A QUALITY STANDARD FOR CONTRACEPTIVE SERVICES

APRIL 2014
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.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FOREWORD</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>STATEMENT FROM PROFESSOR KEVIN FENTON</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>MAPPED AREAS OF CARE: CONTRACEPTION</strong></td>
<td>6</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>QUALITY STATEMENTS</strong></td>
<td>8</td>
</tr>
<tr>
<td>1 ACCESS TO SERVICES</td>
<td>8</td>
</tr>
<tr>
<td>2 ACCESS TO ALL METHODS OF CONTRACEPTION</td>
<td>9</td>
</tr>
<tr>
<td>3 ACCESS TO CHOICE OF CONTRACEPTION</td>
<td>10</td>
</tr>
<tr>
<td>4 SERVICE USER INPUT</td>
<td>11</td>
</tr>
<tr>
<td>5 STAFFING</td>
<td>12</td>
</tr>
<tr>
<td>6 GOVERNANCE</td>
<td>13</td>
</tr>
<tr>
<td><strong>APPENDICES</strong></td>
<td>14</td>
</tr>
<tr>
<td>APPENDIX 1 GLOSSARY</td>
<td>14</td>
</tr>
<tr>
<td>APPENDIX 2 FACULTY QUALITY STANDARD CONTRIBUTORS</td>
<td>15</td>
</tr>
<tr>
<td>APPENDIX 3 LEVELS OF SEXUAL HEALTH AND REPRODUCTIVE CARE</td>
<td>16</td>
</tr>
<tr>
<td>APPENDIX 4 MINIMUM PROVISION OF CONTRACEPTIVE MEASURES BY PROVIDER</td>
<td>17</td>
</tr>
<tr>
<td><strong>REFERENCES</strong></td>
<td>18</td>
</tr>
</tbody>
</table>

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

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.

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

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 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 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 in Scotland, the Sexual Health Promotion Strategy and Action Plan 2008–2013 in Northern Ireland, and the Sexual Health and Wellbeing Action Plan for Wales 2010–2015.

This Quality Standard has utilised the FSRH Service Standards for Sexual and Reproductive Healthcare 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.
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

<table>
<thead>
<tr>
<th>Description of What the Quality Measure Means for Each Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong> Evidence of implementation of local needs assessment that includes the contraceptive requirements of individuals (men and women) in the area.</td>
</tr>
<tr>
<td><strong>b.</strong> Evidence that all general practices are commissioned to provide core contraceptive care and where not, that alternative arrangements in primary care are in place.</td>
</tr>
<tr>
<td><strong>c.</strong> Evidence that an open access specialist (Level 3: see Appendix 3) community contraceptive service has been commissioned.</td>
</tr>
</tbody>
</table>

Local data: local evidence that an open access specialist contraceptive service has been commissioned and is being provided.

### 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 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 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
FSRH Service Standard 2.9.1
Evidence of the full range of contraceptive methods being commissioned and delivered at the level indicated by the needs assessment.

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

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.

NICE Clinical Guidance (GC30) 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 states that “Specialist services should be involved in establishing local sexual health networks and there should be clear referral pathways between services”.

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.

NICE Clinical Guidance (GC30)
FSRH Service Standard
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 51 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 2.9.14
### 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

### 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\(^1\) states that “NHS services must reflect the needs and preferences of service users, their families and their carers”.
- Outcome 1 of the CQC Essential Standards\(^1\) states: “People should be able to influence how the service is run”.
- FSRH Service Standard 4\(^1\) 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
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".
### Quality Measure: Structure

Evidence that service providers continually monitor and evaluate their performance and implement initiatives to maintain and improve outcomes.

### Quality Measure: Process

<table>
<thead>
<tr>
<th>Process</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Evidence of a programme of audits against FSRH and local standards to demonstrate compliance and identify areas requiring further training and/or service improvement.</td>
</tr>
<tr>
<td>b.</td>
<td>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.</td>
</tr>
<tr>
<td>c.</td>
<td>Annual audits against local medicines optimisation/management policies, including patient group directions (PGDs).</td>
</tr>
</tbody>
</table>

#### Numerator
- Number of contraceptive providers who are undertaking a programme of audits against FSRH and local standards
- Number of contraceptive providers who are reporting incidents and near misses according to local and national requirements in a timely fashion
- Number of contraceptive providers who are undertaking an annual audit against local policies

#### Denominator
- 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 114 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 Standards11 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 Management12 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

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure</td>
<td>Local data sources</td>
</tr>
<tr>
<td>Process</td>
<td>Local data sources</td>
</tr>
</tbody>
</table>

