4. Providers of specialist contraceptive services and specialist integrated contraception and sexual health services should ensure that they have a trained SRH consultant to deliver this level of care. **Health and social care professionals** assess suitability for all methods appropriate to the level they are providing and assess suitability for all other methods and signpost/refer for all other methods accordingly. **Commissioners** should work with colleagues in NHS England and local clinical commissioning groups (CCGs) to ensure that: –There is evidence that the full range of contraceptive methods are being commissioned and delivered at the level indicated by the needs assessment. –A geographically meaningful network of trained primary care and specialist providers is in place to ensure access to all methods of contraception for all those who need it to prevent unintended pregnancy. Commissioners should ensure that adequate training and updating is commissioned locally. This training should meet the needs of both local authority commissioned services and National Health Service (NHS) commissioned services locally, including general practice. **Individuals** should be able to access all methods of contraception care subject to clinical assessment where required.
DEFINITION	NICE Clinical Guidance (GC30)[9] puts choice of method at the centre of good contraceptive care. National standards for training and qualifications for doctors and nurses in SRH, including contraception and long-acting reversible contraception (LARC), are set by the FSRH (www.fsrh.org). Each commissioner will have a tailored network of providers, according to their local needs. A typical network should include a specialist community SRH service as well as contraceptive services from integrated sexual health services, pharmacies, GP practices and outreach services. FSRH Service Standard 2.9.16[6] states that "Specialist services should be involved in establishing local sexual health networks and there should be clear referral pathways between services".
DATA SOURCES PROCESS	–Benchmark pattern of contraceptive prescribing between general practices: prescribing analyses and cost (PACT) data. –Pattern of contraceptive provision in community specialist services: Sexual and Reproductive Health Activity Dataset (SRHAD). –Evidence of commissioned training meeting local training needs.
SOURCE GUIDANCE	NICE Clinical Guidance (GC30)[9] FSRH Service Standard[6]

QUALITY STATEMENT

3

ACCESS TO CHOICE OF CONTRACEPTION

Individuals should have timely access to the method of contraception of choice and to urgent contraceptive care.

QUALITY MEASURE STRUCTURE	Evidence that individuals can access contraception and contraceptive care in a timely manner that minimises the risk of unintended pregnancy.
QUALITY MEASURE PROCESS	a. Evidence of 2 working days access for non-emergency care at open access services. Numerator – the number of individuals attending services offered an appointment to be seen within 2 working days of contacting the service Denominator – the total number of individuals contacting the service b. Evidence that all women choosing intrauterine (IUD/IUS), subdermal devices (SD) LARC methods are offered an appointment to have this fitted within 2 weeks if medically appropriate. c. All women requesting emergency contraception are informed about the full choice and availability of methods (as listed in Appendix 4) on the day of presentation. d. Proportion of service users who wait less than 2 hours to be seen at a non-appointment (walk-in) service. Numerator – the number of under 2-hour waits Denominator – the number of walk-ins
DESCRIPTION OF WHAT THE QUALITY MEASURE MEANS FOR EACH AUDIENCE	**Service providers** ensure that they organise services and the skill mix of staff to ensure timely access to methods. **Health and social care professionals** work to ensure timely access to contraception where there is no medical requirement to delay starting a method. **Commissioners** monitor and work with providers to ensure equitable timely access to contraception. **Individuals** should expect to be able to receive the method of choice in a timely manner.
DEFINITION	**Timeframes for providing contraception advice and provision** FSRH Service Standard 5[6] provide details on how contraception advice and provision should be provided within the following timeframes including: —Individuals should be able to access urgent provision on the same working day. —Individuals should be able to access telephone advice on the same working day. —Walk-in clinics should have staffing to provide safe medical practice and enable a maximum waiting time of 2 hours. —Services that operate an appointment system instead of walk-in clinics should provide appointments within 2 working days for non-specialist, non-urgent consultations.
DATA SOURCES STRUCTURE	Local monitoring data – average waiting times in walk-in clinics
DATA SOURCES PROCESS	Local data sources
SOURCE GUIDANCE	FSRH Service Standard 2.9.1[6]

QUALITY STATEMENT

4

SERVICE USER INPUT

The design and review of services should include input from the service users and the public.