### Source Guidance

Sexual Health: Clinical Governance13
# APPENDIX 1

**Glossary**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASHH</td>
<td>British Association for Sexual Health and HIV</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CSRH</td>
<td>The medical specialty of Community Sexual &amp; Reproductive Health established in parliament in 2010</td>
</tr>
<tr>
<td>DFSRH</td>
<td>Diploma in Sexual and Reproductive Healthcare</td>
</tr>
<tr>
<td>FPA</td>
<td>Family Planning Association</td>
</tr>
<tr>
<td>FSRH</td>
<td>Faculty of Sexual &amp; Reproductive Healthcare</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HEALTHWATCH</td>
<td>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</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>IUD/IUS/IU</td>
<td>Intrauterine (contraceptive) device/intrauterine system/intrauterine</td>
</tr>
<tr>
<td>LARC</td>
<td>Long-acting reversible contraception</td>
</tr>
<tr>
<td>MEDFASH</td>
<td>Medical Foundation for HIV &amp; Sexual Health</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>OPEN ACCESS SERVICES</td>
<td>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</td>
</tr>
<tr>
<td>PACT</td>
<td>Prescribing analyses and cost</td>
</tr>
<tr>
<td>PGD</td>
<td>Patient group direction</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>RCOG</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>SDI/SD</td>
<td>Subdermal implants/subdermal</td>
</tr>
<tr>
<td>SHRAD</td>
<td>Sexual and Reproductive Health Activity Dataset</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive healthcare</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>WALK-IN SERVICE</td>
<td>A service that accepts individuals on a walk-in basis and with no appointment required</td>
</tr>
</tbody>
</table>
APPENDIX 2
Faculty Quality Standard contributors

WORKING GROUP MEMBERS
13 SEPTEMBER 2012*

Dr Gabriel Scally
Former Regional Director for the South West

Rosie Gagnon
Health Improvement Manager, East and North Herts PCT

Natika Halil
Director of Information, FPA

Debbie Mennim
Sexual Health Nurse, Brook

Ruth Lowbury
Chief Executive, MEdFASH

Dr Jill Shawe
Centre for Nursing and Midwifery Research, UCL

Dr David Richmond
Vice President, RCOG

Judith Hind
Department of Health

Dr Jane Dickson
Consultant in SRH, London

Dr Kate Guthrie
Consultant in SRH, Hull

Dr Asha Kasliwal
Chair, Clinical Standards Committee, FSRH

Hong Tan
Director, London Sexual Programme

Shelly Mehigan
Nurse Specialist, Bournemouth

Dr Paula Briggs
General Practitioner, Sefton

Dr Alyson Elliman
Vice-President FSRH

James Hollaway
Munro & Forster Communications

INVITED WRITTEN CONTRIBUTIONS WERE RECEIVED FROM:

Dr Jane Muller
Deputy Director Public Health, Cumbria

Dr Paula Baraitser
Consultant in Public Health, King’s Health Partners

Dr Chris Wilkinson
President, FSRH

Linda Pepper
Lay member FSRH/RCOG Women’s Network

Brian Gunson
Director, Healthwatch Hertfordshire

Jane Hatfield
Chief Executive, FSRH

Advisory Group on Contraception

*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 England? 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

<table>
<thead>
<tr>
<th>CONTRACEPTIVE METHOD</th>
<th>General practice</th>
<th>Specialist/Level 3 SRH services</th>
<th>Level 1 or 2 provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENCY CONTRACEPTION — PROGESTOGEN-ONLY</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>EMERGENCY CONTRACEPTION — ULIPRISTAL ACETATE</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>EMERGENCY CONTRACEPTION — INTRAUTERINE DEVICE</td>
<td>Referral*</td>
<td>✓</td>
<td>Referral</td>
</tr>
<tr>
<td>CONDOMS — MALE</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CONDOMS — FEMALE</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>DIAPHRAGM</td>
<td>Referral</td>
<td>✓</td>
<td>Referral</td>
</tr>
<tr>
<td>PROGESTOGEN-ONLY — ORAL</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>PROGESTOGEN-ONLY — INJECTABLE</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>PROGESTOGEN ONLY — SUBDERMAL</td>
<td>Referral*</td>
<td>✓</td>
<td>Referral</td>
</tr>
<tr>
<td>PROGESTOGEN ONLY — INTRAUTERINE</td>
<td>Referral*</td>
<td>✓</td>
<td>Referral</td>
</tr>
<tr>
<td>COMBINED HORMONAL — ORAL&lt;sup&gt;†&lt;/sup&gt;</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>COMBINED HORMONAL — TRANSDERMAL</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>COMBINED HORMONAL — VAGINAL RING</td>
<td>✓</td>
<td>✓</td>
<td>Referral</td>
</tr>
<tr>
<td>COPPER — INTRAUTERINE</td>
<td>Referral*</td>
<td>✓</td>
<td>Referral</td>
</tr>
<tr>
<td>NATURAL FAMILY PLANNING</td>
<td>Referral</td>
<td>✓</td>
<td>Referral</td>
</tr>
<tr>
<td>STERILISATION — MALE</td>
<td>Referral</td>
<td>Referral&lt;sup&gt;‡&lt;/sup&gt;</td>
<td>Referral&lt;sup&gt;‡&lt;/sup&gt;</td>
</tr>
<tr>
<td>STERILISATION — FEMALE</td>
<td>Referral</td>
<td>Referral&lt;sup&gt;‡&lt;/sup&gt;</td>
<td>Referral&lt;sup&gt;‡&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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