QUALITY MEASURE STRUCTURE	Evidence of local service user and public engagement programmes at a locality and service provider level.
QUALITY MEASURE PROCESS	a. Proportion of contraceptive providers who have developed and implemented an annual service user and Public Engagement Plan. Numerator – the number of contraceptive providers who have developed and implemented an annual service user and Public Engagement Plan Denominator – the number of contraceptive providers within the locality b. Proportion of service users who respond to annual service user questionnaire that are satisfied with the service. Numerator – the number of service users responding to the questionnaire who are satisfied with the service Denominator – the number of service users responding to the questionnaire Evidence that feedback from service users and the public has led to service improvements.
DESCRIPTION OF WHAT THE QUALITY MEASURE MEANS FOR EACH AUDIENCE	**Service providers** should have an ongoing programme of service user feedback and responding to service user views with an action plan. Service providers should consult with service users when designing services or reconfiguring services. Service providers should act on complaints and compliments and demonstrate how they have done this. Feedback should be sought on continuous improvement: –Timeliness in accessing advice or provision of contraceptive methods. –Waiting times in clinic (promptness if they have appointments) and if they are accessing via walk-in and wait services. –Whether the care they received involved them in decision making, whether the health care providers listened to their concerns. Whether they would recommend friends to access the service if they had similar sexual health care needs. **Commissioners** should ensure services are developed in line with their joint strategic needs assessments including a public engagement programme of men and women of all ages with a specific focus on contraceptive provision. **Service users and the public** should have a number of opportunities to feed into the design and development of services. Importantly, women of all ages should have been consulted on contraceptive services provision.
DEFINITION	Individuals should have the opportunity to comment on services and there should be a public consultation to enable the continuing development of services that are responsive to their needs (for example, by consulting GP practice panels, Healthwatch to also understand why some individuals are not accessing available services). Evidence of the provider's response to service user feedback should be in a written plan, and communication to service users about changes made in the light of results should be undertaken. The NHS Constitution[10] states that "NHS services must reflect the needs and preferences of service users, their families and their carers". Outcome 1 of the CQC Essential Standards11 states: "People should be able to influence how the service is run". FSRH Service Standard 4[6] on 'User and Public Involvement' states: "Services should demonstrate that user and public involvement has been fundamental to service development, provision, monitoring and evaluation".
DATA SOURCES STRUCTURE	Local data sources of service user and public engagement feedback
DATA SOURCES PROCESS	Local data sources

QUALITY STATEMENT

5

STAFFING

Individuals requesting contraception to minimise their risk of unintended pregnancy have the right to expect appropriately trained and competent staff.

**At Level 3 as specified in the National Strategy for Sexual Health and HIV for England[7].*

QUALITY MEASURE STRUCTURE	Evidence that all staff working in contraceptive services are competent to provide the level of care they are undertaking. Evidence of local arrangements of clinical leadership, training, support and regular supervision of practitioners to maintain and improve their skills.
QUALITY MEASURE PROCESS	a. Proportion of all service providers undertaking regular audit of qualifications and training of all staff to ensure they are competent to provide the level of care they are undertaking and updating qualifications where necessary. Numerator – the number of contraceptive provider services who are undertaking an annual audit of qualifications of all staff Denominator – the number of contraceptive provider services within the locality
DESCRIPTION OF WHAT THE QUALITY MEASURE MEANS FOR EACH AUDIENCE	**Service providers** should ensure that systems are in place to ensure that all levels of contraceptive provision are provided by practitioners who are competent and receive appropriate training, support and regular appraisal to ensure maintenance and enhancement of their skills. Service providers should ensure that the qualifications of all staff are reviewed in the annual appraisal to ensure that the appropriate qualifications are held and being maintained. Service providers should ensure that: —Clinical staff hold and maintain appropriate nationally recognised qualifications or equivalent. —Ensure they provide access to training qualifications needed to achieve competencies. Have a process to review maintenance of competencies and recertification. **Commissioners** should ensure that there is adequate provision of training in elements of contraception to enable increased access. **Commissioners** should ensure specialist contraceptive services are led by a consultant in SRH – to ensure adequate quality of service provision, training, clinical governance and risk management across all three levels of service provision. **Commissioners** should ensure that services specify the level of training required to work in their service. **Service users** should expect that contraceptive care will be provided by trained and competent practitioners who maintain their skills.
DEFINITION	FSRH Service Standard 6[6] on 'Training' states: "All doctors, nurses and other health professionals working in contraceptive services should be trained to the competencies and training programmes jointly agreed by all the education bodies including the RCGP, RCOG, FSRH, RCN, RPSGB, and supported by user representatives such as the FPA". —Doctors should hold a current Diploma in Sexual and Reproductive Healthcare (DFSRH) or be trained to equivalent competencies and show evidence of recertification. —Doctors and nurses offering IUD/IUS insertions and contraceptive implant insertions and removals should hold a current Letter of Competence or Royal College of Nursing (RCN) accreditation (or equivalent) in these and show evidence of recertification/ reaccreditation. —Nurses delivering SRH should have completed a recognised post-registration course/ Nurse Diplomate Assessment of the Faculty of Sexual and Reproductive Healthcare in contraception and sexual health. FSRH Service Statement[6] 1.1 on 'Leadership' states: "All specialist* contraceptive services should be consultant-led and have one full-time consultant accredited in Community Sexual & Reproductive Health to ensure adequate quality of service provision, training, clinical governance and risk management across all three levels of service provision". The NHS Constitution[11] states the NHS commits "to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed". Outcome 12 of the CQC Essential Standards[11] states: "People should be cared for by staff who are properly qualified and able to do their job". Outcome 13 of the CQC Essential Standards[11] states: "There should be enough members of staff to keep people safe and meet their health and welfare needs".
DATA SOURCES STRUCTURE	Workforce census for the number of consultants leading SRH services Local monitoring data
DATA SOURCES PROCESS	Local data sources

QUALITY STATEMENT

6

GOVERNANCE

Individuals have the right to expect all contraceptive providers to continually monitor, evaluate and benchmark themselves to maintain and improve the quality of care.

QUALITY MEASURE STRUCTURE	Evidence that service providers continually monitor and evaluate their performance and implement initiatives to maintain and improve outcomes.
QUALITY MEASURE PROCESS	a. Evidence of a programme of audits against FSRH and local standards to demonstrate compliance and identify areas requiring further training and/or service improvement. Numerator – the number of contraceptive providers who are undertaking a programme of audits against FSRH and local standards Denominator – the number of contraceptive providers within the locality b. Evidence that services report incidents and near misses according to local and national requirements in a timely fashion, and should cascade learning from these events to the staff. Numerator – the number of contraceptive providers who are reporting incidents and near misses according to local and national requirements in a timely fashion Denominator – the number of contraceptive providers within the locality c. Annual audits against local medicines optimisation/management policies, including patient group directions (PGDs). Numerator – the number of contraceptive providers who are undertaking an annual audit against local policies Denominator – the number of contraceptive providers within the locality
DESCRIPTION OF WHAT THE QUALITY MEASURE MEANS FOR EACH AUDIENCE	**Service providers** should demonstrate that they continually monitor and evaluate performance to maintain and improve outcomes. **Commissioners** should establish structures and processes for monitoring and evaluation of all contraceptive services to improve local provision. **Individuals** should have access to published evidence from contraceptive services demonstrating structures and processes for monitoring and evaluation of improvements to provision.
DEFINITION	FSRH Service Standard 11[6] on 'Monitoring and Evaluation' states services should have a programme to regularly audit clinical service provision. Audits against FSRH and local standards to demonstrate compliance and identify areas requiring further training and/or service improvement. Services should report incidents and near misses according to local and national requirements in a timely fashion, and should cascade learning from these events to the staff. FSRH Service Standard 96 on 'Record Keeping' states that data should be submitted to commissioners and the appropriate body in a timely manner. Services should provide quarterly SRHAD reports to the Department of Health in a timely manner. Outcome 16 of the CQC Essential Standards[11] states: "The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care". The FSRH *Service Standards for Risk Management*[12] set out how quality and safety of healthcare services can be improved by identifying circumstances that put service users and staff at risk and acting to prevent or control those risks.
DATA SOURCES STRUCTURE	Local data sources
DATA SOURCES PROCESS	Local data sources
SOURCE GUIDANCE	*Sexual Health: Clinical Governance*[13]

APPENDIX 1
Glossary

BASHH	British Association for Sexual Health and HIV
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CSRH	The medical specialty of Community Sexual & Reproductive Health established in parliament in 2010
DFSRH	Diploma in Sexual and Reproductive Healthcare
FPA	Family Planning Association
FSRH	Faculty of Sexual & Reproductive Healthcare
GP	general practitioner
HEALTHWATCH	The consumer champion for both health and social care established in April 2013. It exists in two distinct forms: local Healthwatch, at local level, and Healthwatch England, at national level
HIV	human immunodeficiency virus
IUD/IUS/IU	intrauterine (contraceptive) device/intrauterine system/intrauterine
LARC	long-acting reversible contraception
MEDFASH	Medical Foundation for HIV & Sexual Health
NICE	National Institute for Health and Care Excellence
OPEN ACCESS SERVICES	Services that are available through self-referral for all individuals regardless of where they live (open access), rapid (within two working days of contacting the service) and with mechanisms to record access data routinely
PACT	prescribing analyses and cost
PGD	patient group direction
RCN	Royal College of Nursing
RCGP	Royal College of General Practitioners
RCOG	Royal College of Obstetricians and Gynaecologists
SDI/SD	subdermal implants/subdermal
SHRAD	Sexual and Reproductive Health Activity Dataset
SRH	sexual and reproductive healthcare
STI	sexually transmitted infection
WALK-IN SERVICE	A service that accepts individuals on a walk-in basis and with no appointment required

APPENDIX 2

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**Titles at time of working group meeting'*

APPENDIX 3

Levels of sexual and reproductive healthcare*

LEVEL 1
(EVERY GENERAL PRACTICE)

- Sexual history and risk assessment
- STI testing for women
- Assessment and referral of men with STI symptoms
- HIV testing and counselling
- Hepatitis B immunisation
- Provision of oral hormonal contraception
- Information about choice of full range of contraceptive methods and where available
- Cervical cytology screening and referral
- Pregnancy testing and referral

LEVEL 2
(PRIMARY CARE TEAMS WITH A SPECIAL INTEREST)

- Testing and treating STIs
- Partner notification
- IUD and implant insertion
- Management of psychosexual problems
- Vasectomy surgery

SPECIALIST/LEVEL 3
(SPECIALIST SERVICES)

- Outreach for STI prevention/contraception
- Specialised STI management/partner notification
- Specialist HIV treatment and care
- Highly specialised contraception
- Termination of pregnancy services
- Local co-ordination and back up for sexual assault
- Psychosexual/sexual dysfunction services
- Make sure local guidelines and framework for monitoring and improving practice are in place
- Support clinical governance requirements at all levels
- Provide professional training, designing and updating care pathways and developing new services

**Although these levels originate from the National Strategy for Sexual Health and HIV for England7 they are used to define the elements of what is meant by specialist and non-specialist care UK-wide.*

APPENDIX 4

Minimum provision of contraceptive measures by provider

CONTRACEPTIVE METHOD	General practice	Specialist/Level 3 SRH services	Level 1 or 2 provider
EMERGENCY CONTRACEPTION – PROGESTOGEN-ONLY	✓	✓	✓
EMERGENCY CONTRACEPTION – ULIPRISTAL ACETATE	✓	✓	✓
EMERGENCY CONTRACEPTION – INTRAUTERINE DEVICE	Referral*	✓	Referral
CONDOMS – MALE	✓	✓	✓
CONDOMS – FEMALE	✓	✓	✓
DIAPHRAGM	Referral	✓	Referral
PROGESTOGEN-ONLY – ORAL	✓	✓	✓
PROGESTOGEN-ONLY – INJECTABLE	✓	✓	✓
PROGESTOGEN ONLY – SUBDERMAL	Referral*	✓	Referral
PROGESTOGEN-ONLY – INTRAUTERINE	Referral*	✓	Referral
COMBINED HORMONAL – ORAL†	✓	✓	✓
COMBINED HORMONAL – TRANSDERMAL	✓	✓	✓
COMBINED HORMONAL – VAGINAL RING	✓	✓	Referral
COPPER – INTRAUTERINE	Referral*	✓	Referral
NATURAL FAMILY PLANNING	Referral	✓	Referral
STERILISATION – MALE	Referral	Referral‡	Referral‡
STERILISATION – FEMALE	Referral	Referral‡	Referral‡

** Optional if provides an intrauterine contraceptive service.*
† This includes all types available within the UK.
‡ Referral back to GP unless direct referral agreed locally.

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1 Health and Social Care Act 2012. http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted [accessed 23 December 2013].

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